SUMMARY PLAN DESCRIPTION

COLGATE UNIVERSITY

DELTA DENTAL GROUP NUMBER 2504

Dental Benefits Administered by:

Delta Dental of New York
The benefit explanations contained herein are subject to all provisions of the Group Dental Contract, and do not modify such contract in any way, nor shall a participant or beneficiary ("Subscriber") accrue any rights because of any statement in or omission from this booklet. If there is any inconsistency between the Group Dental Service Contract ("Contract"), this booklet shall be interpreted in such a way so that the Contract provisions govern.
SUMMARY PLAN DESCRIPTION
COLGATE UNIVERSITY
DELTA DENTAL GROUP NUMBER 2504

1. NAME OF PLAN:
   Colgate University

2. NAME AND ADDRESS OF EMPLOYER, TRUST OR PLAN SPONSOR:
   Colgate University
   13 Oak Drive
   Hamilton, NY 13346

3. TAX IDENTIFICATION NUMBER AND PLAN NUMBER:
   Tax Identification Number: 15-0532078
   Plan Number: 513

4. TYPE OF WELFARE PLAN:
   Group Dental.

5. TYPE OF ADMINISTRATION:
   Insurer providing claims administration

6. NAME, BUSINESS ADDRESS AND TELEPHONE NUMBER OF ADMINISTRATORS:
   The Plan Administrator is:
   Colgate University
   13 Oak Drive
   Hamilton, NY 13346
   Tel. 315-228-7565

   The Claims Administrator is:
   Delta Dental of New York (“Delta Dental”)
   One Delta Drive
   Mechanicsburg, PA 17055
   Tel. 800-932-0783
   Web: www.deltadentalins.com
7. NAME AND ADDRESS OF PERSON DESIGNATED FOR SERVICE OF PROCESS:

Associate Vice President for Human Resources
Colgate University
13 Oak Drive
Hamilton, NY 13346

8. NAME, TITLE AND BUSINESS ADDRESS OF EACH TRUSTEE:

Associate Vice President for Human Resources
Colgate University
13 Oak Drive
Hamilton, NY 13346

9. COLLECTIVE BARGAINING AGREEMENTS APPLICABLE TO PLAN:

The Plan is maintained pursuant to the collective bargaining agreements for Local 200 United and SEIU: A copy of any such agreement or agreements may be obtained by participants and beneficiaries upon written request to the Plan Administrator and is available for examination by participants and beneficiaries.

10. ELIGIBILITY TO PARTICIPATE IN THE PLAN:

Regular full-time or part-time employees in established positions who work a minimum of 1,040 hours per academic year.

While you are an eligible employee, dental coverage is available to you until you terminate employment, subject to continuation of coverage under COBRA explained in Section 13.

You may enroll for Individual or Family membership if you are an eligible employee. Family coverage provides not only for you and your spouse or domestic partner, but also for:

- your unmarried children, including legally adopted children and stepchildren who actually live with you, until the end of the month they attain nineteen (19) years of age;

- such unmarried children who are full-time students, until they leave school or they attain twenty-five (25) years of age;

- unmarried children of any age who are mentally or physically disabled and incapable of self-support, if you are the parent or legal guardian and if disabled before age nineteen (19);

- newborn children of any covered person for thirty-one (31) days after birth; and,

- children who are the subject of a Court Order directed to you. Participants and beneficiaries can obtain, without charge, a copy of procedures governing Qualified Medical Child Support Orders (“QMCSOs”) from the Plan Administrator.
You may change from Individual coverage to Family coverage by applying for it within thirty-one (31) days after you marry. If you apply, your new coverage becomes effective as of the date of marriage as long as we have been notified within thirty-one (31) days. Employees who do not change from Individual coverage to Family coverage when first eligible may change later – during a subsequent open enrollment period, as applicable.

You can also change from Family coverage to Individual coverage at any time by completing a new application. The change becomes effective on the first of the month after you complete the application.

11. BENEFITS:

The Plan provides benefits for dental procedures which are summarized below in this Section and described in the brochure furnished to Subscribers at no cost by the Plan Administrator. Notification is given of changes which may occur in the coverage from time to time. Replacements for lost or misplaced copies of the brochure or changes in coverage will be furnished by the Plan Administrator.

Diagnostic – Procedures to assist dentists to evaluate existing conditions and dental care required – to include visits, exams, diagnoses and x-rays.

Preventive – Prophylaxis (cleaning); fluoride treatments, limited to age nineteen (19); space maintainers, limited to age fourteen (14); and sealants, limited to age nineteen (19).

Basic Restorative – Amalgam (“silver”) and composite (“white”) fillings.

Major Restorative – Crowns, inlays, and onlays are benefited where above materials are not adequate.

Oral Surgery – Extraction and oral surgery procedures, including pre- and post-operative care.

Endodontics – Procedures for pulpal therapy and root canal filling.

Periodontics – Surgical and non-surgical procedures for treatment of gums and supporting structures of teeth.

Prosthodontics – Procedures for construction or repair of fixed bridges, partial or complete dentures.

Implants – Appliances placed into bone serving as prosthodontics abutments.

Injectable Antibiotics - Antibiotic drugs that are administered by injection.
Copayment Schedule

<table>
<thead>
<tr>
<th>Service</th>
<th>Paid by Delta Dental</th>
<th>Paid by Subscriber</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnostic</td>
<td>100%</td>
<td>0%</td>
</tr>
<tr>
<td>Preventive</td>
<td>100%</td>
<td>0%</td>
</tr>
<tr>
<td>Basic Restorative</td>
<td>80%</td>
<td>20%</td>
</tr>
<tr>
<td>Major Restorative</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Oral Surgery</td>
<td>80%</td>
<td>20%</td>
</tr>
<tr>
<td>Endodontics</td>
<td>80%</td>
<td>20%</td>
</tr>
<tr>
<td>Periodontics</td>
<td>80%</td>
<td>20%</td>
</tr>
<tr>
<td>Prosthodontics</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Implants</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Tomographic Surveys</td>
<td>100%</td>
<td>0%</td>
</tr>
<tr>
<td>Management of Acute Infections and Oral Lesions</td>
<td>80%</td>
<td>20%</td>
</tr>
<tr>
<td>Treatment of Fractures and Dislocations</td>
<td>80%</td>
<td>20%</td>
</tr>
<tr>
<td>Diagnostic and Treatment of Cysts and Abscesses</td>
<td>80%</td>
<td>20%</td>
</tr>
<tr>
<td>Bacteriological Studies</td>
<td>80%</td>
<td>20%</td>
</tr>
<tr>
<td>Pulp Vitality Tests</td>
<td>80%</td>
<td>20%</td>
</tr>
<tr>
<td>Injectable Antibiotics</td>
<td>80%</td>
<td>20%</td>
</tr>
<tr>
<td>Occlusal Guards</td>
<td>80%</td>
<td>20%</td>
</tr>
<tr>
<td>Gold Foils</td>
<td>80%</td>
<td>20%</td>
</tr>
<tr>
<td>Splinting</td>
<td>80%</td>
<td>20%</td>
</tr>
</tbody>
</table>

The payment percentages listed above are subject to exclusions and limitations, described below in this Section, and more specifically in the Contract. The Copayment Schedule is used in determining Payment for Services explained below in this Section.

Note: Maximum benefit is $1,500 per person per calendar year. All services are subject to a calendar year deductible of $25 per person (not to exceed $50 per family).

Procedures and Services Not Covered

- Prescription drugs, premedications, relative analgesia.
- Charges for hospitalization, including hospital visits.
- Plaque control programs, including oral hygiene and dietary instruction.
- Procedures to correct congenital or developmental malformations except for covered dependent children and newborn children eligible at birth.
- Procedures, appliances or restorations primarily for cosmetic purposes.
- Increasing vertical dimension.
- Replacing tooth structure lost by attrition.
- Gnathological recordings.
Equilibration.
Treatment of dysfunctions of the temporomandibular joint.
Orthodontic services, including tooth guide appliances.
Experimental procedures.

Benefit Limitations

- Prophylaxis and exams are a benefit twice in any calendar year.
- Bitewing x-rays are a benefit twice in any calendar year.
- Full mouth x-rays are a benefit once in any three (3) year period.
- Sealants are a benefit, limited to age nineteen (19), once in any thirty-six (36) month period on unfilled permanent first and second molars.
- Fluoride is a benefit, limited to age nineteen (19), twice in any calendar year.
- Replacement of restorative crowns, inlays and onlays is a benefit once only in any five (5) year period irrespective of who provided previous restoration or paid benefits therefore.
- Replacement of prosthodontic devices is a benefit once only in any five (5) year period irrespective of who provided previous devices or paid benefits therefore. The five (5) year frequency limitation is waived if the replacement is a result of an accidental injury.
- Episodes of periodontal treatment must be separated by a period of no less than twelve (12) months per quadrant to qualify the patient for additional periodontal benefits.
- Crowns on patients up to age fifteen (15) are limited to the cost of plastic or stainless steel crowns; crowns on patients age fifteen (15) and older are paid according to the plan allowance.
- Gold fillings are a covered benefit.
- Gold foils are a covered benefit.
- Occlusal guards are a covered benefit, once in any three (3) year period.
- General Anesthesia is benefited with oral and periodontal surgery.
- Management of acute infections and oral lesions is a covered benefit.
- Substandard work until corrected.

Important: The covered procedures, copayments, exclusions and limitations previously described and in the brochure are subject to all provisions of the Contract.

Participating Dentists Networks

Participating Dentists are licensed dentists who have entered into an agreement with Delta Dental to abide by Delta Dental's policies regarding services, your portion of the charged fees, and other matters pertinent to Delta Dental's obligations to Subscribers. For your program, Delta Dental has two networks: Participating Dentists who are Delta Dental PPO℠ Dentists, the smaller of the two networks, and Participating Dentists who are not Delta Dental PPO Dentists (Delta Dental Premier® Dentists only.)

Listings are made available to Subscribers separately and the Listings and Updates are furnished automatically by the Plan Administrator without charge. Names of Participating Dentists can be obtained, upon request, by calling Delta Dental or from directory listings furnished to the Plan Administrator or from the Delta Dental Internet web site at www.deltadentalins.com.
Payment for Services

Payment for services is determined in accordance with the specific terms of your dental plan or with the terms of Delta Dental’s agreements with Delta Dental network dentists.

Payment for services performed for you by Participating Dentists who are Delta Dental PPO (“PPO”) Dentists is calculated by Delta Dental on the basis of a reduced Maximum Plan Allowance (“reduced MPA”) or the fee charged, whichever is less (“PPO Allowed Amount”). Participating Dentists who are Delta Dental PPO Dentists have agreed to accept the PPO Allowed Amount as full payment for services covered by the Contract.

Payment for services performed for you by Participating Dentists who are not Delta Dental PPO Dentists (Delta Dental Premier Dentists only) is calculated by Delta Dental on the basis of a Maximum Plan Allowance (“MPA”) or the fee charged, whichever is less (“Delta Dental Premier Allowed Amount”). Participating Dentists who are Delta Dental Premier Dentists only have agreed to accept the Delta Dental Premier Allowed Amount as full payment for services covered by the Contract.

Delta Dental calculates its share of the PPO Allowed Amount or Delta Dental Premier Allowed Amount using the previously described Copayment Schedule (“Delta Dental Payment”) and sends it to the Participating Dentist. Delta Dental advises you of any charges not payable by Delta Dental for which you are responsible (“Patient Payment”). If your Dentist is a Delta Dental PPO Dentist, the Patient Payment is generally the difference between the Delta Dental Payment and the PPO Allowed Amount – i.e., copayments, deductibles, charges where maximums have been exceeded – and charges for services not covered by the Contract. If your Dentist is a Delta Dental Premier Dentist only, the Patient Payment is generally the difference between the Delta Dental Payment and the Delta Dental Premier Allowed Amount – i.e., copayments, deductibles, charges where maximums have been exceeded – and charges for services not covered by the Contract.

Payment for services performed for you by a Non-Participating Dentist is calculated by Delta Dental using a maximum fee level that may be higher than Delta Dental's Maximum Plan Allowance. Delta Dental pays its Delta Dental Payment to you. You are responsible for payment of the Non-Participating Dentist’s total fee, which may include amounts in addition to the Delta Dental Payment amount and services not covered by the Contract.

Assignment of Benefits

The Assignment of Benefits claim form should be used if you choose to visit a non-participating dentist. After dental services have been rendered, the dentist should complete this claim form and you should sign your name in the box labeled, “Direction to pay benefit to dentist,” at the bottom of the form. (If you would like the benefit payment sent directly to you rather than to the dentist, you should not sign this box.)
The claim form should be mailed to:

**Delta Dental**  
**One Delta Drive**  
**Mechanicsburg, PA 17055**  
**attn: Claims Department**

After the claim is processed, the benefit payment will be mailed to the dentist along with an Explanation of Benefits.

You are responsible for paying the difference between the Delta Dental payment and the dentist's total fee. This amount may include any applicable deductibles, maximums or copayments. Delta Dental will mail you an Explanation of Benefits.

**Predetermination of Benefits**

Neither preauthorization nor utilization review are conditions for obtaining benefits under the plan. There are no special conditions or limitations applicable to obtaining emergency care.

If total charges for a treatment plan for you, your spouse or domestic partner or a dependent child exceed an amount which Delta Dental establishes ($300), predetermination is recommended for approval of the charges for payment. The attending dentist is requested to submit the claim form in advance of performing services. Delta Dental will act promptly in returning a predetermination voucher to the attending dentist and the Subscriber to be treated with verification of eligibility, scope of benefits and definition of sixty (60) day period for completion of services.

The notification shall also state the amount which will be paid by you and Delta Dental provided the Subscriber to be treated is eligible on the date when each respective procedure is commenced, the procedures are completed within a sixty (60) day period following the date of the predetermination notice, the claim is submitted not more than twelve (12) months after the date of service and the benefits continue to be within applicable benefit maximums and frequency of procedure limitations. Subject to the continuing eligibility of the Subscriber to be treated, applicable benefit maximums not being exhausted and the continuing inapplicability of frequency of procedure limitations, Delta Dental will grant extensions of a benefit predetermination period upon request from the attending dentist or Subscriber to be treated.

**Coordination of Benefits Without Internal COB**

If separate dental benefits are available to you, your spouse or domestic partner, or a dependent child under other programs, except ones available to you, your spouse or a dependent child because you, your spouse or domestic partner or a dependent child are employed by the same employer, there are specific conditions applicable to determination of payment. The ratio of each carrier's liability to total cost incurred is reviewed. Payment is made according to the “birthday” rule adopted by most insurance carriers, but in no case does Delta Dental pay in excess of its total contractual obligation, if it were the only carrier involved. If the other carrier determines its benefits first, Delta Dental will pay any difference between the amount paid by the other carrier and the charge for the covered
service, to the extent of Delta Dental's benefit for a given procedure. If separate dental benefits are available to you because you, your spouse or a dependent child are employed by the same employer, payment is made by Delta Dental according to the Delta Dental program covering you, your spouse or domestic partner or a dependent child as an employee without reference to the other programs of the same employer. If separate dental benefits are available for a dependent child of you and your spouse or domestic partner as employees of the same employer, payment is made by Delta Dental according to the Delta Dental program of the employee indicated by the birthday rule without reference to the other programs of the same employer.

12. DISQUALIFICATION, LOSS OF ELIGIBILITY AND TERMINATION:

Please refer to the Colgate Plan Document for eligibility requirements.

Your dependent children will be disqualified for benefits when they reach the disqualifying age. You will lose eligibility on termination of your employment and you do not qualify for continuation coverage under COBRA, described in Section 13, or, if you qualify for continuation coverage, you will lose eligibility on termination of that coverage.

Dental coverage ceases on the last day of the month you stop working for Colgate University or immediately when this program ends.

Coverage for all dependents ceases on the last day of the month in which your active employee coverage ends, or when dependent status is lost.

On termination of coverage under the Plan, you, your spouse or domestic partner, or dependent child may be eligible for Continuation Coverage, as described in Section 13, at your or their own expense.

The Employer or Plan Sponsor, named in Section 2, reserves the right to terminate the Plan, in whole or in part, at any time (subject to applicable collective bargaining agreements). Termination of the Plan will result in loss of benefits for all covered persons.

13. CONTINUATION COVERAGE UNDER COBRA:

Introduction

This section contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This section generally explains COBRA continuation coverage, when it may become available to you, your spouse, your domestic partner, and your dependent children, and what you need to do to protect the right to receive it.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and
obligations under the Plan and under federal law, you should contact the Plan Administrator.

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 later in this section. After a qualifying event, COBRA continuation coverage must be offered to each person who is a “qualified beneficiary.” You, your spouse, your domestic partner and your dependent 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 coverage under the Plan because either one of the following events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

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

- Your spouse/domestic partner dies,
- Your spouse/domestic partner’s hours of employment are reduced;
- Your spouse/domestic partner’s employment ends for any reason other than his or her gross misconduct;
- Your spouse/domestic partner becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

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

- The parent-employee dies;
- The parent-employee’s hours of employment are reduced;
- The parent-employee’s employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan as a “dependent 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.

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 of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of 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), your divorce or legal separation, or a dependent child’s losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a 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 to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation 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 in writing along with a copy of the Social Security Administration Determination within sixty (60) days from the date of the Determination to:
Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse or domestic partner and dependent children in your family can get 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 or domestic partner and any dependent 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 dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or domestic partner, or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

If your dependent children attain the age of nineteen (19), or twenty-five (25) if full-time students, or recover from a disability while you are eligible to participate in the Plan or after you have elected continuation coverage, they are eligible to continue to participate in the Plan at their own expense with identical benefits for thirty-six (36) months from the date their eligibility under the Plan ceases.

If you have elected Family membership, any child who is born to or placed for adoption with you during the period of continuation coverage is eligible to participate in the Plan.

Notice:

You, your spouse or domestic partner or dependent children must notify the Plan Administrator of divorce, separation, disability, a change in dependent status or that a child has been born to or placed for adoption with you within sixty (60) days after the later of 1) the date of the event 2) the date of the loss of coverage, 3) the date of the determination from the Social Security Administration of disability or 4) the date on which you are informed through this summary plan description or a general notice of the responsibility to provide notice and the Plan’s procedures for providing notice, whichever is later, in order for your spouse or domestic partner or dependent children to be offered separate applicable continuation coverage or you, your spouse or domestic partner or dependent children to receive extended disability continuation coverage.

When the Human Resources Department is notified or learns of a qualifying event, the Human Resources Department will send you or your eligible dependent(s) a written explanation of the right to elect continuation coverage.

You or an eligible dependent then have sixty (60) days from either the date of this explanation or the date on which your existing coverage would end, whichever occurs later, to notify the Human Resources Department of your election. If you or an eligible dependent do not respond in writing within the time limit, the right to elect to continue coverage under COBRA will be lost.
If you, your spouse or domestic partner or dependent children are on extended continuation coverage for disability and receive a final determination from the Social Security Administration that there is no longer a disability under Titles II or XVI of the Social Security Act, the person on extended continuation coverage must notify the Plan Administrator within thirty (30) days of the final determination.

When the Human Resources Department is notified or learns of a qualifying event, the Human Resources Department will send you or your eligible dependent(s) a written explanation of the right to elect continuation coverage.

You or an eligible dependent then have sixty (60) days from either the date of this explanation or the date on which your existing coverage would end, whichever occurs later, to notify the Human Resources Department of your election. If you or an eligible dependent do not respond in writing within the time limit, the right to elect to continue coverage under COBRA will be lost.

The employer will notify the Plan Administrator within thirty (30) days of the death, termination, reduction of hours or Medicare eligibility of an employee. Within fourteen (14) days (or longer time period under Section 2590.606-4 if applicable) of receiving notice from you or your employer, the Plan Administrator must notify qualified persons of their rights to continuation coverage by mail to their last known address.

**Election:**

Eligible persons will have sixty (60) days from 1) the date when eligibility under the Plan ceases or 2) receipt of notice of rights to continuation coverage, from the Plan Administrator, whichever is later, to elect continuation coverage at their own expense.

When the Human Resources Department is notified or learns of a qualifying event, the Human Resources Department will send you or your eligible dependent(s) a written explanation of the right to elect continuation coverage.

You or an eligible dependent then have sixty (60) days from either the date of this explanation or the date on which your existing coverage would end, whichever occurs later, to notify the Human Resources Department of your election. If you or an eligible dependent do not respond in writing within the time limit, the right to elect to continue coverage under COBRA will be lost.

In considering whether to elect continuation coverage, you should take into account that a failure to continue your group health coverage will affect your future rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage, and election of continuation coverage may help you not have such a gap. Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if you do not get continuation coverage for the maximum time available to you. Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan
sponsored by your spouse’s employer) within 30 days after your group health coverage ends because of the qualifying event listed above. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

**Cost:**

Persons electing continuation coverage shall be charged by the employer an amount not to exceed the premium for similarly situated persons. The employer may also charge an administrative fee of up to two percent (2%) of the premium. Payment may be made in monthly or quarterly installments calculated in advance for twelve (12) month periods. If a person is on extended continuation coverage for disability, the employer is entitled to charge for coverage after eighteen (18) months an amount not to exceed one hundred and fifty percent (150%) of the premium for similarly situated persons. If persons are required to pay for the period of continuation coverage between when coverage ceases under the Plan and the date of election of continuation coverage, such premiums shall be paid within forty-five (45) days of the election.

**Termination:**

Continuation coverage may be terminated before the eighteen (18), twenty-nine (29), or thirty-six (36) month period if:

a. persons electing continuation coverage
   
   1) join another dental plan, which does not have limitations and exclusions for pre-existing conditions as an employee, spouse or dependent child.

   or

   2) are entitled to Medicare benefits which include dental.

b. on the month that begins more than thirty (30) days after the date of final determination by the Social Security Administration that a person on extended continuation coverage is no longer disabled under Titles II or XVI of the Social Security Act.

c. premiums are not paid by or for persons electing coverage.

d. employer discontinues all health plans available to the employee.

Continuation coverage may also be terminated for any reason the Plan would terminate coverage of a participant or beneficiary not receiving continuation coverage (such as fraud).
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

Colgate University
13 Oak Drive
Hamilton, NY 13346
Tel. 315-228-7565

14. FUNDING MECHANISM:

Unfunded plan maintained by employer and employee contribution.

Employee and Pre-7/1/96 Retiree:

Employer (or other Sponsor), named in Section 2, pays 100% of premium for basic dental coverage for you. Employee pays 0% of premium for basic dental coverage for you.

Dependents:

Employer (or other Sponsor), named in Section 2, pays 0% of premium for basic dental coverage for your dependents. Employee pays 100% of premium for basic dental coverage for your dependents.

Post-7/1/96 Retiree:

Employer (or other Sponsor), named in Section 2, pays 0% of premium for basic dental coverage for you and your dependents. Retiree pays 100% of premium for basic dental coverage for you and your dependents.
15. HEALTH PLAN ISSUER INVOLVEMENT:

Delta Dental is the health plan issuer involved with the Plan. Its address is stated in Section 6.

The benefits under the Plan are not guaranteed by Delta Dental under the Contract.

As Claims Administrator, Delta Dental pays or denies claims and reviews requests for review of claims as described in Section 18. The Delta Dental Affairs Committee hears appeals as described in Section 18.

16. END OF PLAN YEAR:

The end of the plan year for purposes of maintaining the Plan’s fiscal records is December 31.

17. HOW TO FILE A CLAIM:

Obtain a claim form from the Human Resources office. Present it to a dentist when making a first visit. If predetermination is necessary, the attending dentist will submit the claim for planned treatment in advance directly to Delta Dental. Otherwise, he/she will perform the service and then submit the claim. If the predetermination process is favorably completed, the form will be returned to the dentist for execution by you and him/her. On completion of the covered predetermined course of treatment, the dentist will resubmit the claim. In both situations, Delta Dental will pay the attending dentist if he/she is a Delta Dental Participating Dentist, or will pay you if he/she is not, that amount of the payments for which it is obligated under the group contract. Delta Dental will notify you in writing of the amount of benefits which are paid on your behalf and the amount which you must pay.

18. HOW TO HAVE A CLAIM DENIAL REVIEWED:

The Claims Denial Review Procedure is furnished automatically without charge, as a separate document which accompanies this Summary Plan Description.

19. STATEMENT OF ERISA RIGHTS:

Colgate University

As a participant in Colgate University’s Group Dental Program, you are entitled to certain rights and protections under 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 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) and updated Summary Plan Description. The Administrator may make a reasonable charge for the copies.

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

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for pre-existing conditions

Your Plan does not have exclusionary periods for pre-existing conditions and, because it is limited to dental coverage, your Plan is exempted from the certification of creditable coverage provisions of the Health Insurance Portability and Accountability Act (“HIPAA”), and Section 733 of ERISA.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate 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 thirty (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 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a State or Federal court. In addition, if you disagree with the Plan’s decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

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 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.