AMENDMENT NUMBER TWO
TO THE
DICKINSON COLLEGE PREFERRED PROVIDER ORGANIZATION HEALTH PLAN

BY THIS AGREEMENT, Dickinson College Preferred Provider Organization Health Plan, the medical plan (herein called the "Plan") is hereby amended as follows, effective as of July 1, 2011.

1. **The Section entitled "SCHEDULE OF BENEFITS", sub-section "MEDICAL BENEFITS" is hereby amended with the addition of the following language at the end of the sub-section:**

Please note: Coinsurance and other payments to Network Providers may be based on an approved rate schedule, but a Network Provider's compensation ultimately is determined on the basis of each particular Network Provider's agreement with the Claims Administrator and may be an amount less than the approved rate. The Claims Administrator may receive a retrospective discount or rebate from a Network Provider or vendor related to the volume of services, supplies, equipment or pharmaceuticals purchased by persons enrolled in health care plans offered or administered by the Claims Administrator and its affiliates. Neither the Plan nor the Covered Person shall share in such retrospective volume-based discounts or rebates, except as provided for under the context of the fees the Plan pays to the Claims Administrator for its services.

2. **The Section entitled "SCHEDULE OF BENEFITS", the "DICKINSON COLLEGE SCHEDULE OF BENEFITS", is hereby deleted in its entirety and amended as follows:**

DICKINSON COLLEGE

DEDUCTIBLES AND MAXIMUMS	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
Annual Deductible (Inpatient and Infertility Deductibles apply separately from annual Deductible)		
Individual	None	$300
Family (aggregate)	None	$900
Out-of-Pocket Maximum (excludes Deductibles and Copays)		
Individual	None	$500
Family (aggregate)	None	$1,500
OUTPATIENT SERVICES	**Participating MEMBER RESPONSIBILITY**	**Non-Participating MEMBER RESPONSIBILITY**
Physician Services (for Illness or Injury)		
Primary Care Visit (PCP)	$15 Copay	30% Allowable Charges (after annual Deductible)
Specialist Visit (SCP)	$20 Copay	30% Allowable Charges (after annual Deductible)
Preventive Services*		
Gynecological Exam (PCP/SCP)	$0 Copay	30% Allowable Charges (after annual Deductible)
Well Child Visit	$0 Copay	30% Allowable Charges (after annual Deductible)
Adult Physical Visit	$0 Copay	30% Allowable Charges (after annual Deductible)
Routine Pediatric Immunizations	0%	30% Allowable Charges
Hearing Exams (under age 18)	0%	30% Allowable Charges (after annual Deductible)
Routine Mammograms	0%	30% Allowable Charges (after annual Deductible)
Therapeutic Injections	0%	30% Allowable Charges (after annual Deductible)
Allergy Testing & Allergy Injections	0%	30% Allowable Charges (after annual Deductible)

Allergy Antigen & Allergy Serum	0%	Not Covered
Chiropractic Care (x-rays and Spinal Manipulations are subject to Deductible) Maximum 20 visits per Calendar Year, combined.	0%	30% Allowable Charges (after annual Deductible)
Outpatient Surgery	0%	30% Allowable Charges (after annual Deductible)
Lab Services	0%	30% Allowable Charges (after annual Deductible)
Diagnostic X-ray	0% after $25 Copay	30% Allowable Charges (after annual Deductible)
Radiology (CAT, MRI, Ultrasound, PET)	0% after $25 Copay	30% Allowable Charges (after annual Deductible)
HOSPITAL SERVICES	**Participating MEMBER RESPONSIBILITY**	**Non-Participating MEMBER RESPONSIBILITY**
Hospital Care		
Semi-private room (private room if Medically Necessary)	0% after $150 Copay	30% Allowable Charges (after annual Deductible)
Physician and Surgeon Fees	0%	30% Allowable Charges (after annual Deductible)
Surgery	0%	30% Allowable Charges (after annual Deductible)
Lab and X-ray services	0%	30% Allowable Charges (after annual Deductible)
All Medically Necessary Ancillary Services	0%	30% Allowable Charges (after annual Deductible)
Anesthesia	0%	30% Allowable Charges (after annual Deductible)
Administration of Blood	0%	30% Allowable Charges (after annual Deductible)
Blood Products	0%	30% Allowable Charges (after annual Deductible)
Therapy Services (Chemotherapy & Radiation Therapy)	0%	30% Allowable Charges (after annual Deductible)
Transplant Services Services must be provided within the Coventry Transplant Network in order to be covered under the Plan.	**Donor screening services are limited to $10,000. Costs over $10,000 are the responsibility of the Participant or donor.**	**Not Covered**
MATERNITY SERVICES	**Participating MEMBER RESPONSIBILITY**	**Non-Participating MEMBER RESPONSIBILITY**
Pregnancy Care (PCP/SCP) (Copay for the first office visit only)	$20 Copay for first prenatal visit only	30% Allowable Charges (after annual Deductible)
Delivery	$150 Inpatient care Copay for each maternity admission	30% Allowable Charges (after annual Deductible)
FAMILY PLANNING	**Participating MEMBER RESPONSIBILITY**	**Non-Participating MEMBER RESPONSIBILITY**
Infertility Counseling/Testing/Services	$300 One Time Deductible Then 0%	**Not Covered**
Tubal Ligation/Vasectomy	0% after $150 Inpatient Copay	30% Allowable Charges (after annual Deductible)
$2,400 combined Lifetime Benefit Maximum for Family Planning		

PRESCRIPTION DRUGS	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
(Includes oral contraceptives & managed Formulary. Mandatory Generic substitution may apply)	**(Quantity Limits Apply)** **<u>Retail:</u> $10 Generic/30% Coinsurance Brand/50% Coinsurance Non-Formulary** **<u>Mail Order:</u> 2X Retail Copayment** **Out-of-pocket Maximum is $1500/Individual per Calendar Year** **COVERED ONLY AT PARTICIPATING PHARMACIES**	
EMERGENCY CARE	**Participating MEMBER RESPONSIBILITY**	**Non-Participating MEMBER RESPONSIBILITY**
Emergency Room Services (not subject to Deductible)	0% after $50 Copay (ER Copay waived if admitted)	
Ambulance Services (non-Emergency transportation must be Preauthorized)	0%	30% Allowable Charges (after annual Deductible)
REHABILITATION SERVICES	**Participating MEMBER RESPONSIBILITY**	**Non-Participating MEMBER RESPONSIBILITY**
Cardiac & Pulmonary Rehabilitation	0%	30% Allowable Charges (after annual Deductible)
Occupational, Speech, Physical Therapy	0% after $150 Inpatient Care Copay	30% Allowable Charges (after annual Deductible)
	45 Inpatient days per contract year 24 outpatient visits per contract year	
MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES	**Participating MEMBER RESPONSIBILITY**	**Non-Participating MEMBER RESPONSIBILITY**
General Mental Health:	**(Mental Health Services must be Preauthorized)**	
Inpatient	$150 Inpatient Copay, then 0%	30% Allowable Charges (after annual Deductible)
Physician Services (Outpatient)	0%	30% Allowable Charges (after annual Deductible)
Serious Mental Health: Inpatient	$150 Inpatient Copay, then 0%	30% Allowable Charges (after annual Deductible)
Physician Services (Outpatient)	0%	30% Allowable Charges (after annual Deductible)
Substance Abuse: Inpatient Detoxification	$150 In patient Copay, then 0%	0% Allowable Charges (not subject to annual Deductible)
Inpatient Rehabilitation	$150 In patient Copay, then 0%	30% Allowable Charges (after annual Deductible)
Transitional Partial Hospitalization	0%	30% Allowable Charges (after annual Deductible)
OTHER BENEFITS	**Participating MEMBER RESPONSIBILITY**	**Non-Participating MEMBER RESPONSIBILITY**
Claim Forms Required	**No**	**Yes**
Durable Medical Equipment (DME) – Limited to once every 2 years for irreparable damage and/or normal wear.	0%	30% Allowable Charges (after annual Deductible)

Corrective Appliances	0%	30% Allowable Charges (after annual Deductible)
	$7,000 Lifetime Benefit Maximum combined	
Home Health Care Services	0% 120 visits per contract year	30% Allowable Charges (after annual Deductible) 60 visits per contract year
	120 visits combined per Calendar Year	
Hospice Care	0%	30% Allowable Charges (after annual Deductible)
	$30,000 Lifetime Benefit Maximum combined.	
Skilled Nursing Facility Copayment waived if admitted from an acute care Hospital	$150 Inpatient Copay, then 0%	30% Allowable Charges (after annual Deductible)
	240 days combined maximum per Calendar Year	
Dental Services		
Emergency treatment of dental Injury	0%	30% Allowable Charges (after annual Deductible)
Removal of third molars	0%	30% Allowable Charges (after annual Deductible)
Vision Services	**Vision One Eyecare Program**®: Receive immediate savings on all eyecare needs--discounts on frames, lenses, disposable contacts, and even LASIK surgery--at Participating Providers through the EyeMed Vision Care network.	
Health Education	Members receive reimbursement of the cost of approved wellness programs offered through local Hospitals and organizations.**	
PREAUTHORIZATION REQUIREMENT	By Physician	By Patient
When using a Non-Participating Provider, the member must obtain Preauthorization of non-emergency Hospital and other facility (e.g., Skilled Nursing Facilities, rehabilitation facilities, drug and alcohol treatment facilities) admissions, outpatient surgery and certain other services. If these services or admissions are not Preauthorized and the service is not Medically Necessary, the member may be responsible for 100% of the cost of the services.		
LIFETIME MAXIMUM	Unlimited	
Dependent Coverage Age Limit is 26		

3. The Section entitled "ELIGIBILITY, FUNDING, EFFECTIVE DATE AND TERMINATION PROVISIONS", sub-section "ELIGIBILITY", "Eligible Classes of Dependents" is hereby deleted in its entirety and is amended as follows:

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

The term "Spouse" shall also mean the person who is currently registered with the Employer as the domestic partner of the Employee, this includes same sex couples only. An individual is a domestic partner of an Employee if that individual and the Employee meet each of the following requirements:

(a) The Employee and individual are 18 years of age or older and are mentally competent to enter into a legally binding contract.

(b) The Employee and the individual are not married to anyone.

(c) The Employee and the individual are not related by blood to a degree of closeness that would prohibit legal marriage between individuals in the state in which they reside.

(d) The Employee and the individual share the same principal residence(s), the common necessities of life, the responsibility for each other's welfare, are financially interdependent with each other and have a long-term committed personal relationship in which each partner is the other's sole domestic partner. Each of the foregoing characteristics of the domestic partner relationship must have been in existence for a period of at least twelve (12) consecutive months and be continuing during the period that the applicable benefit is provided. The Employee and the individual must have the intention that their relationship will be indefinite.

(e) The Employee and the individual have common or joint ownership of a residence (home, condominium, or mobile home), motor vehicle, checking account, credit account, mutual fund, joint obligation under a lease for their residence or similar type ownership.

To obtain more detailed information or to apply for this benefit, the Employee must contact the Plan Administrator, Dickinson College, 55 N. West Street, PO Box 1773, Carlisle, Pennsylvania, 17013, 1-717-245-1503.

In the event the domestic partnership is terminated, either partner is required to inform Dickinson College of the termination of the partnership.

The Plan Administrator may require documentation proving a legal marital and/or domestic partner relationship.

(2) A covered Employee's Child(ren).

The term "children" shall include natural children of the Employee or domestic partner, adopted children, Foster Children or children placed with a covered Employee (or domestic partner) in anticipation of adoption. Step-children who reside in the Employee's household may also be included as long as a natural parent remains married to the Employee and also resides in the Employee's household. An Employee's Child will be an eligible Dependent until reaching the limiting age of 26, without regard to student status, marital status, financial dependency or residency status with the Employee or any other person.

If a covered Employee or domestic partner is the Legal Guardian of a child or children, these children may be enrolled in this Plan as covered Dependents.

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

When the child reaches the applicable limiting age, coverage will end on the last day of the child's birthday month.

(3) A covered Employee's Qualified Dependents.

Any child of a Plan Participant who is an alternate recipient under a Qualified Medical Child Support Order shall be considered as having a right to Dependent coverage under this Plan. A Participant of this Plan may obtain, without charge, a copy of the procedures governing Qualified Medical Child Support Order (QMCSO) determinations from the Plan Administrator.

(4) A covered Dependent child who reaches the limiting age and is Totally Disabled, incapable of self-sustaining employment by reason of mental or physical handicap, primarily dependent upon the covered Employee for support and maintenance and unmarried. The Plan Administrator may require, at reasonable intervals during the two years following the Dependent's reaching the limiting age, subsequent proof of the child's Total Disability and dependency.

After such two-year period, the Plan Administrator may require subsequent proof not more than once each year. The Plan Administrator reserves the right to have such Dependent examined by a Physician of the Plan Administrator's choice, at the Plan's expense, to determine the existence of such incapacity.

The Plan Administrator may require documentation proving eligibility for Dependent coverage, including birth certificates, tax records or initiation of legal proceedings severing parental rights.

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

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

If both mother and father are Employees, their children will be covered as Dependents of the mother or father, but not of both. If both husband and wife are Employees, each may enroll as an Employee or as an eligible Dependent of the other, but not as both.

4. All references of opposite sex domestic partners are deleted in their entirety.

4. The Section entitled "MEDICAL BENEFITS", "MAXIMUM BENEFIT AMOUNT" is hereby deleted in its entirety and amended as follows:

MAXIMUM BENEFIT AMOUNT

Any Maximum Benefit Amount is shown in the Schedule of Benefits, when applicable. It is the total amount of benefits that will be paid under the Plan for certain Covered Charges incurred by a Covered Person during the Plan Year. The Maximum Benefit applies to all Plans and benefit options offered under the College Preferred Provider Organization Health Plan, including the ones described in this document.

5. The Section entitled "MEDICAL BENEFITS", (7) (p) Inhalation Therapy is hereby amended by the deletion of the following:

Covered Services are payable as described in the Schedule of Benefits.

6. The Section entitled "MEDICAL BENEFITS", (7) (e) radiation or chemotherapy and treatment, the following language is hereby deleted:

For coverage of phase III and IV clinical trials, the trial must be approved by the National Cancer Institute and the Claims Administrator.

7. The Section entitled "MEDICAL BENEFITS", (7) (t) Mental Disorders and Substance Abuse is hereby amended by the deletion of the following:

Psychiatrists (M.D.), psychologists (Ph.D.), counselors (Ph.D.) or Masters of Social Work (M.S.W.) may bill the Plan directly. Other licensed mental health practitioners must be under the direction of and must bill the Plan through these professionals.

8. The Section entitled "MEDICAL BENEFITS", (8) (x) organ transplants is hereby amended by the deletion of the following:

Benefit payments for transplant charges are included under the Organ Transplant Maximum Benefit Limit shown in the Schedule of Benefits.

9. The Section entitled "MEDICAL BENEFITS", (7) (z) physical therapy is hereby by the addition of the following:

Physical therapy rendered by an appropriately licensed chiropractor is covered.

10. The Section entitled "MEDICAL BENEFITS", (7) (bb) preventive care is hereby deleted in its entirety and is amended as follows:

(bb) Routine **preventive care.** Covered Charges under Medical Benefits are payable for routine Preventive Care Services as described in the Schedule of Benefits. Additional preventive care shall be provided as required by applicable law. A current listing of Preventive Care Services can be accessed at the Claims Administrators website or at www.HealthCare.gov/center/regulations/prevention.html.

Preventive Care Services does not include any service or benefit intended to treat an existing Illness, Injury, or condition.

Charges for routine well adult care. Routine well adult care is care by a Physician that is not for an Injury or Sickness.

Charges for routine well child care. Routine well child care is routine care by a Physician that is not for an Injury or Sickness.

11. The Section entitled "MEDICAL BENEFITS", number (7) (jj) therapeutic injections is hereby deleted and replaced in its entirety:

(jj) **Therapeutic injections and IV infusions** are covered when FDA-approved and Medically Necessary. Therapeutic injections and IV infusions are covered when administered in an Inpatient setting, an outpatient facility, or Provider's office.

Certain self-administered injectable medications may be covered under the Prescription Drug benefit and are excluded from the medical benefit. Self-administered injections are subject to the Claims Administrator's preferred drug list and substitution by therapeutically interchangeable drugs according to clinical guidelines used by the Claims Administrator and may require Prior Authorization.

12. . The Section entitled "PRESCRIPTION DRUG BENEFITS", sub-section "DEFINED TERMS" is hereby amended by the addition of the following:

Tier 0 (Value Formulary)
The group of medications on the Formulary, Value Formulary Tier 0 Drugs, which are available for a limited period of time at no Copayment and/or Coinsurance to Covered Persons who meet the Plan criteria specified in the Formulary.

13. The Section entitled "PRESCRIPTION DRUG BENEFITS", sub-section "COVERED SERVICES", is hereby amended by the addition of the following:

Preventive Care Services
Preventive Care Services shall mean the services set forth in Section 2713(a)(1) of the federal Public Health Service Act.

Coverage for In-Network Preventive Care Services and preventive drug products will be provided at 100% of the Allowable Charge/Allowed Amount in a manner consistent with Section 2713 of Federal H.R. 3590.

Value Formulary ("Tier 0") Copay/Coinsurance Waiver Program. Value Formulary or Tier 0 Drugs are offered at no Copayment and/or Coinsurance on a **temporary** basis to qualified Covered Persons.

Qualified Covered Persons are those that meet the "Plan Criteria" applicable to each Tier 0 Drug, as designated by the

Claims Administrator to promote effective and efficient drug therapy. Covered Persons who are on or have recently received **certain Prescription Drugs,** or who receive a new Prescription Order for **certain Prescription Drugs, as designated by the Claims Administrator**, may qualify for Tier 0 benefit coverage.

Tier 0 Drugs and their Plan criteria are listed in the Formulary, Value Formulary Tier 0 Drugs, found on the Claims Administrator's website at www.healthamerica.cvty.com. Covered Persons can also call the Customer Service Department at the telephone number on the back of their ID card to get a current listing of the Value Formulary Tier 0 Drugs. **The Value Formulary Tier 0 Drugs Formulary may change from time to time without prior notice**.

To be eligible for coverage at the Tier 0 level, Covered Persons must meet the Plan criteria specified on the Value Tier 0 Formulary. **When drugs are temporarily added to Tier 0, Covered Persons who appear to meet the Plan criteria will be notified by the Claims Administrator that they qualify for a Tier 0 Drug.**

Please note, just because a Covered Person fills a Prescription Order or Refill for a Tier 0 Drug, does not qualify him/her for the Tier 0 Copayment. Rather, only Covered Persons who meet Plan criteria will receive the selected drug at the Tier 0 benefit. Therefore, there may be instances where a drug is on Tier 0 and also on Tier 1 or Tier 2. If a Covered Person does not satisfy the Tier 0 criteria, the drug shall be subject to the Tier 1 or Tier 2 benefit, as applicable. Refer to the current Formulary, Value Formulary Tier 0 Drugs, for Plan criteria. An example is below:

Example Value Formulary Tier 0 Drug Formulary:

(*Note that this is an example only. Drug names are fictitious.*)

Brand Drug Prescribed	Class of Brand Drug	Filled During	Tier 0 Drug	Offer Period
Expensinex	Allergy	Oct-Dec 2009	Genericadine	Jan-Mar 2010

14. The Section entitled "DEFINED TERMS", the definition of Experimental and/or Investigational is hereby deleted in its entirety and is amended as follows:

Experimental and/or Investigational means services, supplies, care and treatment which does not constitute accepted medical practice properly within the range of appropriate medical practice under the standards of the case and by the standards of a reasonably substantial, qualified, responsible, relevant segment of the medical community or government oversight agencies at the time services were rendered.

The Plan Administrator or its designee must make an independent evaluation of the Experimental/non-Experimental standings of specific technologies. The Plan Administrator or its designee shall be guided by a reasonable interpretation of Plan provisions. The decisions shall be made in good faith and rendered following a detailed factual background investigation of the claim and the proposed treatment. The decision of the Plan Administrator or its designee will be final and binding on the Plan. The determination will be guided by the following principles:

(1) if the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or

(2) if the drug, device, medical treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval; or

(3) if reliable evidence shows that the drug, device, medical treatment or procedure is the subject of on-going Phase I or Phase II clinical trials, is the research, Experimental, study or Investigational arm of on-going Phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or any health product or service that is the subject of a clinical trial that meets criteria for Phase I, II, III or IV as set forth by FDA regulations, except as specifically covered; or

(4) if reliable evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

"Reliable evidence" shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, service, medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure.

Drugs are considered Experimental if they are not commercially available for purchase and/or they are not approved by the Food and Drug Administration for general use.

15. The Section entitled "PLAN EXCLUSIONS", number 12. is hereby deleted in its entirety:

12. All non-Emergency Services provided at Shadyside Hospital and The University of Pittsburgh Medical Center (Eye and Ear Hospital, Falk Clinic, Montefiore Hospital, Pittsburgh Cancer Institute, Presbyterian University Hospital) or their affiliated clinics are excluded from coverage under the Plan unless authorized for payment in advance by the Claims Administrator. If a preauthorization is not received, no coverage will be provided for non-Emergency Services received at these Hospitals or their clinics.

16. The Section entitled "PLAN EXCLUSIONS", number (25) Durable Medical Equipment is hereby deleted in its entirety and is amended as follows:

(25) Except as specified in the Schedule of Benefits, replacement coverage for **Durable Medical Equipment** or Corrective Appliances is limited to once every two (2) years for irreparable damage and/or normal wear, or a significant change in medical condition. Replacement resulting from malicious damage, culpable neglect, wrongful disposition or for the convenience or personal preference of the Plan Participant.

17. The Section entitled "PLAN EXCLUSIONS", number (66) oral surgery is hereby deleted in its entirety and is amended as follows:

(66) **Oral surgery** required as part of an orthodontic treatment program, required for correction of an occlusal defect (except when determined to be Medically Necessary), encompassing orthoganathic or prognathic surgical procedures.

18. The Section entitled "BENEFIT DETERMINATIONS AND INQUIRY AND APPEAL PROCEDURES", including the Table of Contents, is hereby deleted in its entirety and is amended as follows:

CLAIMS REVIEW AND APPEALS

Following is a description of how the Plan processes claims for benefits and reviews the Appeal of any claim that is denied. The terms used in this section are defined below.

A "Claim" is defined as any request for a Plan benefit, made by a claimant or by a representative of a claimant, which complies with the Plan's reasonable procedure for filing claims and making benefit claims determinations.

A "Claim" does not include a request for a determination of an individual's eligibility to participate in the Plan.

If a Claim is denied, in whole or in part, or if Plan coverage is rescinded retroactively for fraud or intentional misrepresentation, the denial is known as an "Adverse Benefit Determination."

A claimant has the right to request a review of an Adverse Benefit Determination. This request is an "Appeal." If the Claim is denied at the end of the Appeal process, as described below, the Plan's final decision is known as a "Final Adverse Benefit Determination." If the claimant receives notice of a Final Adverse Benefit Determination, the claimant then has the right to request an independent external review. The External Review procedures are described below.

A claimant must follow all Claims and Appeal procedures both internal and external, before he or she can file a lawsuit. If a lawsuit is brought, it must be filed within two years after the final determination of an Appeal.

Any of the authority and responsibilities of the Plan Administrator under the Claims and Appeal Procedures or the External Review Process, including the discretionary authority to interpret the terms of the Plan, may be delegated to a third party. If you have any questions regarding these procedures, please contact the Plan Administrator.

There are different kinds of Claims and each one has a specific timetable for each step in the review process. Upon receipt of the Claim, the Plan Administrator must decide whether to approve or deny the Claim. The Plan Administrator's notification to the claimant of its decision must be made as required by law. However, if the Claim has not been filed properly, or if it is incomplete, or if there are other matters beyond the control of the Plan Administrator, the claimant may be notified that the period for providing the notification will need to be extended. If the period is extended because the Plan Administrator needs more information from the claimant, the claimant must provide the requested information within the time as communicated. Once the Claim is complete, the Plan Administrator must make its decision as required by law. If the Claim is denied, in whole or in part, the claimant has the right to file an Appeal. Then the Plan Administrator must decide the Appeal and, if the Appeal is denied, provide notice to the claimant within the time periods as required by law. These time periods begin at the time the Claim or Appeal is filed in accordance with the Plan's procedures. Decisions will be made within a reasonable period of time appropriate to the circumstances, but within the maximum time periods required by law. Unless otherwise noted, "days" means calendar days.

The definitions of the types of Claims are:

Urgent Care Claim

A Claim involving Urgent Care is any Claim for medical care or treatment where the Plan conditions receipt of benefits, in whole or in part, on approval in advance of obtaining the care or treatment, and using the timetable for a non-Urgent Care determination could seriously jeopardize the life or health of the claimant; or the ability of the claimant to regain maximum function; or in the opinion of the attending or consulting Physician, would subject the claimant to severe pain that could not be adequately managed without the care or treatment that is the subject of the Claim.

A Physician with knowledge of the claimant's medical condition may determine if a Claim is one involving Urgent Care. If there is no such Physician, an individual acting on behalf of the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine may make the determination.

If there is an Adverse Benefit Determination on a Claim involving Urgent Care, a request for an expedited Appeal may be submitted orally or in writing by the claimant. All necessary information, including the Plan's benefit determination on review, may be transmitted between the Plan and the claimant by telephone, facsimile, or other similarly expeditious method. Alternatively, the claimant may request an expedited review under the External Review Process.

Concurrent Care Claims

A Concurrent Care Claim is a special type of Claim that arises if the Plan informs a claimant that benefits for a course of treatment that has been previously approved for a period of time or number of treatments is to be reduced or eliminated. In that case, the Plan must notify the claimant sufficiently in advance of the effective date of the reduction or elimination of treatment to allow the claimant to file an Appeal. This rule does not apply if benefits are reduced or eliminated due to Plan amendment or termination. A similar process applies for Claims based on a rescission of coverage for fraud or misrepresentation.

Pre-Service Claim

A Pre-Service Claim means any Claim for a benefit under this Plan where the Plan conditions receipt of the benefit, in whole or in part, on approval in advance of obtaining medical care. These are, for example, Claims subject to pre-certification. Please see the Cost Management section of this booklet for further information about Pre-Service Claims.

Post-Service Claim

A Post-Service Claim means any Claim for a Plan benefit that is not a Claim involving Urgent Care or a Pre-Service Claim; in other words, a Claim that is a request for payment under the Plan for medical services already received by the claimant.

Notice to claimant of Adverse Benefit Determinations

If a Claim is denied in whole or in part, the denial is considered to be an Adverse Benefit Determination. Except with Urgent Care Claims, when the notification may be oral followed by written or electronic notification within three days of the oral notification, the Plan Administrator shall provide written or electronic notification of the Adverse Benefit Determination. The notice will state in a manner calculated to be understood by the claimant:

(1) Information sufficient to allow the claimant to identify the Claim involved (including date of service, the healthcare Provider, the claim amount, if applicable, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning).

(2) The specific reason or reasons for the adverse determination, including the denial code and its corresponding meaning, and a description of the Plan's standard, if any, that was used in denying the Claim.

(3) Reference to the specific Plan provisions on which the determination was based.

(4) A description of any additional material or information necessary for the claimant to perfect the Claim and an explanation of why such material or information is necessary.

(5) A description of the Plan's internal and external Appeal procedures. This description will include information on how to initiate the Appeal and the time limits applicable to such procedures. This will include a statement of the claimant's right to bring a civil action under section 502 of ERISA following a Final Adverse Benefit Determination.

(6) If the Adverse Benefit Determination was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the Adverse Benefit Determination and a copy will be provided free of charge to the claimant upon request.

(7) If the Adverse Benefit Determination is based on the Medical Necessity or Experimental or Investigational treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided free of charge, upon request.

(8) Information about the availability of and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under applicable federal law to assist individuals with the internal claims and Appeals and external review process.

Appeals

First Level Internal Appeal Process (Non-Urgent)
When a claimant receives notification of an Adverse Benefit Determination, the claimant generally has 180 days following receipt of the notification in which to file a written request for an Appeal of the decision. However, for Concurrent Care Claims, the Claimant must file the Appeal prior to the scheduled reduction or termination of treatment. For a claim based on rescission of coverage, the claimant must file the Appeal within 30 days. A claimant may submit written comments, documents, records, and other information relating to the Claim. If submitted in writing, it should be sent to;

HealthAmerica

P.O. Box 67103
Harrisburg, PA 17106-7103
Attention: Appeal Process

The Appeal review will be completed and written notification will be sent to the Covered Person or Authorized Representative within the following time periods:

- Pre-service Appeal – fifteen (15) calendar days after the date on which the Appeal is filed.
- Post-service Appeal – thirty (30) calendar days after the date on which the Appeal is filed.

This notification shall include the basis and clinical rationale for the decision and the procedure to file a request for a second level review of the decision.

Second Level Internal Appeal Process (Non-Urgent)

If the Covered Person or Authorized Representative is not satisfied with the decision of the first level Appeal, a request for a second level review of the Appeal may be submitted orally or in writing. If submitted in writing, it should be sent to;

HealthAmerica
P.O. Box 67103
Harrisburg, PA 17106-7103
Attention: Appeal Process

A Covered Person has forty-five (45) days from receipt of the notice of the first level of Appeal decision to request the second level Appeal review.

Each second level Appeal review includes the following:

- An investigation of the Appeal;
- Written notification to the Covered Person or Authorized Representative that they have the right, but are not required to appear before the review committee;
- Written notification to the Covered Person or Authorized Representative of the review committee hearing date and hearing procedures;
- A review of the initial decision by a committee which consists of three (3) or more individuals who did not participate in the first level Appeal or the event that caused the Appeal and who are not subordinates of the individuals who made the initial decision or the first level Appeal. When appropriate, the committee will include a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment for which the Covered Person is seeking coverage, or will include his or her consultative report in their deliberations.

The Appeal will be reviewed and written notification of the Plan Administrator's decision will be sent to the Covered Person or Authorized Representative within the following time periods:

- Pre-service Appeal – fifteen (15) calendar days after the date on which the Appeal is filed.
- Post-service Appeal – thirty (30) calendar days after the date on which the Appeal is filed.

Urgent Care Internal Appeal Process

A Covered Person or Authorized Representative may request an expedited review of an Urgent Care Claim by providing the Plan with clinical rationale and facts to support the request. The Urgent Care Appeal hearing will be completed and written notification of the decision of the Plan will be sent to the Covered Person and/or Authorized Representative within seventy-two (72) hours of the filing of the Urgent Care Appeal. A Covered Person is not entitled to further Appeal under the Plan's internal Appeal processes after the final decision regarding payment for a service that is the subject of an Urgent Care Claim.

If the claimant so requests, he or she will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim. The Plan Administrator shall provide the claimant, as soon as possible and sufficiently in advance of the time within which a final determination on Appeal is required to

allow the claimant time to respond, any new or additional evidence that is relied upon, considered or generated by or at the direction of the Plan. This evidence shall be provided free of charge.

A document, record, or other information shall be considered relevant to a Claim if it:

(1) was relied upon in making the benefit determination;

(2) was submitted, considered, or generated in the course of making the benefit determination, without regard to whether it was relied upon in making the benefit determination;

(3) demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that benefit determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all claimants; or

(4) constituted a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit.

The period of time within which a benefit determination on Appeal is required to be made shall begin at the time an Appeal is filed in writing in accordance with the procedures of the Plan. This timing is without regard to whether all the necessary information accompanies the filing.

Before the Plan Administrator or its designee issues its Final Adverse Benefit Determination based on a new or additional rationale or new or additional information or records, the claimant must be provided, free of charge, with a copy of the rationale or new or additional information or records. The rationale or additional information or records must be provided as soon as possible and sufficiently in advance of the time within which a final determination on Appeal is required to allow the claimant time to respond.

The review shall take into account all comments, documents, records, and other information submitted by the claimant relating to the Claim, without regard to whether such information was submitted or considered in the initial benefit determination. The review will not afford deference to the initial Adverse Benefit Determination and will be conducted by a fiduciary of the Plan who is neither the individual who made the adverse determination nor a subordinate of that individual.

If the determination was based on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is Experimental, Investigational, or not Medically Necessary or appropriate, the fiduciary shall consult with a health care professional who was not involved in the original benefit determination. This health care professional will have appropriate training and experience in the field of medicine involved in the medical judgment. Additionally, medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the initial determination will be identified.

If the Appeal of a Claim is denied, in whole or in part, the Plan Administrator or its designee shall provide written notification of the Adverse Benefit Determination on Appeal. The notice will state, in a manner calculated to be understood by the claimant:

(1) Information sufficient to allow the claimant to identify the Claim involved (including date of service, the healthcare Provider, the claim amount, if applicable, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning).

(2) The specific reason or reasons for the adverse determination, including the denial code and its corresponding meaning, and a description of the Plan's standard, if any, that was used in denying the Claim.

(3) Reference to the specific Plan provisions on which the determination was based.

(4) A description of any additional material or information necessary for the claimant to perfect the Claim and an explanation of why such material or information is necessary.

(5) A description of the Plan's internal and external review procedures and the time limits applicable to such procedures. This will include a statement of the claimant's right to bring a civil action under section 502 of ERISA following an Adverse Benefit Determination on review.

(6) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.

(7) If the Adverse Benefit Determination was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the Adverse Benefit Determination and a copy will be provided free of charge to the claimant upon request.

(8) If the Adverse Benefit Determination is based on the Medical Necessity or Experimental or Investigational treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided free of charge, upon request.

(9) Information about the availability of and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under applicable federal law to assist individuals with the internal claims and Appeals and external review process.

External Review Process

If the Covered Person or Authorized Representative is not satisfied with the decision of the Plan Administrator or its designee, he/she may request an external review of the Appeal. In order to request an external Appeal review, you must have completed both the mandatory first and voluntary second level of the internal Appeal process.

The external Appeal review request must be submitted in writing. The request should be sent to the Claims Administrator, Attention: Appeals Process. The request should include justification for the request and all reasonably necessary supporting information.

The external Appeal request must be filed within the following time periods:

- Non-Urgent Care Appeals - within fifteen (15) days following receipt of the notice of the Adverse Benefit Determination.
- Urgent Care Appeals - within two (2) business days following receipt of the notice of the Adverse Benefit Determination.

The Claims Administrator will notify the claimant and/or Authorized Representative and the Department of Health within the following time periods that an external Appeal has been filed:

- Non-Urgent Care Appeals - five (5) business days of receiving the Covered Person or Authorized Representative’s request for an external Appeal review.
- Urgent Care Appeals – twenty-four (24) hours of receiving the Covered Person or Authorized Representative’s request for an external Appeal review.

The Department of Health will assign an independent review organization to conduct the external Appeal review. In the absence of an assigned independent review organization (IRO) by the Department of Health, the Claims Administrator will designate and notify a IRO.

The Plan Administrator or its designee will notify the Covered Person or Authorized Representative of the name, address and telephone number of the IRO assigned for the external Appeal within the following time periods:

- Non-Urgent Care Appeals - within two (2) business days of receiving the notice regarding selection of the URE.
- Urgent Care Appeals - within one (1) business day of receiving the notice regarding selection of the URE.

The Plan Administrator or its designee shall forward to the IRO conducting the external Appeal copies of all written documentation regarding the Appeal, including the decisions, all reasonably necessary supporting information, a summary of applicable issues and the basis and clinical rationale for the decisions. Any additional written information may also be submitted to both the Claims Administrator and the IRO by the Covered Person or Authorized Representative. All information must be submitted within the following time periods:

- Non-Urgent Care Appeals - within fifteen (15) days of receipt of notice that the external Appeal was filed.
- Urgent Care Appeals - the next business day after receipt of notice that the external Appeal was filed.

The IRO conducting the external Appeal shall review all information considered in reaching any prior decisions and any other written submission by the Covered Person or Authorized Representative.

The IRO conducting the external Appeal shall issue a written decision, including the basis and clinical rationale for the decision to Plan Administrator or its designee, the Covered Person, and Authorized Representative. The standard of the review shall be whether the health care service denied by the internal Appeal process was Medically Necessary and appropriate under the terms of the Plan. The written decision will be sent within the following time periods:

- Non-Urgent Care Appeals - within sixty (60) days of the filing of the external Appeal.
- Urgent Care Appeals - within two (2) business days of the filing of the external Appeal.

If a health care Provider is representing the Covered Person in the external Appeal review, all fees and costs of the external Appeal review (not including attorney fees) must be paid by the party who does not win the Appeal. If the external Appeal review is requested by the Covered Person, the Plan Administrator will pay all fees and costs (not including attorney fees) related to the external Appeal review.

If the Covered Person does not agree with the decision of the external IRO, the Covered Person may request review of the decision by a court of competent jurisdiction. Such requests must be made within sixty (60) days of the Covered Person's receipt of notice of the IRO's decision. There shall be a rebuttable presumption in favor of the decision of the IRO conducting the external Appeal.

19. All other terms, conditions and provisions of the Plan Document and Summary Plan Description for the Dickinson College Preferred Provider Organization and its amendments, addendums, attachments and exhibits shall remain in full force and effect.

IN WITNESS WHEREOF this Amendment has been executed on behalf of Dickinson College to be effective as of July 1, 2011.

By: _____ Date: 12/21/11

Witness: _____ Date: 12/21/11