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

BY THIS AGREEMENT, the Dickinson College Preferred Provider Organization Health Plan, the medical plan (herein called the "Plan") is hereby amended as follows, effective as of July 1, 2013.

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

Value-Based Benefits for Disease Management

HealthAmerica has identified 5 disease states for Value-based insurance Benefits. **Asthma, Diabetes, COPD, Congestive Heart Failure and Coronary Artery Disease** protocols are targeted in this program. The program includes cost reduction for both necessary preventive medical services and drug therapies to influence better outcomes for these chronic diseases. When Members are compliant and participate in disease management and complex case management programs they are given Copay waivers and cost reductions on prescription medications used to treat Asthma, Diabetes, COPD, Congestive Heart Failure and Coronary Artery Disease. The goal of Value-based insurance design is to improve care and outcomes for chronically ill Members by making essential care affordable and involving them in established disease management programs.

Members are offered the following basic medical services at no out of pocket costs:

VALUE- BASED MEDICAL SERVICES	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
Lab Services (LDL and Micro albumin)	**0%**	30% Allowable Charges (after annual Deductible)
Lab Services (HbAlc)	**0%**	30% Allowable Charges (after annual Deductible)
Diabetic Eye Exam	**$0 Copay**	30% Allowable Charges (after annual Deductible)
Cardiac Rehabilitation	**0%**	30% Allowable Charges (after annual Deductible)
Outpatient Pulmonary function test	**0%**	30% Allowable Charges (after annual Deductible)

DEDUCTIBLES AND MAXIMUMS	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
Annual Plan Year Deductible (Inpatient Copays and Infertility Deductibles apply separately from annual Deductible)		
Individual	$100	$500
Family (aggregate)	$300	$1,500
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% (after annual Deductible)	30% Allowable Charges (after annual Deductible)
Allergy Testing & Allergy Injections	0% (after annual Deductible)	30% Allowable Charges (after annual Deductible)
Allergy Antigen & Allergy Serum	0% (after annual Deductible)	Not Covered
Chiropractic Care (x-rays and spinal manipulations are subject to Deductible) Maximum 24 visits per Plan Year, combined.	0% (after annual Deductible)	30% Allowable Charges (after annual Deductible)
Outpatient Surgery	0% (after annual Deductible)	30% Allowable Charges (after annual Deductible)
Lab Services (Lab services received at Primary Care Physician's office are not subject to In-Network Deductible)	0% (after annual Deductible)	30% Allowable Charges (after annual Deductible)
Diagnostic X-ray	$25 Copay then 0% (after annual Deductible)	30% Allowable Charges (after annual Deductible)
Radiology (CAT, MRI, Ultrasound, PET)	$25 Copay then 0% (after annual Deductible)	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)	$200 Inpatient Copay, then 0% (after annual Deductible)	30% Allowable Charges (after annual Deductible)
Physician and Surgeon Fees	0% (after annual Deductible)	30% Allowable Charges (after annual Deductible)
Surgery	0% (after annual Deductible)	30% Allowable Charges (after annual Deductible)
Lab and X-ray services	0% (after annual Deductible)	30% Allowable Charges (after annual Deductible)
All Medically Necessary Ancillary Services	0% (after annual Deductible)	30% Allowable Charges (after annual Deductible)
Anesthesia	0% (after annual Deductible)	30% Allowable Charges (after annual Deductible)
Administration of Blood	0% (after annual Deductible)	30% Allowable Charges (after annual Deductible)
Blood Products	0% (after annual Deductible)	30% Allowable Charges (after annual Deductible)
Therapy Services (Chemotherapy & Radiation Therapy)	0% (after annual Deductible)	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) Diagnostic Testing	$20 Copay for first prenatal office visit only 0% (after annual Deductible)	30% Allowable Charges (after annual Deductible)
Delivery	$200 Inpatient care Copay, then 0% (after annual Deductible) for each maternity admission	30% Allowable Charges (after annual Deductible)
FAMILY PLANNING	**Participating MEMBER RESPONSIBILITY**	**Non-Participating MEMBER RESPONSIBILITY**
Tubal Ligation*	0%	30% Allowable Charges (after annual Deductible)
Vasectomy	$200 Inpatient Copay , then 0% (after annual Deductible)	30% Allowable Charges (after annual Deductible)
Infertility Counseling/Testing/Services	$300 one-time Deductible then 0%	Not Covered
	$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)** **Retail: $10 Generic/30% Coinsurance Brand/50% Coinsurance Non-Formulary** **Mail Order: 2X Retail Copayment** **Out of Pocket Maximum is $1500/Individual per Plan Year** **COVERED ONLY AT PARTICIPATING PHARMACIES**	

EMERGENCY CARE	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
Emergency Room Services (not subject to Deductible)	0% after $100 Copay (ER Copay waived if admitted)	
Ambulance Services (Non-emergency transportation must be Preauthorized)	0% (after annual Deductible)	30% Allowable Charges (after annual Deductible)
REHABILITATION SERVICES	**Participating MEMBER RESPONSIBILITY**	**Non-Participating MEMBER RESPONSIBILITY**
Cardiac & Pulmonary Rehabilitation	0% (after annual Deductible)	30% Allowable Charges (after annual Deductible)
Occupational, Speech, Physical Therapy	$200 Inpatient Copay, then 0% (after annual Deductible)	30% Allowable Charges (after annual Deductible)
	45 Inpatient days per Plan Year 24 Outpatient visits per Plan Year	
MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES	**Participating MEMBER RESPONSIBILITY**	**Non-Participating MEMBER RESPONSIBILITY**
General Mental Health:	**(Mental Health services must be Preauthorized)**	
Inpatient	$200 Inpatient Copay, then 0% (after annual Deductible)	30% Allowable Charges (after annual Deductible)
Physician Services (Outpatient)	0% (after annual Deductible)	30% Allowable Charges (after annual Deductible)
Serious Mental Health: Inpatient	$200 Inpatient Copay, then 0% (after annual Deductible)	30% Allowable Charges (after annual Deductible)
Physician Services (Outpatient)	0% (after annual Deductible)	30% Allowable Charges (after annual Deductible)
Substance Abuse: Inpatient Detoxification	$200 Inpatient Copay, then 0% (not subject to annual Deductible)	30% Allowable Charges (not subject to annual Deductible)
Inpatient Rehabilitation	$200 Inpatient Copay, then 0% (after annual Deductible)	30% Allowable Charges (after annual Deductible)
Transitional Partial Hospitalization	0% (after annual Deductible)	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% (after annual Deductible)	30% Allowable Charges (after annual Deductible)
Corrective Appliances	0% (after annual Deductible)	30% Allowable Charges (after annual Deductible)
	$7,000 Lifetime benefit maximum combined.	
Home Health Care Services	0% (after annual Deductible) 120 visits per Plan Year	30% Allowable Charges (after annual Deductible) 60 visits per Plan Year
	120 visits combined per Plan Year	
Hospice Care	0% (after annual Deductible)	30% Allowable Charges (after annual Deductible)
	$30,000 Lifetime benefit maximum combined.	
Skilled Nursing Facility Copayment waived if admitted from an acute care Hospital	$200 Inpatient Copay, then 0% (after annual Deductible)	30% Allowable Charges (after annual Deductible)
	240 days combined maximum per Plan Year	

Dental Services		
Emergency treatment of dental Injury	0% (after annual Deductible)	30% Allowable Charges (after annual Deductible)
Removal of third molars	0% (after annual Deductible)	30% Allowable Charges (after annual Deductible)
Vision Services	**Vision One Eyecare Program®**: Receive immediate savings on all eye care 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. Reimbursement for Weight Management programs is limited to $350 per Member per Plan Year.	
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 as stated in the Summary Plan Description. 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		
*Preventive Services covered at 100% In-Network in accordance with the Affordable Care Act of 2010. For a listing of covered services visit www.healthcare.gov/prevention.		

2. **The Section entitled "MEDICAL BENEFITS", sub-section "COVERED CHARGES", number (7) "Other Medical Services and Supplies" is hereby amended by the addition of the following:**

   (n) **Family health planning.** Covered Services includes counseling, treatment, and follow-up exam. Information on birth control, insertion and removal of intrauterine devices, and Norplant and measurement for contraceptive diaphragms.

3. **The Section entitled "PRESCRIPTION DRUG BENEFITS", sub-section "DEFINITIONS, is hereby amended by the addition of the following:**

   Contraceptive Drugs and/or Devices that prevent unwanted Pregnancy, including, but not limited to:
   - Oral contraceptives;
   - IUD's;
   - Contraceptive implants; or
   - Any similar drug, device or method.

4. **The Section entitled "PRESCRIPTION DRUG BENEFITS", sub-section "LIMITATIONS & EXCLUSIONS", number (12) is hereby amended by the deletion of the following:**

   Implantable time-released contraceptives are not Covered Charges.

5. **The Section entitled "PRESCRIPTION DRUG BENEFITS", sub-section "LIMITATIONS & EXCLUSIONS", under "The following are not Covered Charges under the Plan", number (5) is hereby deleted in its entirety and amended as follows:**

   (5) Implantable time-released medication (e.g., Eligard, Zoladex);

6. **The Section entitled "DEFINED TERMS", the term "Benefit Year" is hereby deleted in its entirety and amended as follows:**

   Benefit Year means July 1 through June 30.

7. **All other terms, conditions and provisions of the Plan Document and Summary Plan Description for the Dickinson College Preferred Provider Organization Health Plan 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 the Dickinson College Preferred Provider Organization Health Plan, to be effective as of July 1, 2013.

By: _____ Date: 8/13/13
John A. Weis, Vice President for Human Resource Services

Witness: _____ Date: 8/13/13