

GANNON UNIVERSITY
Summary Plan Description

EFFECTIVE DATE: 1/1/02
RESTATED: 04/01/06

Claims Administered by:



Benefit Administrators,

Inc.

1250 Tower Lane • Erie, PA 16505
Nationwide: (800) 777-2524 • Local: (814) 454-0167
E-Mail – BAI@HBKW.NET

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this booklet, contact Benefit Administrators, Inc. (BAI).

All benefits will be paid directly to the provider of the service unless you submit receipted bills showing that payment has been made.

SECTION I

SCHEDULE OF BENEFITS

A. RESPONSIBILITY FOR USE OF PROVIDERS

It is your responsibility to use BAI Participating Dental Providers in order to receive a discount to the BAI allowance for covered services. Payment for services performed will be made to the dentist on the basis of the BAI fee schedule or the amount charged, whichever is less. If you elect to go to a non-participating provider, payment for services will be paid only up to the amount that would have been paid to a participating provider.

B. SCHEDULE OF BENEFITS

	Year 1	Year 2 and thereafter
Diagnostic & Preventive	80%	100%
X-rays		
Prophylaxis		
Routine Exams		
Sealants		
Fluoride Treatments (under age 19)		
Space Maintainers		
Palliative Emergency Treatments		
Primary Services	75%*	100%
Basic Restorative		
Oral Surgery		
Endodontics		
Non-surgical Periodontal		
Simple Extractions		
Repair of Broken Dentures		
Anesthesia		
Inpatient Consultation		
Major Restorative	25%*	75%
Crowns, Inlays and Onlays		
Surgical Periodontics		
Prosthodontics		
Orthodontics		Not covered.
Diagnostic, Active, Retention Treatment		
 Annual Program Maximum		\$1,250.00
Annual Program Deductible		*\$50 per person/\$150 per family
*Deductible applies to Primary and Major Restorative benefits for year 1 only.		

1. **DIAGNOSTIC SERVICES:**

- a. Routine oral examinations, but not more than once in any period of 6 consecutive months.
- b. Dental X-Rays:
 - i. Full mouth x-rays, or panoral accompanied by bitewings, are limited to full-mouth series allowance, but not more than once in any period of 60 consecutive months.
 - ii. Bitewing x-rays, but not more than once in any period of 6 consecutive months for subscribers under age 19, and once in 12 months for age 19 and over.
 - iii. Periapical x-rays as required.
- c. Palliative emergency treatment of an acute condition requiring immediate care.

2. **PREVENTIVE SERVICES:**

- a. Routine prophylaxis (including cleaning, scaling, and polishing of teeth), but not more than once in any period of 6 consecutive months.
- b. Topical fluoride application for dependent children under 19 years of age, but not more than once in any period of 6 consecutive months.
- c. Space maintainers (not made of precious metals) that replace prematurely lost teeth for dependent children less than 19 years of age.
- d. Sealants for dependent children through age 10 on permanent first molars -- 3, 14, 19, 30, and through age 15 on permanent second molars -- 2, 15, 18, 31 (only if teeth to be sealed are free of topical caries and there are no previous restorations on the surface to be sealed). Limited to one sealant per tooth in any 36 consecutive months.

3. **PRIMARY SERVICES:**

- a. Amalgam, silicate, acrylic, synthetic porcelain, and composite filling restorations to restore diseased or accidentally broken teeth. (Limited to amalgam for posterior teeth.)
- b. Repair of broken partial or full removable dentures.
- c. Simple extractions.
- d. Endodontics, including pulpotomy and root canal treatment.
- e. Administration of medically-necessary anesthesia in connection with covered services when rendered by or under the direct supervision of a dentist. Anesthetic services consists of the administration of an anesthetic agent or anesthetic drug by injection or inhalation, the purpose of which is to render the patient unconscious. The administration of a local infiltration or block anesthetic is not covered.
- f. Consultations, limited to one consultation per consultant during any one period of hospitalization when the member is an inpatient and his dental condition requires such consultation.

4. **ORAL SURGERY:**

NOTE: Services covered by a medical plan must be submitted to medical plan first.

- a. Surgical removal of teeth.
- b. Surgical removal of maxillary or mandibular intrabony cysts.
- c. Apicoectomy (surgical removal of the end of a root).
- d. Services of a dentist who actively assists the operating surgeon in the performance of covered surgery when the condition of the patient or the type of surgery performed requires assistance. Surgical assistance is not covered when performed by a dentist who himself performs and bills for another surgical procedure during the same operative session.

5. **MAJOR RESTORATIVE:**

Coverage for prosthetics, crown, inlays, or onlays may be limited to the least expensive but adequate treatment plan consistent with established dental standards. The member may elect to accept a more expensive treatment plan than that covered under this dental program with the understanding that the member will be responsible for paying the difference in cost between the treatment received and the Administrator allowance. (Refer to Alternative Treatment Section.)

- a. Initial insertion of bridges (including pontics and abutment crowns, inlays, and onlays).
- b. Initial insertion of partial or full dentures (including any adjustments during the six-month period following insertion).
- c. Replacement of an existing partial or full denture or bridge by a new denture or new bridge, but only if satisfactory evidence is presented that:
 - i. The existing denture or bridge was inserted at least five years prior to the replacement: and
 - ii. The existing denture or bridge is not serviceable and cannot be made serviceable. Payment will be made toward the cost of the services which are necessary to render such appliance serviceable.
- d. The addition of teeth to an existing partial denture or to a bridge, but only if satisfactory evidence is presented that the addition of teeth is required to replace one or more teeth extracted after the existing denture or bridge was inserted.
- e. Relining or rebasing of dentures more than six months after the insertion of an initial or replacement denture, but not more than one relining or rebasing in any period of 36 consecutive months.
- f. Single unconnected crown, inlays, and onlays (none of which is part of a bridge or are splinted together).
- g. Replacement of crowns, inlays, and onlays, but only if satisfactory evidence is presented that at least five years have elapsed since the date of the insertion of the existing crown, inlay, or onlay and only if the existing crown, inlay, or onlay is not serviceable and cannot be made serviceable.
- h. Repair of broken crowns, inlays, onlays or bridges.

Exclusions and Limitations on Prosthetics and Crown, Inlay, and Onlay Restorations:

1. If a cast chrome or acrylic partial denture will restore the dental arch satisfactorily, payment of the applicable percentage of the BAI allowance for such procedure will be made toward a more elaborate or precision attachment denture or bridge that the member and dentist may choose to use, and the balance of the cost remains the responsibility of the member.
2. If the member and dentist decide on personalized prosthetics or crown, inlay, and onlay restorations or specialized techniques as opposed to standard procedures, payment of the applicable percentage of the BAI allowance for the standard services will be made toward such treatment and the balance of the cost remains the responsibility of the member.
3. Any denture or bridge replacement made necessary by reason of loss or theft or member alteration of a denture or bridge shall not be considered a covered service.
4. No payment will be made for any crown, inlay, or onlay restoration or for any denture or bridge and the fitting thereof which was prescribed within a 90 day period preceding the effective date of coverage. Such benefits will be covered after you have been covered for more than 12 months under this Program. Restorative treatment initiated or the denture or bridge prescribed while the member was covered under this Program and which is finally inserted more the 30 days after termination of coverage will not be eligible.
5. No payment will be made for any duplicate or temporary denture or bridge or any other duplicate or temporary appliance.
6. No payment will be made for precious metal dentures. Payment of the applicable percentage of the BAI allowance for a nonprecious metal denture will be made toward the charge for the precious metal denture selected by the member and dentist. The balance of the treatment charge remains the responsibility of the member.
7. Payment will be made for crown, inlay, and onlay restorations only if the tooth cannot be restored with another material, such as amalgam. However, if the tooth can be restored with another material, payment of the applicable percentage of the BAI allowance for that procedure will be made toward the charge for the restoration selected by the member and the dentist. The balance of the treatment charge remains the responsibility of the member.
8. No payment will be made until services are completed. Crowns, inlays, onlays, bridges and dentures shall be considered completed on the date they are finally inserted.

6. **PERIODONTAL SERVICES:**

- a. Diagnosis and treatment planning including periodontal examination.
- b. Non-surgical periodontal therapy including periodontal scaling and root planning. Periodontal scaling in the presence of gingival inflammation once per 2-year period.
- c. Surgical periodontal therapy.
- d. Maintenance post-treatment preventive periodontal procedures (periodontal prophylaxis).

Limitations on Periodontal Services:

Post treatment preventive periodontal procedures are limited to 4 in any period of 12 consecutive months. This maximum shall be reduced by the number of routine prophylaxis received during that 12-month period so that the total number of prophylaxis for a given 12-month period, including both routine and periodontal prophylaxis, shall not exceed 4.

HOW TO SUBMIT A CLAIM

When a Covered Person has a claim to submit for payment that person must:

For Plan reimbursements, attach bills for services rendered. **ALL BILLS MUST SHOW:**

- Name of Employer
- Colleague's name and Social Security Number
- Name, Social Security Number, and Date of Birth of patient
- Name, address, telephone number of the provider
- Diagnosis (Oral Surgery Related Claims)
- Type of services rendered, with valid diagnosis and/or procedure codes
- Date of services
- Charges

Send the above to the Claims Administrator at this address:

BENEFIT ADMINISTRATORS, INC.
P.O. Box 6279
ERIE, PENNSYLVANIA 16512-6279
(814) 454-0167 OR 1 (800) 777-2524
(814) 459-2250 FAX NUMBER

WHEN CLAIMS SHOULD BE FILED

Claims should be filed with the Claims Administrator within 30 days of the date charges for the service(s) were incurred. Benefits are based on the Plan's provisions at the time the charges were incurred. Claims filed later than that date may be declined unless:

- (a) it's not reasonably possible to submit the claim in that time; and
- (b) the claim is submitted within one year from the date incurred. This one-year period will not apply when the person is not legally capable of submitting the claim.

CLAIMS REVIEW PROCEDURE**Benefit Determination By The Plan**

BAI, not your employer or your physician, makes the determination (decision) regarding your dental benefits. BAI will notify you in writing in the case of any urgent, preservice, or adverse determinations within a reasonable time – not to exceed 45 days from the date that BAI receives your dental claim.

Before the expiration of the 45-day time period, BAI will, among other things:

1. Assign the claim to a dental claim professional;
2. Verify whether the Colleague's is covered under the plan;
3. Assess whether the Colleague's meets the plan's eligibility requirements;
4. Investigate and gather facts regarding the dental claim;
5. Evaluate dental and vocational reports; and
6. Make a determination regarding the claim for dental benefits.

BAI may notify you in writing that it intends to extend the time to make a determination regarding your claim for dental benefits 30 days (hereinafter referred to as a 30-day extension notice). BAI may extend the time to make a determination twice if it determines it is necessary due to matters beyond its control. For example, BAI may extend the time to notify you of a determination if you, your employer or your attending Physician fail to submit important information or documentation requested information or documents necessary to process your claim.

BAI will determine if enough information has been submitted to enable proper consideration of the claim. If not, additional information may be requested from the claimant.

A request for Plan benefits will be considered a claim for Plan benefits, and it will be subject to a full and fair review.

If a claim is wholly or partially denied, the Claims Administrator will furnish the Plan Participant with a written notice of this denial. The written notice will contain the following information:

- (a) the specific reason or reasons for the denial;
- (b) a description of any additional information or material necessary to correct the claim; and
- (c) appropriate information as to the steps to be taken if a Plan Participant wishes to submit the claim for review.

In cases where a claim for benefits payment is denied in whole or in part, the Plan Participant may appeal the denial. This appeal provision will allow the Plan Participant to:

- (a) Request from the Plan Administrator a review of any claim for benefits. Such request must include: the name of the Colleague, his or her Social Security number, the name of the patient and the Group Identification Number, if any.
- (b) File the request for review in writing, stating in clear and concise terms the reason or reasons for this disagreement with the handling of the claim.

The request for review must be directed to the Plan Administrator or Claims Administrator within 60 days after the claim payment date or the date of the notification of denial of benefits.

A review of the denial will be made by the Plan Administrator and the Plan Administrator will provide the Plan Participant with a written response within 90 days of the date the Plan Administrator receives the Plan Participant's written request for review and if not notified, the Plan Participant may deem the claim denied. If, because of extenuating circumstances, the Plan Administrator is unable to complete the review process within 90 days, the Plan Administrator shall notify the Plan Participant of the delay within the 90 day period and shall provide a final written response to the request for review within 120 days of the date the Plan Administrator received the Plan Participant's written request for review.

The Plan Administrator's written response to the Plan Participant shall cite the specific Plan provision(s) upon which the denial is based.

A Plan Participant must exhaust the claims appeal procedure before filing a suit for benefits.

ERISA requires BAI to follow all of its rules, procedures, guidelines and protocols while it processes your dental claim. You may file a civil suit in the federal district court where the plan is administered or where you live if BAI fails to follow all of its rules, procedures, guidelines and protocols while it processes your dental claim.

BAI has the right to utilize any reasonable method, such as a debt collection agency, or file a civil action to

recover any amount overpaid. An overpayment may occur by fraud, by provider billing error, or any error BAI makes in processing a claim.

ELIGIBILITY, FUNDING, EFFECTIVE DATE AND TERMINATION PROVISIONS

Eligibility Requirements for Colleague's Coverage. All Active Colleagues of the Employer are eligible for coverage from the first day that he or she:

- (1) is a Full-Time, Active Colleague of the Employer. A Colleague is considered to be Full-Time if he or she normally works at least 40 hours per week and is on the regular payroll of the Employer for that work.
- (2) is in a class eligible for coverage.
- (3) completes the employment Waiting Period (if applicable) as an Active Colleague. A "Waiting Period" is the time between the first day of employment and the first day of coverage under the Plan.

Eligible Classes of Dependents.

A Dependent is any one of the following persons:

- (1) A covered Colleague's Spouse and unmarried children from birth to the limiting age of 19 years. The Dependent children must be primarily dependent upon the covered Colleague for support and maintenance. However, a Dependent child will continue to be covered after **age 19**, provided the child is a full-time student at an accredited school, primarily dependent upon the covered Colleague for support and maintenance, is unmarried and under the limiting **age of 25**. When the child reaches either limiting age, coverage will end on the last day of the child's birthday month. If the child does not maintain full-time status or graduates, coverage closes independent of limiting age.

Full-time student coverage continues only between semester/quarters if the student is enrolled as a full-time student in the next regular semester/quarter. If the student is not enrolled as a full-time student, coverage will be terminated retroactively to the last day of the attended school term.

The term "Spouse" shall mean the person recognized as the covered Colleague's husband or wife under the laws of the state where the covered Colleague lives. The Plan Administrator may require documentation proving a legal marital relationship.

The term "children" shall include natural children living in the same household as the Colleague adopted children or children placed with a covered Colleague in anticipation of adoption. Step-children who reside in the Colleague's household may also be included as long as a natural parent remains married to the Colleague and also resides in the Colleague's household.

The phrase "child placed with a covered Colleague in anticipation of adoption" refers to a child whom the Colleague intends to adopt, whether or not the adoption has become final, who has not attained the age of eighteen (18) as of the date of such placement for adoption. The term "placed" means the assumption and retention by such Colleague of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child must be available for adoption and the legal process must have commenced.

A covered Dependent child who reaches the limiting age and is Totally Disabled, incapable of self-sustaining employment by reason of mental or physical handicap, primarily dependent upon the covered Colleague for support and maintenance and unmarried. The Plan Administrator may

require, at reasonable intervals following the Dependent's reaching the limiting age, subsequent proof of the child's Total Disability and dependency.

These persons are excluded as Dependents: other individuals living in the covered Colleague's home, but who are not eligible as defined; the divorced former Spouse of the Colleague, any person who is on active duty in any military service of any country; or any person who is covered under the Plan as A Colleague.

If a person covered under this Plan changes status from Colleague to Dependent or Dependent to Colleague, and the person is covered continuously under this Plan before, during and after the change in status, credit will be given for deductibles and all amounts applied to maximums.

If both mother and father are Colleagues, their children will be covered as Dependents of the mother or father, but not of both. (Dependent will be covered according to the birthday rule as stated in Coordination of Benefits section of this plan)

Eligibility Requirements for Dependent Coverage. A family member of a Colleague will become eligible for Dependent coverage on the first day that the Colleague is eligible for Colleague coverage and the family member satisfies the requirements for Dependent coverage.

At any time, the Plan may require proof that a Spouse or a child qualifies or continues to qualify as a Dependent as defined by this Plan.

WAITING PERIOD

The Waiting Period is waived for all dental services for Colleagues who were hired prior to January 1, 2002 and were, at that time, enrolled in the health plan.

The Waiting Period for new Colleague's hired on or after January 1, 2002 is the first of the month following 30 consecutive days.

PROVISIONS RELATING TO QUALIFIED MEDICAL CHILD SUPPORT ORDERS

Purposes

Plan Administrator pursuant to the Employee Retirement Income Security Act Section 609(a) adopts the following procedures for determining whether medical child support orders are qualified in accordance with the ERISA requirements. Plan Administrator also adopts these procedures to administer payments and other provisions under Qualified Medical Child Support Orders (QMCSOs), and to enforce these procedures as legally required. Plan Administrator may alter, amend or terminate these procedures and substitute alternative procedures to satisfy legal requirements.

Definitions

For purposes of the QMCSO requirements, the following terms have these meanings:

1. Qualified Medical Child Support Order means a medical child support order which:
 - a. creates or recognizes an alternate recipient's right to receive benefits for which a participant or beneficiary is eligible under a group medical plan, and
 - b. has been determined by Plan Administrator to meet the qualification requirements of Section 3 of these procedures.

2. Medical Child Support Order means any court judgment, decree or order (including approval of settlement agreement) which:
 - a. provides for child support for a child of a participant under the group medical plan or
 - b. provides for medical coverage to such a child under state domestic relations law (including a community property law); and
 - c. relates to benefits under this plan.
3. Alternate Recipient means any child of a participant who is recognized under a medical child support order as having a right to enroll in a group medical plan with respect to the participant.
4. Plan means the Colleague's medical benefit plan, including all supplements and amendments in effect.

Any term used in these QMCSO procedures and defined in the Plan shall have the meaning assigned to such term under the Plan.

Qualified Medical Child Support Order

1. A Qualified Medical Child Support Order is a medical child support order which creates or receives benefits for which a participant or beneficiary is eligible, and which Plan Administrator has determined meets the requirements of subsections (b) and (c) of this Section.
2. A Medical Child Support Order to be qualified must clearly:
 - (1) specify the name and the last known mailing address (if any) of the participant and the name and mailing address of each alternate recipient covered by the order;
 - (2) include a reasonable description of the type of coverage to be provided by the plan to each alternative recipient, or the manner in which such type of coverage is to be determined;
 - (3) specify each period to which such order applies; and
 - (4) specify each plan to which such order applies.
3. A Medical Child Support Order to be qualified must not require the Plan to provide any type or form of benefits or any option not otherwise provided under the Plan except to the extent necessary to meet the requirements described in Section 1908 of the Social Security Act (relating to enforcement of state laws regarding child support and reimbursement of Medicaid).

Procedures

Upon receipt of a Medical Child Support Order, the Plan Administrator shall:

1. promptly notify in writing the participant, each alternative recipient covered by the order, and each representative for these parties of the receipt of the Medical Child Support Order. Such notice shall include a copy of the order and these QMCSO procedures for determining whether such order is a QMCSO.
2. permit the alternate recipient to designate a representative to receive copies of notices sent the alternate recipient regarding the medical child support order.

3. within a reasonable period after receiving a Medical Child Support Order, determine whether it is a qualified order and notify the parties indicated in subsection (a) of such determination.
4. ensure the alternate recipient is treated by the plan as a beneficiary for ERISA reporting and disclosure purposes, such as by distributing to the alternate recipient a copy of the Summary Plan Description and any subsequent Summaries of Material Modifications generated by a Plan amendment.

Effective Date

The QMCSO procedures are effective for QMCSOs entered into on or after August 10, 1993.

FUNDING

Cost of the Plan.

The Plan Administrator sets the level of any Colleague contributions. The Plan Administrator reserves the right to change the level of Colleague contributions.

The Employer contributions are as follows:

NONE

The Employee contributions are as follows:

100%

Source: Payroll deductions.

TERMINATION OF COVERAGE

When coverage under this Plan stops, Plan Participants will receive a certificate that will show the period of coverage under this Plan. Please contact the Plan Administrator for further details.

When Colleague Coverage Terminates. Colleague coverage will terminate on the earliest of these dates (except in certain circumstances, a covered Colleague may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, see the section entitled COBRA Continuation Options):

- (1) The last day of the calendar month in which the Plan is terminated.
- (2) The last day of the calendar month in which the covered Colleague ceases to be in one of the Eligible Classes. This includes death or termination of Active Employment of the covered Colleague. (See the COBRA Continuation Options.)
- (3) The last day of the month for which the required contribution has been paid if the charge for the next period is not paid when due.

Continuation During Periods of Employer-Certified Disability, Leave of Absence or Layoff. A person may remain eligible for a limited time if Active, full-time work ceases due to disability, leave of absence or layoff. This continuance will end as follows:

For disability leave only: the date the Employer ends the continuance.

For leave of absence or layoff only: the last day of the month in which the Employer ends the continuance.

The plan of coverage will be the benefits, which were in force on the last day the Colleague worked as an Active Colleague. However, if benefits reduce for others in the group, then they will also reduce for the continued person.

Continuation During Family and Medical Leave. Regardless of the established leave policies mentioned above, this Plan shall at all times comply with the Family Medical Leave Act of 1993 as promulgated in regulations issued by the Department of Labor.

During any leave taken under the Family Medical Leave Act, the Employer will maintain coverage under this Plan on the same conditions as coverage would have been provided if the covered Colleague had been continuously employed during the entire leave period.

If Plan coverage terminates during the FMLA leave, coverage will be reinstated for the Colleague and his or her covered Dependents if the Colleague returns to work in accordance with the terms of the FMLA leave. Coverage will be reinstated only if the person(s) had coverage under this Plan when the FMLA leave started, and will be reinstated to the same extent that it was in force when that coverage terminated. For example, Pre-Existing Conditions limitations and other Waiting Periods will not be imposed unless they were in effect for the Colleague and/or his or her Dependents when Plan coverage terminated.

Rehiring a Terminated Colleague's. A terminated Colleague who is rehired will not be required to satisfy Eligibility and Enrollment requirements. Coverage will begin on the first day of the month following the rehire date.

Employees on Military Leave. Colleagues going into or returning from military service may elect to continue Plan coverage as mandated by the Uniformed Services Employment and Reemployment Rights Act under the following circumstances. These rights apply only to Colleagues and their Dependents covered under the Plan before leaving for military service.

- (1) The maximum period of coverage of a person under such an election shall be the lesser of:
 - (a) The 18 month period beginning on the date on which the person's absence begins; or
 - (b) The day after the date on which the person was required to apply for or return to a position
or
employment and fails to do so.
- (2) A person who elects to continue health plan coverage may be required to pay up to 102% of the full contribution under the Plan, except a person on active duty for 30 days or less cannot be required to pay more than the Colleague's share, if any, for the coverage.
- (3) An exclusion or Waiting Period may not be imposed in connection with the reinstatement of coverage upon reemployment if one would not have been imposed had coverage not been terminated because of service. However, an exclusion or Waiting Period may be imposed for coverage of any Illness or injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated

during,
the performance of uniformed service.

When Dependent Coverage Terminates. A Dependent's coverage will terminate on the earliest of these dates (except in certain circumstances, a covered Dependent may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, see the section entitled COBRA Continuation Options):

- (1) The last day of the month in which Dependent coverage under the Plan is terminated.
- (2) The last day of the month in which a covered Spouse loses coverage due to loss of dependency status.
(See the COBRA Continuation Options.)
- (3) On the last day of the month that a Dependent child ceases to be a Dependent as defined by the Plan.
(See the COBRA Continuation Options.)
- (4) The last day of the month for which the required contribution has been paid if the charge for the next period is not paid when due.

Verification or Change of Coverage: call the Benefit Administrators, Inc. Services Department at (814) 454-0167 locally, or out-of-area at (800) 777-2524.

Call this number to verify coverage for Plan benefits before the charge is incurred.

COBRA CONTINUATION OPTIONS

A federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), requires that most employers sponsoring a group health plan ("Plan") offer Colleagues and their families covered under their health plan the opportunity for a temporary extension of health coverage (called "COBRA continuation coverage") in certain instances where coverage under the Plan would otherwise end. This notice is intended to inform Plan Participants and beneficiaries, in summary fashion, of the rights and obligations under the continuation coverage provisions of COBRA, as amended and reflected in final and proposed regulations published by the Department of the Treasury.

This notice is intended to reflect the law and does not grant or take away any rights under the law. Complete instructions on COBRA, as well as election forms and other information, will be provided by the Plan Administrator to Plan Participants who become Qualified Beneficiaries under COBRA.

What is COBRA continuation coverage? COBRA continuation coverage is group health plan coverage that an employer must offer to certain Plan Participants and their eligible family members (called "Qualified Beneficiaries") at group rates for up to a statutory-mandated maximum period of time or until they become ineligible for COBRA continuation coverage, whichever occurs first. The right to COBRA continuation coverage is triggered by the occurrence of one of certain enumerated events that result in the loss of coverage under the terms of the employer's Plan (the "Qualifying Event"). The coverage must be identical to the Plan coverage that the Qualified Beneficiary had immediately before the Qualifying Event, or if the coverage has been changed, the coverage must be identical to the coverage provided to similarly situated active Colleagues who have not experienced a Qualifying Event (in other words, similarly situated non-COBRA beneficiaries).

Who is a Qualified Beneficiary? In general, a Qualified Beneficiary is:

- (i) Any individual who, on the day before a Qualifying Event, is covered under a Plan by virtue of being on that day either a covered Colleague, the Spouse of a covered Colleague, or a Dependent child of a covered Colleague. If, however, an individual is denied or not offered coverage under

the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

- (ii) Any child who is born to or placed for adoption with a covered Colleague during a period of COBRA continuation coverage. If, however, an individual is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.
- (iii) A covered Colleague who retired on or before the date of substantial elimination of Plan coverage which is the result of a bankruptcy proceeding under Title 11 of the U.S. Code with respect to the Employer, as is the Spouse, surviving Spouse or Dependent child of such a covered Colleague if, on the day before the bankruptcy Qualifying Event, the Spouse, surviving Spouse or Dependent child was a beneficiary under the Plan.

The term "covered Colleague" includes not only common-law Colleagues (whether part-time or full-time) but also any individual who is provided coverage under the Plan due to his or her performance of services for the employer sponsoring the Plan (e.g., self-employed individuals, independent contractor, or corporate director).

An individual is not a Qualified Beneficiary if the individual's status as a covered Colleague is attributable to a period in which the individual was a nonresident alien who received from the individual's Employer no earned income that constituted income from sources within the United States. If, on account of the preceding reason, an individual is not a qualified beneficiary, then a Spouse or Dependent child of the individual is not considered a Qualified Beneficiary by virtue of the relationship to the individual.

Each Qualified Beneficiary (including a child who is born to or placed for adoption with a covered Colleague during a period of COBRA continuation coverage) must be offered the opportunity to make an independent election to receive COBRA continuation coverage.

What is a Qualifying Event? A Qualifying Event is any of the following if the Plan provides that the Plan participant would lose coverage (i.e., cease to be covered under the same terms and conditions as in effect immediately before the Qualifying Event) in the absence of COBRA continuation coverage:

- (i) The death of a covered Colleague.
- (ii) The termination (other than by reason of the Colleague's gross misconduct), or reduction of hours, of a covered Colleague's employment.
- (iii) The divorce or legal separation of a covered Colleague from the Colleague Spouse.
- (iv) A covered Colleague's enrollment in the Medicare program.
- (v) A Dependent child's ceasing to satisfy the Plan's requirements for a Dependent child (e.g., attainment of the maximum age for dependency under the Plan).
- (vi) A proceeding in bankruptcy under Title 11 of the U.S. Code with respect to an Employer from whose employment a covered Colleague retired at any time.

If the Qualifying Event causes the covered Colleague, or the Spouse or a Dependent child of the covered Colleague to cease to be covered under the Plan under the same terms and conditions as in effect immediately before the Qualifying Event (or in the case of the bankruptcy of the Employer, any substantial elimination of coverage under the Plan occurring within 12 months before or after the date the bankruptcy proceeding commences), the persons losing such coverage become Qualified Beneficiaries under COBRA if all the other conditions of the COBRA law are also met.

The taking of leave under the Family Medical Leave Act of 1993 ("FMLA") does not constitute a Qualifying Event. A Qualifying Event occurs, however, if a Colleague does not return to employment at the end of the FMLA leave and all other COBRA continuation coverage conditions are present. If a Qualifying Event occurs, it occurs on the last day of FMLA leave and the applicable maximum coverage period is measured from this date (unless coverage is lost at a later date and the Plan provides for the extension of the required periods, in which case the maximum coverage date is measured from the date when the coverage is lost.) Note that the covered Colleague and family members will be entitled to COBRA continuation coverage even if they failed to pay the Colleague portion of premiums for coverage under the Plan during the FMLA leave.

What is the election period and how long must it last? An election period is the time period within which the Qualified Beneficiary can elect COBRA continuation coverage under the Employer's Plan. A Plan can condition availability of COBRA continuation coverage upon the timely election of such coverage. An election of COBRA continuation coverage is a timely election if it is made during the election period. The election period must begin not later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event and must not end before the date that is 60 days after the later of the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event or the date notice is provided to the Qualified Beneficiary of her or his right to elect COBRA continuation coverage.

Is a covered Colleague or Qualified Beneficiary responsible for informing the Plan Administrator of the occurrence of a Qualifying Event? In general, the Employer or Plan Administrator must determine when a Qualifying Event has occurred. However, each covered Colleague or Qualified Beneficiary is responsible for notifying the Plan Administrator of the occurrence of a Qualifying Event that is:

- (i) A Dependent child's ceasing to be a Dependent child under the generally applicable requirements of the Plan.
- (ii) The divorce or legal separation of the covered Colleague.

The Plan is not required to offer the Qualified Beneficiary an opportunity to elect COBRA continuation coverage if the notice is not provided to the Plan Administrator within 60 days after the later of: the date of the Qualifying Event, or the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event.

Is a waiver before the end of the election period effective to end a qualified beneficiary's election rights?

If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of COBRA continuation coverage. However, if a waiver is later revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent to the Employer or Plan Administrator, as applicable.

When may a Qualified Beneficiary's COBRA continuation coverage be terminated? During the election period, a Qualified Beneficiary may waive COBRA continuation coverage. Except for an interruption of coverage in connection with a waiver, COBRA continuation coverage that has been elected for a Qualified Beneficiary must extend for at least the period beginning on the date of the Qualifying Event and ending not before the earliest of the following dates:

- (i) The last day of the applicable maximum coverage period.
- (ii) The first day for which Timely Payment is not made to the Plan with respect to the Qualified Beneficiary.
- (iii) The date upon which the Employer ceases to provide any group health plan (including successor plans) to any Colleague.

- (iv) The date, after the date of the election, that the Qualified Beneficiary first becomes covered under any other Plan that does not contain any exclusion or limitation with respect to any pre-existing condition, other than such an exclusion or limitation that does not apply to, or is satisfied by, the Qualified Beneficiary.
- (v) The date, after the date of the election, that the Qualified Beneficiary first enrolls in the Medicare program (either part A or part B, whichever occurs earlier).
- (vi) In the case of a Qualified Beneficiary entitled to a disability extension, the later of:
 - (a) (i) 29 months after the date of the Qualifying Event, or (ii) the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier; or
 - (b) the end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension

The Plan can terminate for cause the coverage of a Qualified Beneficiary on the same basis that the Plan terminates for cause the coverage of similarly situated non-COBRA beneficiaries, for example, for the submission of a fraudulent claim.

In the case of an individual who is not a Qualified Beneficiary and who is receiving coverage under the Plan solely because of the individual's relationship to a Qualified Beneficiary, if the Plan's obligation to make COBRA continuation coverage available to the Qualified Beneficiary ceases, the Plan is not obligated to make coverage available to the individual who is not a Qualified Beneficiary.

What is the maximum coverage periods for COBRA continuation coverage? The maximum coverage periods are based on the type of the Qualifying Event and the status of the Qualified Beneficiary, as shown below.

- (i) In the case of a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period ends 18 months after the Qualifying Event if there is not a disability extension and 29 months after the Qualifying Event if there is a disability extension.
- (ii) In the case of a covered Colleague's enrollment in the Medicare program before experiencing a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period for Qualified Beneficiaries other than the covered Colleague ends on the later of:
 - (a) 36 months after the date the covered Colleague becomes enrolled in the Medicare program;
 - or
 - (b) 18 months (or 29 months, if there is a disability extension) after the date of the covered Colleague's termination of employment or reduction of hours of employment.
- (iii) In the case of a bankruptcy Qualifying Event, the maximum coverage period for a Qualified Beneficiary who is the retired covered Colleague ends on the date of the retired covered Colleague's death. The maximum coverage period for a Qualified Beneficiary who is the Spouse, surviving Spouse or Dependent child of the retired covered Colleague ends on the earlier of the

date of the Qualified Beneficiary's death or the date that is 36 months after the death of the retired covered Colleague.

- (iv) In the case of a Qualified Beneficiary who is a child born to or placed for adoption with a covered Colleague during a period of COBRA continuation coverage, the maximum coverage period is the maximum coverage period applicable to the Qualifying Event giving rise to the period of COBRA continuation coverage during which the child was born or placed for adoption.
- (v) In the case of any other Qualifying Event than that described above, the maximum coverage period ends 36 months after the Qualifying Event.

Under what circumstances can the maximum coverage period be expanded? If a Qualifying Event that gives rise to an 18-month or 29-month maximum coverage period is followed, within that 18- or 29-month period, by a second Qualifying Event that gives rise to a 36-months maximum coverage period, the original period is expanded to 36 months, but only for individuals who are Qualified Beneficiaries at the time of both Qualifying Events. In no circumstance can the COBRA maximum coverage period be expanded to more than 36 months after the date of the first Qualifying Event.

How does a Qualified Beneficiary become entitled to a disability extension? A disability extension will be granted if an individual (whether or not the covered Colleague) who is a Qualified Beneficiary in connection with the Qualifying Event that is a termination or reduction of hours of a covered Colleague's employment, is determined under Title II or XVI of the Social Security Act to have been disabled at any time during the first 60 days of COBRA continuation coverage. To qualify for the disability extension, the Qualified Beneficiary must also provide the Plan Administrator with notice of the disability determination on a date that is both within 60 days after the date of the determination and before the end of the original 18-month maximum coverage.

Can a Plan require payment for COBRA continuation coverage? Yes. For any period of COBRA continuation coverage, a Plan can require the payment of an amount that does not exceed 102% of the applicable premium except the Plan may require the payment of an amount that does not exceed 150% of the applicable premium for any period of COBRA continuation coverage covering a disabled qualified beneficiary that would not be required to be made available in the absence of a disability extension. A group health plan can terminate a qualified beneficiary's COBRA continuation coverage as of the first day of any period for which timely payment is not made to the Plan with respect to that qualified beneficiary.

Must the Plan allow payment for COBRA continuation coverage to be made in monthly installments? Yes. The Plan is also permitted to allow for payment at other intervals.

What is Timely Payment for payment for COBRA continuation coverage? Timely Payment means payment that is made to the Plan by the date that is 30 days after the first day of that period. Payment that is made to the Plan by a later date is also considered Timely Payment if either under the terms of the Plan, covered Colleague's or Qualified Beneficiaries are allowed until that later date to pay for their coverage for the period or under the terms of an arrangement between the Employer and the entity that provides Plan benefits on the Employer's behalf, the Employer is allowed until that later date to pay for coverage of similarly situated non-COBRA beneficiaries for the period.

Notwithstanding the above paragraph, a Plan cannot require payment for any period of COBRA continuation coverage for a Qualified Beneficiary earlier than 45 days after the date on which the election of COBRA continuation coverage is made for that Qualified Beneficiary. Payment is considered made on the date on which it is sent to the Plan.

COORDINATION OF BENEFITS

Coordination of the benefit plans. Coordination of benefits sets out rules for the order of payment of Covered Charges when two or more plans -- including Medicare -- are paying. When a Covered Person is covered by this Plan and another plan, or the Covered Person's Spouse is covered by this Plan and by another plan or the couple's Covered children are covered under two or more plans, the plans will coordinate benefits when a claim is received.

The plan that pays first according to the rules will pay as if there were no other plan involved. The secondary and subsequent plans will pay the balance due up to 100% of this plan's **allowable expenses**, or the primary plan's allowable expenses, whichever is less.

Benefit plan. This provision will coordinate the dental benefits of a benefit plan. The term benefit plan means this Plan or any one of the following plans:

- (1) Group or group-type plans, including franchise or blanket benefit plans.
- (2) Blue Cross and Blue Shield group plans.
- (3) Group practice and other group prepayment plans.
- (4) Federal government plans or programs. This includes Medicare.
- (5) Other plans required or provided by law. This does not include Medicaid or any benefit plan like it that, by its terms, does not allow coordination.
- (6) No Fault Auto Insurance, by whatever name it is called, when not prohibited by law.

Allowable charge. For a charge to be allowable it must be a Usual and Reasonable Charge and at least part of it must be covered under this Plan.

In the case of HMO (Health Maintenance Organization) or other in-network only plans: This Plan will not consider any charges in excess of what an HMO or network provider has agreed to accept as payment in full. Also, when an HMO or network plan is primary and the Covered Person does not use an HMO or network provider, this Plan will not consider as an allowable charge any charge that would have been covered by the HMO or network plan had the Covered Person used the services of an HMO or network provider.

Automobile limitations. When dental payments are available under vehicle insurance, the Plan shall pay excess benefits only, without reimbursement for vehicle plan deductibles. This Plan shall always be considered the secondary carrier regardless of the individual's election under PIP (personal injury protection) coverage with the auto carrier.

Coordinated Care. Any care or service that is rendered under the direction of or with an appropriate Referral or Preauthorization from the Member's Primary Care Physician.

In the case of service type plans where services are provided as benefits, the reasonable cash value of each service will be the allowable charge

Benefit plan payment order. When two or more plans provide benefits for the same allowable charge, benefit payment will follow these rules.

- (1) Plans that do not have a coordination provision, or one like it, will pay first. Plans with such a provision will be considered after those without one.

- (2) Plans with a coordination provision will pay their benefits up to the Allowable Charge:
- (a) The benefits of the plan which covers the person directly (that is, as a Colleague member or subscriber) ("Plan A") are determined before those of the plan which covers the person as a dependent ("Plan B").
 - (b) The benefits of a benefit plan which covers a person as a Colleague who is neither laid off nor retired are determined before those of a benefit plan which covers that person as a laid-off or Retired Colleague. The benefits of a benefit plan which covers a person as a Dependent of an Colleague who is neither laid off nor retired are determined before those of a benefit plan which covers a person as a Dependent of a laid off or Retired Colleague. If the other benefit plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.
 - (c) The benefits of a benefit plan which covers a person as an Colleague who is neither laid off nor retired or a Dependent of a Colleague who is neither laid off nor retired are determined before those of a plan which covers the person as a COBRA beneficiary.
 - (d) When a child is covered as a Dependent and the parents are not separated or divorced, these rules will apply:
 - (i) The benefits of the benefit plan of the parent whose birthday falls earlier in a year are determined before those of the benefit plan of the parent whose birthday falls later in that year;
 - (ii) If both parents have the same birthday, the benefits of the benefit plan, which has covered the patient for the longer time, are determined before those of the benefit plan which covers the other parent.
 - (e) When a child's parents are divorced or legally separated, these rules will apply:
 - (i) This rule applies when the parent with custody of the child has not remarried. The benefit plan of the parent with custody will be considered before the benefit plan of the parent without custody.
 - (ii) This rule applies when the parent with custody of the child has remarried. The benefit plan of the parent with custody will be considered first. The benefit plan of the stepparent that covers the child as a Dependent will be considered next. The benefit plan of the parent without custody will be considered last.
 - (iii) This rule will be in place of items (i) and (ii) above when it applies. A court decree may state which parent is financially responsible for medical and dental benefits of the child. In this case, the benefit plan of that parent will be considered before other plans that cover the child as a Dependent.
 - (iv) If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined above when a child is covered as a Dependent and the parents are not separated or divorced.
 - (f) If there is still a conflict after these rules have been applied, the benefit plan which has

covered the patient for the longer time will be considered first. When there is a conflict in coordination of benefit rules, the Plan will never pay more than 50% of allowable charges when paying secondary.

- (3) Medicare will pay primary, secondary or last to the extent stated in federal law. When Medicare is to be the primary payer, this Plan will base its payment upon benefits that would have been paid by Medicare under Parts A and B, regardless of whether or not the person was enrolled under both of these parts.
- (4) If a Plan Participant is under a disability extension from a previous benefit plan, that benefit plan will pay first and this Plan will pay second.

Right to receive or release necessary information. To make this provision work, this Plan may give or obtain needed information from another insurer or any other organization or person. This information may be given or obtained without the consent of or notice to any other person. A Covered Person will give this Plan the information it asks for about other plans and their payment of allowable charges.

Facility of payment. This Plan may repay other plans for benefits paid that the Plan Administrator determines it should have paid. That repayment will count as a valid payment under this Plan.

Right of recovery. This Plan may pay benefits that should be paid by another benefit plan. In this case this Plan may recover the amount paid from the other benefit plan or the Covered Person. That repayment will count as a valid payment under the other benefit plan.

Further, this Plan may pay benefits that are later found to be greater than the allowable charge. In this case, this Plan may recover the amount of the overpayment from the source to which it was paid.

RIGHT OF SUBROGATION, RECOVERY AND REFUND

When this provision applies. The Covered Person may incur dental or medical charges due to injuries which may be caused by the act or omission of a third party or a third party may be responsible for payment. In such circumstances, the Covered Person may have a claim against that third party, or insurer, for payment of the dental or medical charges. Accepting benefits under this Plan for those incurred medical or dental expenses automatically assigns to the Plan any rights the Covered Person may have to recover payments from any third party or insurer. This subrogation right allows the Plan to pursue any claim which the Covered Person has against any third party, or insurer, whether or not the Covered Person chooses to pursue that claim. The Plan may make a claim directly against the third party or insurer, but in any event, the Plan has a lien on any amount recovered by the Covered Person whether or not designated as payment for dental expenses. This lien shall remain in effect until the Plan is repaid in full.

The Covered Person:

- (1) automatically assigns to the Plan his or her rights against any third party or insurer when this provision applies; and
- (2) must repay to the Plan the benefits paid on his or her behalf out of the recovery made from the third party or insurer.

Amount subject to subrogation or recovery. The Covered Person agrees to recognize the Plan's right to subrogation and reimbursement. These rights provide the Plan with a priority over any funds paid by a third party to a Covered Person relative to the Injury or Sickness, including a priority over any claim for non-dental or dental charges, attorney fees, or other costs and expenses.

Notwithstanding its priority to funds, the Plan's subrogation and refund rights, as well as the rights assigned to it, are limited to the extent to which the Plan has made, or will make, payments for dental or dental charges as well as any costs and fees associated with the enforcement of its rights under the Plan. However, the Plan's

right to subrogation still applies if the recovery received by the Covered Person is less than the claimed damage, and, as a result, the claimant is not made whole.

When a right of recovery exists, the Covered Person will execute and deliver all required instruments and papers as well as doing whatever else is needed to secure the Plan's right of subrogation as a condition to having the Plan make payments. In addition, the Covered Person will do nothing to prejudice the right of the Plan to subrogate.

Defined terms: "Recovery" means monies paid to the Covered Person by way of judgment, settlement, or otherwise to compensate for all losses caused by the Injuries or Sickness whether or not said losses reflect dental or dental charges covered by the Plan.

"Subrogation" means the Plan's right to pursue the Covered Person's claims for dental or medical charges against the other person.

"Refund" means repayment to the Plan for dental or medical benefits that it has paid toward care and treatment of the Injury or Sickness.

Recovery from another plan under which the Covered Person is covered. This right of refund also applies when a Covered Person recovers under an uninsured or underinsured motorist plan, homeowner's plan, renter's plan, dental malpractice plan or any liability plan.

In the event Gannon University provides benefits for personal injury, illness or other loss to any beneficiary, it shall be subrogated to all rights of recovery that the beneficiary or his/her heirs, guardians, executors or other representatives have arising out of the injury and is entitled to reimbursement of the total amount of benefits it disbursed as a result of that injury if the beneficiary obtains recovery from any third party or other source, including, but not limited to, Workers' Compensation. Gannon University subrogation and/or reimbursement rights include, without limitation, all rights to reimbursement of all benefits disbursed and all rights of recovery a beneficiary has: (1) against any person, insurance company or other entity that is in any way responsible for providing compensation, damages or indemnification for the injury; (2) under any law, policy of insurance or accident benefit plan providing no fault, personal injury protection or financial responsibility coverage and under, uninsured or underinsured motorist insurance; (3) under dental reimbursement insurance coverage not purchased by the beneficiary submitting the claim; and (4) under specific risk accident and health coverage or insurance, including, without limitation, "school" or "team" coverages or insurance. Gannon University subrogation and/or reimbursement rules and its provisions may not be modified by beneficiaries or other persons unless the modification is specifically authorized in writing by Gannon University.

The beneficiary and anyone acting on his/her behalf shall, on request, provide Gannon University with information it deems necessary to protect its right of subrogation and/or reimbursement and shall do nothing to prejudice that right and shall cooperate with Gannon University in the enforcement of its subrogation and/or reimbursement rights. The Trustees of Gannon University are vested with full discretionary authority to determine eligibility for benefits, to construe subrogation and/or reimbursement and other provisions and to reduce or compromise the amount of Gannon University's recoverable interest where, in the sole discretion of the Trustees, circumstances warrant such reduction. The amount Gannon University's subrogation and/or reimbursement interest shall be deducted first from any recovery by or on behalf of the beneficiary. Gannon University shall not be responsible for any expenses or fees incurred in connection with a recovery unless it shall have agreed in writing to pay those expenses or fees. Gannon University reserves the right to initiate an action in the name of the beneficiary in order to recovery its subrogation and/or reimbursement interest. The Trustees reserve the right to require, as a condition precedent to disbursement of benefits, the beneficiary's execution of a subrogation and/or reimbursement agreement of the type provided by Gannon University.

Should it be necessary for Gannon University to institute legal action against the beneficiary for failure to reimburse Gannon University in full, or to honor the equitable interest in the amount recovered by the beneficiary from a third party, the beneficiary shall be liable for all costs of collection, including reasonable attorney's.

RESPONSIBILITIES FOR PLAN ADMINISTRATION

PLAN ADMINISTRATOR. THE GANNON UNIVERSITY DENTAL PLAN is the benefit plan of GANNON UNIVERSITY the Plan Administrator, also called the Plan Sponsor. It is to be administered by the Plan Administrator in accordance with the provisions of ERISA. An individual may be appointed by GANNON UNIVERSITY to be Plan Administrator and serve at the convenience of the Employer. If the Plan Administrator resigns, dies or is otherwise removed from the position, GANNON UNIVERSITY shall appoint a new Plan Administrator as soon as reasonably possible.

The Plan Administrator shall administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits, to decide disputes which may arise relative to a Plan Participant's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator will be final and binding on all interested parties.

Service of legal process may be made upon the Plan Administrator.

DUTIES OF THE PLAN ADMINISTRATOR

- (1) To administer the Plan in accordance with its terms.
- (2) To interpret the Plan, including the right to remedy possible ambiguities, inconsistencies or omissions.
- (3) To decide disputes which may arise relative to a Plan Participant's rights.
- (4) To prescribe procedures for filing a claim for benefits and to review claim denials.
- (5) To keep and maintain the Plan documents and all other records pertaining to the Plan.
- (6) To appoint a Claims Administrator to pay claims.
- (7) To perform all necessary reporting as required by ERISA.
- (8) To establish and communicate procedures to determine whether a medical child support order is qualified under ERISA Sec. 609.
- (9) To delegate to any person or entity such powers, duties and responsibilities, as it deems appropriate.

PLAN ADMINISTRATOR COMPENSATION. The Plan Administrator serves **without** compensation; however, all expenses for plan administration, including compensation for hired services, will be paid by the Plan.

FIDUCIARY. A fiduciary exercises discretionary authority or control over management of the Plan or the disposition of its assets, renders investment advice to the Plan or has discretionary authority or responsibility in the administration of the Plan.

FIDUCIARY DUTIES. A fiduciary must carry out his or her duties and responsibilities for the purpose of providing benefits to the Colleagues and their Dependent(s), and defraying reasonable expenses of administering the Plan. These are duties, which must be carried out:

- (1) with care, skill, prudence and diligence under the given circumstances that a prudent person, acting in a like capacity and familiar with such matters, would use in a similar situation;
- (2) by diversifying the investments of the Plan so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so; and
- (3) in accordance with the Plan documents to the extent that they agree with ERISA.

THE NAMED FIDUCIARY. A "named fiduciary" is the one named in the Plan. A named fiduciary can appoint others to carry out fiduciary responsibilities (other than as a trustee) under the Plan. These other

persons become fiduciaries themselves and are responsible for their acts under the Plan. To the extent that the named fiduciary allocates its responsibility to other persons, the named fiduciary shall not be liable for any act or omission of such person unless either:

- (1) the named fiduciary has violated its stated duties under ERISA in appointing the fiduciary, establishing the procedures to appoint the fiduciary or continuing either the appointment or the procedures; or
- (2) the named fiduciary breached its fiduciary responsibility under Section 405(a) of ERISA.

CLAIMS ADMINISTRATOR IS NOT A FIDUCIARY. A Claims Administrator is **not** a fiduciary under the Plan by virtue of paying claims in accordance with the Plan's rules as established by the Plan Administrator.

PLAN IS NOT AN EMPLOYMENT CONTRACT

The Plan is not to be construed as a contract for or of employment.

CLERICAL ERROR

Any clerical error by the Plan Administrator or an agent of the Plan Administrator in keeping pertinent records or a delay in making any changes will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered.

If, due to a clerical error, an overpayment occurs in a Plan reimbursement amount, the Plan retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money. In the case of a Plan Participant, if it is requested, the amount of overpayment will be deducted from future benefits payable.

ADMINISTRATION OF THE PLAN

The Plan is administered through the personnel office of the Employer. The Employer has retained the services of Benefit Administrators, Inc. (BAI) experienced in claims processing. Fiscal records are maintained for a Plan Year ending the last day of each year.

The Plan is a legal entity. Legal notices may be filed with and legal process served upon the Agent for Legal Services.

PLAN AND AMENDMENT

The Company establishes this Plan with the intention of maintaining it for an indefinite period of time. However, the Company reserves the right to amend or terminate this Plan at any time, in compliance with the following provisions:

1. The Company shall have the right to amend this Plan in whole or in part. Amendment shall be by a resolution of the Board of Directors or other similar governing body of the Company or by the written approval of an authorized officer of the Company. No amendment may retroactively affect Colleagues' benefits unless necessary to conform the Plan to the requirements of ERISA, the Internal Revenue Code of 1986, as amended, or regulations issued under those statutes.
2. The Company reserves the right at any time to terminate the Plan by a written resolution of the Board of Directors or other similar governing body of the Company or by the written approval of an authorized officer of the Company.

PLAN TERMINATION

The Employer may terminate the Plan at any time. Upon termination, the rights of the Plan Members to benefits are limited to claims incurred and due up to the date of termination. Any termination of the Plan will be communicated to Plan Members.

THE GROUP DENTAL PROGRAM IS NOT AVAILABLE ON A DIRECT BILLING BASIS.

A. PREDETERMINATION

Predetermination is used by the Administrator to determine eligibility of the member and to review the treatment plan to determine the extent of coverage. This assures both the member and the dentist that the particular service that will be performed is a covered service. However, approval by the Administrator of the treatment plan during the predetermination process does not necessarily constitute acceptance by the Administrator of liability for the services involved in the treatment plan. For example, if the patient's coverage is terminated before the planned treatment is completed, the Administrator will not be liable for any services provided after the date of such termination.

Predetermination is required for:

1. Prosthetics and Crown, Inlay, and Onlay Restorations;
2. Periodontics; and
3. Orthodontics.

Predeterminations, including proposed treatment codes, charge, and x-rays and/or narrative, should be sent to BAI by the dentist.

B. ALTERNATE TREATMENT

Frequently, your dentist can choose from several alternate methods of treating a particular dental problem. For example, a tooth can be restored with either a crown or a filling; and missing teeth can be replaced with either a fixed bridge or a partial denture. In cases where alternate methods of treatment are possible, the Administrator will make payment based on its allowance for the less expensive procedure provided that the less expensive procedure meets accepted standards of dental treatment.

The Administrator's decision on the allowance it will pay does not commit you to the less expensive procedure. You may decide to have the more costly treatment and to be responsible for the additional charges beyond those for the treatment paid by the Administrator.

C. PAYMENT FOR SERVICES TO MEMBERS WILL BE LIMITED AS FOLLOWS:

1. In the event a member transfers from the care of one dentist to that of another dentist during the course of treatment, or if more than one dentist performs services for one dental procedure, the Administrator shall be liable for not more than the amount it would have been liable for had but one dentist performed the service.
2. A contract between member and dentist, prior to the effective date of coverage under this contract, is not invalidated by a subsequent contract made between the Administrator and/or member and/or dentist. The member will be liable for any difference due to the dentist under such a contract after the Administrator's liability has been satisfied.
3. Any additional treatment that is necessitated by lack of member cooperation with the dentist or non-compliance with prescribed dental care that results in additional liability will be the responsibility of the member.

D. PROOF OF CLAIMS

The Plan Administrator shall have the right and opportunity to examine records for you or your eligible dependents when it may be required during pendency of any claim under the Plan.

The Plan Administrator shall have the right to require the dentist's statement of the treatment, study models, pre- and post-operative x-rays and any such additional evidence it deems necessary as proof of loss on which a claim under the Dental Assistance Benefits may be based and has the right to deny any claim when this information has not been furnished.

SECTION IV

GENERAL EXCLUSIONS AND LIMITATIONS

A. EXCEPT AS SPECIFICALLY PROVIDED IN THIS BOOKLET, YOU ARE NOT COVERED FOR SERVICES, SUPPLIES, OR CHARGES THAT:

1. Are not prescribed by or performed by or under the direct supervision of a dentist;
2. Are submitted by a dentist and another professional provider which are the same services performed on the same date for the same patient;
3. Are not medically or dentally necessary as determined by the Administrator;
4. Are experimental or investigative in nature;
5. Are for any illness or bodily injury which occurs in the course of employment, if benefits or compensation are available, in whole or in part, under the provisions of any legislation of the Worker's Compensation Act as amended from time to time. This exclusion applies whether or not you claim the benefits or compensation;
6. The cost of which has been or is later recovered in any action at law or in compromise or settlement of any claim except where prohibited by law;
7. Are provided by any governmental unit;
8. You would have no legal obligation to pay in the absence of this or any similar coverage;
9. Are received from a dental or medical department maintained by or on behalf of any employer, a mutual benefit association, labor union, trust, or similar person or group;
10. Are performed prior to the effective date;
11. Are incurred after your termination date unless otherwise indicated;
12. Are not necessary, according to accepted standards of dental practice, or which are not recommended or approved by the attending dentist;
13. Do not meet accepted standards of dental practice;
14. Are for unusual procedures and techniques;
15. Are not billed by the dentist;
16. Are performed by a dentist who in any case is compensated by the facility for similar covered services performed for patients;
17. Telephone consultations, charges for failure to keep a scheduled appointment, or charges for completion of a claim form;

18. Are cosmetic in nature, including, but not limited to, charges for personalization or characterization of prosthetic appliances;
19. Duplicate and temporary devices, appliances, and services;
20. Are related to the diagnoses and treatment of temporomandibular joint dysfunction;
21. Plaque control programs and for oral hygiene and dietary instructions;
22. Implantology and related services;
23. Alter vertical dimension and/or restore or maintain the occlusion. Such procedures include, but are not limited to: equilibration, periodontal splinting, full mouth rehabilitation, restoration for malalignment of the teeth;
24. Local anesthesia and nitrous oxide when billed for separately by a dentist;
25. Gold foil restorations;
26. Treatment or services for injuries resulting from the maintenance or use of a motor vehicle if such treatment or service is paid or payable under a plan or policy of motor vehicle insurance, including a certified self-insured plan, or payable in any manner under the Pennsylvania Motor Vehicle Financial Responsibility Law;
27. Any other dental service or treatment except as provided in this booklet.
28. Orthodontics
29. Services related to the removal of partial and/or full bony impacted wisdom teeth.

SECTION V

ERISA

STATEMENT OF ERISA RIGHTS

As a participant in your employer's dental plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA), ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits.

Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

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

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

In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operations of the Colleague benefit plan. The people who operate your plan, called “fiduciaries” of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a dental benefit or exercising your rights under ERISA.

If your claim for dental benefits 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 limits. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to \$110.00 a day until you receive the materials, unless the materials were not sent because of reasons beyond the administrator’s control. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan’s decision or lack thereof concerning the qualified status of a domestic relations order or dependent support order, you may file suit in Federal court. If it should happen that the plan’s fiduciaries misuse the plan’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in Federal court. The court will decide who should pay the 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 frivolous.

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Pension and Welfare Benefit Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publication hotline of Pension and Welfare Benefits Administration.

SECTION VI

PERMITTED USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

A. Use and Disclosure of Protected Health Information (PHI)

The Dental Plan ("Plan") will use protected health information (PHI) to the extent of and in accordance with the uses and disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Specifically, the Plan will use and disclose PHI for purposes related to health care treatment, payment for health care and health care operations.

Payment includes activities undertaken by the Plan to obtain premiums or determine or fulfill its responsibility for coverage and provision of plan benefits that relate to an individual to whom health care is provided. These activities include, but are not limited to, the following:

- determination of eligibility, coverage and cost sharing amounts (for example, cost of a benefit, plan maximums and copayments as determined for an individual's claim);
- coordination of benefits;
- adjudication of health benefit claims (including appeals and other payment disputes);
- subrogation of health benefit claims;
- establishing employee contributions;
- billing, collection activities and related health care data processing;
- claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes and responding to participant

- inquiries about payments;
- obtaining payment under a contract for reinsurance (including stop-loss and excess of loss insurance);
- medical necessity reviews or reviews of appropriateness of care or justification of charges;
- utilization review, including precertification, preauthorization, concurrent review and retrospective review;
- disclosure to consumer reporting agencies related to the collection of premiums or reimbursement (the following PHI may be disclosed for payment purposes: name and address, date of birth, Social Security number, payment history, account number and name and address of the provider and/or health plan); and
- reimbursement to the plan.

Health Care Operations include, but are not limited to, the following activities:

- quality assessment;
- population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting health care providers and patients with information about treatment alternatives and related functions;
- rating provider and plan performance, including accreditation, certification, licensing or credentialing activities;
- underwriting, premium rating and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing or placing a contract for reinsurance of risk relating to health care claims (including stop-loss insurance and excess of loss insurance);
- conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;
- business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the Plan, including formulary development and administration, development or improvement of payment methods or coverage policies;
- business management and general administrative activities of the Plan, including, but not limited to:
 - (a) management activities relating to the implementation of and compliance with HIPAA's administrative simplification requirements, or
 - (b) customer service, including the provision of data analyses for policyholders, plan sponsors or other customers;
- resolution of internal grievances; and
- due diligence in connection with the sale or transfer of assets to a potential successor in interest, of the potential successor in interest is a "covered entity" under HIPAA or, following completion of the sale or transfer, will become a covered entity.

B. The Plan Will Use and Disclose PHI as Required by Law and as Permitted by Authorization of the Participant or Beneficiary

With an authorization, the Plan will disclose PHI to the following plans for purposes related to administration of these plans: Dental Plan

C. Your Employer Is the Plan Sponsor

The Plan will disclose PHI to the Plan Sponsor only upon receipt of a certification from the Plan Sponsor that the plan documents have been amended to incorporate the following provisions.

D. With Respect to PHI, the Plan Sponsor Agrees to Certain Conditions

The Plan Sponsor agrees to:

- not use or further disclose PHI other than as permitted or required by the plan document or as required by law;
- ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;
- not use or disclose PHI for employment-related actions and decisions unless authorized by an individual;
- not use or disclose PHI in connection with any other benefit or employee benefit plan of the Plan Sponsor unless authorized by an individual;
- report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which it becomes aware;
- make PHI available to an individual in accordance with HIPAA's access requirements;
- make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;
- make available the information required to provide an accounting of disclosures;
- make internal practices, books and records relating to the use and disclosure of PHI received from Plan available to the HHS Secretary for the purposes of determining the Plan's compliance with HIPAA; and
- if feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form, and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible).

E. Adequate Separation Between the Plan and the Plan Sponsor Must Be Maintained

In accordance with HIPAA, only the following employees or classes of employees may be given access to PHI:

- the benefits manager; and
- staff designated by the benefits manager.

F. Limitations of PHI Access and Disclosure

The persons described in section E may only have access to and use and disclose PHI for plan administration functions that the Plan Sponsor performs for the Plan.

G. Noncompliance Issues

If the persons described in section E do not comply with this plan document, the Plan Sponsor shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

PLAN NAME: THE GANNON UNIVERSTIY DENTAL PLAN

IRS PLAN NUMBER: NONE

TAX ID NUMBER: 25-0496976

PLAN EFFECTIVE DATE: 1/1/02
Restated 4/1/06

PLAN YEAR ENDS: 12/31/

EMPLOYER INFORMATION:
GANNON UNIVERSITY
109 UNIVERSITY SQUARE
ERIE, PA 16541

PLAN ADMINISTRATOR:
GANNON UNIVERSITY
109 UNIVERSITY SQUARE
ERIE, PA 16541

NAMED FIDUCIARY:
GANNON UNIVERSITY
109 UNIVERSITY SQUARE
ERIE, PA 16541

AGENT FOR SERVICE OF LEGAL PROCESS:
GANNON UNIVERSITY
109 UNIVERSITY SQUARE
ERIE, PA 16541

CLAIMS ADMINISTRATOR:
BENEFIT ADMINISTRATORS, INC.
P.O BOX 6279
ERIE, PENNSYLVANIA 16512
(814) 454-0167