

Standard Benefits

Summary Plan Description

For

Research Fellows and
Research Associate B Employees

This booklet is not the Plan document for any of the Plans, but only a summary of the main provisions concerning eligibility, coverage and benefits under the Plans. Not every limitation or detail of any of the Plans is included in this booklet. Every attempt has been made to provide concise and accurate information. However, if there is a discrepancy between this booklet and the official Plan document for any of the Plans or the Certificate of Coverage issued to a covered Eligible Employee or Eligible Fellow in the case of the Medical Plan, Dental Plan, the Life Insurance Plan, or the Long Term Care Plan, the Plan document or Certificate of Coverage shall control.

Benefits under the Medical Plan, Dental Plan, Life Insurance Plan and the Long Term Care Plan, including limits and restrictions on benefits, are described in the Certificate of Coverage issued to a covered Eligible Employee or Eligible Fellow. The Certificate of Coverage constitutes a portion of the summary plan description for the particular Plan.

Claims and appeals related to eligibility are determined under the Dartmouth College Employee Benefit Plan Claims and Appeal Procedures, which are set forth in a separate booklet, a copy of which is distributed to Eligible Employees and Eligible Fellows.

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Introduction

Dartmouth College provides important benefit plan coverages for eligible employees classified as Research Associate B employees (“Eligible Employees”) and eligible persons classified as Research Fellows (“Eligible Fellows”). This booklet summarizes the eligibility requirements and benefits provided under the following plans for covered Eligible Employees and Eligible Fellows and their covered Eligible Dependents:

- Medical coverage and benefits are provided under the Medical Plan for Dartmouth College Employees.
- Dental coverage and benefits are provided under the Dental Plan for Dartmouth College Employees.
- Life insurance coverage for Eligible Employees and Eligible Fellows who elect coverage, plus accidental death and dismemberment (“AD&D”) coverage for the Eligible Employee or Eligible Fellow, is provided under the Dartmouth College Life Insurance Plan.
- Long Term care coverage for Eligible Employees who elect coverage, and any eligible family members who are covered, is provided under the Dartmouth College Group Long Term Care Plan. Research Fellows are not eligible for the Long Term Care Plan.

When referring to all of these plans, the term “the Plans” is used in this booklet. When referring to a specific plan, the name of that plan is used.

Eligibility and Enrollment

Participation in any of the Plans is limited to those persons who satisfy the eligibility requirements described below. To participate, such an Eligible Employee or Eligible Fellow must enroll in the desired Plan(s) and coverage levels and agree to pay the required Participant Contribution for the coverage(s) selected. These requirements are described in more detail in this section. (As an exception, the Long Term Care Plan has its own enrollment process; see the Long Term Care portion of this booklet.)

Eligibility Requirements

You must be in one of the following two classifications and meet the stated requirements to be eligible to participate in the Plans. Research Fellows are not eligible for the Long Term Care Plan.

- **Research Associate B.** A person classified as “Research Associate B” is eligible if he or she has an appointment for less than three years and is regularly scheduled to work at least half time during at least nine consecutive months of the year.
- **Research Fellow.** A person classified as a Research Fellow is eligible if he or she has an appointment for at least nine consecutive months and is regularly scheduled to work at least half time.

Classifications and other questions relating to eligibility are determined by the Plan Administrator using Dartmouth’s normal personnel classifications, practices and policies.

Enrollment Process

You choose the coverages you want under the Plans you are eligible for. Elections are made on a calendar year basis during the open enrollment period for that year, which occurs during the preceding fall. Your enrollment decisions are effective the following January 1 and will remain in effect for all of that year (the only exception is a mid-year change due to a qualified change in status). The enrollment materials include information about any significant changes in the Plans from the prior year, contribution amounts for different coverages under the Plans, other important information, and enrollment forms.

New Hires

If you are a new hire in an Eligible Employee or Eligible Fellow category, you must elect benefits within 30 days after your date of appointment, or within 30 days after the date of your notification to enroll in benefits. If you do not enroll within the 30-day period you will be given default coverages described below and you will not be able to change your elections until the next open enrollment period.

If you do not meet the eligibility requirements and subsequently become an Eligible Employee or Eligible Fellow, you may enroll within 30 days after attaining eligibility (or after receiving enrollment information) as if you were a new hire.

Default Coverage

If you fail to enroll, you will be covered by the default coverage. Once you have enrolled initially, your Medical Plan, Dental Plan and Life Insurance Plan coverage elections will remain in effect unless you change them during an open enrollment period (or mid-year due to a qualified change in status). If you fail to make a change, your coverage choices in effect for a year under these plans will automatically carry forward to the next calendar year and you will be required to pay the applicable Participant Contributions for those coverages.

For new hires who fail to enroll, the following default coverages will be provided:

- Medical Plan - \$1,500 deductible individual coverage under the Traditional Medical (fee-for-service) Plan.
- Dental Plan - No coverage.
- Life Insurance Plan - No coverage.
- Long Term Care - No coverage.

Dependents

You may cover the following dependents (“Eligible Dependents”) under the Medical Plan or the Dental Plan:

- your spouse;
- your unmarried children up to age 19;
- your unmarried dependent children between the ages of 19 and 25 who are full-time students at an accredited secondary school, college, or university;
- your unmarried dependent children who are physically or mentally handicapped, if they were covered as your dependent before their 19th birthday or as a dependent full-time student. To enroll a handicapped child, you must apply for handicapped status for the child within 30 days after the date when the dependent’s coverage would otherwise end. Contact the Benefits Office for more information.
- your same sex domestic partner that meets Dartmouth’s eligibility requirements for a domestic partnership, and who have a signed Affidavit of Domestic Partnership on file at the Benefits Office. Also

eligible are your same sex partner and children of your same sex partner are Eligible Dependents. Please contact the Benefits Office for the Affidavit form.

Contribution Information

- **Dartmouth Contribution.** Each year Dartmouth contributes an amount for you for Medical Plan coverage as explained in the enrollment booklet for the year. If you are an Eligible Employee or Eligible Fellow with a part-time appointment, the Dartmouth contribution is pro-rated.
- **Participant Contribution.** By electing the various coverages you want during the open enrollment process (or making a mid-year change in elections due to a qualified change in status), you agree to have the total Participant Contribution needed above the Dartmouth contribution taken from your pay. Your contributions will be deducted from your pay in equal increments throughout the year. No change in your deduction amount will be made during the year unless you have changed coverage elections mid-year due to a qualified change in status or the required Participant Contribution amount changes during the year.

Tax Information

- **Research Associate B/Research Fellow Distinction.** The funding source for your appointment determines whether you are providing service as a common law employee or you are in a training (non-employee) position. Persons classified as Research Associate B employees are considered employees of Dartmouth; persons classified as Research Fellows are non-employee trainees. This distinction-employee or trainee-has an impact on your Dartmouth benefits. If you are classified as a Research Associate B employee, benefits under the Plans are provided “pre-tax.” Dartmouth’s contributions for your Plan coverages are not considered part of your taxable income and your Participant Contributions reduce your pay for income tax purposes. If you are a Research Fellow, benefits are provided “after-tax.” Dartmouth contributions on your behalf are considered taxable income to you, and your Participant Contributions do not reduce your taxable income. These distinctions are required by the IRS.
- **Participant Contributions.**
 - Research Associate B. As noted above, your Participant Contributions reduce your pay for income tax purposes. Nevertheless, Participant Contributions do not reduce your pay for purposes of determining your Life Insurance Plan coverage if you elect a multiple of pay.

If your annual pay is below the Social Security wage base in effect for a year, you will also be paying less in Social Security taxes because pre-tax Participant Contributions also are not taxable for Social Security purposes. Because Social Security benefits are based on the taxes you pay, your eventual Social Security benefits may be reduced, usually by a small amount. For most people the reduction will be only a few dollars a month. If you invested your tax savings over the years, you should more than make up for any decrease in Social Security benefits. If your earnings are higher than the wage base, pre-tax contributions won't affect your Social Security benefits, unless your contributions reduce your taxable income below the wage base.

- **Research Fellow.** Your Participant Contributions are after-tax. They do not reduce your pay for income tax or Social Security tax purposes.
- **Medical Plan and Dental Plan.** For Research Associate B employees, except for domestic partnership situations, the value of your coverage under the Plans, and any benefits paid on your behalf for Covered Services to you or a covered Eligible Dependent, are not subject to income tax. If you are covering a same sex domestic partner, the value of your partner's coverage is a post-tax deduction. This is required by IRS rules. Coverage for children of your domestic partner who are not your dependents for federal income tax purposes are done via a post-tax deduction. As noted above, for Research Fellows, contributions for Medical Plan or Dental Plan coverage are after-tax. Benefits paid are not considered taxable income.
- **Life Insurance Plan.** For Research Associate B employees, under IRS rules, the premium value of any life insurance coverage for you in excess of \$50,000 is considered taxable. The taxable value is determined under tables prescribed by the IRS. The amounts prescribed under the table will be added to your W-2 income and you will have to pay income taxes on that amount.

In the event of your death, the Life Insurance Plan death benefit is not considered taxable income to the recipient.

For Research Fellows, the Participant Contribution for coverage is after-tax.

- **Long Term Care Plan.** The Participant Contribution for Long Term Care coverage is after-tax. It does not reduce your Dartmouth pay for income tax or Social Security tax purposes.

Termination of Coverage

Except for Medical Plan and Dental Plan continuation coverage under COBRA, your coverage under the Plans will end as of the earliest of:

- The date on which you are no longer entitled to coverage or benefits under the terms of a Plan;
- The date on which you stop paying any required Participant Contribution amounts for a Plan coverage you elected;
- The date on which you cease to be an Eligible Employee or Eligible Fellow, either by termination of employment with Dartmouth, or by a reduction in regularly scheduled hours resulting in your becoming benefits ineligible, or by reassignment or reclassification to an ineligible position or category; in such a case, your coverage would end at the end of the month in which the termination, reduction or reassignment or reclassification occurs.
- The date on which a particular Plan terminates.

Changing Coverage Elections

After initially enrolling, you may elect a change in coverage under any of the Plans only during the annual open enrollment period during the fall of each year or if you have a qualified change in status. A qualified change in status includes:

- your marriage;
- your divorce, legal separation or annulment of marriage; or revocation of your Affidavit of Domestic Partnership;
- death of your spouse, child, or domestic partner;
- birth, adoption or placement for adoption of a child;
- gain or loss of custody of a dependent;
- termination or commencement of employment by you, your spouse, domestic partner, or a dependent;
- a change in work schedule for you, your spouse, domestic partner, or a dependent, for example, from full-time to part-time employment or vice versa, that affects the availability of coverage;
- significant changes in your or your spouse's or domestic partner's non-Dartmouth medical, dental, or life insurance coverage; or
- a dependent's satisfying or ceasing to satisfy the requirements for dependent status due to an increase in age or a change in student status.

The following are considered a qualified change in status, but only for purposes of changing your elections under the Medical Plan or Dental Plan:

- change of residence or work site by you, your spouse, domestic partner, or dependent that affects the availability of coverage under a health plan;
- you, your spouse, domestic partner, or a dependent become covered under Medicare or Medicaid; or Dartmouth receives a qualified medical child support order (“QMCSO”) to provide health coverage for your dependent;
- an event that permits special enrollment by you, your spouse, your domestic partner, or dependent in the Medical Plan or Dental Plan in accordance with the Health Insurance Portability and Accountability Act (“HIPAA”); or
- open enrollment for your spouse’s or domestic partner’s health plan.

Coverage changes due to a qualified status change must be reviewed and approved by the Benefits Office. You must request the coverage change(s) under the Plan(s) within 30 days after the qualified change in status event by filing the appropriate form with the Benefits Office and providing any documentation requested by the Benefits Office. The requested coverage change must be consistent with the qualified change in status event permitting the coverage change. If you do not request the coverage change within 30 days of the qualified change in status event, you will not be eligible to change until the next open enrollment period. A requested coverage change will not be permitted if it is contrary to the terms of the particular Plan(s).

Participation During Leave

The following information about participation during leave applies only to Research Associate B employees. Non-employee Research Fellows are not covered by the FMLA or by Dartmouth’s other leave policies. Whether a Research Fellow would be eligible for any type of paid or unpaid absence depends on the terms of the grant or other financial source supporting his or her stipend payments.

- **Family and Medical Leave Act (FMLA).** A covered Eligible Employee who is absent on a FMLA leave shall be entitled to continue coverage under the Plans during the period of the FMLA leave. If your FMLA leave is paid, your coverages shall remain in effect and the Participant Contribution will continue to be taken from your compensation. If the leave is unpaid, you must arrange to pay the Participant Contribution on an after-tax basis in order to retain coverage during FMLA leave.

Upon return to work you will be given the same coverage(s) you had prior to the leave unless you had a qualified change in status during the leave and changed elections accordingly. In that case you would be given the elections made due to the qualified change in status.

- **Military Leave.** If you are absent from work due to a period of duty in the uniformed services, you will have the same choices offered to covered employees on FMLA leave.
- **Participation During Other Leave of Absence.** During an approved unpaid non-FMLA leave of absence you may continue your existing Plan coverages or, if you prefer, you may cancel one or more coverages for the duration of your leave. You must pay the full cost of any continued coverages on an after-tax basis in order to retain coverage during the leave. In the event of nonpayment, coverage will be cancelled. Upon return to work you will be given the same coverages you had prior to the leave unless you had a qualified change in status during the leave and changed elections accordingly. In that case you would be given the elections made due to the qualified change in status.

Summary of Medical Plan and Dental Plan Covered Services

Medical Plan Enrollment - Choosing a Plan and Membership Category

When you enroll in the Medical Plan, you must choose the particular medical plan and the membership category you want. You may choose the Traditional Medical Plan (a fee-for-service plan), the Preferred Provider Organization Plan, or the Blue Choice Plan (a point-of-service plan with managed care features). The membership categories are Employee Only (One Person Coverage), Employee and One Eligible Dependent (Two Person Coverage), or Employee plus two or more Eligible Dependents (Family Coverage). The Participant Contribution is different for each plan and each category of membership. The Participant Contribution amount is set by Dartmouth each year based on the cost of the coverage and the Dartmouth subsidy. Dartmouth can change the Participant Contribution more frequently than once per year, but in the past changes have been made annually.

Covered Services

Covered Services provided under the Medical Plan are specified in the Certificate(s) issued by Anthem BCBS of NH to the Eligible Employee or Eligible Fellow upon enrollment, which are incorporated by this reference into this summary plan description. Limitations and restrictions on obtaining Covered Services (for example, pre-admission approval requirements, limitations on experimental procedures or treatments, etc.) are specified in the Certificate(s). The following is a summary of certain important Medical Plan provisions on Covered Services, amounts you must pay (Deductibles and Coinsurance), and certain important limitations and restrictions. Be sure to review the Certificate(s) of Coverage for the plan you enrolled in for complete information.

Medical Plan Terms

The following special terms are used in describing the medical plans.

Deductible: The amount a covered Eligible Employee or Eligible Fellow pays for Covered Services before the Plan begins paying claims.

Coinsurance: After the deductible has been paid, this is the percentage the covered Eligible Employee or Eligible Fellow must pay.

Covered Services: Those medical services, prescriptions, equipment and supplies that the Plan will pay for, subject to your payment of the applicable Deductible and Coinsurance amounts for the particular plan you enrolled in, as specified in the applicable Certificate of Coverage issued by Anthem BCBS of NH.

Maximum Allowable Benefit (MAB): This is the maximum amount Anthem BCBS of NH will pay for a particular Covered Service.

Out-of-Pocket Maximum: The maximum amount an Eligible Employee or Eligible Fellow would have to pay from his/her own pocket for Covered Services. This amount includes anything paid for a Deductible or Coinsurance. Participant Contributions for coverage under the Plan, the Blue Choice Coinsurance, and mental health, alcohol or drug treatment Coinsurance must always be paid, even if the out-of-pocket maximum has been reached.

Traditional Medical Plan

Under this fee-for-service plan, the covered Eligible Employee or Eligible Fellow is responsible for paying a Deductible and Coinsurance amount for each Covered Service.

When you reach your out-of-pocket maximum for a year, this plan pays for Covered Services at 100% up to the maximum allowable benefit except for mental health, alcohol, and drug treatment. Anthem BCBS of NH "participating providers" agree not to charge more than the maximum allowable benefit for a Covered Service. (For up-to-date information on participating providers call Anthem BCBS of NH at 1-800-437-9282 or visit their web site at: www.anthem.com.)

Medical expenses incurred in the last three months of a calendar year (October, November, and December) which were applied toward a covered Eligible Employee's or Eligible Fellow's Deductible, will also count toward his or her Deductible in the following calendar year.

Mental Health, Alcohol, and Drug Treatment: Unlike other Covered Services, covered mental health, alcohol, and drug treatment services are always paid at the Coinsurance percentage after the Deductible has been satisfied. The traditional fee-for-service plan has a Coinsurance amount of 20% for these types of claims. There is no out-of-pocket maximum for these expenses.

Prescription Drugs: Prescription drugs are paid the same as any other covered expense and are processed by Anthem BCBS of NH Prescription Management.

Blue Choice

Blue Choice is a managed care, point-of-service plan.

If you elect Blue Choice you should contact Anthem BCBS of NH within 30 days of enrollment to choose a primary care physician (PCP) from the Blue Choice network of providers, for yourself and any other family members you are covering under the plan. To choose your PCP or find out about physicians in the network, call 1-800-437-9282 or visit the web site at www.anthem.com.

The benefits received depend upon where the Covered Services are provided. Option 2 Benefits will generally require you to pay a larger portion of the cost than Option 1, and Option 3 Benefits more than Option 2.

Option 1 Benefits - What you receive when you go to your PCP or to a provider you are referred to by your PCP.

Option 2 Benefits - What you receive when you use a Blue Choice network provider but are not referred by your PCP.

Option 3 Benefits - What you receive when you go out of network. **IMPORTANT:** You will need to call Blue Choice Managed Care at 1-800-531-4450 to precertify certain services.

To receive Option 1 benefits for mental health and substance abuse services you must call the Behavioral Health Network (BHN) at 1-800-228-5975, which will refer you to a network provider. You are not required to consult your PCP for these services. Alcohol, drug, or mental health services received from a non-BHN network provider would be covered under Option 3. You will still need to call BHN to notify them that you are receiving care from an out-of-network provider so Anthem BCBS of NH can process your claims correctly.

Prescription Drugs - The cost of prescription drugs is \$5 for generic, \$15 for formulary brand, or \$30 for non-formulary brand. You can also obtain a 90-day supply at these rates by placing a mail order with Anthem Prescription Management (call 1-800-962-8192 or visit their website at www.anthemprescription.com).

Preferred Blue

Preferred Blue is a preferred provider organization (PPO) plan. A PPO is similar to a traditional fee-for-service plan in that participants coordinate their own care and are not required to get specialist referrals from their primary care physician. If you receive care from an in-network provider, your costs are generally lower than if you choose an out-of-network provider. The PPO allows you to choose providers from national networks of doctors, hospitals and other medical professionals.

Preferred Blue has the following important features:

Maximum Allowable Benefit: Services are covered up to the Maximum Allowable Benefit (MAB) set by Anthem BCBS of NH. In-network providers agree to accept the MAB as payment in full. If you receive services from an out-of-network provider, it is your responsibility to pay any difference between the MAB and the actual charge.

In-Network: Refers to the use of providers who participate in the PPO's Provider Network. The PPO requires Eligible Employees to use participating providers to receive the highest level of benefits.

Deductible and coinsurance amounts for in-network services and providers are lower than for out-of-network services and providers.

Out of Network: Refers to the use of out of the network providers. PPO members can go out-of-network but usually must pay some additional costs.

Mental Health and Substance Abuse Services: To receive these services with the least out-of-pocket cost to you, you must call Behavioral Health Network (BHN) at 1-800-228-5975. They will refer you to an in-network provider. If you receive alcohol, drug, or mental health services from a non-BHN network provider, these services would be subject to the higher out-of-network deductibles and coinsurance amounts.

Prescription Drugs - The cost of prescription drugs is \$5 for generic, \$15 for formulary brand, or \$30 for non-formulary brand. You can also obtain a 90-day supply at these rates by placing a mail order with Anthem Prescription Management (call 1-800-962-8192 or visit their website at www.anthemprescription.com).

Other Medical Resources

Your Lifestyle Program - Anthem BCBS of NH has arranged wellness discounts with various vendors for anyone covered under the Blue Choice plan. Wellness discounts are available at certain ski areas, golf courses, exercise programs, and weight loss programs. There are also incentives for child safety products, hearing aids, and eye wear. To receive a discounts directory, call the Benefits Office or call the Anthem BCBS of NH customer service number at 1-800-437-9282.

Dick's House Pharmacy - Persons eligible for our medical plans may fill their prescriptions at Dick's House Pharmacy, which offers personalized service and on-campus delivery.

Dental Plan Enrollment — Choosing a Membership Category

Dental benefits are a separate election from medical benefits. Enrollment is voluntary. When you enroll, you must choose from the following membership categories: Employee Only (One Person Coverage), Employee and One Eligible Dependent (Two Person Coverage), or Employee plus two or more Eligible Dependents (Family Coverage). The Participant Contribution depends on the category of membership.

Important Features of Dental Coverage

This dental plan does not have a Deductible. After you obtain dental Covered Services, you pay a Coinsurance amount based on the type of

service received. Covered Eligible Employees or Eligible Fellows are responsible for the following coinsurance amounts:

Patient Claim Payment Responsibility

- 0% - preventive care
- 20% - restorative care
- 50% - prosthodontics

Northeast Delta Dental will then pay the Plan's share for the Covered Service, 100% for preventive care, 80% for restorative care, and 50% for prosthodontics, up to the Usual, Reasonable and Customary Charge. This is the amount established by Northeast Delta Dental as the typical amount for the particular Covered Service charged by dental providers generally in the area.

When patients go to a dentist who participates with Northeast Delta Dental, they are protected from paying any amount over and above the Usual, Reasonable, and Customary charge. To find out if a dentist participates with Northeast Delta Dental, call the Northeast Delta Dental Customer Service Department 1-800-832-5700, visit their web site www.nedelta.com or call the dentist's office.

Orthodontia is not covered under the Dental Plan.

Northeast Delta Dental has waived the waiting period for this plan so that there is currently no waiting period for coverage.

Northeast Delta Dental is the Dental Plan claims processor. See the Certificate of Coverage issued by Northeast Delta Dental (which is incorporated into this summary plan description by reference) for complete details on dental Covered Services, including requirements for certain services and exclusions.

Other Coverage or Payors

Under certain circumstances, benefits otherwise payable under the Medical Plan or Dental Plan will be offset by benefits available from other coverage or another payor. Some circumstances when this happens are as follows:

- **Coordination of Benefits.** If you are also covered under another hospital, medical or dental plan or policy, the Medical Plan or Dental Plan benefits will be coordinated with that other plan or policy. There are specific rules for determining which plan or policy is the primary payor and which is the secondary payor.
- **Subrogation.** If another person is responsible for an injury to you, the Medical Plan or Dental Plan is entitled to recover any benefits it paid to the extent that you recover damages from the responsible party for your medical or dental expenses. In some cases, you must assign your rights against the responsible party to the Medical Plan

or Dental Plan and to cooperate in trying to recover damages from the responsible party.

- **Medicare.** If for any reason you have dual coverage under both the Medical Plan and the Medicare program, there are rules for determining when the Medical Plan or Medicare will be primary and the other secondary in paying for medical expenses.
- **Worker's Compensation.** If you incur medical expenses for which you are entitled to receive benefits under a Worker's Compensation or similar employer liability law, the Medical Plan will not pay for those expenses.

These situations are explained in detail in the Certificate of Coverage issued by Anthem BCBS of NH or Northeast Delta Dental.

HIPAA Statement of Medical Plan or Dental Plan Coverage

You may upon request receive a certificate of Medical Plan or Dental Plan coverage from the Plan Administrator when:

- (i) You cease to have coverage under the Plan and become eligible for continued coverage as provided by COBRA.
- (ii) Your continued coverage under COBRA ends.
- (iii) You request a certificate of coverage within 24 months of your loss of coverage under the Medical Plan or Dental Plan.

COBRA Continuation Coverage

The Medical Plan and Dental Plan offer covered Eligible Employees, Eligible Fellows and their Eligible Dependents the opportunity to elect extended medical or dental coverage (called "continuation coverage") under certain circumstances. This continuation coverage complies with the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"). Separate COBRA elections are available to the Eligible Employee or Eligible Fellow, and to each Eligible Dependent, for medical coverage or for dental coverage.

COBRA Qualifying Events

COBRA continuation coverage is available only if the covered Eligible Employee, Eligible Fellow or Eligible Dependent would otherwise lose medical or dental coverage under the Plan because of a qualifying event.

- **Employee/Fellow COBRA Qualifying Events** - A covered Eligible Employee or Eligible Fellow may elect COBRA continuation coverage when he/she loses Dartmouth Medical Plan or Dental Plan coverage because of a reduction in work hours or termination of employment/appointment (for reasons other than gross misconduct).

- **Dependent COBRA Qualifying Events** - A covered spouse or other Eligible Dependent may elect COBRA continuation coverage if he/she loses Dartmouth Medical Plan or Dental Plan coverage because of any of the following events:
 - Death of the Eligible Employee or Eligible Fellow
 - Termination of the Eligible Employee's or Eligible Fellow's employment/ appointment (for reasons other than gross misconduct) or a reduction in the Eligible Employee's or Eligible Fellow's work hours
 - Divorce or legal separation of the Eligible Employee or Eligible Fellow
 - The Eligible Employee or Eligible Fellow becomes covered by Medicare
 - The dependent ceases to be a "dependent child" under the Plan, because he/she reaches the age of 19, ceases to be a full-time student, or marries.

- **Bankruptcy and COBRA** - In the unlikely event that Dartmouth becomes bankrupt, COBRA provides that a covered retired Eligible Employee or Eligible Fellow or the retiree's covered spouse or a dependent child may elect COBRA continuation coverage if the retiree, spouse or dependent child loses medical or dental coverage within one year before or after the bankruptcy.

Notifying the Benefits Office of a Qualifying Event

The Eligible Employee or Eligible Fellow (or spouse or other dependent) is responsible for informing the Benefits Office within 60 days of a divorce, legal separation, or child losing dependent status under Dartmouth's medical or dental plan. Notice is also required within 60 days after you (or your spouse or child) becomes covered by Medicare. **Failure to give notice within the time limit may result in forfeiture of COBRA coverage.**

When COBRA is Not Elected

When COBRA continuation coverage is not elected, coverage under the Medical Plan or Dental Plan ends on the last day of the month of the qualifying event.

COBRA Coverage; Premium

COBRA coverage is identical to the coverage under the Medical Plan or Dental Plan for active Eligible Employees or Eligible Fellows. This means that persons with COBRA continuation coverage can make election

changes during open enrollment (or in the event of a qualified change of status event) and are subject to any changes that Dartmouth makes to the Medical Plan or Dental Plan, including changes in carriers or in the availability of certain Covered Services.

Under COBRA, you have to pay the full premium cost for continuation coverage (which is calculated by Dartmouth in accordance with COBRA regulations). You also pay an additional 2% of the premium for administrative charges. If coverage is extended because of disabled status, you will be charged an additional 50% of the premium for the 11 months of extended coverage. **Failure to pay premiums timely results in permanent loss of COBRA coverage.**

Maximum Period of COBRA Coverage

If the COBRA qualifying event is termination of employment/ appointment or a reduction in work hours of the Eligible Employee or Eligible Fellow, the maximum period of continuation coverage is 18 months. If the covered person is disabled at any time during the first 60 days of COBRA continuation coverage, continuation may be extended by 11 months to a total of 29 months (this extension also applies to any covered Eligible Dependents). “Disability” for this purpose means totally disabled under the meaning of the Social Security Act at the time of the qualifying event. The Eligible Employee, Eligible Fellow, spouse, domestic partner, or child must obtain a disability determination from the Social Security Administration and must notify the Benefits Office of the determination within 60 days after the date of the determination and before the end of the initial 18-month COBRA continuation period. Also, the Eligible Employee, Eligible Fellow, spouse or child must notify the Benefits Office within 30 days after the date of any final determination that he or she is no longer disabled. During the 11-month extension period, the COBRA premium is 150% of the cost set by Dartmouth.

For all other qualifying events the coverage period is 36 months. If a second qualifying event occurs affecting an Eligible Dependent who has COBRA coverage, the Eligible Dependent’s coverage may be extended from 18 to 36 months.

Special rules apply to determining the maximum duration of COBRA continuation coverage in the event of bankruptcy of Dartmouth.

Birth or Adoption During the COBRA Continuation Period

A newborn or newly adopted child of an Eligible Employee or Eligible Fellow who has elected family COBRA continuation coverage will automatically be covered. If an Eligible Employee or Eligible Fellow had not elected such coverage, he may elect to make a coverage change to cover the newborn or newly adopted child as long as the election is made within 30 days after birth or adoption.

End of Continuation Coverage

Continuation coverage may be cut short for any of the following reasons:

- The premium for continuation coverage is not paid on time.
- The COBRA beneficiary becomes covered under another group health plan.
- The COBRA beneficiary becomes covered under Medicare.
- The spouse's qualifying event was a divorce, he/she subsequently remarries and is covered under the new spouse's group health plan.
- Dartmouth College no longer provides group health coverage to any Employees.

Coverage will not terminate due to coverage under another group health plan if that group health plan has provisions limiting or excluding coverage for pre-existing conditions. In this instance COBRA continuation coverage would extend to the end of the other plan's pre-existing condition waiting period (unless terminated earlier under the normal COBRA rules).

At the end of the 18, 29 or 36 months continuation coverage period, the individual may enroll in an individual conversion health plan if available. Check with Anthem BCBS of NH or Northeast Delta Dental directly (or see the applicable Certificate of Coverage) for information about individual conversion policies.

Administration of COBRA Benefits

Dartmouth has retained Crosby Benefit Systems to administer COBRA continuation coverage for the Medical Plan and Dental Plan. When Crosby Benefit Systems has been notified that a qualifying event has occurred, they will in turn notify the individual of the right to elect COBRA continuation coverage. Under the law, the individual has 60 days from the date of the notification he/she receives from Crosby Benefit Systems or the date when coverage under the Plans would end, whichever is later, to elect COBRA continuation coverage. **These time limits are not subject to extension. Failure to elect COBRA continuation coverage within the time limit results in forfeiture of any COBRA election opportunity.** Either spouse may elect COBRA coverage on behalf of an Eligible Dependent who is a child. The individual electing COBRA then has 45 days from the date of their election to make the initial COBRA premium payment (which must include all premiums back to the effective date of COBRA continuation coverage).

If you have any questions about the law, or have any of the COBRA qualifying events, please notify the Benefits Office, or contact Crosby Benefit Systems at 1-800-462-2235 or visit the website at www.crosbybenefits.com.

Life Insurance and AD&D Benefits

The Life Insurance Plan provides financial protection to your beneficiary(ies) in the event of your death. If you die while covered under the Life Insurance Plan, your beneficiary will receive the death benefit you elected. The Plan provides additional benefits in the event of your accidental death or dismemberment (AD&D coverage).

Benefits under this plan are insured by MetLife. A covered Eligible Employee or Eligible Fellow will receive a Certificate of Coverage (which is incorporated herein by reference) with full details on coverage, including limitations and exclusions.

Important Features

MetLife's Life / AD&D programs for Dartmouth College include the following innovative features:

- Life Insurance Calculator – A user friendly enrollment resource designed to assist in the determination of the correct level of life insurance protection for your specific circumstances. The Life Insurance Calculator can be accessed on-line at www.metlifeeasier.net/na.
- Will Preparation Service – All employees electing Supplemental Life Insurance protection will be provided with complimentary access to MetLife's national network of Hyatt Legal attorneys who will assist in the preparation or updating of your will.
- MetLife Travel Assistance – Employees and dependents enrolled in MetLife's Optional AD&D coverage will have access to travel assistance services that provide immediate access to doctors, hospitals, pharmacies, and certain other services when faced with an emergency while traveling internationally or domestically more than 100 miles from home.
- Portability – Portability is available on all MetLife programs allowing employees to continue coverage on an individual basis upon the termination of employment with Dartmouth.
- Accelerated Benefits Option (ABO) – ABO is available with all MetLife Group Life solutions and allows a terminally ill insured with a life expectancy of six months or less to receive an advanced pay-out of their life insurance benefits.

- Total Control Account (TCA) – TCA is a claim settlement option for all MetLife Group Life solutions, which helps to protect the financial security of beneficiaries and offers immediate access to and control of their insurance proceeds via check-writing privileges.

Choosing Coverage for Yourself

You can elect the coverage level you want (see below), but you will have to pay the cost by Participant Contributions from your pay. The cost is specified in each year’s enrollment booklet.

Life Insurance Options
No Coverage
\$5,000
1 x pay
2 x pay
2.5 x pay

For Research Associate B Employees, “pay” for purposes of the Life Insurance Plan means your annual base salary without overtime, bonuses or other extra compensation. For Research Fellows, “pay” for this purpose is your annual stipend amount. Pay is rounded up to the next even multiple of \$1,000. Pay is based on your January 1 pay; changes during the year do not affect your coverage.

When you initially enroll, you may choose any option without evidence of good health (unless the option elected would result in \$500,000 or more in coverage). If your elected coverage would exceed \$500,000, you must provide a Medical History Statement and be approved by the insurance carrier. The additional insurance coverage above \$500,000 will become effective upon approval by the insurance carrier.

If you elect to increase your coverage during any open enrollment period (or for a qualified change of status), you must provide a Medical History Statement and be approved for the increase by the insurance carrier. Your coverage will remain in effect at the current level until the Benefits Office receives notice of approval from the carrier. The coverage will increase effective on the first day of the following month and your Participant Contribution amount would increase accordingly.

Death Benefits

If you die while covered under the Life Insurance Plan, the death benefit in effect will be paid to the beneficiary. You designate the beneficiary to receive the death benefit in the event of your death and you may change beneficiaries by filing a new beneficiary form with the Benefits Office.

If no designated beneficiaries are named or are alive at your death, the benefits will be paid to the executor or administrator of your estate, or at the insurer's option, any one or more of these surviving relatives: a spouse, a child, a parent, a brother or a sister. The benefit amount is usually paid in a single payment, but other methods of settlement may be available from the insurance carrier.

Accidental Death & Dismemberment (AD&D) Benefits

You also receive AD&D coverage equal to your life insurance coverage, up to a maximum of \$250,000.

If you suffer an accidental death or a qualifying dismemberment, the insurer will pay the AD&D benefits, up to the full amount of AD&D coverage. You must sustain bodily injuries as a result of an accident and suffer one of the following losses within 12 months after the date of the accident:

- Loss of life. The insurer will pay the full coverage amount.
- Loss of a hand severed at or above the wrist; or loss of a foot severed at or above the ankle; or permanent loss of sight of an eye. The insurer will pay one-half of the full amount. For loss in any one accident of more than one of these members, the insurer will pay the full amount.

Not more than the full amount will be paid for all losses sustained in any one accident. Payment will be made directly to you if you are living on the date of the payment. If you are not living, payment will be made to your beneficiary.

No AD&D benefit will be paid if your death or other loss is caused by:

- A disease or illness of any kind, physical or mental infirmity, or medical or surgical treatment of these; ptomaine or bacterial infection, except infection as a result of an accidental cut or wound.
- Suicide or an injury or a sickness that is intentionally self-inflicted.
- War declared or not declared; any act incident to war; service in any military of any country while the country is engaged in war; or police duty as a member of any military organization.
- Taking part in, or as a result of taking part in, the commission of a felony.

The insurer should receive both the notice of a claim and the written proof of such injury within 90 days after the date of loss. All forms and proof of loss must be satisfactory to the insurer, and it has the right to have you examined or to request information and documents.

The AD&D coverage may be assigned but not converted. This benefit will not be continued for you during a Total Disability.

Termination of Coverage

Your Life Insurance Plan will cease on the earliest of the following events:

- the group life insurance policy terminates or that coverage under the group policy for the employment class to which you belong terminates;
- you stop active work as an Eligible Employee or Eligible Fellow; or
- you stop paying the Participant Contributions required to maintain your coverage.

Conversion of Life Insurance

When your life insurance coverage ceases under the group life insurance policy, you may purchase an individual policy of life insurance from the insurer without providing proof of good health. This is called conversion. The details on conversion, including the amount of conversion coverage available, the type of policy the insurer will issue, and premiums are covered in the Certificate of Coverage issued by the insurer.

You must make application for an individual conversion policy and pay the first premium for that policy **within 31 days** after the date your insurance ceases under the group policy. If you die during the conversion period, the insurer will pay the amount of life insurance that could have been converted.

Assignment

You may assign your Life Insurance and AD&D benefits as provided under the group policy. No assignment will bind the insurer unless it is in writing and until it is filed at the insurer's home office. The insurer is not responsible for whether any assignment is valid. You may not assign insurance as collateral security.

Introduction

Dartmouth offers a group Long Term Care Plan that permits you to purchase insurance to pay benefits in the event you become unable to care for yourself while covered by the insurance. This Plan is available only to Research Associate B employees; Research Fellows are not eligible to purchase this coverage.

You pay the premiums on an after-tax basis out of your pay. You may purchase different coverages, called Plan A, Plan B and Plan C, each providing different benefit maximums. For each plan, you may choose an option providing benefits for a maximum of three years (Option 1) or five years (Option 2). A complete description of the benefits, restrictions and limitations is contained in the Certificate of Coverage issued by the carrier (which is incorporated by reference).

When You Receive Benefits

To receive benefits you must be certified by a Licensed Health Care Practitioner as being chronically ill. There are two ways to be considered chronically ill:

- You are expected to be unable to perform, without hands-on assistance or stand-by assistance from another person, at least 2 of 6 Activities of Daily Living for a period of 90 consecutive days. The Activities of Daily Living are: Bathing, Continence, Dressing, Eating, Toileting and Transferring. You will not be considered Chronically Ill unless within the preceding 12 months a Licensed Health Care Practitioner has certified that the above requirements have been met.
- You require substantial supervision to protect yourself from threats to health and safety due to a Severe Cognitive Impairment. A Severe Cognitive Impairment is a loss or deterioration in your intellectual capacity (including Alzheimer's disease and organic brain diseases) that is measured by clinical evidence and standardized tests.

Benefits; Care Settings

- *Long Term Care Benefit For Facility Care.* Facility care consists of nursing home care, a bed reservation benefit, hospice facility care, and an assisted living facility benefit. Facility care must be received in a facility operated pursuant to law by the state in which it is located and which meets the other requirements stated in the certificate.
- *Long Term Care Benefit For Home Based Care.* Home based care consists of a home care benefit, home hospice care, adult day care, a caregiver training benefit, and a home medical technology benefit. It must be received from a provider that is licensed or certified by the state in which it is located and which meets the other requirements stated in the

certificate. We will waive the licensing and certification requirements for adult day care centers in states which do not regulate these facilities, provided they are certified by a recognized accrediting agency.

- *Long Term Care Benefit For Respite Care.* Respite care is the temporary use of the Facility Care or Home Based Care benefits to relieve informal caregivers of their duties so that they may have time off. The policy's waiting period does not apply to this benefit. You cannot receive respite care for more than the number of days stated in the certificate.

Additional Benefits

The Plan provides the following additional benefits:

- *Waiver of Premium.* After your waiting period is satisfied, while you are receiving benefits you will not have to pay premiums in order to keep your coverage. Your premiums will be waived while you are receiving benefits. This means you never have to repay those premiums.
- *Refund of Premium at Death.* This feature gives your beneficiaries a refund of the premiums you've paid upon your death, depending on your age at the time of death. The refund amount is the premium you've paid, less any benefits that have been paid to you. The refund amount begins decreasing at age 65 and decreases by 10% each year until age 75. If you are 75 or older at death, there is no refund.
- *Future Benefit Guarantee.* If you stop paying premiums after having coverage for at least three years, the Future Benefit Guarantee keeps your daily benefits the same but reduces your lifetime maximum benefit. Your reduced lifetime maximum benefit equals the total of premiums paid or 30 times the Daily Facility Care Benefit, whichever is higher, less any benefits paid.
- *Caregiver Benefit.* While receiving care at home, you may need the services of an Informal Caregiver such as a family member. These services could include housekeeping or personal care. It may be used when receiving Home Based Care but not Facility Care. This benefit will pay 10 times the Daily Facility Care Benefit you select each year.
- *Home Medical Technology.* This feature pays for the technology you may need to best meet your needs and still remain living in your home residence. The plan will pay up to \$1000 annually for the cost of this home medical technology.
- *Guaranteed Benefit Increase.* This feature gives you the option of buying increased coverage at routine intervals to allow your coverage to keep up with inflation. Premiums for the increase in coverage will be based on your attained age on the effective date of the offer.

Optional Benefits

- If this option is chosen the daily and lifetime benefits automatically increase by 5% each year while the premiums will remain level. The Daily Facility and Home Based Care maximums, as well as Lifetime Maximum Benefit, all increase. Increases continue, even while on claim, for life unless premium payments stop for any reason except waiver of premium.

Other Features

The Plan has other features that may be of value to you:

- Inflation Protection. You may purchase automatic inflation protection for an additional premium; if you do not purchase this, the carrier will offer opportunities to purchase more coverage.
- Refund of Premiums. If you die before age 75 and before receiving benefits that equal or exceed your premium payments, the carrier will refund to your estate all or a portion of your unused premiums depending on your age.
- Paid-up Benefits. Under certain circumstances, you may stop paying premiums and still have benefit coverage, up to a portion of your Lifetime Maximum Benefit. The portion depends on the number of years that you paid premiums.

These features are described in detail in the Certificate of Coverage.

No Cancellation for any Reason

As long as you have not received benefits up to your lifetime maximum, your coverage cannot be cancelled as long as you keep paying your premiums. Premium amounts may be changed by the carrier, but only if the change applies to everyone in your age category who has the kind of coverage plan that you do. You can never be singled out for a rate increase because you get older or become ill or because of claims you file.

Enrollment; Premiums

The Long Term Care Plan has its own separate enrollment process. If you are an Eligible Employee, you can purchase this Group Long Term Care plan by completing the enrollment form, available from the Benefits Office. If you enroll when initially eligible, you are guaranteed coverage, as long as you are still actively at work when your coverage goes into effect. If you enroll later, you will have to complete a questionnaire about your health and medical history and meet the carrier's good health and other underwriting standards to be accepted into the plan. Your spouse can also apply for coverage by completing the spouse's questionnaire.

A parent, parent-in-law, grandparent or grandparent-in-law of an Eligible Employee may enroll by completing a separate questionnaire. Such a person must meet the carrier's good health and other underwriting standards to be accepted into the plan. Please note that not all medical conditions are disqualifying.

Once coverage begins for an active Eligible Employee, all premiums will be deducted from your paycheck post tax. Your premium is based on the plan and option you choose and on your age at the time your coverage begins. A table of premium amounts for various options and plans is available from the Benefits Office. If you are a retiree (or retiree's spouse), parent, parent-in-law, grandparent or grandparent-in-law, premiums must be paid directly to the carrier.

Plan Amendment and Termination

Dartmouth reserves the right to amend or terminate any of the Plans at any time. This includes the right to terminate any Plan with respect to one or more employment classes. Dartmouth may change any service provider providing claims processing or other administrative services for a Plan or may change the carrier that has issued any insurance policy under which Plan benefits are paid. Dartmouth also has the right to change the Participant Contribution for different coverages under any of the Plans at any time. Dartmouth does not expect to make any amendments that would deprive you of the right to receive benefits attributable to events (such as incurring Covered Services or death) that occur before the effective date of the amendment. However, the right to any coverage or benefits under any Plan is not vested.

Amendments to a Plan may be approved by Dartmouth's Board of Trustees, or the Executive Committee of the Board. In addition, amendments may be approved by the President or any Vice President of the College or by the Chief Human Resources Officer or the Director of Human Resources/Total Compensation (or by any person filling any such a position in an acting capacity or fulfilling the duties of any such a position).

Administration of the Plan

Plan Administrator Powers and Responsibilities

The Plan Administrator supervises and controls the operation of the Plans and has all powers necessary to accomplish that purpose, including the power to make rules and regulations pertaining to the administration of these Plans. The Plan Administrator's principal duty is to see that the Plans are operated and maintained, in accordance with their terms, for the benefit of the Eligible Employees (and their Eligible Dependents). The Plan Administrator has the exclusive power to administer the Plans (subject to any applicable requirements of law). The Plan Administrator's powers include, but are limited to, the following:

- Establishing rules and regulations that it determines to be necessary for the proper administration of the Plans;
- Resolving and interpreting, in its sole discretion, any and all questions with respect to the operation and the administration of the Plans, including but not limited to the eligibility of any person to participate in a Plan; and
- Delegating all or part of its duties and designating other persons to carry out any of its duties under the Plans.

Employee Statements: Overpayments

The Benefits Office and the Plan Administrator, and the insurance carrier or claims processor have the right to request from any Eligible Employee, Eligible Fellow or Eligible Dependent any information that is needed to determine his or her eligibility, Participant Contribution amount, coverage or benefits. Dartmouth and the Plan Administrator shall be fully protected in relying on any such statement, or on any notice, request, consent, letter, telegram, or other document believed to be genuine and to have been signed or sent by the proper person. If any statement or representation by you or your Eligible Dependent is incorrect or incomplete, or if you or your Eligible Dependent fail to provide information relating to a change of status that affects your eligibility, coverage or benefits, or omit any other relevant information, any claims or benefits incorrectly paid as a result (or any underpayments by you of the correct Participant Contribution amount) may be recovered from you. In addition, if any such statement, representation or omission is determined by the Plan Administrator to be fraudulent or intentionally false, incomplete, or misleading, the Plan Administrator may terminate your eligibility (and that of your Eligible Dependents) to participate in any or all of the Plans, and, depending on the circumstances, additional disciplinary action may be taken. Any inadvertent or mistaken payments or overpayments to you or an Eligible Dependent or beneficiary may also be recovered even if not caused by you.

No Employment Guarantee

The adoption and maintenance of any of the Plans does not create any contract of employment between Dartmouth and any Research Associate B employee or Research Fellow. Neither the existence of the Plans nor your participation in any of them will affect the right of Dartmouth to deal with you in all respects, including hiring, discipline, discharge, compensation, and conditions of employment, subject to legal requirements.

Claims Procedure

Benefits will ordinarily be paid in accordance with the particular Plan's terms, as long as you have filed the necessary enrollment forms with the Benefits Office and any required claims form as required for that Plan. However, if you believe you are entitled to a right or benefit under a Plan that you are not receiving, you may file a formal claim with the Plan Administrator or with the applicable claims processor: Anthem (Medical Plan claims); Northeast Delta Dental (Dental Plan claims); MetLife (Life Insurance Plan claims); or Continental Casualty Company, an affiliate of the CNA Insurance Companies (Long Term Care Plan).

The Plan Administrator generally determines questions relating to eligibility, election of changes in coverage and/or enrollment. Claims that fall within the purview of the Plan Administrator should be filed with the Plan Administrator. If the Plan Administrator denies your claim, you have the right to appeal and have your claim reconsidered by the Claim Review Committee. The procedures for handling such claims and appeals are set forth in the separate booklet entitled Dartmouth College Employee Benefit Plan Claims and Appeals Procedures.

Claims that relate to Covered Services or benefits under other Plans should be filed with the applicable claims processor (see above) in accordance with the procedures described in the applicable Certificate(s) or in this booklet. These claims or appeals will be decided by the claims processor in accordance with their procedures, which are required to satisfy the requirements of regulations issued by the U.S. Department of Labor.

Rights under ERISA

As an Eligible Employee or Eligible Fellow participating in the Plans, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants are entitled to:

Receive Information About a Plan. Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plans, including insurance contracts, and a copy of the latest annual report (Form 5500 Series) filed by a Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefit Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plans. Available documents include any insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

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

Continue Group Health Plan Coverage. Continue medical and/or dental coverage for yourself, spouse or dependents if there is a loss of coverage under the Medical Plan or Dental Plan as a result of a qualifying event under COBRA. You or your dependents have to pay for such coverage. Review this summary plan description and the documents governing the Medical Plan or Dental Plan on the rules governing your COBRA continuation rights, which are described in greater detail in the COBRA Continuation Coverage section in the Medical Plan or Dental Plan part of this booklet.

Reduction or elimination of any exclusionary periods of coverage for pre-existing conditions. Under the Medical Plan, if you have creditable coverage from another group health plan, such creditable coverage counts against the period of time (if any) under the Medical Plan when pre-existing conditions are not covered. You should be provided a certificate of creditable coverage, free of charge, from your prior group health plan or health insurance issuer when you lose coverage under that plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request such a certificate before losing coverage or at any time up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for up to 12 months (18 months for late enrollees) after your enrollment date for your coverage.

Dartmouth's Medical Plan currently has no pre-existing condition exclusions.

Prudent Actions by Plan Fiduciaries. In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate the Plans, called "fiduciaries" of the Plans, 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 benefit or exercising your rights under ERISA.

Enforce Your Rights. If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from a Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with a 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 any assets of a Plan, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions. If you have any questions about a Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Qualified Medical Child Support Orders

Generally, your benefits under the Plans may not be assigned or reached through attachment, levy or otherwise by anyone else, including your creditors. However, as required by Federal law, the Medical Plan or Dental Plan will recognize and comply with any court orders requiring coverage of a dependent, provided that the order constitutes a Qualified Medical Child Support Order (“QMCSO”). Upon receipt of an order that appears to be a QMCSO, the Plan Administrator shall promptly take appropriate steps to make a determination as to whether the order qualifies.

Maternity and Newborn Benefits

The Medical Plan will comply with the following rules relating to maternity and natal care. The Plan may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a Caesarean 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 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).

Post-Mastectomy Breast Reconstruction

If you or your dependent have had or are going to have a mastectomy, you or your dependent may be entitled to certain benefits under the Women’s Health and Cancer Rights Act of 1998. For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician for all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses and treatment of physical complications resulting from a mastectomy, including lymphedema. These benefits will be available subject to the same deductibles and coinsurance applicable to other medical and surgical benefits.

Plan Administration

Plan Names and Numbers:	<p>For purposes of ERISA reporting, Dartmouth maintains the following Plans:</p> <p>The Flexible Benefits Plan of Dartmouth College Employees (Plan No. 506; the plan year for Plan 506 is the calendar year) (for purposes of ERISA's annual reporting requirements, the Medical Plan, Dental Plan, Life Insurance Plan, and Long Term Care Plan are reported as part of the Flexible Benefits Plan)</p>
Plan Sponsor:	<p>Dartmouth College Hanover, NH 03755-2112</p>
Employer Identification Number:	<p>2-0222111</p>
Sources of Benefit Payments:	<p>Benefits under certain Plans are self-insured. This means that the benefits under these Plans are paid entirely from the general assets of Dartmouth (including Participant Contributions and COBRA premiums). Dartmouth has purchased re-insurance that will reimburse Dartmouth for large individual or aggregate benefit claims under the Medical Plan. However, the re-insurance company is not liable for Medical Plan benefits to covered Eligible Employees, Eligible Fellows or Eligible Dependents. There is no insurance company to pay benefits under a self-insured plan. A covered Eligible Employee, Eligible Fellow or other person shall not have any claim for benefits under a self-insured plan against Dartmouth or its assets (including reinsurance payments) other than as an unsecured general creditor.</p> <p>Benefits under an insured Plan are paid under a group policy issued by an insurance company. The issuing insurance company is responsible for the benefit payments; Dartmouth has no financial responsibility for benefit payments under an insured plan.</p>

The self-insured and insured plans are specified in the following table.

Plan	Insured (Insurer) or Self-Insured by Dartmouth
Medical Plan	Self-Insured
Dental Plan	Insured (Northeast Delta Dental)
Life Insurance Plan	Insured (MetLife)
Long Term Care Plan	Insured (Continental Casualty Company)

Plan Administrator:

Dartmouth College
Benefits Office
7 Lebanon Street, Suite 203
Hanover, NH 03755-2112
603-646-3588
email:
Human.Resources.Benefits@dartmouth.edu

Although Dartmouth is the official “Plan Administrator” under ERISA, the Director of Human Resources/ Total Compensation has been designated to handle Plan administration on a day-to-day basis. As the designated Plan Administrator, the Director of Human Resources/ Total Compensation has the authority and discretion to interpret and apply the terms of the Plan and to make all decisions regarding Plan administration.

Agent for Service of Legal Process:

Dartmouth College
Director of Human Resources/
Total Compensation
Benefits Office
7 Lebanon Street, Suite 203
Hanover, NH 03755-2112
603-646-3588



HR The Office of Human Resources
at Dartmouth College
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