

**SUMMARY PLAN DESCRIPTION
OF THE DENTAL BENEFITS
UNDER THE
UTICA COLLEGE HEALTH BENEFITS PLAN**

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Summary Plan Description
of the Dental Benefits under the
Utica College Health Benefits Plan

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INTRODUCTION

Utica College (the “Employer”) established the Utica College Health Benefits Plan (the “Plan”) effective July 1, 1995 to provide health benefits for its eligible employees. This Summary Plan Description (“SPD”) presents a brief description of the Plan. It is not meant to interpret, extend, or change the official Plan documents. If there is any conflict between this SPD and the Plan documents, the Plan documents will govern your rights to benefits. Copies of the Plan documents are available for inspection in the Plan Office at the office of the Compensation & Benefits Manager, Utica College, 1600 Burrstone Road, Utica, New York, 13502, during regular business hours.

The information in this SPD may be modified by a “Summary of Material Modification” (“SMM”). Check to see if there are any SMMs attached when you refer to this SPD.

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IMPORTANT PLAN INFORMATION YOU SHOULD KNOW

Plan Name: Utica College Health Benefits Plan

Plan Number: 501

Plan Type: Welfare Plan providing dental benefits

Plan Year: The Plan Year begins on January 1 and ends on December 31.

Employer and Plan Sponsor: Utica College
1600 Burrstone Road
Utica, New York 13502
315-792-3024

Employer Identification Number: 16-1476258

Plan Administrator: Utica College
1600 Burrstone Road
Utica, New York 13502
315-792-3024

Type of Plan Administration: The Plan is self-funded by the Employer, which means all of the benefits are paid from the general assets of the Employer. Delta Dental of New York, One delta Drive, Mechanicsburg, PA, 17055, processes claims and pays benefits for the Employer, but is not the Plan Administrator or an insurer of the Plan. The Employer is responsible for determining the benefits available under the Plan, deciding requirements for eligibility to participate in the Plan, and setting participants' costs for coverage. The Compensation & Benefits Manager is the primary source for information about these aspects of the Plan.

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**Plan Agent for Service
of Legal Process:**

Utica College
1600 Burrstone Road
Utica, New York 13502

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1. Who is eligible to become a participant in the Plan?

An employee of the Employer is eligible to become a participant if he is a benefit eligible employee of the Employer who works at least 17 1/2 hours per week, excluding Adjunct Faculty.

Notwithstanding the above, a person providing services to the Employer through a temporary agency or employee leasing organization, or as an independent contractor, is not eligible to participate even if that person is later classified as an employee of the Employer for employment tax, unemployment insurance, or other purpose, by a government agency or a court.

2. How do I become a participant in the Plan?

You must complete an enrollment form and return it to the Compensation & Benefits Manager no later than:

- within 30 days after you satisfy the requirements for eligibility
- or before the end of any open enrollment period announced by the Employer (assuming you still satisfy the eligibility requirements)

You must indicate your choice for the level of coverage (single, employee +1, or family coverage) on the enrollment form. By returning a completed enrollment form, you agree to pay your portion of the cost for Plan coverage through payroll deductions.

If you do not enroll during the periods described above, special enrollment rules may allow you to enroll at other times. (See Question & Answer 4).

3. When does Plan coverage begin?

If you satisfy all of the requirements for coverage, your Plan coverage for an employee will begin on:

- the date you satisfy the requirements for eligibility if you complete and file your enrollment form within 30 days of satisfying the requirements

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- the first day of the Plan Year after the end of an open enrollment period if you complete and file your enrollment form during the open enrollment period
- if a special enrollment rule applies (see Question & Answer 4), the date you complete and file your enrollment form

Except when a special enrollment rule applies (see Question & Answer 4), if your spouse, domestic partner or child satisfies all of the requirements for coverage, his or her Plan coverage will begin on:

- the date your Plan coverage begins if you enrolled the spouse, domestic partner or child for coverage
- the date you acquire the spouse, domestic partner or child (through marriage, or birth or adoption of a child), provided you enroll the spouse, domestic partner or child and change to the appropriate coverage level within thirty (30) days thereafter.

For purposes of the Plan, your “spouse” is the person to whom you are legally married for purposes of State law. However, if your spouse is covered under the Plan but is not considered your spouse for federal income tax purposes and is not your tax dependent, you will have imputed taxable income equal to the fair market value of your spouse’s coverage (less any amount paid for that coverage on an after-tax basis).

For a person to be considered an employee’s domestic partner for purposes of Plan coverage, the employee and domestic partner must satisfy the following requirements:

- You must share a close committed personal relationship, and have shared the same regular permanent residence for at least six (6) months.
- You must be financially interdependent.
- You can not have a blood relationship that would bar you from marrying in the State where you reside.
- Each of you must be at least eighteen (18) years old.
- Each of you must be the other’s sole domestic partner and intend to remain so indefinitely.

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- Neither of you may be legally married to, or have had another domestic partner relationship with, anyone else within the last six (6) months.
- You must both sign and file an affidavit with the employer stating: (i) the date your domestic relationship began; (ii) that you satisfy all of the requirements above; and (iii) that you will give the employer written notice no later than thirty (30) days after the date you fail to satisfy any of the requirements above. The affidavit must also state whether your domestic partner qualifies as your dependent for federal income tax purposes.

The employee and domestic partner must also provide any other information and documentation that the employer may require to verify the domestic partner relationship.

The fair market value of Plan coverage for an employee's domestic partner (less any amount paid for that coverage on an after-tax basis) is treated as taxable income to the employee if the domestic partner does not qualify as a dependent under tax law. The employer will comply with all federal and state tax withholding and reporting requirements for domestic partner coverage.

Your child is eligible for Plan coverage:

- if the child is an unmarried child under age 20 who is not on active military duty in the armed services of any country
- if the child is an unmarried child under age 26 who is a full-time college student and is financially dependent on you
- if the child is an unmarried child who became physically or mentally disabled (provided such condition occurred before the child reached the age at which his coverage under the Plan would otherwise terminate).

Your child is:

- a newborn, natural child, or a child placed with you for adoption;
- a stepchild who receives more than one-half of his or her support from you;
or

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- any other child for whom you have legal guardianship or court-ordered custody, provided that the child receives more than one-half of his or her support from you.

Note that a domestic partner's child is not eligible for Plan coverage unless the child qualifies as the employee's child.

If you and your spouse are both employees and participating in the Plan, your children will be considered children of one, but not both, of you.

4. When do the special enrollment rules apply?

Generally, these special rules apply in the following situations:

- If you initially decline Plan coverage because you had other health care coverage, but you later lose that other coverage through no fault of your own (including a situation in which you, your spouse, domestic partner or child, incur a claim under that other health care coverage that meets or exceeds a lifetime limit on all benefits under that coverage), you can enroll yourself, your spouse or your domestic partner and your children within thirty (30) days after losing the other health care coverage. Note, in order for this special enrollment rule to apply, at the time you initially declined Plan coverage you must have provided in writing your reason for declining it.
- If you initially decline Plan coverage because you had other health care coverage from another employer, but that employer stops contributing toward the cost of that other coverage, you can enroll yourself, your spouse or your domestic partner and any child within thirty (30) days after that employer stops contributing toward the cost of the other coverage. Note, in order for this special enrollment rule to apply, at the time you initially declined Plan coverage you must have provided in writing your reason for declining it.
- If you decline Plan coverage and you later acquire a new spouse, domestic partner or child (through birth or adoption of a child), and you wish to cover that person, you can enroll yourself, your spouse or domestic partner and your children within the thirty (30) day period after the marriage, birth, adoption or placement for adoption.

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- If you, your spouse, domestic partner or child loses eligibility for Medicaid coverage or coverage under a State Children's Health Insurance Program, you can enroll yourself, your spouse, domestic partner or your child within the sixty (60) day period following the loss of that coverage.
- If you, your spouse, domestic partner or child becomes eligible to participate in a premium assistance program under Medicaid or a State Children's Health Insurance Program, you can enroll yourself, your spouse, domestic partner or your child within the sixty (60) day period following that eligibility determination.

5. How much must I pay for Plan coverage?

You are required to pay for Plan coverage you select. The following chart shows your cost for coverage.

Option	Employee Monthly Cost
Single	39.94
Employee+1	78.05
Family	120.92

If there are ordinary increases or decreases in your cost for coverage, your payroll deductions will automatically be adjusted to reflect the change in cost. The Employer will provide participants with advance written notice of any changes to their cost.

6. When can I change my Plan coverage?

In general, once you have enrolled (or decided not to enroll) in the Plan and selected your level of Plan coverage, you cannot change your decision until an open enrollment period, which is usually just before the next Plan Year. However, you may be able to change your enrollment decision, and/or your type or level of coverage, if any event occurs that entitles you to special enrollment rights (see Question & Answer 4).

You may also be able to make a change if any of the following occurs during a Plan Year:

- a change in health coverage available through your spouse's or domestic partner's employment

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- your domestic partner relationship terminates (i.e., the date you and your domestic partner no longer satisfy the requirements listed in the Answer to Question 3).
- a change in legal marital status (e.g., through marriage, divorce, legal separation, annulment, or death of spouse)
- a change in your employment status, or the employment status of your spouse, domestic partner or child
- a change in the number of your children eligible for coverage
- your residence changes to a place outside the area for the type of coverage you chose
- a change in your work schedule or the work schedule of your spouse, domestic partner or child (e.g., an unpaid leave of absence, switch between full-time and part-time, or a strike or lockout)
- the coverage you chose is eliminated or is significantly curtailed
- the cost of the coverage you chose significantly increases.

Contact the Compensation & Benefits Manager immediately if any of these events occurs and you want to change your enrollment decision and/or your type or level of coverage. Even if you can make the change you desire, you will have a limited period of time after the event (e.g., 30 days) to make it.

7. What benefits are available if I am a participant in the Plan?

The benefits available under the Plan are described in the Appendix at the end of this SPD

8. When does my Plan coverage end?

Unless you are eligible for and elect COBRA coverage (see Question & Answer 17 for explanation of this coverage), your Plan coverage will end on:

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- the date your employment terminates or you no longer satisfy the eligibility requirements to participate in the Plan
- the last day of the month for which you paid your cost for Plan coverage

9. When does Plan coverage for my spouse, domestic partner or child end?

Unless your spouse or child is eligible for and elects COBRA coverage (see Question & Answer 17 for an explanation of this coverage), his or her coverage under the Plan will end on:

- the date your Plan coverage ends
- the date as of which you remove the spouse or child from coverage
- in the case of your spouse, upon divorce
- in the case of a child, when he or she no longer qualifies as a child for purposes of the Plan (See Question & Answer 3.)

If your domestic partner is covered under the Plan, his or her coverage will end on the earlier of the date:

- your coverage under the Plan ends;
- the date as of which you remove your domestic partner from Plan coverage
- your domestic partner relationship terminates (i.e., the date you and your domestic partner no longer satisfy the requirements listed in the Answer to Question 3).

Note that employees' domestic partners are not eligible for COBRA coverage.

10. What happens when I retire?

Retirement is treated as the termination of your employment and your Plan coverage will end as described above. (See Question 8 "When does my Plan coverage end?")

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11. What happens if the Plan pays or provides a benefit that it should not have paid or provided?

If payments are made by the Plan that exceed the Plan's benefit limits, or any other Plan rule or provision, the excess amount may be recovered from the person who received the payments, the person for whom the payments were made, or from any insurance company or other party that should have paid the expense for which the excess payment was made. The Plan Administrator can also decrease (up to the amount of the excess payment) any future benefits otherwise payable under the Plan to the participant who benefited from the excess payment.

12. What happens if the Plan pays a benefit for a participant, his spouse, domestic partner or child relating to an injury, sickness or condition caused by another person?

In that case, the Plan is subrogated to any right the participant, spouse, domestic partner or child (or his or her legal representative, heirs or beneficiaries) may have against the person(s) who caused the injury, sickness or condition. The participant, spouse, domestic partner or child (and his or her legal representative, heirs and beneficiaries) may not act to prejudice this right of subrogation, and must execute and deliver documents and do whatever else is necessary to secure the Plan's right of subrogation (including the right to sue). The Plan Administrator may require the participant, spouse, domestic partner or child (and his or her legal representative, heirs or beneficiaries) to sign an agreement acknowledging these subrogation rights as a condition to receiving payment from the Plan. However, the Plan's subrogation rights will not be affected if the Plan Administrator does not require such an agreement. These subrogation rights are not diminished or otherwise affected if the total recovery obtained by the participant, spouse, domestic partner or child is less than the amount necessary to make him whole for all of the expenses and other damages related to the injury, sickness or condition.

13. Who decides what benefits are available under the Plan and which employees are eligible to participate?

The Plan Administrator has the power and discretion to: change the terms of the Plan (including rules for eligibility to participate); establish, increase, decrease or eliminate specific Plan benefits; and administer the Plan in all of its details, including the authority to: (i) decide issues of fact relevant to the eligibility of any person to receive benefits, or the amount or time of payment of benefits; (ii) interpret the terms of the Plan; (iii) supply any omission, interpret any ambiguous or uncertain provision of the Plan; and (iv) reconcile any inconsistency that may appear in the Plan.

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14. Can the Employer ever amend or terminate the Plan?

Yes. The Employer maintains the Plan on a voluntary basis and has the right to amend or terminate the Plan, and terminate any provided under the Plan, at any time with respect to any individual, group, or class of employees or former employees. No person ever has a vested right to Plan coverage.

15. What if I have questions about coverage or benefits, or want to make a claim for benefits?

If you have questions about eligibility under the Plan or the cost of Plan coverage, you should contact the Compensation & Benefits Manager, Utica College, 1600 Burrstone Road, Utica, New York, 13502, 315-792-3024. If you have questions about specific benefits, you should contact:

Delta Dental of New York
One Delta Drive
Mechanicsburg, PA 17055

Claims for benefits should also be submitted to:

Delta Dental of New York
PO Box 2105
Mechanicsburg, PA 17055-2105

The claim procedures are different for “concurrent claims,” “pre-service claims,” “post-service claims,” and “urgent claims.” A concurrent claim is a request for an extension of health treatment (i.e., treatment provided over a period of time or a number of treatments). A pre-service claim is a claim requiring advance approval to receive all or part of the benefit. A post-service claim is any claim that is not a pre-service claim. An urgent claim is any claim for medical care or treatment that, if non-urgent claim procedures were followed, could seriously jeopardize the life or health of the patient or his ability to regain maximum function, or in the opinion of a physician with knowledge of the patient’s medical condition would subject the patient to severe pain that cannot be adequately managed without the care or treatment requested.

You may appoint someone to file a claim and act on your behalf; provided you give the Plan signed written notification of the appointment. In the case of an urgent claim, a health care professional with knowledge of your medical condition will be permitted to act as your representative.

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Post-service claims must be filed within 90 days after the service or expense claimed was incurred. All claims must be filed on forms provided by Delta Dental of New York and submitted by mail, except urgent claims may be made orally and information may be transmitted by telephone (800) 932-0783, provided that any necessary written forms are later completed and filed.

If you make a request for benefits that does not comply with the Plan's procedure for pre-service claims, you will be notified of the proper procedure within 24 hours if it involves an urgent pre-service claim, or within five days if it involves a non-urgent pre-service claim. (This notification may be oral, unless you request written notification.)

If a claimant fails to submit sufficient information for a determination on an urgent claim, he will be notified of the specific information necessary to complete the claim within 24 hours after the Plan receives the claim. He may then submit the additional information within 48 hours, and will be notified of the determination on his claim within 48 hours after the earlier of the receipt of the additional information or the end of the period the additional information could have been submitted.

A claimant will be notified of the determination on his claim within: 24 hours in the case of a concurrent claim involving urgent health care if the request is received at least 24 hours before the scheduled expiration of the treatments; 72 hours in the case of any other urgent claim (or earlier if possible); 15 days in the case of a non-urgent pre-service claim; or 30 days in the case of a post-service claim. However, if an extension to make a determination on a non-urgent claim is necessary due to reasons beyond the Plan's control, the time to make the determination may be extended for up to another 15 days. In that case, the claimant will receive written notice of the reasons for the extension, any additional information required from him to make the determination, and the date the determination is expected. Also, if the extension is necessary because additional information is needed from the claimant, the claimant will be given 45 days from the date he receives the notice to provide the information.

If an adverse determination is made, the claimant will be sent a notice containing: (i) the specific reasons for the adverse determination; (ii) references to the specific Plan provisions on which it is based; (iii) the names of any medical or vocational experts whose advice was obtained by the Plan in connection with the determination; (iv) a description of any additional material or information necessary to complete the claim and an explanation of why it is necessary; (v) a description of the Plan's review procedures and time limits; (vi) a statement that the claimant has a right to sue under the Employee Retirement Income Security Act following an adverse determination upon review; (vii) if

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the Plan relied upon an internal rule, guideline, protocol or similar criterion in making the determination, either the criterion relied upon or a statement that the Plan relied upon such criterion and that a copy of the criterion is available free of charge upon request; (viii) if the determination was based upon a medical necessity, experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination (applying the terms of the Plan to the claimant's medical circumstances), or a statement that such explanation will be provided free of charge upon request; and (ix) for urgent claims, a description of the expedited review procedure for such claims. This notice may be provided orally for an urgent claim, but will then be sent to the claimant in writing within three days after oral notification.

Within 180 days after receiving an adverse determination, a claimant may file a written appeal to the Customer Advocate Division of Delta Dental of New York or to your Plan Administrator for a full and fair review of the claim and determination. He may submit written comments, documents and other information relating to the claim, and may have reasonable access to, and copies of, all documents, records, and other information relevant to the claim. For an urgent claim, the claimant may request, in writing or orally, an expedited review of the initial determination, and information may be transmitted by telephone (800) 932-0783, provided that any necessary written forms are later completed and filed.

A reduction or termination of health treatment (other than by Plan amendment or termination) will be treated as an adverse determination, and the participant or beneficiary will be notified sufficiently in advance to allow him to appeal before the reduction or termination occurs.

The review on appeal will take into account all documents, records and information submitted by the claimant, and will be conducted by an appropriate named fiduciary who did not make the initial determination and who is not a subordinate of the person who did. For a claim based on medical judgment (e.g., whether a treatment or drug is experimental, investigational, or medically necessary or appropriate), the person conducting the review will consult with a state licensed or certified independent health care professional with appropriate training and experience in the field who was not consulted in connection with the initial determination and is not a subordinate of any health care professional who was consulted.

The claimant will be notified of the determination on review within 72 hours after the Plan receives the request for review of an urgent claim (or earlier if possible), 30 days after the Plan receives a request for review of a non-urgent pre-service claim, or 60 days after the Plan receives a request for review of a post-service claim.

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The notice of an adverse determination on review will contain: (i) the specific reasons for the adverse determination; (ii) reference to the specific Plan provisions on which the determination is based; (iii) a statement that, upon request, the claimant is entitled free of charge to reasonable access to, and copies of, all documents and records relevant to the claim; (iv) if the Plan relied upon some internal rule, guideline, protocol, or similar criterion in making the determination, either the criterion relied upon or a statement that the Plan relied upon such criterion and a copy of the criterion is available free of charge upon request; (v) if the determination is based upon a medical necessity, experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; (vi) a statement that the claimant has a right to sue under the Employee Retirement Income Security Act; and (vii) the following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

16. What additional rights does a participant have?

Federal law gives participants rights with regard to coverage and certain specific benefits. The following is a summary of those rights.

Health Insurance Portability and Accountability Act of 1996

You may be entitled to commence, continue, suspend and recommence participation in this Plan in accordance with your rights under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Information concerning your HIPAA rights is available from the Compensation & Benefits Manager, Utica College, 1600 Burrstone Road, Utica, New York, 13502, 315-792-3024.

Family and Medical Leave Act

If you are eligible for and take a leave of absence under the Family and Medical Leave Act ("FMLA Leave"), you may continue Plan coverage during the FMLA Leave, provided you would have been continuously employed during the entire FMLA Leave and you pay the participant cost for Plan coverage during the FMLA Leave. Plan coverage will continue as if you were actively employed by the Employer until the earlier of the date (1) the FMLA Leave ends or, (2) you notify the Employer that you will not return to work. If you choose not to continue Plan coverage during an FMLA Leave, you

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may resume Plan coverage when you return to work, provided you return when the FMLA Leave expires and you are still eligible to participate in the Plan (see Question and Answer 1), and any pre-existing condition exclusion rules under the Plan will be waived.

You are also eligible to elect COBRA coverage after the FMLA Leave if you:

- were covered under the Plan on the day before the FMLA Leave,
- do not return to work at the end of the FMLA Leave, and
- would otherwise lose coverage under the Plan.

You also may be able to elect COBRA coverage even if you choose not to continue regular Plan coverage during the FMLA Leave, or you stop paying your cost for Plan coverage during the FMLA Leave.

Information concerning your right to and obligations during a leave is available from the Compensation & Benefits Manager, Utica College, 1600 Burrstone Road, Utica, New York, 13502, phone 315-792-3024 or fax 315-792-3386.

HIPAA Privacy Rights

The Plan has responsibilities under Health Insurance Portability and Accountability Act (“HIPAA”) regarding the use and disclosure of your protected health information (“PHI”). Your PHI is any information that: (i) identifies you or may reasonably be used to identify you; (ii) is created or received by a health care provider, health plan, employer or health care clearinghouse; and (iii) relates to your past, present or future physical or mental health or condition, or the provision of or payment for health care.

The Plan is required to maintain the privacy of your PHI. It is also required to provide you with a notice of its legal duties and privacy practices, and to follow the terms of the privacy notice. However, the Plan is also permitted by law to use and disclose your PHI in certain ways, which are described in the privacy notice.

If you believe your PHI has been impermissibly used or disclosed, or that your privacy rights have been violated in any way, you may file a complaint with the Plan or with the Secretary of United States Department of Health and Human Services. If you want a copy of the Plan’s privacy notice or more information about the Plan’s privacy practices, or you want to file a privacy violation complaint, please contact Lisa Green, Utica College, 1600 Burrstone Road, , Utica, New York, 13502, phone (315) 792-3024 or fax (315) 792-3386.

COBRA Continuation Coverage

You may have a right under “COBRA” to continue to participate in the Plan after you would otherwise lose coverage under the Plan by continuing to make payments to the Plan, plus an administrative charge, on an after-tax instead of a pre-tax basis. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage may become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family when they would otherwise lose your group health coverage. Below is a summary of COBRA continuation coverage, when it may become available, and what you need to do to protect the right to receive it.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a “qualifying event.” Specific qualifying events are listed below. After a qualifying event, COBRA continuation coverage must be offered to each person who is a “qualified beneficiary.” You, your spouse, and your children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- (1) Your hours of employment are reduced; or
- (2) Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- (1) Your spouse dies;
- (2) Your spouse's hours of employment are reduced;
- (3) Your spouse's employment ends for any reason other than his or her gross misconduct;
- (4) Your spouse becomes enrolled in Medicare (Part A, Part B, or both); or
- (5) You become divorced or legally separated from your spouse.

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Note that employees' domestic partners are not eligible for COBRA coverage.

Your children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- (1) The parent-employee dies;
- (2) The parent-employee's hours of employment are reduced;
- (3) The parent-employee's employment ends for any reason other than his or her gross misconduct;
- (4) The parent-employee becomes enrolled in Medicare (Part A, Part B, or both);
- (5) The parents become divorced or legally separated; or
- (6) The child stops being eligible for coverage under the Plan as a child.

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the Employer must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse or a child's losing eligibility for coverage), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: Compensation & Benefits Manager, Utica College, 1600 Burrstone Road, Utica, New York, 13502. The notice must be in writing, and must contain your name and address, the name and address of any affected persons, a description of the qualifying event, and the date of the qualifying event. You may be asked to provide additional documentation or information after you have submitted the notice.

How is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each qualified beneficiary. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of

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their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), divorce or legal separation, or loss of a child's eligibility, COBRA continuation coverage lasts for up to total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration ("SSA") to be disabled and you provide proper and timely notice of the SSA determination, you and your entire family may be entitled to receive up to an additional 11 months of COBRA coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. You must provide this notice to the Compensation & Benefits Manager, Utica College, 1600 Burrstone Road, Utica, New York, 13502 within 60 days of the date of the SSA determination and before the end of the 18-month period of COBRA continuation coverage. The notice must be in writing, and must contain your name and address, the name and address of the disabled qualified beneficiary, and the date the disability was determined to have begun. You must also attach a copy of the SSA determination. You may be asked to provide additional documentation or information after you have submitted the notice.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event while receiving 18 months of

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COBRA continuation coverage and you provide proper and timely notice of the second qualifying event, the spouse and children in your family may be entitled to up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the child stops being eligible under the Plan, but only if the event would have caused the spouse or child to lose coverage under the Plan had the first qualifying event not occurred. You must provide this notice to the Compensation & Benefits Manager, Utica College, 1600 Burrstone Road, Utica, New York, 13502 within 60 days after the second qualifying event. The notice must be in writing, and must contain your name and address, the name and address of any affected persons, a description of the second qualifying event, and the date of the second qualifying event. You may be asked to provide additional documentation or information after you have submitted the notice.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan Contact Information

Information about the Plan and COBRA continuation coverage can be obtained from the Compensation & Benefits Manager, Utica College, 1600 Burrstone Road, Utica, New York, 13502, 315-792-3024.

Uniformed Services Employment and Reemployment Rights Act

The Uniformed Services Employment and Reemployment Rights Act (“USERRA”) also gives an employee who is absent from work due to service in the uniformed services (including active or reserve duty, whether voluntary or involuntary, and time off for training or instruction) the right to continuation coverage under the Plan if the employee is covered under the Plan when the period of military service begins, and certain other requirements are satisfied. For example, the period of military service generally cannot exceed five years, and the employee (or an appropriate officer) must give advance oral or written notice of the absence to the Employer as early as is reasonable under the circumstances, unless notice is prevented by military necessity or is otherwise impossible or unreasonable under the circumstances.

An employee entitled to USERRA continuation coverage may elect continuation coverage (for him/herself and his/her covered spouse and covered children) for a period of up to 24 months. However, USERRA continuation coverage will terminate if the employee’s military service ends because of: (i) separation from service with a dishonorable or bad-conduct discharge; (ii) separation from service under certain less-than-honorable conditions; or (iii) for a commissioned officer, dismissal in connection with a court-martial or, in time of war, by the President, or dropping of the commissioned officer from the rolls as a result of an unauthorized absence for at least three months or as a result of a sentence imposed after a court-martial or a conviction in another court. USERRA continuation coverage will also terminate if the employee fails to report back to work or apply for reemployment within the time period required under USERRA after completion of military leave.

All election and payment procedures, rules and deadlines for USERRA continuation coverage under the Plan are the same as the COBRA continuation coverage election and payment procedures, rules and deadlines, except to the extent any of those procedures, rules or deadlines conflict with USERRA regulations (e.g., if compliance with any particular procedure, rule or deadline is precluded by military necessity or is otherwise impossible or unreasonable under the circumstances).

An employee also has the right to reinstatement in the Plan, without any exclusions or waiting periods due to the military leave, when he/she timely returns to work after a military leave, assuming he/she is otherwise eligible for Plan coverage. If the employee timely returns to work after a military leave before the maximum USERRA continuation coverage period but the employee is not reinstated in the Plan because he/she is not eligible for coverage at that time (for reasons unrelated to the military leave), then the

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employee has a right to continuation coverage for the entire 24 month USERRA continuation coverage period (or, if sooner, the date he/she is reinstated).

Qualified Medical Child Support Order

A Qualified Medical Child Support Order (QMCSO) is an order by a court for one parent to provide a child or children with health coverage. If the Plan receives a QMCSO for your child or children, you will be contacted about the procedure for the QMCSO. Copies of the Plan's QMCSO procedures are available, without charge, from the Plan Administrator.

Your Rights Under ERISA

As a participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

This includes the ability to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series), if applicable, filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series), if applicable, and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report, if any. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report, if applicable.

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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 Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your Employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance With Your Questions

If you have any questions about 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 Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and

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Inquiries, Employee Benefits Security 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 publications hotline of the Employee Benefits Security Administration.

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APPENDIX

DESCRIPTION OF BENEFITS

Delta Dental PPO* – Easy, Friendly, Accessible

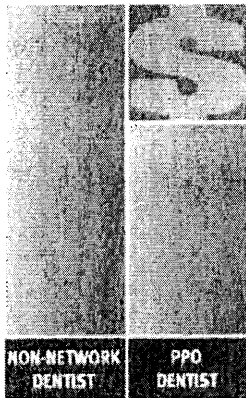


We'll do whatever it takes and then some.

Greatest potential savings when you visit a Delta Dental PPO dentist.

OUT-OF-POCKET COSTS

SAVE LESS SAVE MORE



AMOUNT YOU SAVE
AMOUNT YOU PAY

Illustration showing sample enrollee share of cost for information purposes only. Actual dentist fees and contract allowances will vary by region, procedure and by group contract.

We're pleased to be your partner in maintaining great oral health. The Delta Dental PPO* plan makes it easy for you to find a dentist, and easy to control your costs when you visit a network dentist. Here are some of the great things you'll need to know about enrolling with Delta Dental:

- **Save money with a Delta Dental PPO dentist.** Our PPO network dentists accept reduced fees for covered services they provide you, so you'll usually pay the least when you visit a PPO network dentist. This also ensures Delta Dental dentists won't balance bill you the difference between the contracted amount and their usual fee.
- **Visit the dentist of your choice.** Want to visit a non-Delta Dental dentist? No problem. You can visit any licensed dentist, but your costs are usually lowest when you see a PPO dentist.
- **Many network dentists to choose from.** Since Delta Dental offers access to some of the largest dentist networks in the U.S., chances are there's a wide choice of network dentists near your home or office. Four out of five dentists nationwide

are contracted Delta Dental dentists, giving more enrollees convenient access to more dentists. Visit us at www.deltadentalins.com to search our dentist directory by location or specialty.

- **Easy to use your benefits.** When you visit a Delta Dental dentist, pay only your portion for services. Delta Dental dentists will file claim forms for you and receive payment directly from us. Many non-Delta Dental dentists ask that you pay the entire cost up front and wait for reimbursement.
- **Delta Dental's Online Services make getting information quick and easy.** Access your benefits and eligibility, print ID cards and get information about your claims. And check out Delta Dental's oral health resources too for tips and information that can help keep your smile healthy.

* In Texas, Delta Dental Insurance Company offers a Dental Provider Organization (DPO) plan.

 **DELTA DENTAL**

WE KEEP YOU SMILING.®

Plan Benefit Highlights for: Utica College

Group No: 10898

Eligibility	Primary enrollee, spouse (includes domestic partner) and eligible dependent children to age 20 or the end of the month in which dependent graduates or the exact day in which dependent reaches age 26, whichever comes first, if dependent is full-time student
Deductibles Deductibles waived for Diagnostic & Preventive (D & P), & Orthodontics?	\$50 per person / \$150 per family each calendar year Yes
Maximums D & P counts toward maximum?	\$1,000 per person each calendar year Yes

Delta Dental PPOSM
Benefit Highlights

Benefits and Covered Services*	Delta Dental PPO dentists**	Non-PPO dentists** (Delta Dental Premier[®] & Non-Delta Dental Dentists)
Diagnostic & Preventive Services Exams, cleanings, x-rays, sealants, periodontal prophylaxes	100 %	100 %
Basic Services Fillings, stainless steel crowns	80 %	80 %
Endodontics (root canals) Covered Under Basic Services	80 %	80 %
Periodontics (gum treatment) Covered Under Basic Services	80 %	80 %
Oral Surgery Covered Under Basic Services	80 %	80 %
Major Services Crowns, inlays, onlays and cast restorations	40 %	40 %
Prosthodontics Bridges and dentures	40 %	40 %
Orthodontic Benefits dependent children to age 19	50 %	50 %
Orthodontic Maximums	\$ 1,250 Lifetime	\$ 1,250 Lifetime

* Limitations or waiting periods may apply for some benefits; some services may be excluded from your plan. Reimbursement is based on Delta Dental maximum contract allowances and not necessarily each dentist's submitted fees.

** Reimbursement is based on PPO contracted fees for PPO dentists, Premier contracted fees for Premier dentists and 90th percentile for non-Delta Dental dentists.

Delta Dental of New York
One Delta Drive
Mechanicsburg, PA 17055

Customer Service
800-932-0783
(Business Hours: 8 am to 8 pm ET)

Claims Address
P.O. Box 2105
Mechanicsburg, PA 17055-2105

deltadentalins.com

This benefit information is not intended or designed to replace or serve as the plan's Evidence of Coverage or Summary Plan Description. If you have specific questions regarding the benefits, limitations or exclusions for your plan, please consult your company's benefits representative.