

**YOUR EMPLOYEE
BENEFIT PLAN**

OBERLIN

Oberlin College
173 W. Lorain Street
Oberlin, Ohio 44074

TO OUR EMPLOYEES:

All of us appreciate the protection and security insurance provides.

This certificate describes the benefits that are available to you. We urge you to read it carefully.

Benefits are provided through a group policy issued to Oberlin College by Metropolitan Life Insurance Company.

Oberlin College



Metropolitan Life Insurance Company
One Madison Avenue, New York, New York 10010-3690

Certifies that, under and subject to the terms and conditions of the Group Policy issued to the Employer, coverage is provided for each Employee as defined herein.

The date when an Employee is eligible for coverage is set forth in the form with the title Eligibility for Benefits.

The date when an Employee's Personal Benefits become effective is set forth in the form with the title Effective Dates of Personal Benefits.

The date when an Employee's Dependent Benefits become effective is set forth in the form with the title Effective Dates of Dependent Benefits.

The amounts of coverage are determined by the form with the title Schedule of Benefits.

METROPOLITAN LIFE INSURANCE COMPANY,

Robert H. Benmosche
Chairman of the Board,
President and Chief Executive Officer

Employer: **Oberlin College**

Group Policy No.: **94807-G**

If any prior certificate relating to the coverage set forth herein has been given to the Employee, such certificate is void.

Form G.23000-Cert.-1

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SCHEDULE OF BENEFITS
(Also see SCHEDULE SUPPLEMENT)

The following Benefits are provided subject to the provisions below.
BENEFITS (EMPLOYEE AND DEPENDENT)

DENTAL EXPENSE BENEFITS

DEDUCTIBLE AMOUNT

(For Type B Expenses)

Individual	\$25
Family	\$75

COVERED PERCENTAGE

Type A Expenses	100%
Type B Expenses	90%

MAXIMUMS

Maximum Benefit (For One Dental Expense Period)	\$750
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NOTE(S)

If a dental bill is expected to be \$200 or more, see DENTAL EXPENSE BENEFITS, section F, PRE-DETERMINATION OF BENEFITS.

COORDINATION OF BENEFITS

The Dental Expense Benefits are subject to the provisions of the form entitled COORDINATION OF BENEFITS.

WHEN YOU RETIRE

Dental Expense Benefits are provided under This Plan on or after the day you retire.

Form G.23000-B

SCHEDULE SUPPLEMENT

A. Statements Made by You Which Relate to Insurability

Any statement made by you will be deemed a representation and not a warranty.

No such statement made by you which relates to insurability will be used:

1. in contesting the validity of the benefits with respect to which such statement was made; or
2. to reduce the benefits;

unless the conditions listed in items (a) and (b) below have been met:

- a. The statement must be contained in a written application which has been signed by you.
- b. A copy of the application has been furnished to you.

No such statement made by you will be used at all after such benefits have been in force prior to the contest for a period of two years during the lifetime of the person to whom the statement applies.

B. Assignment

This certificate may not be assigned by you. Your benefits may not be assigned prior to a loss.

C. Refund to Us for Overpayment of Benefits

If we pay Dental Expense Benefits to you for expenses incurred on your own account or on account of a Dependent, and it is found that we paid more Dental Expense Benefits to you than we should have paid because:

1. all or some of those expenses were not paid for by the Covered Persons in your Family; or
2. any Covered Person in your Family was repaid for all or some of those expenses by a source other than from:
 - a. an insurer under a policy of insurance issued to you in your name; and
 - b. an insurer under a policy of insurance issued to a Covered Person in your Family who ordinarily lives in your home; and
 - c. us;

we will have the right to a refund from you. The amount of the refund is the difference between:

1. the amount of Dental Expense Benefits paid by us for those expenses; and
2. the amount of Dental Expense Benefits which should have been paid by us for those expenses.

However, at our option, we may recover the excess amount by reducing or offsetting any future benefits payable to such person by the amount of the overpayment.

D. Additional Provisions

1. The benefits under This Plan do not at any time provide paid-up insurance, or loan or cash values.
2. No agent has the authority:
 - a. to accept or to waive the required proof of a claim; nor
 - b. to extend the time within which a proof must be given to us.

Form G.23000-B1

DEFINITIONS OF CERTAIN TERMS USED HEREIN

“Covered Person” means an Employee, Dependent or Eligible Retired Employee on whose account benefits are in effect under This Plan.

“Dependent” means your spouse or your unmarried child except for:

1. a person who is in the military or like forces of any country or of any subdivision of a country;
2. a person who is eligible under This Plan as an Employee;
3. a person who lives outside the United States or Canada;
4. a child who:
 - a. is 19 years of age or older and who is employed on a full-time basis; or
 - b. is 19 years of age or older and who is not a full-time student at an approved school, as determined by the Employer; or

5. a child who is 23 years of age or older.

If a Dependent child is a Covered Person on the day before that child has reached the applicable age limit, that child will continue to be a Dependent after the age limit as long as:

- a. that child is and remains unable to work in self-sustaining employment because of:
 - i. physical handicap; or
 - ii. mental retardation; and
- b. that child is and remains chiefly dependent upon you for support; and
- c. that child is and remains a Dependent, as defined, except for the age limit; and
- d. you give us proof, when we ask for it, that the child is and remains so unable to work and dependent upon you since the age limit. We will not ask for proof more than once a year. The proof must be satisfactory to us; and
- e. you make any payment which is required by the Employer.

Child includes:

- a. a child who is supported solely by you and permanently living in the home of which you are the head; and
- b. a child who is legally adopted; and
- c. a stepchild who lives in your home.

No person may be covered as a Dependent of more than one Employee.

“Dependent Benefits” mean the benefits which are provided on account of a Dependent under This Plan.

“Doctor” means a person who is legally licensed to practice medicine. A licensed practitioner will be considered a Doctor if.

1. There is a law which applies to This Plan and that law requires that any service performed by such a practitioner must be considered for benefits on the same basis as if the service were performed by a Doctor; and
2. The service performed by the practitioner is within the scope of his or her license.

“Employee” means a person who is employed and paid for services by the Employer on a full-time basis.

“Family” means you and your Dependents.

“No Fault Law” means a motor vehicle liability law or other similar law which requires that benefits be provided for personal injury without regard to fault.

“Occupational Injury” means an injury which happens in the course of any work performed by the Covered Person for wage or profit.

“Occupational Sickness” means a sickness which entitles the Covered Person to benefits under a worker’s compensation or occupational disease law.

“Personal Benefits” mean the benefits which are provided on account of an Employee under This Plan.

“Qualifying Event” means a change in your family status due to one or more of the following events:

1. marriage;
2. the birth or adoption of a child;
3. divorce;
4. the death of a Dependent;
5. termination or commencement of employment by your spouse.

“This Plan” means the Group Policy which is issued by us to provide Personal Benefits and Dependent Benefits.

“We”, “us” and **“our”** mean Metropolitan.

“You” and **“your”** mean the Employee or Retired Employee who is a Covered Person for Personal Benefits. They do not include a Dependent of the Employee.

Form G.23000-A

ELIGIBILITY FOR BENEFITS

Personal Benefits Eligibility Date

If you are an Employee on January 1, 1998, that is your Personal Benefits Eligibility Date.

If you become an Employee after January 1, 1998, your Personal Benefits Eligibility Date is the date you become an Employee of the Employer.

Dependent Benefits Eligibility Date

Your Dependent Benefits Eligibility Date is the later of your Personal Benefits Eligibility Date and the date you first acquire a Dependent.

Form G.23000-C

EFFECTIVE DATES OF PERSONAL BENEFITS

APPLICABLE TO CONTRIBUTORY DENTAL EXPENSE BENEFITS

A. Making a Request for Dental Expense Benefits

1. Under the Dental Expense Benefits coverage, enrollment may only occur during the annual enrollment period. In order to become covered for Personal Benefits under This Plan, you must make a written request to the Employer on the enrollment form furnished by the Employer.

Requests to be covered for Personal Dental Expense Benefits may only be made:

- a. during the first annual enrollment period, as designated by the Employer and reported to you, following your Personal Insurance Eligibility Date; or
- b. within thirty-one days of a Qualifying Event; or
- c. during any subsequent annual enrollment period, as designated by the Employer and reported to you, following your Personal Benefits Eligibility Date.

Request for changes in Personal Dental Expense Benefits may only be made:

- a. during the annual enrollment period, as designated by the Employer and reported to you; or
 - b. within thirty-one days of a Qualifying Event.
2. If you make a request to be covered for Personal Dental Expense Benefits during the initial annual enrollment period applicable to you, your Personal Dental Expense Benefits will become effective on the first day of the calendar year following the annual enrollment period, subject to the Active Work Requirements.

3. If you make a request to be covered for Personal Dental Expense Benefits or a request for change(s) in Personal Dental Expense Benefits within thirty-one days of a Qualifying Event, your Personal Dental Expense Benefits or the change(s) in Personal Dental Expense Benefits will become effective on the first day of the month following the date of your request, subject to the Active Work Requirements.
4. If you make a request to be covered for Personal Benefits during an annual enrollment period, but after:
 - a. the initial annual enrollment period; or
 - b. electing no coverage at your initial eligibility date;your Personal Benefits will become effective one year following the date of your request.

B. Active Work Requirements

You must be actively at work in order for your Personal Benefits to become effective. If you are not actively at work on the date when your Personal Benefits would otherwise become effective, your Personal Benefits will become effective on the first day after you return to active work. If you are an Eligible Retired Employee, the actively at work provision does not apply.

C. Reinstatement of Benefits

If your Personal Benefits end because you do not make a required contribution to their cost, you may make a request to reinstate them, subject to the foregoing provisions.

Form G.23000-D1

EFFECTIVE DATES OF DEPENDENT BENEFITS

A. Making a Request for Benefits

1. In order to become insured for Dependent Dental Expense Benefits under This Plan, you must make a written request to the Employer on the enrollment form furnished by the Employer.

Requests to be covered for Dependent Benefits may only be made:

- a. during the first annual enrollment period, as designated by the Employer and reported to you, following your Dependent Benefits Eligibility Date; or
- b. within thirty-one days of a Qualifying Event; or
- c. during any subsequent annual enrollment period, as designated by the Employer and reported to you, following your Dependent Benefits Eligibility Date.

Requests for changes in your Dependent Benefits may only be made:

- a. during an annual enrollment period as designated by the Employer and reported to you; or
- b. within thirty-one days of a Qualifying Event.

2. If you make a request to be covered for Dependent Dental Expense Benefits during the initial annual enrollment period applicable to you, your Dependent Dental Expense Benefits will become effective, on the latest of.

- a. the first day of the calendar year following that enrollment period; and
- b. your Dependent Benefits Eligibility Date; and

DENTAL EXPENSE BENEFITS

A. DEFINITIONS

“Covered Dental Expense” means the charges based on the Preferred Dentist Program Table of Maximum Allowed Charges for the types of dental services shown in section C. These services must be:

1. performed or prescribed by a Dentist who is:
 - a. a Participating Provider; or
 - b. a Provider; and
2. necessary in terms of generally accepted dental standards.

No more than the Maximum Allowed Charge for the types of dental services shown in section C will be covered by the Dental Expense Benefits. The Maximum Allowed Charge is the lower of:

- a. the amount charged by the Preferred Provider for the service or supply; and
- b. the maximum amount that the Preferred Provider agreed with us to charge for that service or supply. This maximum amount is specified or based on the amounts specified in the Preferred Dentist Program Table of Maximum Allowed Charges.

There may be more than one way to treat a dental problem. If, in our view, an adequate method or material which costs less could have been used, the Dental Expense Benefits will be based on the method or material which costs less. The rest of the cost will not be a Covered Dental Expense.

“Deductible Amount” means the amount shown in the SCHEDULE OF BENEFITS.

The Deductibles during any one Dental Expense Period will not apply to Covered Dental Expenses for your Family after you incur

Covered Dental Expenses for Covered Persons in your Family and those expenses equal the Family Deductible Amount.

“Dental Expense Period” means a period which starts on any January 1 and ends on the next December 31.

“Dentist” means a person licensed by law to practice dentistry. A type of dental service which is performed or prescribed by a Doctor will be considered for Dental Expense Benefits as if it were performed or prescribed by a Dentist.

“Covered Percentage” means the percentage or percentages shown in the SCHEDULE OF BENEFITS.

“In-Network Benefits” means the Dental Expense Benefits provided under This Plan for covered dental services that are provided by a Dentist who is a Participating Provider.

“Out-of-Network Benefits” means the Dental Expense Benefits provided under This Plan for covered dental services that are not provided by a Dentist who is a Participating Provider.

“Preferred Dentist Program Table of Maximum Allowed Charges” means our fee agreement with a Participating Provider in which such Participating Provider has agreed to accept a schedule of maximum fees as payment in full for services rendered.

“Preferred Dentist Program” means our program to offer a Covered Person the opportunity to receive dental care from Dentists who are designated by us as Participating Providers. When dental care is given by Participating Providers, the Covered Person will generally incur less out-of-pocket cost for the services rendered.

“Participating Provider” means a Dentist who has been selected by us for inclusion in the Preferred Dentist Program. These Participating Providers agree to accept our Preferred Dentist Program Table of Maximum Allowed Charges as payment in full for services rendered.

“Provider” means a Dentist who is not a Participating Provider.

“Preferred Dentist Program Directory” means the list which consists of selected Dentists who:

1. are located in the Covered Person’s area; and
2. have been selected by us to be Participating Providers and part of the Preferred Dentist Program. These Participating Providers agree to accept our Preferred Dentist Program Table of Maximum Allowed Charges as payment in full for services rendered.

The list will be periodically updated.

B. COVERAGE

1. When Benefits May Be Payable

We will pay Dental Expense Benefits if you incur Covered Dental Expenses:

- a. for a Covered Person during a Dental Expense Period; and
- b. while you are covered for the Dental Expense Benefits for that Covered Person; and
- c. the Covered Dental Expenses are more than the Deductible Amount.

An expense is “incurred” on the date the type of dental service for which the charge is made is completed.

2. How Benefits Are Determined

Benefits will be equal to the Covered Percentage of those Covered Dental Expenses which are more than the Deductible Amount.

However, the sum of all benefits for all Covered Dental Expenses incurred for a Covered Person during any one Dental Expense Period will not be more than the Maximum Benefit For One Dental Expense Period shown in the SCHEDULE OF BENEFITS.

In order to determine what are the amounts of Covered Dental Expenses, we may ask for X-rays and other diagnostic and evaluative materials. If they are not given to us, we will determine Covered Dental Expenses on the basis of the information which is available to us. This may reduce the amount of benefits which otherwise would have been payable.

3. How the Preferred Dentist Program Works

Free Choice Of A Dentist:

A Covered Person is always free to choose the services of a Dentist who is either:

- a. a Participating Provider; or
- b. a Provider.

Benefits under This Plan will be determined and paid in either case, except that the Covered Person will generally incur less out-of-pocket cost if a Participating Provider is chosen.

C. DENTAL SERVICES WHICH MAY BE COVERED DENTAL EXPENSES

1. Type A Expenses

- a. Oral exams but not more than twice in a Dental Expense Period.
- b. X-rays:
 - i. full mouth X-rays but not more than once every 60 months; and

ii. bitewing X-rays but not more than:

- twice in a Dental Expense Period for Dependent children under age 19; and
- once in a Dental Expense Period for all other Covered Persons.

c. Preventive treatment:

- i. cleaning and scaling of teeth (oral prophylaxis) but not more than twice in a Dental Expense Period; and
- ii. topical fluoride treatment for a Dependent child under 19 years of age but not more than once in a Dental Expense Period.

d. Space maintainers for a Dependent child under 19 years of age.

e. Emergency palliative treatment.

2. Type B Expenses

a. Fillings - amalgam, silicate, acrylic, synthetic porcelain or composite fillings.

b. Extractions.

c. Root canal treatment, but no more than one time for the same tooth in a dental expense period.

d. periodontal maintenance where periodontal therapy (such as osseous surgery, gingivoplasty, or gingival curettage) has been previously performed, but the total of:

- the number of covered periodontal maintenance treatments; and
- the number of covered oral prophylaxes.

- e.** treatment of periodontal disease (other than by periodontal maintenance) and treatment of other diseases of the gums and tissues of the mouth.
- f.** Oral surgery.
- g.** Administration of general anesthesia, when medically necessary in connection with oral surgery, extractions, or other covered dental services.
- h.** Injections of antibiotic drugs.
- i.** Relinings and rebasings of existing removable dentures but not more than once in 36 months.
- j.** Repair or re-cementing of.
 - i.** crowns; or
 - ii.** inlays or onlays; or
 - iii.** dentures; or
 - iv.** bridgework.

D. EXCLUSIONS - DENTAL SERVICES WHICH ARE NOT COVERED DENTAL EXPENSES

1. Services or supplies received by a Covered Person before the Dental Expense Benefits start for that person.
2. Services not performed by a Dentist except for those services of a licensed dental hygienist which are supervised and billed by a Dentist and which are for:
 - a. cleaning and scaling of teeth; or
 - b. fluoride treatments.
3. Cosmetic surgery, treatment or supplies, unless required for the treatment or correction of a congenital defect of a newborn Dependent child.
4. Services or supplies which are covered by any workers' compensation laws or occupational disease laws.
5. Services or supplies which are covered by any employers' liability laws.
6. Services or supplies which any employer is required by law to furnish in whole or in part.
7. Services or supplies received through a medical department or similar facility which is maintained by the Covered Person's Employer.
8. Services or supplies received by a Covered Person for which no charge would have been made in the absence of Dental Expense Benefits for that Covered Person.
9. Services or supplies for which a Covered Person is not required to pay.
10. Services or supplies which are deemed experimental in terms of generally accepted dental standards.

- 11.** Services or supplies received as a result of dental disease, defect or injury due to an act of war, or a warlike act in time of peace, which occurs while the Dental Expense Benefits for the Covered Person are in effect.
- 12.** Use of materials to prevent decay other than fluorides such as toothpaste and fluoride gels.
- 13.** Instruction for oral care such as hygiene or diet.
- 14.** Periodontal splinting.
- 15.** Services or supplies to the extent that benefits are otherwise provided under This Plan or under any other plan which the Employer (or an affiliate) contributes to or sponsors.
- 16.** Myofunctional therapy or correction of harmful habits.
- 17.** Implantology.
- 18.** Charges for broken appointments.
- 19.** Charges by the Dentist for completing dental forms.
- 20.** Sterilization supplies.
- 21.** Services or supplies furnished by a family member.
- 22.** Major restorative services, such as dentures, bridgework, inlays, onlays or crowns.
- 23.** Treatment of temporomandibular joint disorders.
- 24.** Orthodontia
- 25.** Repair or replacement of Orthodontic appliance.

E. ALTERNATE BENEFITS

Dental Expense Benefits will be based on the materials and method of treatment which cost the least and which, in our view, meet generally accepted dental standards.

F. PRE-DETERMINATION OF BENEFITS

If a dental bill is expected to be \$200 or more, before the Dentist starts the treatment, a Covered Person can find out what Dental Expense Benefits will be paid under This Plan. To do this, the Covered Person should send a claim form to us in which the Dentist tells us:

1. the work to be done; and
2. what the cost will be.

We will then tell the Covered Person what Dental Expense Benefits This Plan will pay. If the Covered Person does not use this method to find out what Dental Expense Benefits This Plan will pay, our decision will be final and binding with regard to what are Covered Dental Expenses and what Dental Expense Benefits This Plan will pay.

This method should not be used for:

- a. emergency treatment; or
- b. routine oral exams; or
- c. X-rays, cleaning and scaling, and fluoride treatments; or
- d. dental services which cost less than \$200.

G. IMPACT OF GOVERNMENT PLANS ON DENTAL EXPENSE BENEFITS

To the extent that services or supplies, or benefits for them, are available to a Covered Person under a Government Plan, as defined below, they will not be considered for Dental Expense Benefits under This Plan. This provision will apply whether or not the Covered Person is enrolled for all Government Plans for which that Covered Person is eligible.

This provision will not apply to a Government Plan if that Government Plan requires that Dental Expense Benefits under This Plan be paid first.

A "Government Plan" is any plan, program or coverage, other than Medicare:

1. which is established under the laws or the regulations of any government; or
2. in which any government participates other than as an employer.

H. DENTAL EXPENSE COVERAGE AFTER BENEFITS END

No benefits will be payable for Covered Dental Expenses incurred by a Covered Person after the Dental Expense Benefits for that person end. This will apply even if we have pre-determined benefits for dental services.

I. PAYMENT OF BENEFITS

Dental Expense Benefits will be paid to you. We will pay benefits when we receive satisfactory written proof of your claim. Proof must be given to us not later than 90 days after the end of the Dental Expense Period in which the Covered Dental Expenses were incurred. If proof is not given on time, the delay will not cause a claim to be denied or reduced as long as proof is given as soon as possible.

Form G.23000-13A

WHEN BENEFITS END

- A.** All of your benefits will end on the last day of the calendar month in which your employment ends. Your employment ends when you cease active work as an Employee. However, for the purpose of benefits, the Employer may deem your employment to continue for certain absences. See **CONDITIONS UNDER WHICH YOUR ACTIVE WORK IS DEEMED TO CONTINUE**.
- B.** If This Plan ends in whole or in part, your benefits which are affected will end.
- C.** Your Dependent Benefits will end on the earlier of:
 - 1.** the date that the Dependent ceases to be your Dependent;
or
 - 2.** the date of your death.
- D.** If a Covered Person does not make a payment which is required by the Employer to the cost of any benefits, those benefits will end; they will end on the last day of the period for which a payment required by the Employer was made.

The end of any type of benefits on account of a Covered Person will not affect a claim which is incurred before those benefits ended.

Form G.23000-F

**CONDITIONS UNDER WHICH YOUR ACTIVE
WORK IS DEEMED TO CONTINUE**

If you are not actively at work as an Employee because of a situation set forth below, the Employer may deem you to be in active work as an Employee only for the purpose of continuing your employment and only for the periods specified below in order that certain of your benefits under This Plan may be continued.

All such benefits will be subject to prior cessation as set forth in WHEN BENEFITS END.

In any case, the benefits will end on:

1. the date the Employer notifies us that your benefits are not to be continued; or
2. the end of the last period for which the Employer has paid premiums to us for your benefits.

Your Sickness or Injury, Your Leave of Absence, Your Lay Off

With respect to all Personal Benefits and all Dependent Benefits, the period determined in accordance with the Employers general practice for an Employee in your job class.

However, in the event the leave qualifies under the Family and Medical Leave Act of 1993 (FMLA), the period cannot be longer than 12 weeks in any 12 month period following the date the leave of absence begins.

Form G.23000-L

COORDINATION OF BENEFITS

A. Definitions

“Plan” means a plan which provides benefits or services for, or by reason of, dental care and which is:

1. a group insurance plan; or
2. a group blanket plan, but not including school accident-type coverages covering students in:
 - a. a grammar school;
 - b. a high school; or
 - c. a college;

for accident only (including athletic injuries) either on a 24 hour basis or on a “to and from school basis”; or

3. a group practice plan; or
4. a group service plan; or
5. a group prepayment plan; or
6. any other plan which covers people as a group; or
7. a governmental program or coverage required or provided by any law, except Medicaid, but including any motor vehicle No Fault coverage which is required by law.

Each policy, contract or other arrangement for benefits or services will be treated as a separate Plan. Each part of such a Plan which reserves the right to take the benefits or services of other Plans into account to determine its benefits will be treated separately from those parts which do not.

“This Plan” means only those parts of This Plan which provide benefits or services for dental care. The provisions of This Plan which limit benefits based on benefits or services provided under:

1. Government Plans; or
2. Plan which the Employer (or an affiliate) contributes to or sponsors;

will not be affected by these Coordination of Benefits provisions.

“Primary Plan/Secondary Plan” When This Plan is a Primary Plan, it means that This Plan’s benefits are determined:

1. before those of the other Plan; and
2. without considering the other Plan’s benefits.

When This Plan is a Secondary Plan, it means that This Plan’s benefits:

- a. are determined after those of the other Plan; and
- b. may be reduced because of the other Plan’s benefits.

When there are more than two Plans covering the person, This Plan may be a Primary Plan as to one or more of those other Plans and may be a Secondary Plan as to a different Plan or Plans.

“Allowable Expense” means any reasonable and customary charge which meets all of the following tests:

1. it is a charge for an item of necessary dental expense; and
2. it is an expense which a Covered Person must pay; and
3. it is an expense at least a part of which is covered under at least one of the Plans which covers the person for whom claim is made.

When a Plan provides fixed benefits for specified events or conditions rather than benefits based on expenses, any benefits under that Plan will be deemed to be Allowable Expenses.

When a Plan provides benefits in the form of services rather than cash payment, the reasonable cash value of each service rendered will be deemed to be both an Allowable Expense and a benefit paid.

However, Allowable Expenses do not include expenses for services rendered because of:

- a. an Occupational Sickness; or
- b. an Occupational Injury.

“Claim Determination Period” means a period which starts on any January 1 and ends on the next December 31. However, a Claim Determination Period for any Covered Person will not include periods of time during which that person is not covered under This Plan.

“Custodial Parent” means a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than half of the calendar year without regard to any temporary visitation.

B. Effect on Benefits

1. When there is a basis for a claim under This Plan and another Plan, This Plan is a Secondary Plan which has its benefits determined after those of the other Plan, unless:
 - a. the other Plan has rules coordinating its benefits with those of This Plan; and
 - b. both those rules and This Plan’s rules in subsection 3 of this Section B require that This Plan’s benefits be determined before those of the other Plan.

2. If This Plan is a Secondary Plan, when the total Allowable Expenses incurred for a Covered Person in any Claim Determination Period are less than the sum of:
 - a. the benefits that would be payable under This Plan without applying this Coordination of Benefits provision; and
 - b. the benefits that would be payable under all other Plans without applying Coordination of Benefits or similar provisions;

the benefits described in item 2(a) of this section B will be reduced. The sum of these reduced benefits plus all benefits payable for such Allowable Expenses under all other Plans will not exceed the total of the Allowable Expenses. Benefits payable under all other Plans include all benefits that would be payable if the proper claims had been given on time.

When the benefits of This Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against the benefit limits of This Plan.

3. Rules for Determining the Order in which Plans Determine Benefits. When more than one Plan covers the person for whom Allowable Expenses were incurred, the order of benefit determination is:
 - a. Non-dependent/Dependent. The Plan which covers that person other than as a dependent (for example, as an employee, member, subscriber or retiree) determines its benefits before the Plan which covers that person as a dependent; except that if the person is also a Medicare beneficiary, and as a result of the rules established by Title XVIII of the Social Security Act and implementing regulations, Medicare is:
 - i. Secondary to the Plan covering the person as a dependent; and

- ii. Primary to the Plan covering the person as other than a dependent (e.g., a retired person);

then the benefits of the Plan covering the person as a dependent are determined before those of the Plan covering that person as other than a dependent.

- b. Child Covered under More than One Plan. When This Plan and another Plan cover the same child as a dependent of different persons, called “parents”:

- i. the Primary Plan is the Plan of the parent whose birthday is earlier in the year if:
 - 1. the parents are married;
 - 2. the parents are not separated (whether or not they ever have been married); or
 - 3. a court decree awards joint custody without specifying that one party is responsible for providing health care coverage.

For example, if one parent’s birthday were January 8 and the other parent’s birthday were March 3, then the Plan covering the parent with the January 8 birthday would determine its benefits before the Plan covering the parent with the March 3 birthday.

- ii. if both parents have the same date of birth (excluding year of birth), the Plan which covered the parent for the longer time determines its benefits before the Plan which covered the other parent for the shorter time.
- iii. if the specific terms of a court decree state that one of the parents is responsible for the child’s healthcare expenses or healthcare coverage and the Plan of that parent has actual knowledge of those terms, that Plan is Primary. This paragraph does not apply with respect to any Claim Determination Period during which any benefits are actually paid or provided before that Plan has that actual knowledge of the terms of the court decree.

- iv. if the parents are not married or are separated (whether or not they have ever been married) or are divorced, the order of benefits is:
 - 1. the Plan of the Custodial Parent;
 - 2. the Plan of the spouse of the Custodial Parent;
 - 3. the Plan of the Non-Custodial Parent;
 - 4. the Plan of the spouse of the Non-Custodial Parent.
- c. Active/Laid-off or Retired Employee. The Plan which covers that person as an active employee (or as that employee's dependent) is Primary to a Plan which covers that person as a laid-off or retired employee (or as that employee's dependent). If the Plan which covers that person has not adopted this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule shall not apply.
- d. Continuation Coverage. The Plan which covers the person as an active employee, member or subscriber (or as that employee's dependent) is Primary to a Plan which covers that person under a right of continuation pursuant to federal law (e.g., COBRA) or state law. If the Plan which covers that person has not adopted this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule d. shall not apply.
- e. Longer/Shorter Time Covered. If none of the above rules determines the order of benefits, the Plan which has covered the employee, member or subscriber for the longer time determines its benefits before the Plan which covered that person for the shorter time.

C. Right to Receive and Release Needed Information

Certain facts are needed to apply these Coordination of Benefits rules. We have the right to decide which facts we need. We may get facts from or give them to any other organization or person. We need not tell, nor get the consent of, any person or organization to do this. To obtain all benefits available, a claim should be filed under each Plan which covers the person for whom Allowable Expenses were incurred. Each person claiming benefits under This Plan must give us any facts we need to pay the claim.

D. Facility of Payment

A payment made under another Plan may include an amount which should have been paid under This Plan. If it does, we may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under This Plan. We will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

E. Right of Recovery

If the amount of the payments made by us is more than we should have paid under this Coordination of Benefits provision, we may recover the excess from one or more of

1. the persons we have paid or for whom we have paid;
2. insurance companies; or
3. other organizations.

The "amount of the payment made" includes the reasonable cash value of any benefits provided in the form of services.

NOTICES

This certificate is of value to you. It should be kept in a safe place.

As soon as your benefits end, you should consult your Employer to find out what rights, if any, you may have to continue your protection.

The fact that a Dentist may recommend that a Covered Person receive a dental service does not mean:

1. that the dental service will be deemed to be necessary; or
2. that benefits under This Plan will be paid for the expenses of the dental service.

Metropolitan will make the decision as to whether the dental service:

1. is necessary in terms of generally accepted dental standards;
and
2. is qualified for benefits under This Plan.

Our Home Office is located at One Madison Avenue, New York, New York 10010.

Form G.23000-E

**NOTICE OF YOUR RIGHT AND YOUR DEPENDENTS' RIGHT
TO CONTINUE DENTAL BENEFITS**

For you or your covered dependents who are not covered under any other group health care plan when your employment terminates for any reason other than your gross misconduct, or if your hours worked are reduced so that your coverage terminates, you and your covered dependents may continue coverage under This Plan for a period of up to 18 months. However, if you are determined under the terms of the Social Security Act to have been disabled at the time of your termination of employment or reduction in hours, you may continue your dental coverage under This Plan for an additional 11 months after the expiration of the 18 month period. During the additional 11 months of coverage, your cost for that coverage will be approximately 50% higher than it was during the preceding 18 months. In addition, if you should die, become divorced or legally separated, or become eligible for Medicare, your covered dependents who are not covered under any other group health care plan may continue coverage under This Plan for up to 36 months. Also, your covered children who are not covered under any other group health care plan may continue coverage under This Plan for up to 36 months after they no longer qualify as covered dependents under the terms of This Plan.

This continuation will terminate on the earliest of:

- a.** the end of the 18, 29 or 36 month continuation period, as the case may be;
- b.** the date of expiration of the last period for which the required payment was made;
- c.** the date This Plan is cancelled.

Notice will be given when you or your covered dependents become entitled to continue coverage under the Plan. You, or they, will then have at least 60 days to elect to continue coverage. However, you or your covered spouse or your covered child must notify the Employer within 60 days in the event you receive a determination of disability under the terms of the Social Security Act, you become divorced or legally separated, or when your dependent child no longer qualifies as a covered dependent under This Plan.

Any person who elects to continue coverage under the Plan must pay the full cost of that coverage (including both the share you now pay and the share your Employer now pays), plus any additional amounts permitted by law. Your payments for continued coverage must be made on the first day of each month in advance.

ERISA INFORMATION

NAME OF THE PLAN

Oberlin Health & Welfare Plan

NAME AND ADDRESS OF EMPLOYER AND PLAN ADMINISTRATOR

Oberlin College
173 W. Lorain Street
Oberlin, Ohio 44074
(216)775-8430

EMPLOYER IDENTIFICATION NUMBER AND PLAN NUMBER

34-0714363

501

TYPE OF ADMINISTRATION

The Plan is insured by Metropolitan Life Insurance Company.

AGENT FOR SERVICE OF LEGAL PROCESS

For disputes arising under the Plan, service of legal process may be made upon the Plan administrator at the above address. For disputes arising under those portions of the Plan insured by Metropolitan Life Insurance Company, service of legal process may be made upon Metropolitan Life Insurance Company at one of its local offices, or upon the supervisory official of the Insurance Department in the state in which you reside.

CONTRIBUTIONS

Policy dividends declared by the insurer under the group insurance policy or policies may be used to reduce Oberlin College's cost for the coverages in the same or prior years. In the unlikely event that total dividends were to exceed Oberlin College's cumulative costs for the coverage, the excess would be used for the benefit of employees covered by the group insurance policies.

In view of the fact that Oberlin College has in the past, and expects in the future, to pay a substantial share of the combined cost of the insurance coverages, it is unlikely that any such excess of policy dividends over Oberlin College's costs will occur.

You must make a contribution to the cost of Dental Expense Benefits.

PLAN YEAR

The Plan's fiscal records are kept on a plan year basis beginning each January 1 and ending on the following December 31.

CLAIMS INFORMATION

Procedures for Presenting Claims for Benefits

All claim forms needed to file for benefits under the group insurance program can be obtained from your employer who will also be ready to answer questions about the insurance benefits and to assist you or, if applicable, your beneficiary in filing claims. The instructions on the claim form should be followed carefully. This will expedite the processing of the claim. Be sure all questions are answered fully.

The completed claim form should be sent to Metropolitan at the address shown on the claim form.

When the claim has been processed, you or, if applicable, your beneficiary will be notified of the benefits paid. If any benefits have been denied, you or, if applicable, your beneficiary will receive a written explanation.

Routine Questions

If there is any question about a claim payment, an explanation may be requested from the employer who is usually able to provide the necessary information.

Requesting a Review of Claims Denied In Whole or In Part

In the event a claim has been denied in whole or in part, you or, if applicable, your beneficiary can request a review of your claim by

Metropolitan. This request for review should be sent to Group Insurance Claims Review at the address of Metropolitan's office which processed the claim within 60 days after you or, if applicable, your beneficiary received notice of denial of the claim. When requesting a review, please state the reason you or, if applicable, your beneficiary believe the claim was improperly denied and submit any data, questions or comments you or, if applicable, your beneficiary deems appropriate.

Metropolitan will re-evaluate all the information and you or, if applicable, your beneficiary will be informed of the decision in a timely manner.

**Discretionary Authority of Plan Administrator
and Other Plan Fiduciaries**

In carrying out their respective responsibilities under the Plan, the Plan administrator and other Plan fiduciaries shall have discretionary authority to interpret the terms of the Plan and to determine eligibility for and entitlement to Plan benefits in accordance with the terms of the Plan. Any interpretation or determination made pursuant to such discretionary authority shall be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

STATEMENT OF ERISA RIGHTS

The following statement is required by federal law and regulation.

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

Examine, without charge, at the Plan administrators office and at other specified locations, all Plan documents, including insurance contracts and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports and Plan descriptions.

Obtain all copies of all Plan documents and other Plan information upon written request to the Plan administrator. The administrator may make a reasonable charge for the copies.

In addition, ERISA provides that if there are 100 or more participants in the Plan, all such participants shall be entitled to receive a summary of the Plan's financial report. In such event, the Plan administrator is required by law to furnish each participant with a copy of this summary annual report.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the 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 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. If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for denial. You have the right to have the Plan review and reconsider your claim.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials 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 \$100 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.

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. 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, you should contact the nearest Area Office of the U.S. Labor-Management Services Administration, Department of Labor.



FUTURE OF THE PLAN

It is hoped that This Plan will be continued indefinitely, but Oberlin College reserves the right to change or terminate This Plan in the future. Any such action would be taken only after careful consideration.

The Board of Directors of Oberlin College shall be empowered to amend or terminate This Plan or any benefit under This Plan at any time.

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