PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION FOR

DICKINSON COLLEGE PREFERRED PROVIDER ORGANIZATION HEALTH PLAN

Restated SPD: July 1, 2014

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INTRODUCTION

This document is a description of Dickinson College Preferred Provider Organization Health Plan (the Plan). No oral interpretations can change this Plan. The Plan described is designed to protect Plan Participants against certain catastrophic health expenses.

The Plan Administrator for the Plan is Dickinson College. The Plan Administrator's duties are more fully described in the Section of this document titled "Responsibilities For Plan Administration".

The Claims Administrator for the Plan is HealthAmerica. The Claims Administrator performs administrative services only with respect to the Plan (such as adjudication of claims for benefits under the Plan). The Claims Administrator does not underwrite or insure the Plan and has no financial responsibility for the cost of Covered Charges provided under the Plan.

Coverage under the Plan will take effect for an eligible Employee and designated Dependents when the Employee and such Dependents satisfy the Waiting Period and all the eligibility requirements of the Plan.

The Plan Administrator fully intends to maintain this Plan indefinitely. However, it reserves the right to terminate, suspend, discontinue or amend the Plan at any time and for any reason.

Changes in the Plan may occur in any or all parts of the Plan including benefit coverage, Deductibles, maximums, Copayments, exclusions, limitations, definitions, eligibility and the like.

For Plan Years that begin on or after January 1, 2014, to the extent that an item or service is a covered benefit under the Plan, the terms of the Plan shall be applied in a manner that does not discriminate against a health care Provider who is acting within the scope of the Provider's license or other required credentials under applicable State law. This provision does not preclude the Plan from setting limits on benefits, including cost sharing provisions, frequency limits, or restrictions on the methods or settings in which treatments are provided and does not require the Plan to accept all types of Providers as a Participating Provider.

Failure to follow the eligibility or enrollment requirements of this Plan may result in delay of coverage or no coverage at all. Reimbursement from the Plan can be reduced or denied because of certain provisions in the Plan, such as coordination of benefits, subrogation, exclusions, timeliness of COBRA elections, utilization review or other Utilization Management requirements, lack of Medical Necessity, lack of timely filing of claims or lack of coverage.

The Plan will pay benefits only for the expenses incurred while this coverage is in force. No benefits are payable for expenses incurred before coverage began or after coverage terminated. An expense for a service or supply is incurred on the date the service or supply is furnished.

No action at law or in equity shall be brought to recover under any Section of this Plan until the Appeal rights provided have been exercised and the Plan benefits requested in such Appeals have been denied in whole or in part.

If the Plan is terminated, amended, or benefits are eliminated, the rights of Covered Persons are limited to Covered Charges incurred before termination, amendment or elimination.

This document summarizes the Plan rights and benefits for covered Employees and their Dependents and is divided into the following parts:

Eligibility, Funding, Effective Date and Termination. Explains eligibility for coverage under the Plan, funding of the Plan and when the coverage takes effect and terminates.

Schedule of Benefits. Provides an outline of the Plan reimbursement formulas as well as payment limits on certain services.

Benefit Descriptions. Explains when the benefit applies and the types of charges covered.

Utilization Management Services. Explains the methods used to curb unnecessary and excessive charges.

This part should be read carefully since each Participant is required to take action to assure that the maximum payment levels under the Plan are paid.

Defined Terms. Defines those Plan terms that have a specific meaning.

Plan Exclusions. Shows what charges are **not** covered.

Claim Provisions. Explains the rules for filing claims and the claim Appeal process.

Coordination of Benefits. Shows the Plan payment order when a person is covered under more than one plan.

Third Party Recovery Provision. Explains the Plan's rights to recover payment of charges when a Covered Person has a claim against another person because of Injuries sustained.

Continuation Coverage Rights Under COBRA. Explains when a Covered Person's coverage under the Plan ceases and the continuation options which are available.

ERISA Information. Explains the Plan's structure and the Participants' rights under the Plan.

LEGISLATIVE NOTICES

IMPORTANT NOTICE FOR MASTECTOMY PATIENTS

If a Covered Person elects breast reconstruction in connection with a mastectomy, the Covered Person is entitled to coverage under this Plan for:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prosthesis and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

Such services will be performed in a manner determined in consultation with the attending Physician and the patient. See Medical Benefits Section for further detail regarding this coverage.

Preauthorization is required.

PATIENT PROTECTION NOTICE

If this Plan generally allows for the designation of a Primary Care Physician (PCP), You have the right to designate any PCP who participates in the Network and who is available to accept You or Your family members. Until You make this designation the Claims Administrator may make one for You. For information on how to select a PCP, and for a list of Participating Primary Care Physicians, contact the Claims Administrator at the Customer Service number printed on Your ID card or visit their website at www.healthamerica@cvty.com.

NOTICE FOR MEDICARE ELIGIBLE PARTICIPANTS

Important Notice About Your Prescription Drug Coverage and Medicare

Please read this Section carefully and keep this document where You can find it. This Section has information about Your current Prescription Drug coverage and about Your options under Medicare's Prescription Drug coverage. This information can also help You decide whether or not You want to join a Medicare drug plan. If You are considering joining, You should compare Your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare Prescription Drug coverage in Your area. Information about where You can get help to make decisions about Your Prescription Drug coverage is at the end of this Section.

There are two important things You need to know about Your current coverage and Medicare's Prescription Drug coverage:

1. **Medicare Prescription Drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if You join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers Prescription Drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**
2. **The Plan has determined that the Prescription Drug coverage offered under this Plan is, on average for all Covered Persons, expected to pay out as much as the standard Medicare Prescription Drug coverage pays and is therefore considered Creditable Coverage. Because Your existing coverage is Creditable Coverage, You can keep this coverage and not pay a higher premium (a penalty) if You later decide to join a Medicare drug plan.**

When Can You Join A Medicare Drug Plan

You can join a Medicare drug plan when You first become eligible for Medicare and each year from October 15th through December 7th.

However, if You lose Your current creditable Prescription Drug coverage, through no fault of Your own, You will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide To Join A Medicare Drug Plan

If You decide to join a Medicare drug plan, Your current Plan coverage will not be affected.

If You decide to join a Medicare drug plan and drop Your current Plan coverage, be aware that You and Your Dependents will be able to get this coverage back provided You and Your Dependents are still eligible under the Plan.

When Will You Pay a Higher Premium (Penalty) To Join a Medicare Drug Plan

You should also know that if You drop or lose Your current coverage with the Plan and do not join a Medicare drug plan within sixty-three (63) continuous days after Your current coverage ends, You may pay a higher premium (a penalty) to join a Medicare drug plan later.

If You go sixty-three (63) days or longer without creditable Prescription Drug coverage, Your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that You did not have that coverage. For example, if You go nineteen months without Creditable Coverage, Your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as You have Medicare Prescription Drug coverage. In addition, You may have to wait until the following October to join.

For More Information About This Section or Your Current Prescription Drug Coverage

Contact the Plan Administrator for further information. You may receive this information at other times in the future such as before the next period You can enroll in Medicare Prescription Drug coverage, and if this coverage through the Plan changes. You also may request a copy of this document at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage

More detailed information about Medicare plans that offer Prescription Drug coverage is in the “Medicare & You” handbook. You will get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about the Medicare Prescription Drug coverage:

- Visit www.medicare.gov,
- Call Your State Health Insurance Assistance Program (see the inside back cover of Your copy of the “Medicare & You” handbook for their telephone number) for personalized help,
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Remember: Keep this document. If You decide to join one of the Medicare drug plans, You may be required to provide a copy of this Section when You join to show whether or not You have maintained Creditable Coverage and, therefore, whether or not You are required to pay a higher premium (a penalty).

If You have limited income and resources, extra help paying for Medicare Prescription Drug coverage is available. For information about this extra help, visit Social Security Administration on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

SCHEDULE OF BENEFITS

Verification of Eligibility: 1-800-252-5742

Call this number to verify eligibility for Plan benefits **before** the charge is incurred.

MEDICAL BENEFITS

All benefits described in this Schedule are subject to the exclusions and limitations described more fully herein including, but not limited to, the Plan Administrator's determination that: care and treatment is Medically Necessary; that charges are within the Allowable Charge; that services, supplies and care are not Experimental and/or Investigational. The meanings of these capitalized terms are in the Defined Terms Section of this document.

The Plan utilizes a Claims Administrator to administer many of the benefits described in this document. The Claims Administrator is:

HealthAmerica
3721 Tec Port Drive
Harrisburg, PA 17111
1-800-252-5742
www.healthamerica.cvty.com

Certain services must be Preauthorized or Reimbursement from the Plan may be reduced. Please see the Utilization Management Section and the Preauthorization Exhibit in this document for additional details.

The Plan is a Preferred Provider Organization (PPO).

If the Plan generally requires or allows the designation of a primary care Provider, a Covered Person has the right to designate any primary care Provider who is a Participating Provider and who is available to accept the Covered Person. For Children, a Covered Person may designate a pediatrician as the primary care Provider if the pediatrician is a Participating Provider and is available to accept the Child as a patient. A Covered Person does not need Preauthorization from the Plan, a primary care Provider, or any other person in order to obtain access to obstetrical or gynecological care from a health care professional who specializes in obstetrics or gynecology and who is a Participating Provider. However, the health care professional may be required to comply with certain Plan procedures, including obtaining Preauthorization for certain services, following a pre-approved treatment plan, or procedures for making referrals.

Under the following circumstances, the higher In-Network payment will be made for certain Out-of-Network services:

- If a Covered Person has no choice of Participating Providers in the specialty that the Covered Person is seeking within the Plan's service area.
- If a Covered Person is out of the Plan's service area and has a Medical Emergency requiring immediate care.

If You utilize Out-of-Network Providers, this Plan provides benefits only for Covered Charges that are equal to or less than the Allowable Charge. **YOU ARE RESPONSIBLE FOR ANY AMOUNTS OVER THE MAXIMUM ALLOWABLE CHARGE.**

Additional information about this option, including any rules that apply to designation of a primary care Provider, as well as a list of Participating Providers, will be given to Plan Participants, at no cost, and updated as needed. This list will include Providers who specialize in obstetrics or gynecology. The most current listing of Network Providers is available online at www.healthamerica@cvty.com.

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.

Deductibles/Copayments payable by Covered Persons

Deductibles/Copayments are dollar amounts that the Covered Person must pay before the Plan pays.

A Deductible is an amount of money that is paid once a Benefit Year per Covered Person. Typically, there is one Deductible amount per Plan and it must be paid before any money is paid by the Plan for any Covered Charges. Each Benefit Year, a new Deductible amount is required.

A Copayment is the amount of money that is paid each time a particular service is used. Typically, there may be Copayments on some services and other services will not have any Copayments.

Dickinson College

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	$350	$800
Family (aggregate)	$1,050	$2,400
Coinsurance Maximum		
Individual	$700	$800
Family (aggregate)	$2,100	$2,400
Out-of-Pocket Maximum (includes Deductibles, Coinsurance and Copays for medical)		
Individual	$4,850	N/A
Family (aggregate)	$9,700	N/A
OUTPATIENT SERVICES	**Participating MEMBER RESPONSIBILITY**	**Non-Participating MEMBER RESPONSIBILITY**
Physician Services (for Illness or Injury)		
Primary Care Visit (PCP)	$20 Copay	30% Allowable Charges (after annual Deductible)
Specialist Visit (SCP)	$25 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	0%	30% Allowable Charges (after annual Deductible)
Routine Mammograms	0%	30% Allowable Charges (after annual Deductible)

Therapeutic Injections	10% (after annual Deductible)	30% Allowable Charges (after annual Deductible)
Allergy Testing & Allergy Injections	10% (after annual Deductible)	30% Allowable Charges (after annual Deductible)
Allergy Antigen & Allergy Serum	10% (after annual Deductible)	Not Covered
Chiropractic Care (x-rays and spinal manipulations are subject to Deductible) Maximum 24 visits per Plan Year, combined.	10% (after annual Deductible)	30% Allowable Charges (after annual Deductible)
Outpatient Surgery	10% (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)	10% (after annual Deductible)	30% Allowable Charges (after annual Deductible)
Diagnostic X-ray	$25 Copay then 10% (after annual Deductible)	30% Allowable Charges (after annual Deductible)
Radiology (CAT, MRI, Ultrasound, PET)	$25 Copay then 10% (after annual Deductible)	30% Allowable Charges (after annual Deductible)
Hearing Devices	10% (after annual Deductible)	30% Allowable Charges (after annual Deductible)
	Benefit limited to $800 every 24 months at the Participating Provider and Non-Participating Provider Levels of Payment, combined	
HOSPITAL SERVICES	**Participating MEMBER RESPONSIBILITY**	**Non-Participating MEMBER RESPONSIBILITY**
Hospital Care		
Semi-private room (private room if Medically Necessary)	$200 Inpatient Copay, then 10% (after annual Deductible)	30% Allowable Charges (after annual Deductible)
Physician and Surgeon Fees	10% (after annual Deductible)	30% Allowable Charges (after annual Deductible)
Surgery	10% (after annual Deductible)	30% Allowable Charges (after annual Deductible)
Lab and X-ray services	10% (after annual Deductible)	30% Allowable Charges (after annual Deductible)
All Medically Necessary Ancillary Services	10% (after annual Deductible)	30% Allowable Charges (after annual Deductible)
Anesthesia	10% (after annual Deductible)	30% Allowable Charges (after annual Deductible)
Administration of Blood	10% (after annual Deductible)	30% Allowable Charges (after annual Deductible)
Blood Products	10% (after annual Deductible)	30% Allowable Charges (after annual Deductible)
Therapy Services (Chemotherapy & Radiation Therapy)	10% (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)	$25 Copay for first prenatal office visit only	30% Allowable Charges (after annual Deductible)
Diagnostic Testing	10% (after annual Deductible)	30% Allowable Charges (after annual Deductible)

Delivery	$200 Inpatient care Copay, then 10% (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 10% (after annual Deductible)	30% Allowable Charges (after annual Deductible)
Infertility Counseling/Testing/Services	$300 One Time Deductible Then 10%	Not Covered
	$2,400 combined Lifetime Benefit Maximum for Family Planning	
PRESCRIPTION DRUGS	**Participating MEMBER RESPONSIBILITY**	**Non-Participating MEMBER RESPONSIBILITY**
(Includes 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; $3,000 Family 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 $125 Copay (ER Copay waived if admitted)	
Urgent Care (not subject to Deductible)	0% after $40 Copay (UC Copay waived if sent to ER within 24 hours)	
Ambulance Services (non-emergency transportation must be Preauthorized)	10% (after annual Deductible)	30% Allowable Charges (after annual Deductible)
REHABILITATION SERVICES	**Participating MEMBER RESPONSIBILITY**	**Non-Participating MEMBER RESPONSIBILITY**
Cardiac & Pulmonary Rehabilitation	10% (after annual Deductible)	30% Allowable Charges (after annual Deductible)
Occupational, Speech, Physical Therapy	$200 Inpatient Copay, then 10% (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 10% (after annual Deductible)	30% Allowable Charges (after annual Deductible)
Physician Services (Outpatient)	$25 Copay	30% Allowable Charges (after annual Deductible)
Serious Mental Health: Inpatient	$200 Inpatient Copay, then 10% (after annual Deductible)	30% Allowable Charges (after annual Deductible)
Physician Services (Outpatient)	$25 Copay	30% Allowable Charges (after annual Deductible)
Substance Abuse: Inpatient Detoxification	$200 Inpatient Copay, then 10% (not subject to annual Deductible)	30% Allowable Charges (not subject to annual Deductible)

Inpatient Rehabilitation	$200 Inpatient Copay, then 10% (after annual Deductible)	30% Allowable Charges (after annual Deductible)
Transitional Partial Hospitalization	$25 Copay	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.	10% (after annual Deductible)	30% Allowable Charges (after annual Deductible)
Corrective Appliances	10% (after annual Deductible)	30% Allowable Charges (after annual Deductible)
Home Health Care Services	10% (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	10% (after annual Deductible)	30% Allowable Charges (after annual Deductible)
Skilled Nursing Facility Copayment waived if admitted from an acute care Hospital	$200 Inpatient Copay, then 10% (after annual Deductible)	30% Allowable Charges (after annual Deductible) *240 days combined maximum per Plan Year*
Dental Services Emergency treatment of dental Injury Removal of third molars	 10% (after annual Deductible) 10% (after annual Deductible)	30% Allowable Charges (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.*		

ELIGIBILITY, FUNDING, EFFECTIVE DATE AND TERMINATION PROVISIONS

A Plan Participant should contact the Plan Administrator to obtain additional information about Plan benefits or eligibility requirements.

ELIGIBILITY

Eligible Classes of Employees. All Active Employees of the Employer.

Eligibility Requirements for Employee Coverage. A person is eligible for Employee coverage from the first day that he or she:

(1) is a Full-Time, Active Employee of the Employer.

(2) is in a class eligible for coverage.

(3) is a retiree (and their eligible dependents) in approved early retirement programs.

Eligible Classes of Dependents. A Dependent is any one of the following persons:

(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; any former domestic partner of the Employee; 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.

Eligibility Requirements for Dependent Coverage. A family member of an Employee will become eligible for Dependent coverage on the first day that the Employee is eligible for Employee coverage and the family member satisfies the requirements for Dependent coverage.

At any time, the Plan may require proof that a Spouse, domestic partner, or a Child qualifies or continues to qualify as a Dependent as defined by this Plan.

FUNDING

Cost of the Plan. Dickinson College shares the cost of Employee and Dependent coverage under this Plan with the covered Employees. The enrollment application for coverage will include a payroll deduction authorization. This authorization must be filled out, signed and returned with the enrollment application.

The level of any Employee contributions is set by the Plan Administrator. The Plan Administrator reserves the right to change the level of Employee contributions.

ENROLLMENT

Enrollment Requirements. An Employee must enroll for coverage by filling out and signing an enrollment application along with the appropriate payroll deduction authorization. The covered Employee is required to enroll for Dependent coverage also.

Enrollment Requirements for Newborn Children.

A newborn Child of a covered Employee who has Dependent coverage is not automatically enrolled in this Plan. If the newborn Child is not enrolled in this Plan on a timely basis, as defined in the section "Timely Enrollment" following this section, there will be no payment from the Plan and the parents will be responsible for all costs.

If the Child is not enrolled within thirty-one (31) days of birth, the enrollment will be considered a Late Enrollment.

TIMELY OR LATE ENROLLMENT

(1) **Timely Enrollment** - The enrollment will be "timely" if completed enrollment form is received by the Plan Administrator no later than thirty-one (31) days after the person became eligible for the coverage, either initially or under a Special Enrollment Period.

If two Employees (husband and wife or domestic partners) are covered under the Plan and the Employee who is covering the Dependent Children terminates coverage, the Dependent coverage may be continued by the other covered Employee with no Waiting Period as long as coverage has been continuous.

(2) **Late Enrollment** - An enrollment is "late" if it is not made on a "timely basis" or during a Special Enrollment Period. Late Enrollees and their Dependents who are not eligible to join the Plan during a Special Enrollment Period may join only during open enrollment.

If an individual loses eligibility for coverage as a result of terminating employment, reduction of hours of employment, or a general suspension of coverage under the Plan, then upon becoming eligible again due to resumption of employment or due to resumption of Plan coverage, only the most recent period of eligibility will be considered for purposes of determining whether the individual is a Late Enrollee.

The time between the date a Late Enrollee first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a Waiting Period. Coverage begins on January 1.

SPECIAL ENROLLMENT RIGHTS

Federal law provides Special Enrollment provisions under some circumstances. If an Employee is declining enrollment for himself or herself or his or her Dependents (including his or her Spouse) because of other health insurance or group health plan coverage, there may be a right to enroll in this Plan if there is a loss of eligibility for that other coverage (or if the employer stops contributing towards the other coverage). However, a request for enrollment must be made to the Plan Administrator within thirty-one (31) days after the coverage ends (or after the employer stops contributing towards the other coverage).

In addition, in the case of a birth, marriage, adoption or placement for adoption, there may be a right to enroll in this Plan. However, a request for enrollment must be made to the Plan Administrator within thirty-one (31) days after the birth, marriage, adoption or placement for adoption.

The Special Enrollment rules are described in more detail below. To request Special Enrollment or obtain more detailed information of these portability provisions, contact the Plan Administrator, Dickinson College, 55 N. West Street, PO Box 1773, Carlisle, Pennsylvania, 17013, 1-717-245-1503.

SPECIAL ENROLLMENT PERIODS

The Enrollment Date for anyone who enrolls under a Special Enrollment Period is the first date of coverage. Thus, the time between the date a special enrollee first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a Waiting Period.

(1) **Individuals losing other coverage creating a Special Enrollment right.** An Employee or Dependent who is eligible, but not enrolled in this Plan, may enroll if loss of eligibility for coverage meets all of the following conditions:

(a) The Employee or Dependent was covered under a group health plan or had health insurance coverage at the time coverage under this Plan was previously offered to the individual.

(b) If required by the Plan Administrator, the Employee stated in writing at the time that coverage was offered that the other health coverage was the reason for declining enrollment.

(c) The coverage of the Employee or Dependent who had lost the coverage was under COBRA and the COBRA coverage was exhausted, or was not under COBRA and either the coverage was terminated as a result of loss of eligibility for the coverage or because employer contributions towards the coverage were terminated. Coverage will begin no later than the first day of the first calendar month following the date the completed enrollment form, or its equivalent, is received.

(d) The Employee or Dependent requests enrollment in this Plan not later than 31 days after the date of exhaustion of COBRA coverage or the termination of non-COBRA coverage due to loss of eligibility or termination of employer contributions, described above. Coverage will begin no later than the first day of the first calendar month following the date the completed enrollment form, or its equivalent, is received.

(2) For purposes of these rules, a loss of eligibility occurs if one of the following occurs:

(a) The Employee or Dependent has a loss of eligibility due to the plan no longer offering any benefits to a class of similarly situated individuals (i.e.: part-time employees).

(b) The Employee or Dependent has a loss of eligibility as a result of legal separation, divorce, cessation of Dependent status (such as attaining the maximum age to be eligible as a Dependent Child under the plan), death, termination of employment, or reduction in the number of hours of employment or contributions towards the coverage were terminated.

(c) The Employee or Dependent has a loss of eligibility when coverage is offered through an HMO, or other arrangement, in the individual market that does not provide benefits to individuals who no longer reside, live or work in a service area, (whether or not within the choice of the individual).

(d) The Employee or Dependent has a loss of eligibility when coverage is offered through an HMO, or other arrangement, in the group market that does not provide benefits to individuals who no longer reside, live or work in a service area, (whether or not within the choice of the individual), and no other benefit package is available to the individual.

If the Employee or Dependent lost the other coverage as a result of the individual's failure to pay premiums or required contributions or for cause (such as making a fraudulent claim or an intentional

misrepresentation of a material fact in connection with the plan), that individual does not have a Special Enrollment right.

(3) Dependent beneficiaries. If:

(a) The Employee is a Participant under this Plan (or has met the Waiting Period applicable to becoming a Participant under this Plan and is eligible to be enrolled under this Plan but for a failure to enroll during a previous enrollment period), and

(b) A person becomes a Dependent of the Employee through marriage, registration of domestic partnership, birth, adoption or placement for adoption,

then the Dependent (and if not otherwise enrolled, the Employee) may be enrolled under this Plan. In the case of the birth or adoption of a Child, the Spouse or domestic partner of the covered Employee may be enrolled as a Dependent of the covered Employee if the Spouse or domestic partner is otherwise eligible for coverage. If the Employee is not enrolled at the time of the event, the Employee must enroll under this Special Enrollment Period in order for his eligible Dependents to enroll.

The Dependent Special Enrollment Period is a period of thirty-one (31) days and begins on the date of the marriage, birth, adoption or placement for adoption. To be eligible for this Special Enrollment, the Dependent and/or Employee must request enrollment during this 31-day period.

The coverage of the Dependent and/or Employee enrolled in the Special Enrollment Period will be effective:

(a) in the case of marriage, on the date of marriage, or in the case of domestic partner relationship, on the date of registration of the domestic partner relationship; or

(b) in the case of a Dependent's birth, as of the date of birth; or

(c) in the case of a Dependent's adoption or placement for adoption, the date of the adoption or placement for adoption; or

(d) in the case of loss of coverage, the date of the loss of prior coverage if the request for enrollment is received in a timely manner and any required premiums for such new coverage are paid.

(4) Special Enrollment Pursuant to Termination of Medicaid or SCHIP Coverage. Subject to the conditions set forth below, an Employee who is eligible but not enrolled, or the Dependents of such eligible Employee, if eligible but not enrolled, may enroll in this Plan if either of the following two conditions are satisfied:

(a) **Termination of Medicaid or SCHIP Coverage.** The eligible Employee or Dependent may enroll if the eligible Employee or Dependent is covered under a Medicaid plan under Title XIX of the Social Security Act, or under the State Children's Health Insurance Program ("SCHIP") under Title XXI of the Social Security Act, and coverage of the eligible Employee or Dependent under either the Medicaid or SCHIP plan is terminated as a result of loss of eligibility under such plan.

(b) **Eligibility for Premium Assistance Under Medicaid or SCHIP.** The eligible Employee or Dependent may enroll if the eligible Employee or Dependent becomes eligible for premium or other assistance with respect to coverage under this Plan, pursuant to a Medicaid plan or SCHIP plan (including any waiver or demonstration product conducted under or related to such Medicaid or SCHIP plan).

Required Length of Special Enrollment Notification. An eligible Employee and/or his or her Dependents must request Special Enrollment in writing no later than sixty (60) days from the date of termination of the Medicaid/SCHIP eligibility or the date the eligible Employee or Dependent is determined to be eligible for the premium assistance.

If a Dependent becomes eligible to enroll under this provision and the Employee is not then enrolled, the Employee must enroll in order for the Dependent to enroll.

Coverage will become effective as of the first day of the first calendar month following the date the completed enrollment form is received unless an earlier date is established by the Employer or by regulation.

An Employee who is already enrolled in a benefit option may enroll in another benefit option under the Plan if their Dependent has a Special Enrollment right because the Dependent lost other health coverage.

ENROLLMENT OF DEPENDENT PURSUANT TO A QUALIFIED MEDICAL CHILD SUPPORT ORDER

If the Plan Administrator receives a Qualified Medical Child Support Order (QMCSO), as determined by the Plan Administrator, for an eligible Dependent, the effective date shall be the later of (a) the date of the QMCSO, or (b) thirty-one (31) days prior to the date the QMCSO was received by the Plan Administrator. If the Employee is not enrolled in the Plan, the Plan Administrator shall enroll the Employee as of the same effective date as the eligible Dependent and the Employee shall be responsible for any required Employee contributions.

EFFECTIVE DATE

Effective Date of Employee Coverage. An Employee will be covered under this Plan as of the first day that the Employee satisfies all of the following:

(1) The Eligibility Requirement.

(2) The Active Employee Requirement.

(3) The Enrollment Requirements of the Plan.

Active Employee Requirement.

An Employee must be an Active Employee (as defined by this Plan) for this coverage to take effect.

Effective Date of Dependent Coverage. A Dependent's coverage will take effect on the day that the Eligibility Requirements are met; the Employee is covered under the Plan; and all Enrollment Requirements are met.

TERMINATION OF COVERAGE

For Plan Years that begin before January 1, 2014, Plan Participants who lose coverage under the Plan will receive a certificate that will show the period of Creditable Coverage under this Plan. The Plan maintains written procedures that explain how to request this certificate.

The Employer or Plan has the right to rescind any coverage of the Employee and/or Dependents for cause, making a fraudulent Claim or an intentional material misrepresentation in applying for or obtaining coverage, or obtaining benefits under the Plan. The Employer or Plan may either void coverage for the Employee and/or covered Dependents for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage. If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the Plan will provide at least thirty (30) days' advance written notice of such action. The Employer will refund all contributions paid for any coverage rescinded; however, Claims paid will be offset from this amount. The Employer reserves the right to collect additional monies if Claims are paid in excess of the Employee's and/or Dependent's paid contributions.

When Employee Coverage Terminates. Employee coverage will terminate on the earliest of these dates (except in certain circumstances, a covered Employee may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, see the Section entitled Continuation Coverage Rights Under COBRA):

(1) The date the Plan is terminated.

(2) The last day of the calendar month in which the covered Employee ceases to be in one of the Eligible Classes. This includes death or termination of Active Employment of the covered Employee. (See the Section entitled Continuation Coverage Rights Under COBRA.) It also includes an Employee on disability, leave of absence or other leave of absence, unless the Plan specifically provides for continuation during these periods.

(3) The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due.

(4) If an Employee commits fraud, makes an intentional misrepresentation of material fact in applying for or obtaining coverage, or obtaining benefits under the Plan, or fails to notify the Plan Administrator that he or she has become ineligible for coverage, then the Employer or Plan may either void coverage for the Employee and covered Dependents for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage. If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the Plan will provide at least thirty (30) days' advance written notice of such action.

(5) If an Employee misuses the Plan Identification Card or allows persons other than the one specifically named on the ID card to attempt to obtain benefits, then coverage will be terminated for the Employee and covered Dependents upon thirty (30) days written notice from the Plan.

(6) If a Network Provider, after Plan's reasonable efforts to provide this opportunity to the Employee, is unable to establish and maintain a satisfactory Provider-patient relationship with an Employee, Plan may terminate the coverage of the Employee and all other family members covered on that same policy. This can be done with thirty (30) days written notice to the Employee. Repeatedly seeking and receiving services that are not Medically Necessary as determined by the Plan and the Provider in question shall also be considered the inability to establish and maintain a satisfactory Provider-patient relationship.

Continuation During Periods of Employer-Certified Disability, Leave of Absence or Layoff. A person may remain eligible for a limited time if Active, Full-Time work ceases due to disability, leave of absence or layoff. This continuance will end as follows:

For an approved, paid medical leave of absence or FMLA leave of absence: the end of the six (6) calendar month period that next follows the month in which the person last worked as an Active Employee.

For an approved sabbatical: the end of the twelve (12) calendar month period that next follows the month in which the person last worked as an Active Employee.

For an approved, unpaid leave of absence, other than FMLA: coverage will continue at the COBRA contribution rate.

While continued, coverage will be that which was in force on the last day worked as an Active Employee. However, if benefits reduce for others in the class, they will also reduce for the continued person.

Continuation During Family and Medical Leave. Regardless of the established leave policies mentioned above, this Plan shall at all times comply with the Family and Medical Leave Act of 1993 as promulgated in regulations issued by the Department of Labor.

During any leave taken under the Family and Medical Leave Act, the Employer will maintain coverage under this Plan on the same conditions as coverage would have been provided if the covered Employee had been continuously employed during the entire leave period.

If Plan coverage terminates during the FMLA leave, coverage will be reinstated for the Employee and his or her covered Dependents if the Employee returns to work in accordance with the terms of the FMLA leave. Coverage will be reinstated only if the person(s) had coverage under this Plan when the FMLA leave started, and will be reinstated to the same extent that it was in force when that coverage terminated.

Rehiring a Terminated Employee. A terminated Employee who is rehired will be treated as a new hire and be required to satisfy all Eligibility and Enrollment requirements. However, if the Employee is returning to work directly from COBRA coverage, this Employee does not have to satisfy any employment Waiting Period.

Employees on Military Leave. Employees going into or returning from military service may elect to continue Plan coverage as mandated by the Uniformed Services Employment and Reemployment Rights Act (USERRA) under the following circumstances. These rights apply only to Employees and their Dependents covered under the Plan immediately before leaving for military service.

(1) The maximum period of coverage of a person and the person's Dependents under such an election shall be the lesser of:

(a) The twenty-four (24) month period beginning on the date on which the person's absence begins; or

(b) The day after the date on which the person was required to apply for or return to a position of employment and fails to do so.

(2) A person who elects to continue health Plan coverage must pay up to 102% of the full contribution under the Plan, except a person on active duty for thirty (30) days or less cannot be required to pay more than the Employee's share, if any, for the coverage.

(3) An exclusion or Waiting Period may not be imposed in connection with the reinstatement of coverage upon reemployment if one would not have been imposed had coverage not been terminated because of service. However, an exclusion or Waiting Period may be imposed for coverage of any Illness or Injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of uniformed service.

If the Employee wishes to elect this coverage or obtain more detailed information, contact the Plan Administrator Dickinson College, 55 N. West Street, PO Box 1773, Carlisle, Pennsylvania, 17013, 1-717-245-1503. The Employee may also have continuation rights under USERRA. In general, the Employee must meet the same requirements for electing USERRA coverage as are required under COBRA continuation coverage requirements. Coverage elected under these circumstances is concurrent not cumulative. The Employee may elect USERRA continuation coverage for the Employee and his or her Dependents. Only the Employee has election rights. Dependents do not have any independent right to elect USERRA health plan continuation.

When Dependent Coverage Terminates. A Dependent's coverage will terminate on the earliest of these dates (except in certain circumstances, a covered Dependent may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, see the Section entitled Continuation Coverage Rights Under COBRA):

(1) The date the Plan or Dependent coverage under the Plan is terminated.

(2) The date that the Employee's coverage under the Plan terminates for any reason including death. (See the Section entitled Continuation Coverage Rights Under COBRA.)

(3) The date a covered Spouse loses coverage due to loss of dependency status. (See the Section entitled Continuation Coverage Rights Under COBRA.)

(4) On the last day of the calendar month that a Dependent Child ceases to be a Dependent as defined by the Plan. (See the Section entitled Continuation Coverage Rights Under COBRA.)

(5) The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due.

(6) If a Dependent commits fraud or makes a material misrepresentation in applying for or obtaining coverage, or obtaining benefits under the Plan, then the Employer or Plan may either void coverage for the Dependent for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage.

(7) If a Dependent misuses the Plan identification card or allows persons other than the one specifically named on the ID card to attempt to obtain benefits, then coverage will be terminated for the Dependent upon thirty-one (31) days written notice from the Plan.

(8) If a Participating Provider, after Plan's reasonable efforts to provide this opportunity to the Dependent, is unable to establish and maintain a satisfactory Provider-patient relationship with a Dependent, Plan may terminate the coverage of Dependent. This can be done with thirty-one (31) days written notice to the Dependent. Repeatedly seeking and receiving services that are not Medically Necessary as determined by the Plan and the Provider in question shall also be considered the inability to establish and maintain a satisfactory Provider-patient relationship.

OPEN ENROLLMENT

During the annual Open Enrollment Period, covered Employees and their covered Dependents will be able to change some of their benefit decisions based on which benefits and coverages are right for them.

During the annual Open Enrollment Period, Employees and their Dependents who are Late Enrollees will be able to enroll in the Plan.

Benefit choices made during the Open Enrollment Period will become effective January 1 and remain in effect until the next December 31 unless there is a Special Enrollment event or a change in family status during the year (birth, death, marriage, divorce, adoption) or loss of coverage due to loss of a Spouse's employment. To the extent previously satisfied, coverage Waiting Periods will be considered satisfied when changing from one benefit option under the Plan to another benefit option under the Plan.

Benefit choices for Late Enrollees made during the Open Enrollment Period will become effective January 1.

A Plan Participant who fails to make an election during open enrollment will automatically retain his or her present coverages.

Plan Participants will receive detailed information regarding open enrollment from their Employer.

MEDICAL BENEFITS

Medical Benefits apply when Covered Charges are incurred by a Covered Person for care of an Injury or Sickness and while the person is covered for these benefits under the Plan.

COPAYMENT

A Copayment is the amount of money that is paid each time a particular Covered Service is used. Typically, there may be Copayments on some services and other services will not have any Copayments.

DEDUCTIBLE

Deductible Amount. This is an amount of Covered Charges for which no benefits will be paid. Before benefits can be paid in a Benefit Year, a Covered Person must meet the Deductible shown in the Schedule of Benefits.

Family Unit Limit. When the maximum amount shown in the Schedule of Benefits has been incurred by members of a Family Unit toward their Benefit Year Deductibles, the Deductibles of all members of that Family Unit will be considered satisfied for that year.

BENEFIT PAYMENT

Each Benefit Year, benefits will be paid for the Covered Charges of a Covered Person that are in excess of the Deductible and any Copayments. Payment will be made at the rate shown under Reimbursement rate in the Schedule of Benefits. No benefits will be paid in excess of the Maximum Benefit Amount or any listed limit of the Plan. Benefit payable is calculated after subtracting from the Allowable Amount any applicable Deductible, Copayment, Coinsurance or non-Covered Charge owed by the Covered Person. All benefit maximums are combined for In-Network and Out-of-Network unless otherwise specified.

OUT-OF-POCKET LIMIT/MAXIMUM

Covered Charges are payable at the percentages shown each Benefit Year until the Out-of-Pocket Maximum shown in the Schedule of Benefits is reached. Then, Covered Charges incurred by a Covered Person will be payable at 100% (except for the charges excluded) for the rest of the Benefit Year.

When a Family Unit reaches the Out-of-Pocket Maximum, Covered Charges for that Family Unit will be payable at 100% of the Allowable Charge without any Coinsurance for the remainder of the Benefit Year. The amount of the Out-of-Pocket Maximum is listed in the Schedule of Benefits. Even if You reach the Out-of-Pocket Maximum, an Out-of-Network Provider may require You to pay amounts in excess of the Allowable Charge. Amounts above the Allowable Charge which You pay to Out-of-Network Providers do not count toward Your Out-of-Pocket Maximum.

The following expenses do not apply toward the Out-of-Pocket Maximum: utilization review penalties; charges in excess of the Plan limitations; non-Covered Services; and charges in excess of the Allowable Charge.

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 Dickinson College Preferred Provider Organization Health Plan, including the ones described in this document. The Maximum Benefit Amount for Essential Health Benefits will not apply in Plan Years beginning on or after January 1, 2014.

COVERED CHARGES

Covered Charges are the Allowable Charges that are incurred for the following items of service and supply. These charges are subject to the benefit limits, exclusions and other provisions of this Plan. A charge is incurred on the date that the service or supply is performed or furnished.

(1) **Hospital Care.** The medical services and supplies furnished by a Hospital or Ambulatory Surgical Center or a Birthing Center. Covered Charges for room and board will be payable as shown in the

Schedule of Benefits. After twenty-three (23) observation hours, a confinement will be considered an Inpatient confinement.
A semi-private room and general nursing care when part of a covered Inpatient stay are covered. A private room is only covered if Medically Necessary or if a semi-private room is not available.

Specialized care units such as intensive care or cardiac care units are covered when Medically Necessary.

(2) **Coverage of Pregnancy.** The Maximum Allowable Charges for the care and treatment of Pregnancy are covered the same as any other Sickness for a covered Employee or Dependent.

Group health plans generally may not, under Federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn Child to less than forty-eight (48) hours following a vaginal delivery, or less than ninety-six (96) hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than forty-eight (48) hours (or ninety-six (96) hours as applicable). In any case, plans and issuers may not, under Federal law, require that a Provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of forty-eight (48) hours (or ninety-six (96) hours).

The Covered Person has the option, with her Physician's authorization, to leave the Hospital earlier than stated above and receive a home health visit within seventy-two (72) hours of leaving the Hospital. Deductibles, Copayments and Coinsurance shall not apply to such home health visit.

(3) **Skilled Nursing Facility Care.** The room and board and nursing care furnished by a Skilled Nursing Facility will be payable if and when:

(a) the patient is confined as a bed patient in the facility; and

(b) the attending Physician certifies that the confinement is needed for further care of the condition that caused the Hospital confinement; and

(c) the attending Physician completes a treatment plan which includes a diagnosis, the proposed course of treatment and the projected date of discharge from the Skilled Nursing Facility.

Covered Charges for a Covered Person's care in these facilities are payable as described in the Schedule of Benefits.

(4) **Physician Care.** The professional services of a Physician for surgical or medical services.

(5) **Home Health Care Services and Supplies.** Charges for home health care services and supplies are covered only for care and treatment of an Injury or Sickness when Hospital or Skilled Nursing Facility confinement would otherwise be required. The diagnosis, care and treatment must be certified by the attending Physician and be contained in a Home Health Care Plan.

Benefit payment for nursing, home health aide and therapy services is subject to the Home Health Care limit shown in the Schedule of Benefits.

A home health care visit will be considered a periodic visit by either a nurse or therapist, as the case may be, or four hours of home health aide services.

(6) **Hospice Care Services and Supplies.** Charges for hospice care services and supplies are covered only when the attending Physician has diagnosed the Covered Person's condition as being terminal, determined that the person is not expected to live more than six (6) months and placed the person under a Hospice Care Plan.

Covered Charges for Hospice Care Services and Supplies are payable as described in the Schedule of Benefits.

Bereavement counseling services by a licensed social worker or a licensed pastoral counselor for the patient's immediate family (covered Spouse and/or covered Dependent Children). Bereavement services must be furnished within three (3) months after the patient's death.

Charges for Bereavement counseling are subject to the limits as described in the Schedule of Benefits.

(7) **Other Medical Services and Supplies.** These services and supplies not otherwise included in the items above are covered as follows:

(a) Local Medically Necessary professional land or air **ambulance service**. A charge for this item will be a Covered Charge only if the service is to the nearest Hospital or Skilled Nursing Facility where necessary treatment can be provided unless the Claims Administrator finds a longer trip was Medically Necessary.

(b) **Anesthetic**. oxygen; blood and blood derivatives that are not donated or replaced; intravenous injections and solutions. Administration of these items is included.

(c) **Blood,** when Medically Necessary, including;

- Blood and plasma processing fees.
- Costs associated with drawing, preparation, and storage of the Covered Person's blood, blood plasma, or blood derivatives for use by the Covered Person.
- Charges incurred in connection with the treatment of routine bleeding episodes associated with hemophilia and other congenital bleeding disorders. Covered charges include the purchase of blood products and blood infusion equipment required for home treatment of routine bleeding episodes associated with hemophilia and other congenital bleeding disorders when the home treatment program is under the supervision of the state-approved hemophilia treatment center.

(d) **Cardiac rehabilitation** as deemed Medically Necessary provided services are rendered:

(1) under the supervision of a Physician;
(2) in connection with a myocardial infarction, coronary occlusion or coronary bypass surgery;
(3) initiated within twelve (12) weeks after other treatment for the medical condition ends; and
(4) in a Medical Care Facility as defined by this Plan.

Coverage includes Phase I and Phase II. Phase III cardiac rehabilitation services are not covered.

(e) **Radiation or chemotherapy and treatment** with radioactive substances. The materials and services of technicians are included.

(f) Initial **contact lenses or glasses** required following cataract surgery.

(g) **Contraceptive Drugs and/or Devices** including the injectable contraceptives, including Depo-Provera (serum covered under the prescription drug benefit), IUD's (Intrauterine Device), and Norplant.

(h) **Dental Services** including the removal of symptomatic, bony impacted third molars if Medically Necessary. Emergency Services required due to accidental Injury to sound, natural teeth that are rendered during the first 24 hours after accidental Injury. All other dental services are excluded, including, but not limited to: orthodontics, periodontics, endodontics, prosthodontics, preventive, cosmetic, or restorative dentistry.

(i) **Dermatological services,** when Medically Necessary.

(j) **Diabetes supplies** including insulin pumps and insulin pump supplies for the treatment of Insulin-dependent diabetes, insulin-using diabetes, gestational diabetes, and non-insulin using diabetes are provided if prescribed by a Provider legally authorized to prescribe such items under law.

Diabetes equipment, supplies, and self-management training and education must comply with the Claims Administrator's Utilization Management policies and procedures.

(k) **Diabetes treatment** and counseling is covered for in-person outpatient self-management training and education, including medical nutritional therapy required for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes, and non-insulin using diabetes. This coverage is provided if: (i) prescribed by a Provider legally authorized to prescribe such services under law and (ii) provided by a Provider who is a certified, registered, or licensed health care professional.

(l) Peritoneal **Dialysis** and Hemodialysis. Hemodialysis is covered if deemed Medically Necessary and when provided at: (i) an Outpatient or Inpatient facility in an acute general Hospital; (ii) an Outpatient dialysis unit; or (iii) at home.

(m) Rental of **durable medical or surgical equipment** if deemed Medically Necessary. These items may be bought rather than rented, with the cost not to exceed the fair market value of the equipment at the time of purchase, but only if Preauthorized in advance.

Benefit includes ostomy supplies, oxygen and respiratory equipment. Equipment rental for negative pressure wound therapy is covered under the Durable Medical Equipment benefit.

(n) **Epidural sympathetic nerve blocks and facet.** Covered Charges for joint block for intractable pain is payable when deemed to be Medically Necessary and Preauthorized by the Claims Administrator.

(o) Diagnosis and Medically Necessary treatment of diseases and Injuries of the **eye** to include the first pair of cataract lenses or glasses following cataract removal surgery or lenses for the treatment of Keratoconus.

(p) **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.

(q) Care, supplies and services for the diagnosis and treatment of **infertility**. Infertility is the inability to conceive after one year of intercourse without contraception. Charges are subject to the limits as described in the Schedule of Benefits.

(r) **Inhalation Therapy.**

(s) **Laboratory tests** are covered when obtained at the office of a Physician or through a laboratory.

(t) **Maternity** including obstetrical care, prenatal, delivery and postpartum care, in an inpatient setting and/or a home visit or visits in accordance with the medical criteria prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists is covered. A nurse midwife may provide obstetrical care. Obstetrical care does not include services for childbirth performed in a home setting.

(u) A **Medical Emergency** is a sudden onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent layperson to result in (i) serious jeopardy to the mental or physical health of the Covered Person; (ii) danger of serious impairment of the Covered Person's bodily functions; (iii) serious dysfunction of any of the Covered Person's bodily organs; or (iv) in the case of a pregnant woman, serious jeopardy to the health of the fetus. Screening and stabilization services provided in a

Hospital emergency room for a Medical Emergency may be received from either In-Network or Out-of-Network Providers.

A prudent layperson is someone without medical training who draws on his or her practical experience when making a decision regarding whether emergency medical treatment is needed. A prudent layperson will be considered to have acted "reasonably" if other similarly situated laypersons would have believed, on the basis of observation of the medical symptoms at hand, that emergency medical treatment was necessary.

The Claims Administrator reviews all information and documentation with respect to these claims in accordance with established medical criteria and guidelines. If this review results in the determination that the Covered Person did not experience a Medical Emergency, the Covered Person may be responsible for the entire bill. Claims resulting from a Medical Emergency are eligible for payment at the In-Network level of benefits. If a claim is denied or paid at the Out-of-Network benefit level when you believe a Medical Emergency existed, contact the Customer Service Department.

(v) Treatment of **Mental Disorders and Substance Abuse**. For Plan Years beginning on or after October 3, 2009, regardless of any limitations on benefits for Mental Disorders and Substance Abuse Treatment otherwise specified in the Plan, any aggregate lifetime limit, annual limit, financial requirement, Out-of-Network exclusion or treatment limitation on Mental Disorders and Substance Abuse benefits imposed by the Plan shall comply with federal parity requirements, if applicable.

All treatment is subject to the benefit payment maximums shown in the Schedule of Benefits.

(w) **Treatment and surgery related to Morbid Obesity.** Morbid Obesity is a condition that exists when an individual has a body mass index (BMI) greater than forty (40), or a BMI greater than thirty-five (35) with co-morbidities, including, but not limited to severe apnea, Pickwickian Syndrome, obesity-related cardiomyopathy, severe diabetes mellitus, hypertension, or arthritis.

In order to be eligible for coverage for Medically Necessary gastric bypass (Roux-en-Y) or lap banding surgical treatment of morbid obesity, the Plan Participant's medical record must clearly document that all of the following criteria are met:

- Presence of Morbid Obesity for at least three years;
- There is no treatable metabolic cause for the Morbid Obesity;
- The Plan Participant is over 18 years of age;
- The Plan Participant has failed to lose weight (approximately 10% from baseline) or has regained weight despite participation in a three-month Physician-supervised multidisciplinary program within the past six (6) months that included:
  - dietary therapy (under 1200 calorie diet),
  - physical activity for 30-45 minutes, 3 to 5 days per week, and
  - behavior therapy and support;
- The Plan Participant has received cardiac clearance by a cardiologist if there is a history of prior phen-fen or redux use;
- The Plan Participant has been evaluated for restrictive lung disease and received surgical clearance by a pulmonologist;
- There is documentation in the Plan Participant's medical record that he/she has completed a psychological evaluation by a licensed mental health professional and has been recommended for bariatric surgery;
- The Plan Participant's medical record reflects documentation by the treating psychotherapist that all psychosocial issues have been identified and addressed;
- Within three (3) months of the scheduled surgery, the Plan Participant must comply with the post-surgery diet program;
- The Plan Participant agrees to participate in a multidisciplinary program that will provide guidance on diet, physical activity, and behavior and social support after the surgery.

Prior Authorization required. Benefits must be received from Bariatric Surgery Centers of Excellence. "Bariatric Surgery Center of Excellence" is a Hospital or health care facility licensed or accredited where required under the laws of the state in which it operates, operating within the scope of its license or accreditation and designated by the Claims Administrator as qualified to perform bariatric surgery and related services. Plan Participants must meet all of the coverage criteria in order to be eligible for Benefits.

The following limitations and exclusions apply:

1) Services received from any provider not designated by the Claims Administrator as a Bariatric Surgery Center of Excellence are not covered Benefits.
2) Plan Participants who have any of the following are not eligible for coverage:
   - Active substance abuse;
   - Active peptic ulcer disease;
   - Illness that greatly reduces life expectancy and are unlikely to be improved with weight reduction, including but not limited to cancer, symptomatic coronary artery disease, and end-stage renal disease;
   - Psychiatric disorders, including but not limited to schizophrenia, borderline personality disorder, and uncontrolled depression.
3) Plan Participants that have a documented history of not complying with recommended medical care are not eligible for coverage.
4) Plan Participants who have voluntarily ended a weight loss program that produced demonstrable weight loss are not eligible for coverage.
5) The following are not covered Benefits:
   - Vertical banded gastroplasty;
   - Jejunoileal bypass;
   - Biliopancreatic bypass;
   - Gastroplasty;
   - Gastric balloon;
   - Abdominoplasty and other Cosmetic Surgery; and
   - Panniculectomy and other procedures for removal of excess skin unless Medically Necessary.

(x) **Nutritional Supplements** (formulas) deem Medically Necessary for the therapeutic treatment of phenylketonuria, branched-chain ketonuria, galactosemia, and homocystinuria as administered under the direction of a Physician. Other nutritional supplements for diagnoses other than those specifically named are not covered.

(y) **Occupational therapy** by a licensed occupational therapist. Therapy must be ordered by a Physician, result from an Injury or Sickness and improve a body function. Covered Charges do not include recreational programs, maintenance therapy or supplies used in occupational therapy.

Charges for Occupational therapy are subject to the limits as described in the Schedule of Benefits.

(z) **Organ transplant** limits. Services related to Medically Necessary organ transplants are covered when approved by the Claims Administrator and performed at a Coventry Transplant Network Participating facility approved by the Claims Administrator. Charges otherwise covered under the Plan that are incurred for the care and treatment due to an organ or tissue transplant are subject to these limits:

The transplant must be performed to replace an organ or tissue.

Details of the transplant benefit will be provided upon request and at any time Transplant Services are Preauthorized.

Charges for obtaining donor organs or tissues are Covered Services under the Plan when the recipient is a Covered Person. When the donor has medical coverage, his or her plan will pay first. The benefits under this Plan will be reduced by those payable under the donor's plan. Donor charges include those for:

(i) evaluating the organ or tissue;
(ii) removing the organ or tissue from the donor; and
(iii) transportation of the organ or tissue from within the United States and Canada to the place where the transplant is to take place.

Benefit payments for donor screening charges are subject to a separate Lifetime Maximum Benefit limit as shown in the Schedule of Benefits. The cost of any care, including complications, arising from an organ donation by a Covered Person when the recipient is not a Covered Person is excluded.

Travel for Transplant Services. Travel expenses for Covered Persons and living donors are covered according to the Plan transplant travel benefit. Details of the transplant travel benefit will be provided upon request and at any time transplant Services are authorized.

Transplant Services rendered by a Provider not in the Coventry Transplant Network. Transplant services rendered by a Provider not in the Coventry Transplant Network are not covered. Specifically, even if the transplant services are rendered by a Network Provider, unless such Network Provider is also a Coventry Transplant Network Participating facility, there is no coverage for such services. The Plan uses a transplant network. Facilities in this network are contracted to perform specific transplant services. The Plan reserves the right to require a Covered Member to obtain services from a contracted Provider who may be outside of the network service area if the services are to be covered by the Plan at the In-Network benefit level. Organ, tissue, and bone marrow transplants performed by a Non-Participating Provider will be subject to the Out-of-Network benefit level. Any procedures involving organ and tissue donor expenses when the recipient is a Covered Member are also limited to any applicable maximum benefit when performed Out-of-Network.

(aa) **Orthotic appliances** are covered and will accrue toward the Corrective Appliances benefit. Covered orthotic devices must,
(i) be a device added to the body to stabilize or immobilize a body part, prevent deformity or assist with function; and
(ii) be semi-rigid and correct a diagnosed musculoskeletal malalignment of a weakened or diseased body part; or
(iii) be rigid or semi-rigid and stop or limit motion of a weak or diseased body part.

Foot orthotics are not covered.

Replacement coverage is limited to once every two (2) years due to irreparable damage and/or normal wear or a significant change in medical condition, unless otherwise required by law, and must be Preauthorized as Medically Necessary by the Claims Administrator. Replacement costs necessitated as a result of malicious damage, culpable neglect, or wrongful disposition of the equipment or device on the part of the Subscriber are not covered.

(bb) **Physical therapy** by a licensed physical therapist. The therapy must be in accord with a Physician's exact orders as to type, frequency and duration and for conditions which are subject to significant improvement through short-term therapy. Physical therapy rendered by an appropriately licensed chiropractor is covered.

Charges for Physical therapy are subject to the limits as described in the Schedule of Benefits.

(cc) **Prescription** Drugs approved by the Food and Drug Administration for a specific use, which can, under federal or state law, be dispensed only pursuant to a Prescription Order (i.e. a legend medication) and has not been excluded from coverage by the Claims Administrator.

(dd) 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.

(ee) The initial purchase, fitting and repair of fitted **prosthetic devices** which (i) replace all or part of a missing body organ and its adjoining tissue or all or part of the function of a permanently useless or malfunctioning body organ; and (ii) be an implantable prosthetic appliance or equivalent external device.

Replacement coverage is limited to once every two (2) years due to irreparable damage and/or normal wear or a significant change in medical condition, unless otherwise required by law, and must be Preauthorized as Medically Necessary by HealthAmerica. Replacement costs necessitated as a result of malicious damage, culpable neglect, or wrongful disposition of the equipment or device on the part of the subscriber are not covered.

(ff) **Reconstructive Surgery.** Reconstructive surgery or procedures when performed to correct deformity caused by disease, trauma, or a previous therapeutic process that is considered a Covered Service. In the event a Covered Person is undergoing a multi-stage reconstruction or fulfilling a specific Waiting Period that is medically indicated, then the Provider must submit a treatment plan for approval.

Pursuant to the Women's Health and Cancer Rights Act, if a Covered Person elects reconstructive surgery in connection with a mastectomy, the Plan will provide benefits for:

1. Reconstruction of the breast on which the mastectomy has been performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance;
3. Prostheses and physical complications at all stages of mastectomy, including lymphedemas;

Such services shall be performed in a manner determined in consultation with the attending Physician and the patient.

Additionally, the Plan provides benefits in connection with reconstructive breast surgery for:

1. Nipple and areola reconstruction.
2. Medical complications resulting from the rupture of the prostheses/implant, and appropriate treatment, including removal of the prostheses/implant, upon Preauthorization.

(gg) **Speech therapy** by a licensed speech therapist. Therapy must be ordered by a Physician and follow either: (i) surgery for correction of a congenital condition of the oral cavity, throat or nasal complex (other than a frenectomy) of a person; (ii) an Injury; or (iii) a Sickness that is other than a learning or Mental Disorder.

Charges for Speech therapy are subject to the limits as described in the Schedule of Benefits.

(hh) **Spinal Manipulation/Chiropractic services** by a health care Provider acting within the scope of his or her license. Charges for Spinal Manipulation/Chiropractic Services are subject to the limits described in the Schedule of Benefits.

(ii) **Sterilization** procedures. Reversal of Sterilization is not covered.

(jj) **Surgery.** Any surgical operations (major or minor) which are Medically Necessary, not otherwise excluded or limited under the Medical Benefits Section and as Preauthorized for payment by the Claims Administrator (unless Emergency Services).

(kk) **Surgical dressings**, casts and other devices used in the reduction of fractures and dislocations, or as prescribed and determined to be Medically Necessary.

(ll) **Surgical hose, stump socks, and mastectomy bras.** Covered Services for surgical hose, stump socks and mastectomy bras as determined to be Medically Necessary and as approved by the Claims Administrator.

(mm) **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.

(nn) **Termination of pregnancy** during the first trimester is covered, except in the case of multi-fetal pregnancy reduction. Multi-fetal pregnancy reduction is only covered if the life or physical health of the mother or fetuses would be endangered if the fetuses were carried to term. Termination of pregnancy after the first trimester is a Covered Service only if the life or physical health of the mother or fetus would be endangered if the fetus were carried to term or if fetal abnormalities are detected. The first trimester is considered to be the first thirteen (13) weeks of pregnancy.

(oo) **Urgent Care services**, care for an unforeseen Illness, Injury or condition that requires immediate attention to prevent serious deterioration is covered when services are provided in an urgent care center or in a Physician's office.

(pp) Coverage of **Well Newborn Nursery/Physician Care**.

Charges for Routine Nursery Care. Routine well newborn nursery care is care while the newborn is Hospital-confined after birth and includes room, board and other normal care for which a Hospital makes a charge.

This coverage is only provided if the newborn Child is an eligible Dependent and a parent (1) is a Covered Person who was covered under the Plan at the time of the birth, or (2) enrolls himself or herself (as well as the newborn Child if required) in accordance with the Special Enrollment provisions with coverage effective as of the date of birth.

The benefit is limited to charges for nursery care for the newborn Child while Hospital confined as a result of the child's birth.

Group health plans generally may not, under Federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn Child to less than forty-eight (48) hours following a vaginal delivery, or less than ninety-six (96) hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than forty-eight (48) hours (or ninety-six (96) hours as applicable). In any case, plans and issuers may not, under Federal law, require that a Provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of forty-eight (48) hours (or ninety-six (96) hours).

Charges for Routine Physician Care. The benefit is limited to the charges made by a Physician for the newborn Child while Hospital confined as a result of the Child's birth.

(qq) Charges associated with the initial purchase of one **wig after chemotherapy**. This benefit is covered up to $250 per member per Benefit Year.

(rr) **X-rays, laboratory and diagnostic tests.** The Plan will cover the services and materials associated with x-ray and laboratory tests (including, but not limited to: diagnostic and therapeutic x-rays and isotopes, electrocardiograms, and electroencephalograms) when these services are administered in connection with other Covered Services. Coverage may require Preauthorization. Please contact the Claims Administrator for more information.

UTILIZATION MANAGEMENT SERVICES

Preauthorization

Please refer to the member ID card for the Preauthorization and Customer Service phone numbers.

When a Covered Person receives care from a Network Provider, the Provider is responsible for following the Utilization Management policies and procedures. If a Covered Person receives care from an Out-of-Network Provider, the Covered Person must comply with all of the policies and procedures of the Utilization Management Program.

When a Covered Person receives care or intends to receive care from an Out-of-Network Provider, the Covered Person or family member must call the number on the member ID card to receive Preauthorization of certain services in order for those services to be covered under this Plan. This call must be made at least ten (10) days in advance of services being rendered. If there is an **emergency** admission to a Medical Care Facility, the Covered Person or someone on the Covered Person's behalf, such as a family member, the Medical Care Facility or attending Physician, must contact the Claims Administrator **within twenty-four (24) hours** or the first business day after the admission.

General Policies

Under all circumstances, the attending Physician bears the ultimate responsibility for the medical decisions regarding treatment of Covered Persons.

The Claims Administrator will determine the number of days of Medical Care Facility confinement or use of other listed medical services are Preauthorized for payment.

If a Covered Person requests services which are not Medically Necessary having full knowledge that such services were not authorized for payment, then the Covered Person will be responsible for all charges for services incurred and not authorized.

If a Covered Person is admitted to a Medical Facility prior to the date authorized by the Claims Administrator, unless it is an emergency admission, then the Covered Person is responsible for all charges related to the unauthorized days.

Emergency Services (defined below) are covered under this Plan. If a Covered Person receives treatment in the emergency room, only those services that qualify as Emergency Services are considered eligible expenses and covered under this Plan. All other services (non-Emergency Services) provided in an emergency room are expressly excluded from coverage under this Plan.

Emergency Services shall mean: any health care service provided to a Covered Person after the sudden onset of a medical condition that manifests itself by acute symptoms of sufficient severity or severe pain such that a prudent layperson who possesses average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in: (i) placing the health of the Covered Person or, with respect to a pregnant woman, the health of the Covered Person or her unborn Child, in serious jeopardy; (ii) serious impairment to bodily functions; or (iii) serious dysfunction of any bodily organ or part.

If the Claims Administrator Preauthorizes an admission, Outpatient surgery or procedure based on information later determined to be incorrect and the authorized services are not Medically Necessary or a Covered Service, payment will be denied for charges incurred for those services.

A Covered Person has the right to Appeal any Utilization Management Services payment decision according to the complaint and Appeal procedures.

OBTAINING PREAUTHORIZATION FOR VISITS TO NON-PARTICIPATING PROVIDERS

If a Physician feels that there is a need for a Covered Person to be seen by a Physician or other medical Provider who does not participate in the Network and that the services may be eligible for In-Network benefits, then the Physician must submit medical information to the Plan Administrator or its designee prior to the Covered Person receiving services. **Retroactive requests for consideration at the In-Network benefit level**

will not be considered. Covered Services from an Out-of-Network Provider are Preauthorized by the Plan for In-Network benefits only when the Plan does not have an In-Network Provider who can provide the service. The Physician must submit evidence that Participating Plan Providers are unable to perform the requested services. The Plan Administrator or is designee has the right to determine where the services can be provided for coverage when an In-Network Provider cannot render the service.

A Covered Person has the right to Appeal any Utilization Management Program payment decision according to the complaint and Appeal procedures.

UTILIZATION REVIEW

Utilization review is a program designed to help insure that all Covered Persons receive necessary and appropriate health care while avoiding unnecessary expenses.

The program consists of:

(a) Preauthorization of the Medical Necessity for the following non-Emergency Services before Medical and/or Surgical services are provided:

Refer to the Preauthorization Exhibit at the end of this document.

The attending Physician does not have to obtain Preauthorization from the Plan for prescribing a maternity length of stay that is forty-eight (48) hours or less for a vaginal delivery or ninety-six (96) hours or less for a cesarean delivery.

Note: The services mentioned above must be Preauthorized or Reimbursement from the Plan may be reduced.

(b) Retrospective review of the Medical Necessity of the listed services provided on an emergency basis;

(c) Concurrent review, based on the admitting diagnosis, of the listed services requested by the attending Physician; and

(d) Authorization of services and planning for discharge from a Medical Care Facility or cessation of medical treatment.

The purpose of the program is to determine what charges may be eligible for payment by the Plan. This program is not designed to be the practice of medicine or to be a substitute for the medical judgment of the attending Physician or other health care Provider.

If a particular course of treatment or medical service is not Preauthorized, it means that either the Plan will not pay for the charges or the Plan will not consider that course of treatment as appropriate for the maximum Reimbursement under the Plan. The patient is urged to find out why there is a discrepancy between what was requested and what was Preauthorized before incurring charges.

In order to maximize Plan Reimbursement, please read the following provisions carefully.

Here's how the program works.

Pre-Service Requests for benefits (requests for benefits that require Preauthorization and are for services that have not yet been provided).

To make a pre-service request for benefits that will be provided by an Out-of-Network Provider, the Covered Person or the Out-of-Network Provider on the Covered Person's behalf should contact the Claims Administrator at the number provided on the member ID card for Preauthorization and provide the following information:

- The name of the patient and relationship to the covered Employee,
- The name, member ID number and address of the covered Employee,
- The name of the Employer,
- The name and telephone number of the attending Physician,

- The name of the Medical Care Facility, proposed date of admission, and proposed length of stay,
- The diagnosis and/or type of surgery, and
- The proposed rendering of listed medical services.

After the Claims Administrator receives the request, it will notify the Provider of any additional information needed in order make a coverage determination. The Plan Administrator or its designee will make its decision and notify the Provider within fifteen (15) days after it receives the request for benefits.

Urgent Care Requests for benefits (requests for benefits related to services that the health care Provider believes places the Covered Person's life, health or ability to regain maximum function in immediate jeopardy, or for care that the treating Physician determines is urgent, or determines that a delay would subject the Covered Person to severe pain that could not be adequately managed without the treatment requested).

Expedited notification for Urgent Care determinations. The Claims Administrator will make notification for a Claim involving Urgent Care not later than seventy-two (72) hours after receipt of the Claim, and will notify a Covered Person of a benefit determination (whether adverse or not) for a Claim involving Urgent Care as soon as possible, unless the Covered Person fails to provide sufficient information to determine whether, or to what extent, benefits are covered. In some cases, the Covered Person or the Provider may not have provided the Claims Administrator with sufficient information to make a decision. If this is the case, the Claims Administrator, within twenty-four (24) hours after it has received the request, will notify the Covered Person of the additional information that it needs to make a determination. The Claims Administrator will give the Covered Person or Provider a reasonable amount of time, at least forty-eight (48) hours, to provide the information. The Claims Administrator will make its decision within the earlier of: forty-eight (48) hours after it receives the information, or within forty-eight (48) hours of the time it gave the Covered Person or Provider to provide the additional information.

Concurrent Care Benefit Determinations

If a Covered Person is undergoing an approved course of treatment, and the Plan Administrator or its designee determines that the number or course of the treatment should be reduced or terminated and the Covered Person will be held financially responsible, the Claims Administrator on behalf of the Plan will inform the Covered Person of its decision before the end of the approved course of treatment, so that the Covered Person has sufficient time to Appeal the decision to reduce or limit the treatment.

Notifications of Benefit Determinations

If the Plan Administrator or its designee denies a request for services in whole or in part, it will provide the Covered Person with a written explanation of the decision, including the specific reason that the request was denied, the Plan provision on which the denial was based, a description of any additional information that may be submitted and why the information is necessary, and a description of the Appeal procedures.

Admission/Continued Stay Review

In the event of an emergency hospitalization or Outpatient surgery or procedure, the Claims Administrator must be contacted at the number provided on the member ID card must be contacted within forty-eight (48) hours after the Medical Emergency or as soon as reasonably possible following the receipt of the services.

If the Covered Person is being treated by an In-Network Provider, it is the responsibility of the attending In-Network Provider to contact the Claims Administrator.

If the Covered Person is being treated by a Non-Network Provider, it is the Covered Person's responsibility to contact the Claims Administrator. A friend or relative, the attending Physician, the Hospital, or anyone a Covered Person designates may contact the Claims Administrator.

If the Claims Administrator was contacted by the Covered Person or the In-Network Provider and the emergency admission was not Medically Necessary, the services will be denied.

In the event that a Covered Person wants to stay in the Hospital longer than is Preauthorized by the Plan Administrator or its designee, no further benefits will be provided.

CASE MANAGEMENT

Complex Case Management. The Claims Administrator strives for the early identification and effective management of selected Plan Participants for whom intensive management can be expected to improve the quality of care and reduce overall medical expenses. The complex case management program offers special assistance to Plan Participants with serious and complex, long-term medical needs and promotes quality of care to reduce the likelihood of extended, more costly health care. The Claims Administrator identifies serious and complex medical conditions as ones that are persistent and substantially disabling or life-threatening and that require treatments and services across a variety of domains of care to ensure the best possible outcome for each unique Covered Person. Long-term medical needs are those that are more chronic than and acute and can be expected to require extended use of health care resources.

Complex case management is a collaborative process which assesses, plans, implements, coordinates, monitors, and evaluates options and services to meet an individual Covered Person's health care needs through communication and available resources to promote quality, cost-effective outcomes.

Case management is a voluntary service. There are no reductions of benefits or penalties if the patient and family choose not to participate.

Each treatment plan is individually tailored to a specific patient and should not be seen as appropriate or recommended for any other patient, even one with the same diagnosis.

SECOND AND/OR THIRD SURGICAL OPINION PROGRAM

Certain surgical procedures are performed either inappropriately or unnecessarily. In some cases, surgery is only one of several treatment options. In other cases, surgery will not help the condition.

In order to prevent unnecessary or potentially harmful surgical treatments, the second and/or third opinion program fulfills the dual purpose of protecting the health of the Plan's Covered Persons and protecting the financial integrity of the Plan.

Benefits will be provided for a second (and third, if necessary) opinion consultation to determine the Medical Necessity of an elective surgical procedure. An elective surgical procedure is one that can be scheduled in advance; that is, it is not an emergency or of a life-threatening nature. Benefits for the second (and third, if necessary) opinion will be paid as any other Sickness.

The patient may choose any board-certified specialist who is not an associate of the attending Physician and who is affiliated in the appropriate specialty.

PRESCRIPTION DRUG BENEFITS

Many independent retail pharmacies and most national retail chains are Network Pharmacies. To find out if a pharmacy is in the Network, call the Customer Service Department at the number listed on the back of Your Plan Identification Card.

The Plan Administrator understands and agrees that Coventry Prescription Management Services, Inc. may receive a retrospective discount or rebate from a vendor or manufacturer related to the aggregate 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. Covered Persons shall not share in such retrospective volume-based discounts or rebates.

In certain situations, the Claims Administrator can, upon written notification to the Covered Person, give notice that the Covered Person's Prescription Drug benefit is in jeopardy. These situations include, but are not limited to, a Covered Person using medications in a manner that contradicts his/her prescription or standard prescribing practices, consistently using multiple pharmacies, or obtaining prescriptions for the same medication from multiple Physicians. Continued abuse of this nature may result in restrictions in the Covered Person's Prescription Drug benefits including termination upon thirty-one (31) days written notice for the Covered Employee and all Covered Dependents.

Please contact the Customer Service Department at the number on Your member ID card if You have any questions.

DEFINITIONS

Annual Maximum means the limit, if any, the Covered Person may meet during the Benefit Year after which Prescription Drugs are not covered. Calculation of the Annual Maximum includes only the cost to the Plan and does not include any of the following Covered Person payments:

- Copayments or Coinsurance;
- Pharmacy Deductibles;
- Dispense As Written (DAW) Charge or Ancillary Charges; or
- Amounts over the Maximum Allowable Charge.

Authorized Prescriber means any:

- licensed Dentist;
- licensed Physician;
- licensed podiatrist;
- certified nurse midwife to the extent permitted by applicable law; or
- certified nurse practitioner to the extent permitted by applicable law, or other individual authorized by law to prescribe prescription or non-Prescription Drugs or devices.

Benefit Year is the period of twelve (12) consecutive months during which benefits under the Plan accrue.

Coinsurance means the percentage stated in the Schedule of Benefits, if any, that the Covered Person must pay to the Network Retail, Mail Order or Specialty Pharmacy to fill any Prescription Order or Refill with a Generic, Brand Name, Non-Preferred or Specialty Drug. The Claims Administrator calculates Coinsurance based on the negotiated rate between the Plan and the Network Pharmacy. Coinsurance for Prescription Drugs filled by an Out-of-Network Pharmacy is a percentage of the Non-Participating Provider Rate.

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.

Copayment means the flat dollar amount as specified in the Schedule of Benefits that will be charged to the Covered Person by the Participating Retail, Mail Order, or Specialty Pharmacy to dispense any Prescription Order or Refill. The Covered Person is required to pay one Copayment per each Prescription Order or Refill to a Participating Retail, Mail Order, or Specialty Pharmacy at the time of service. Copayment amounts are not

applied to:

- Pharmacy Deductible;
- Annual Maximum.

Covered Drugs means Prescription Drugs that are:

- Listed in the Formulary or Non-Preferred drugs that are covered pursuant to the Plan;
- Prescribed by an Authorized Prescriber;
- Certain Over-the-Counter (OTC) medications as listed on the online Formulary;
- Approved by the Claims Administrator; and
- Not otherwise excluded.

Dispense As Written (DAW) Charge means a charge which the Covered Person is required to pay to a pharmacy for Prescription Drugs when the Covered Person's Physician prescribes a drug as "Brand necessary", "Brand Medically Necessary", or "Brand Name only" or the Physician or Covered Person otherwise directs that a Brand Name Drug be dispensed for which a Federal Food and Drug Administration (FDA) Orange Book Generic Drug exists.

> Mandatory Generic substitution means when a Generic Drug is available, but the pharmacy dispenses the Brand Name Drug for any reason, the Covered Person is to pay the difference between the calculated Average Wholesale Price (AWP) cost of the Brand Name Drug and the calculated AWP cost of the Generic Drug in addition to the Brand Name Copayment and/or Coinsurance. The DAW Charge is not applied toward the Deductible, the Maximum Out-of-Pocket Limit or the Annual Maximum benefit.

Excluded Drugs means Prescription Drugs that are one of the following:

- Not approved by the Claims Administrator for use;
- Not listed in the Formulary or Non-Preferred, when Non-Preferred drugs are excluded from coverage;
- Drugs that are not covered; or
- Further defined in the Limitations & Exclusions Section below.

Experimental or Investigational means a health product or service that is deemed Experimental or Investigational if one or more of the following conditions are met:

- Any drug not approved for use by the Federal Food and Drug Administration ("FDA");
- Any FDA-approved drug prescribed for an off-label use whose effectiveness is unproven based on clinical evidence reported in peer-reviewed medical literature; or any drug that is classified as an Investigational New Drug ("IND") by the FDA. As used herein, off-label prescribing means prescribing Prescription Drugs for treatments, or in doses, other than those stated in the labeling approved by the FDA;
- Any health product or service that is subject to Investigational Review Board (IRB) review or approval;
- 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;
- Any health product or service whose effectiveness is unproven based on clinical evidence reported in peer-reviewed medical literature.

Formulary (Preferred) means a list of Prescription Drugs that the Claims Administrator's Pharmacy and Therapeutics Committee has approved for coverage under the Plan. This list is subject to periodic review and modification by the Committee. The Formulary is available for review:

- By contacting the Customer Service Department; or
- On the Internet at www.healthamerica@cvty.com.

Drugs not listed on the Formulary (Non-Preferred) are covered at the Tier3/Non-Preferred Copayment and/or Coinsurance amount unless excluded from coverage.

Legend Medication means a drug that, by law, can be obtained only by Prescription and that is labeled "Caution: federal law prohibits dispensing without a Prescription."

Mail Order Pharmacy means the Network Pharmacy contracted by the Plan to provide Maintenance Drugs.

Maintenance Drug/Medication means a drug anticipated to be required for six (6) months or more to treat a chronic condition, such as high blood pressure, and designated by the Claims Administrator as a Maintenance

Medication.

Maximum Allowable Charges are charges for Prescription Drugs that are equal to:

- The amount set forth in the Plan; or,
- If no amount is set forth in the Plan:
  - § In the case of a Network Pharmacy or a Non-Network Pharmacy who has agreed to accept the contracted rate, the rate that the Claims Administrator has agreed to pay; or
  - § In the case of all other Non-Network Pharmacies, the lesser of the Non-Network Pharmacy's billed charges or the Non-Participating Provider Rate.

Medical Necessity
Medically Necessary services and/or supplies provided to a Covered Person are those determined by the Claims Administrator to be:

- Medically appropriate, so that the expected health benefits (such as, but not limited to, increased life expectancy, improved functional capacity, prevention of complications, relief of pain) materially exceed the expected health risks;
- Necessary to maintain health or improve physiological function and required for a reason other than improving appearance;
- Rendered in the most cost-efficient manner and setting appropriate for the delivery of the health service;
- Consistent in type, frequency and duration of treatment with scientifically-based guidelines of national medical research, professional medical specialty organizations or governmental agencies that are accepted by the Claims Administrator as national authorities on the services, supplies, equipment or facilities for which coverage is requested;
- Consistent with the diagnosis of the condition at issue;
- Required for reasons other than comfort and convenience of the patient or Physician; and,
- Not Experimental or Investigational as determined by the Claims Administrator under the Experimental Procedures Determination Policy. A copy of the Experimental Procedures Determination Policy is available upon request from the Customer Service Department.

Narrow Therapeutic Index. A drug is said to have a narrow therapeutic index when small variances in a Covered Person's blood levels can change the effectiveness or toxicity of the drug. Safe and effective use of these drugs requires careful dosage adjustment and patient monitoring, regardless of whether the generic or brand name product is used.

Non-Preferred Pharmacies means those Network Pharmacies that are not Preferred Pharmacies.

Out-of-Pocket Limit/Maximum means the amount(s) of Maximum Allowable Charges for benefits under this Plan paid by a Covered Person or family during a Benefit Year, except that the Out-of-Pocket Maximum shall not include amounts in excess of the Maximum Allowable Charges. After the Out-of-Pocket Maximum has been paid, the Covered Person and/or the Covered Person's family, as applicable, is no longer required to pay any portion of the Maximum Allowable Charges for Prescription Drugs covered under the Plan during the remainder of the Benefit Year.

The Covered Person is always responsible to pay amounts in excess of Maximum Allowable Charges.

Pharmacy and Therapeutics Committee (Committee) means the Claims Administrator's panel of Physicians, pharmacists, nurses, and other health care professionals who are responsible for all pharmacy management activities, such as managing, updating and administering the Prescription Drug Formulary.

Pharmacy Deductible means the amount, if any, that a Covered Person must pay for Prescription Drugs each Benefit Year before a Covered Person may receive coverage for Prescription Drugs under this Plan. When the Pharmacy Deductible is met, the Covered Person is responsible for the Copayment and/or Coinsurance per Prescription Order or Refill. The Pharmacy Deductible does not include Copayments, Coinsurance or any DAW Charges.

Preferred Pharmacies are those Network Pharmacies identified as Preferred Pharmacies on the Claims Administrator's website.

Prescription Drug means a drug approved by the FDA for a specific Outpatient use and that is dispensed only pursuant to a Prescription Order or Refill (a Legend Medication) under applicable law. Prescription Drugs

include Contraceptive Drugs and Devices, Self-Administered Injectable Drugs and some Over-the-Counter medications or disposable medical supplies specified by the Plan (for example, insulin, certain diabetic supplies, and select Over-the-Counter drugs). This does not extend to drugs or products that are not FDA approved prescription medications, such as those without an approved FDA application (NDA, ANDA or BLA).

Prescription Order or Refill means the authorization for a Prescription Drug issued by an Authorized Prescriber.

Preauthorization means a determination by the Claims Administrator that a Prescription Order or Refill otherwise not covered under the Plan has been reviewed and based upon the information provided, the Prescription Order or Refill satisfies the Plan's requirements for Covered Charges.

Reimbursement means the Covered Person, upon submission of proof of payment acceptable to the Claims Administrator, shall be entitled to Reimbursement for covered Prescription Drugs of no more than one hundred percent (100%) of the dollar amount paid, less any applicable Prescription Drug Deductible, Prescription Drug Coinsurance, Copayments, and amounts above the Annual Maximum. In addition, the Covered Person will be responsible for any cost above the Maximum Allowable Charge. Covered Persons must submit claims for Reimbursement on a claim form (available from the Claims Administrator) within ninety (90) days of the date of purchase of the Prescription Drugs.

Specialty Medications means the group of medications defined by the Claims Administrator which are typically high-cost drugs and include but are not limited to those with oral, topical, inhaled, inserted or implanted, and injected routes of administration. Specialty Medications are designated as such in the Formulary. Included characteristics of Specialty Medications are by the following definitions and structure:

- Drugs which are used to treat and diagnose rare or complex diseases;
- Drugs which require close clinical monitoring and management;
- Drugs which frequently require special handling; or
- Drugs which may have limited access or distribution.

Except in urgent situations, all Specialty Medications:

- Are distributed by a Participating Specialty Pharmacy;
- Are limited to no more than a thirty (30) day supply;
- Require Prior Authorization unless specified elsewhere; and
- Are subject to quantity limits.

Specialty Pharmacy means a Pharmacy that:

- has a contract with the Claims Administrator, and
- is designated as a Specialty Pharmacy by the Claims Administrator for Covered Persons to obtain Specialty Medications.

Tier 1
The group of Preferred which includes:

- Generic Prescription Drugs which have been designated as Tier 1;
- Select Brand Name Prescription Drugs which have been designated as Tier 1; and
- Non-Prescription Drugs which have been designated as Tier 1.

Tier 2
The group of Preferred medications which includes:

- Brand Name Prescription Drugs which are made by only one manufacturer, do not have a Generic equivalent and which the Plan has designated as Tier 2;
- Brand Name contraceptives which the Plan has designated as Tier 2;
- Brand Name Prescription Drugs which have a Narrow Therapeutic Index (those for which the dose must be monitored through laboratory tests) which the Plan has designated as Tier 2;
- Newly-introduced Generic Drugs which the Plan has designated as Tier 2; and
- Drugs designated as "Drug Efficacy Study Implementation (DESI) drugs" by the U.S. Food and Drug Administration ("FDA") which the Plan has designated as Tier 2. ("Drug Efficacy Study Implementation (DESI) drugs" are being reviewed for their effectiveness by the FDA because they were approved solely on the basis of their safety prior to 1962.)

Tier 3
Drugs which are not otherwise excluded under the Plan and which are not designated as Tier 1 or Tier 2, including Brand Name Prescription Drugs which are not Preferred, Brand Name Prescription Drugs which are Preferred and have Preferred Generic equivalents and are not designated as Tier 1 or Tier 2, and Generic Prescription Drugs which are not Preferred.

COVERED SERVICES

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, preventive drug products and certain contraceptives will be provided at 100% of the Allowable Charge/Allowed Amount in a manner consistent with Section 2713 of Federal H.R. 3590.

Network or Non-Network Retail Pharmacy. Prescription Drugs and Diabetic Prescription Drugs including insulin and pharmacological agents for controlling blood sugar, as well as coverage for diabetic supplies (including diabetes monitors and Plan-approved test strips) syringes and injection aids, and injectable diabetes agents, bee sting kits, and injectable migraine agents are included under this Plan at Network Retail Pharmacies and at Non-Network Retail Pharmacies in the amounts described below when they are:

- Ordered by an Authorized Prescriber for use by a Covered Person;
- Not limited or excluded elsewhere in this Plan.

Network Retail Pharmacy. The Covered Person must present his or her ID card to the Network Retail Pharmacy to receive coverage for Prescription Drugs and Plan-approved supplies under this Plan. The Covered Person pays the following to a Network Retail Pharmacy, as applicable:

- Deductible;
- Coinsurance;
- DAW Charge;
- Amounts above the Annual Maximum, if any; and
- One (1) Copayment or the cost of the Prescription Drug, whichever is less, per one (1) Prescription Order or Refill.

In general, the quantity of a Prescription Drug dispensed by a Retail Pharmacy for each Prescription Order or Refill for a Non-Maintenance Drug is limited to the lesser of:

- The amount prescribed in the Prescription Order or Refill; or
- The amount determined by the Plan to be Medically Necessary; or
- The amount determined by the Plan to be up to a thirty-one (31) day supply; or
- Depending on the form and packaging of the product, the following:
  - 100 tablets/capsules; or
  - 480 cc of oral liquids; or
  - A single, commercially prepackaged item (including, but not limited to: inhalers, topicals, and vials, excluding insulin).

Non-Network Retail Pharmacy. The Plan payment for Prescription Drugs filled by a Non-Network Pharmacy is limited to the Non-Participating Provider Rate. The Covered Person is responsible for the following, as applicable:

- Deductible;
- Coinsurance;
- DAW Charge;
- Amounts above the Annual Maximum, if any; and
- One (1) Copayment or the cost of the Prescription Drug, whichever is less, per one (1) Prescription Order or Refill.

In general, the quantity of a Prescription Drug dispensed by a Retail Pharmacy for each Prescription Order or Refill for a Non-Maintenance Drug is limited to the lesser of:

- The amount prescribed in the Prescription Order or Refill; or
- The amount determined by the Plan to be Medically Necessary; or
- The amount determined by the Plan to be up to a thirty-one (31) day supply; or

- Depending on the form and packaging of the product, the following:
  - § 100 tablets/capsules; or
  - § 480 cc of oral liquids; or
  - § A single, commercially prepackaged item (including, but not limited to: inhalers, topicals, and vials, excluding insulin).

The Covered Person pays the full cost of the Prescription Order or Refill to a Non-Network Pharmacy at the time the Prescription Order or Refill is received.

Prescription Drugs prescribed for Medically Necessary Emergency Services and filled by a Non-Network Pharmacy are covered, in full, only if a Network Pharmacy was not available. Generically equivalent pharmaceuticals will be dispensed whenever there is a FDA-approved Generic Drug. The Covered Person, upon submission of proof of payment acceptable to the Claims Administrator, shall be entitled to Reimbursement for Prescription Drugs described in this Section of no more than one hundred percent (100%) of the amount paid by the Covered Person less applicable Prescription Drug Deductibles, Prescription Drug Coinsurance, Copayments, and amounts above the Annual Maximum. In addition, the Covered Person will be responsible for any cost above the Maximum Allowable Charge. Covered Persons must submit claims for Reimbursement on a claim form (available from the Claims Administrator) within ninety (90) days of the date of purchase of the Prescription Drugs. Reimbursement will be limited to a quantity sufficient to treat the acute phase of the Illness.

Failure to furnish the proof within the time required does not invalidate or reduce any claim if it was not reasonably possible to give proof within the required time, if the proof is furnished as soon as reasonably possible and, except in the absence of legal capacity, not later than one (1) year from the time proof is otherwise required.

Mail Order Pharmacy. To access the Mail Order Pharmacy program, the Covered Person must mail the Prescription Order or Refill to the Mail Order Pharmacy in the designated Mail Order Prescription envelope. Mail Order Prescription envelopes are available from:

- The Customer Service Department, or
- the Mail Order Pharmacy.

A Covered Person shall pay to the Mail Order Pharmacy the following amounts, if applicable:

- Deductible;
- Coinsurance;
- DAW Charge;
- Amounts above the Annual Maximum, if any; and
- One (1) Mail Order Copayment or the cost of the Prescription Drug, whichever is less, per one (1) Mail Order Prescription Order or Refill.

In general, the quantity of a Prescription Drug dispensed by a Mail Order Pharmacy for each Prescription Order or Refill for a Maintenance Drug is limited to the lesser of:

- The amount prescribed in the Prescription Order or Refill; or
- The amount determined by the Plan to be Medically Necessary; or
- The amount determined by the Plan to be up to a ninety (90) day supply.

Specialty Pharmacy. Specialty Drugs are not available through the Mail Order Pharmacy program or at Network Pharmacies except in urgent situations as determined by the Claims Administrator. You must fill Your Prescription Order or Refill for Specialty Drugs through a Specialty Pharmacy. If a Covered Person should choose to fill a Prescription Order or Refill at a Non-Network Pharmacy, those provisions apply.

Specialty Drugs and Medications require Preauthorization.

A Covered Person shall pay the following to a Specialty Pharmacy, as applicable:

- Deductible Charge;
- Amounts above the Annual Maximum, if any; and
- One (1) Specialty Copayment or the cost of the Prescription Drug, whichever is less, per one (1) Prescription;
- Coinsurance;
- DAW Order or Refill.

The quantity of Specialty Drugs dispensed by a Specialty Pharmacy for each Prescription Order or Refill is limited to the lesser of:

- The amount prescribed in the Prescription Order or Refill; or
- The amount determined by the Plan to be Medically Necessary; or
- The amount determined by the Plan to be a thirty-one (31) day supply.

Preauthorization. Regardless of where a Prescription Order or Refill is filled, Covered Charges under this Plan may be subject to Preauthorization, as described below.

Some drugs require Preauthorization in order for them to be Covered Charges. These include, but are not limited to, medications that:

- May require special medical tests before use;
- Are not recommended as a first-line treatment;
- Have a potential for misuse or abuse;
- Are not approved for use by the Food and Drug Administration (FDA);
- Are FDA-approved drugs prescribed for an off-label use whose effectiveness is unproven based on clinical evidence reported in peer-reviewed medical literature;
- Are classified as Investigational New Drugs (IND) by the FDA.

As used herein, off-label prescribing means prescribing Prescription Drugs for treatments other than those in the labeling approved by the FDA.

Drugs requiring Preauthorization are identified as Preferred with "PA" next to the name of the drug. In order for Prescription Drugs that require Preauthorization to be covered under this Plan, the Authorized Prescriber must contact the Claims Administrator, who must approve Preauthorization and payment before filling a Prescription Order or Refill for a drug.

Step Therapy. Step Therapy (ST) is an automated process of Preauthorizing Drugs subject to Step Therapy guidelines. Step Therapy drugs are noted with an "ST" next to the name of the drug on the Formulary. Step Therapy medications require prior use of one or more certain prerequisite medications to be shown in the Covered Person's medication history with the Plan. If the prerequisite medications are not present in the Covered Person's medical history, the Authorized Prescriber must contact the Claims Administrator for Preauthorization and payment before filling a Prescription Order or Refill for any drug requiring Step Therapy.

Specific Quantity Limits. Some medications are subject to Specific Quantity Limits. A Covered Person can get information on Specific Quantity Limits by:

- searching the online Formulary on the website: www.healthamerica@cvty.com.
- contacting the Customer Service Department.

In order for Prescription Drugs in excess of the Specific Quantity Limit to be covered under this Plan, the Authorized Prescriber must contact the Claims Administrator, and the Claims Administrator must approve Preauthorization and payment before filling a Prescription Order or Refill for a drug that exceeds the Specific Quantity Limit.

LIMITATIONS & EXCLUSIONS

The following limitations and exclusions apply to the Plan:

1. A pharmacy shall not dispense a Prescription Order or Refill which, in the pharmacist's professional judgment, should not be filled.

2. Authorized Refills will be provided for the lesser of:
   (i) twelve (12) months from the original date on the Prescription Order unless limited by state or federal law; or
   (ii) the number of Refills indicated by the Authorized Prescriber.

3. Some medications are subject to quantity limits. Specific Quantity Limits can be obtained through the Customer Service Department and by searching the online Prescription Drug Formulary.

4. Coverage of injectable drugs is limited to Self-Administered Injectable Drugs and injectable diabetes agents, bee sting kits, and injectable migraine agents that are commonly and customarily administered by the Covered Person.

5. Except when the Claims Administrator determines the situation to be urgent, Self-Administered Injectable Drugs and Specialty Medications are available only from a Specialty Pharmacy unless otherwise Preauthorized by the Claims Administrator.

6. The Claims Administrator reserves the right to include only one manufacturer's product on the Formulary when the same or similar drug (that is, a drug with the same active ingredient), supply or equipment is made by two or more different manufacturers. The product that is listed on the Formulary will be covered at the applicable benefit. The product or products not listed on the Formulary will be excluded from coverage.

7. The Claims Administrator reserves the right to include only one dosage or form of a drug on the Formulary when the same drug (that is, a drug with the same active ingredient) is available in different dosages or forms (for example, but not limited to, dissolvable tablets, capsules, etc.) from the same or different manufacturers. The product in the dosage or form that is listed on the Formulary will be covered at the applicable benefit. The product or products in other forms or dosages that are not listed on the Formulary will be excluded from coverage.

8. Coverage of therapeutic devices or supplies requiring a Prescription Order or Refill and prescribed by an Authorized Prescriber is limited to Plan-approved diabetic test strips and lancets.

9. Plan-approved blood glucose meters, asthma holding chambers and peak flow meters are Covered Charges, but are limited to one (1) Prescription Order per Benefit Year.

10. Unless this Summary Plan Description (SPD) indicates that Preauthorization is not required, Preauthorization is required for selected products with a Narrow Therapeutic Index, potential for misuse and/or abuse, and a narrow or limited range of FDA approved indications. These products may not be available from the Mail Order Pharmacy. Information about which drugs require Preauthorization can be obtained through the Customer Service Department or the Claims Administrator's searchable Drug Formulary on the website.

11. Coverage through the Mail Order Pharmacy is not available for drugs that are not Maintenance Medications as defined by the Claims Administrator, drugs that cannot be shipped by mail due to state or federal laws or regulations, or when the Claims Administrator considers shipment through the mail to be unsafe. Examples of these types of drugs include, but are not limited to, narcotics, amphetamines, all controlled substances, and anticoagulants.

12. Pharmacologic therapy for sexual dysfunction is a covered benefit, unless specifically excluded.

13. The Claims Administrator reserves the right to limit the location at which a Covered Person can fill a covered Prescription Order or Refill to a pharmacy that is mutually agreeable to both the Claims Administrator and the Covered Person. Such limitation may be enforced in the event that the Claims Administrator identifies an unusual pattern of claims for Covered Charges.

14. Certain vaccines are covered when obtained and administered in a pharmacy by a certified immunizing pharmacist and billed through the online claims adjudication system.

The following are **not Covered Charges** under the Plan:

1. Any Prescription Drugs, injectables, supplies, devices or other items covered under the Medical Benefits.

2. Prescription Drugs dispensed by Non-Network Pharmacies, except as described by the Plan.

3. Devices or supplies of any type, even though requiring a Prescription Order unless otherwise specified as a Covered Charge. These include, but are not limited to: therapeutic devices, support garments, corrective appliances, non-disposable hypodermic needles, or other devices, regardless of their intended use.

4. Drugs prescribed and administered in the Physician's office, or during or as part of an Inpatient or ambulatory surgery procedure or admission.

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

6. Drugs which do not require a Prescription by federal or state law, unless specifically designated for coverage by the Claims Administrator. For example, but not limited to: Over-the-Counter drugs or Over-the-Counter equivalents, behind-the-counter drugs, nutraceuticals, medical foods (except when coverage is required by law), and dietary supplements.

7. Drugs, oral or injectable, used for the primary purpose of, or in connection with, treating Infertility, fertilization and/or artificial insemination, unless coverage is specifically listed in the Schedule of Benefits.

8. Experimental or Investigational drugs.

9. Drugs used for athletic performance enhancement or cosmetic purposes, including, but not limited to: anabolic steroids, tretinoin for aging skin, and minoxidil lotion.

10. Drugs and other products used primarily for smoking cessation unless specifically covered under the Medical Benefits.

11. Vitamins and minerals, both Over-the-Counter and Legend, except Legend prenatal vitamins for pregnant or nursing females, liquid or chewable Legend pediatric vitamins for Children under age thirteen (13), potassium supplements to prevent/treat low potassium, and those whose coverage is mandated by federal law.

12. Oral dental preparations and fluoride rinses, except fluoride tablets or drops.

13. Refill Prescriptions resulting from loss or theft.

14. Growth hormones and insulin-like growth hormone factor-1, when not Medically Necessary to treat an Illness or Injury.

15. Pharmacological therapy for weight reduction.

16. Prescriptions for which the Covered Person is entitled to receive coverage without charge under any Workers' Compensation Law, or occupational disease statute, or any law or regulation.

17. Compounded Prescriptions are excluded unless all of the following apply:
    (i) there is no suitable commercially-available alternative; and
    (ii) the main active ingredient is a covered Prescription Drug; and
    (iii) the purpose is solely to prepare a dose form that is Medically Necessary and is documented by the Authorized Prescriber; and
    (iv) the claim is submitted electronically.

18. Prescriptions directly related to non-Covered Charges, as further described in the Medical Benefits Section of the Plan Document.

19. Non- Preferred Drugs unless Tier 3 Drugs are specifically covered as described in the Schedule of Benefits.

20. Medications to prevent infections related to foreign travel are excluded from coverage. Drugs prescribed for the purpose of facilitating travel, including but not limited to medications, devices and supplies for motion Sickness (e.g. Relief Bands).

21. Medications used for the treatment or ongoing maintenance care of non-congenital transsexualism, gender dysphoria, or sexual reassignment or change.

GENERAL PROVISIONS

Each Covered Person authorizes and directs any Pharmacy that filled a Prescription Order or Refill covered

under this Plan to make available to the Plan information relating to all Prescription Orders or Refills, copies thereof and other records as needed by the Plan to implement and administer the terms of this Plan, conduct appropriate quality review or investigate possible substance abuse or criminal activity. Each Covered Person, by accepting coverage under this Plan, agrees that the Plan and any of its designees shall have the right to release any and all records concerning health care services which are necessary to implement and administer the terms of this Plan, conduct appropriate quality review or investigate possible substance abuse or criminal activity.

The Plan shall not be liable for any claim, Injury, demand or judgment based on tort or other grounds (including warranty of drugs) arising out of or in connection with the sale, compounding, dispensing, manufacturing, or use of any Prescription Drug or insulin whether or not covered under this Plan.

Coverage under this Plan shall terminate when a Covered Person's coverage under the Plan ends.

Nothing contained herein shall be held to vary, alter, waive, or extend any of the terms, conditions, provisions, agreements, or limitations of the Plan other than as stated above.

For all types of plans, including Health Savings Account plans, the following do not apply toward fulfillment of any Out-of-Pocket Maximum specified in the Schedule of Benefits:

- amounts in excess of the Non-Participating Provider Rate.

DEFINED TERMS

The following terms have special meanings and when used in this Plan will be capitalized.

Active Employee is an Employee who is on the regular payroll of the Employer and who has begun to perform the duties of his or her job with the Employer on a full-time basis. The term "Active Employee" does not include independent contractors, temporary employees or part-time employees.

Allowable Amount/Charges is the maximum amount covered under this Plan for approved Covered Charges. This rate will be derived from either a Medicare-based fee schedule, RBRVS or a percent of billed charges as determined by the Claims Administrator, based on the following:

- **The Out-of-Network Rate** for Claims processed by the Claims Administrator is the lesser of the Non-Participating Provider's billed charges or the current Medicare rate, as set forth below. (Please note that the Medicare fee schedule is updated no later than April 1 of each year.) If there is no corresponding Medicare rate noted for a particular service, the Plan will pay the base rate that we would have paid if the Non-Participating Provider furnishing the services were a Provider contracting with the Claims Administrator.

  The Out-of-Network Rate (ONR) under Your Plan is 100% of the Pennsylvania Locality 99 Medicare fee schedule.

  The Out-of-Network Rate for Claims processed by the Claim Administrator's Mental Disorders and Substance Abuse vendor shall be as follows.

  1. For non-facility Claims, the lesser of the Non-Participating Provider's billed charges or the current (updated no later than April 1 of each year) Medicare rate, as set forth below. If there is no corresponding Medicare rate for the particular service, the Claim Administrator's Mental Disorders and Substance Abuse vendor shall pay the average amount the Mental Disorders and Substance Abuse vendor pays its Participating Providers for the same service(s). The Out-of-Network Rate (ONR) under Your Plan is 100% of the regionally adjusted Medicare rate based on the Non-Participating Provider's location.
  2. For all other Claims, the lesser of the Non-Participating Provider's billed charges or the average amount the Mental Disorders and Substance Abuse vendor pays its Participating Providers for the same service(s).

- **Participating Rate/In-Network Rate:** The amount determined by the Claims Administrator that it will pay for a Covered Service. Allowable Charge is the amount that a Participating Provider has agreed to accept as payment in full pursuant to its agreement with the Claims Administrator and/or the Plan.

The examples below illustrate how ONR works:

Assume the Deductible has been met and the Plan covers Inpatient Hospital services at 80%, the Hospital bill is $5,000 (actual charges), and the ONR for the Hospital is $3,000. In this example, the Plan would **not** take into account $2,000 of the $5,000 Hospital bill, because it exceeds the $3,000 ONR. The Plan would pay 80% of the $3,000 ONR, which is $2,400. The Covered Person would pay 20% of the $3,000 ONR, which is $600, ***PLUS*** the $2,000 of actual charges that exceed the $3,000 ONR, for a total cost to the Covered Person of $2,600. Please note that any payments the Covered Person makes in excess of the ONR do not count towards the Out-of-Pocket Maximum.

Assume a specialist visit Copayment is $50. The specialist's bill is $140 (actual charges) and the ONR for the specialist is $80. In this example, the Plan would **not** take into account $60 of the specialist's bill because it exceeds the $80 ONR. The Plan would pay $30 (the ONR minus the Copayment amount). The Covered Person would pay the $50 Copayment ***PLUS*** the $60 of actual charges that exceed the $80 ONR, for a total cost to the Covered Person of $110. Please note that any payments the Covered Person makes in excess of the ONR do not count towards the Out-of-Pocket Maximum.

By way of contrast, the examples below illustrate how In-Network Covered Services would be paid:

Assume the Deductible has been met and the Plan covers In-Network Inpatient Hospital services at 80%, the Hospital bill is $5,000 (actual charges), and the contracted rate for the Hospital is $3,000. In this example, the Plan would **not** take into account $2,000 of the $5,000 Hospital bill, because it exceeds the $3,000 contracted

rate. The Plan would pay 80% of the $3,000 contracted rate, which is $2,400. The Covered Person would pay 20% of the $3,000 contracted rate, which is $600. The amount in excess of the contracted rate would **not** be the Covered Person's responsibility.

Assume a specialist visit Copayment is $50. The specialist's bill is $140 (actual charges) and the contracted rate for the specialist is $80. In this example, the Plan would **not** take into account $60 of the specialist's bill because it exceeds the $80 contracted amount. The Plan would pay $30 (the contracted rate minus the Copayment amount). The Covered Person would pay the $50 Copayment. The amount in excess of the contracted rate would **not** be the Covered Person's responsibility.

Ambulatory Surgical Center is an establishment with an organized medical staff of Physicians, with permanent facilities that are equipped and operated primarily for the purpose of performing surgical procedures, with continuous Physician services and registered professional nursing services available whenever a patient is in the facility, which does not provide services or other accommodations for patients to stay overnight, and which offers the following services whenever a patient is in the center:

(1) Drug services as needed for medical operations and procedures performed;
(2) Provisions for physical and emotional well-being of patients;
(3) Provision for Emergency Services;
(4) Organized administrative structure; and
(5) Administrative, statistical and medical records.

Autism Service Provider shall mean a person, entity or group that provides Treatment of Autism Spectrum Disorders under a treatment plan approved by the Claims Administrator that is:
(1) appropriately licensed or certified in Pennsylvania to provide the service; or
(2) enrolled in Pennsylvania's Medical Assistance program on or before July 9, 2008.

Autism Spectrum Disorder shall mean any pervasive developmental disorders defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), or its successor, including autistic disorder, Asperger's disorder and pervasive developmental disorder not otherwise specified.

Benefit Year means July 1 through June 30.

Birthing Center means any freestanding health facility, place, professional office or institution which is not a Hospital or in a Hospital, where births occur in a home-like atmosphere. This facility must be licensed and operated in accordance with the laws pertaining to Birthing Centers in the jurisdiction where the facility is located.

The Birthing Center must provide facilities for obstetrical delivery and short-term recovery after delivery; provide care under the full-time supervision of a Physician and either a registered nurse (R.N.) or a licensed nurse-midwife; and have a written agreement with a Hospital in the same locality for immediate acceptance of patients who develop complications or require pre- or post-delivery confinement.

Calendar Year means January 1st through December 31st of the same year.

Case Management is a systematic process performed by the Claims Administrator to:

(1) Identify high cost cases;
(2) Assess potential opportunities to coordinate care;
(3) Implement treatment plans that improve quality and control costs; and
(4) Manage total health care to promote optimum outcome.

Claimant is an individual or entity who submits a claim for payment to the Plan and includes a Claimant's Authorized Representative.

Claims Administrator means HealthAmerica.

COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Coinsurance means the percentage stated in the Schedule of Benefits, if any, that You must pay to an In-Network or Out-of-Network Provider. The Plan calculates Coinsurance based on either the Allowed Amount or

the billed amount, as determined by the Plan and stated in the Schedule of Benefits.

Contract Year is July 1 through June 30.

Copayment means the flat dollar amount as specified in the Schedule of Benefits that will be charged to the Covered Person by the Provider.

Covered Charges/Service(s) means those Medically Necessary services or supplies that are covered under this Plan.

Covered Drugs means Prescription Drugs that are:

- listed in the Drug Formulary or Non-Formulary Drugs that are covered pursuant to the Plan;
- prescribed by an Authorized Prescriber; and
- approved by the Plan.

Covered Person is an Employee, Retiree or Dependent who is covered under this Plan.

Creditable Coverage includes most health coverage, such as coverage under a group health plan (including COBRA continuation coverage), HMO membership, an individual health insurance policy, Medicaid, Medicare or public health plans.

Creditable Coverage does not include coverage consisting solely of dental or vision benefits.

Creditable Coverage does not include coverage that was in place before a significant break of coverage of 63 days or more. With respect to the Trade Act of 2002, when determining whether a significant break in coverage has occurred, the period between the trade related coverage loss and the start of the special second COBRA election period under the Trade Act, does not count.

Custodial Care is maintenance care or on-going medical care that is not designed to improve the patient's condition when the patient's medical condition has stabilized, regardless of the place of service or the Provider by whom the services are prescribed, recommended or performed. Custodial Care may include the following services whether performed Inpatient or in another place of service: activities of daily living such as, help walking, getting into or out of bed, bathing, dressing, feeding, and using or applying medications; routine palliative and prophylactic skin care; administration and supervision of catheters, colostomies, tracheotomy, intravenous feeding or ventilator care.

Deductible means the amount of money that is paid once a Benefit Year per Covered Person or Family Unit. Typically, there is one Deductible amount per Plan and it must be paid before any money is paid by the Plan for any Covered Charges.

Dentist means a person who (a) is appropriately licensed and qualified to practice dentistry under the law of the jurisdiction in which the dental procedure is performed; and (b) is operating within the scope of his/her license.

Durable Medical Equipment means equipment which (a) can withstand repeated use, (b) is primarily and customarily used to serve a medical purpose, (c) generally is not useful to a person in the absence of an Illness or Injury and (d) is appropriate for use in the home.

Employee means a person who is an Active, regular Employee of the Employer, regularly scheduled to work for the Employer in an Employee/Employer relationship.

Employer is Dickinson College.

Enrollment Date is the first day of coverage or, if there is a Waiting Period, the first day of the Waiting Period.

ERISA is the Employee Retirement Income Security Act of 1974, as amended.

Essential Health Benefits include, to the extent they are covered under the Plan, ambulatory patient services; Emergency Services; hospitalization; maternity and newborn care; Mental Health and substance use disorder services, including behavioral health treatment; Prescription Drugs; rehabilitative and habilitative services and

devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

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;

(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.

Family Unit is the covered Employee or Retiree and the family members who are covered as Dependents under the Plan.

Formulary Brand Name Drugs means those drugs on the Drug Formulary which are marketed under a specific trade name by a pharmaceutical manufacturer. In most cases, these drugs are still under patent protection.

Formulary Generic Drugs means those drugs on the Drug Formulary that are copies of the Brand Name Drugs and are not marketed under a specific trade name. Generic Drugs contain the same active ingredients in the same strength as the Brand Name Drugs, are equally effective as the Brand Name Drugs at treating the medical condition, and meet the same Federal requirements as the Brand Name Drugs.

Foster Child means a Child under the limiting age shown in the Dependent Eligibility Section of this Plan for whom a covered Employee has assumed a legal obligation. All of the following conditions must be met: the Child is being raised as the covered Employee's; and the covered Employee may legally claim the Child as a federal income tax deduction.

A Foster Child is <u>not</u> a Child temporarily living in the covered Employee's home; one placed in the covered Employee's home by a social service agency which retains control of the Child; or whose natural parent(s) may exercise or share parental responsibility and control.

Genetic Information means information about the genetic tests of an individual or his family members, and information about the manifestations of disease or disorder in family members of the individual. A "genetic test" means an analysis of human DNA, RNA, chromosomes, proteins or metabolites, which detects genotypes, mutations or chromosomal changes. It does not mean an analysis of proteins or metabolites that is directly related to a manifested disease, disorder or pathological condition that could reasonably be detected by a health care professional with appropriate training and expertise in the field of medicine involved. Genetic information does not include information about the age or gender of an individual.

Home Health Care Agency is an organization that meets all of these tests: its main function is to provide Home Health Care Services and Supplies; it is federally certified as a Home Health Care Agency; and it is licensed by the state in which it is located, if licensing is required.

Home Health Care Plan must meet these tests: it must be a formal written plan made by the patient's attending Physician which is reviewed at least every 30 days; it must state the diagnosis; it must certify that the Home Health Care is in place of Hospital confinement; and it must specify the type and extent of Home Health Care required for the treatment of the Covered Person.

Home Health Care Services and Supplies include: part-time or intermittent nursing care by or under the supervision of a registered nurse (R.N.); part-time or intermittent home health aide services provided through a Home Health Care Agency (this does not include general housekeeping services); physical, occupational and speech therapy; medical supplies; and laboratory services by or on behalf of the Hospital.

Hospice Agency is an organization where its main function is to provide Hospice Care Services and Supplies and it is licensed by the state in which it is located, if licensing is required.

Hospice Care Plan is a plan of terminal patient care that is established and conducted by a Hospice Agency and supervised by a Physician.

Hospice Care Services and Supplies are those provided through a Hospice Agency and under a Hospice Care Plan and include inpatient care in a Hospice Unit or other licensed facility, home care, and family counseling during the bereavement period.

Hospice Unit is a facility or separate Hospital Unit, that provides treatment under a Hospice Care Plan and admits at least two unrelated persons who are expected to die within six (6) months.

Hospital is an institution which is engaged primarily in providing medical care and treatment of sick and injured persons on an inpatient basis at the patient's expense and which fully meets these tests: it is accredited as a Hospital by the Joint Commission on Accreditation of Healthcare Organizations or the American Osteopathic Association Healthcare Facilities Accreditation Program; it is approved by Medicare as a Hospital; it maintains diagnostic and therapeutic facilities on the premises for surgical and medical diagnosis and treatment of sick and injured persons by or under the supervision of a staff of Physicians; it continuously provides on the premises 24-hour-a-day nursing services by or under the supervision of registered nurses (R.N.s); and it is operated continuously with organized facilities for operative surgery on the premises.

The definition of "Hospital" shall be expanded to include the following:

1. A facility operating legally as a psychiatric Hospital or residential treatment facility for mental health and licensed as such by the state in which the facility operates.
2. A facility operating primarily for the treatment of Substance Abuse if it meets these tests: maintains permanent and full-time facilities for bed care and full-time confinement of at least 15 resident patients; has a Physician in regular attendance; continuously provides 24-hour a day nursing service by a registered nurse (R.N.); has a full-time psychiatrist or psychologist on the staff; and is primarily engaged in providing diagnostic and therapeutic services and facilities for treatment of Substance Abuse.

Illness means a bodily disorder, disease, physical sickness or Mental Disorder. Illness includes Pregnancy, childbirth, miscarriage or complications of Pregnancy.

In-Network (Provider, Hospital, Pharmacy, Physician or Other Health Care Provider) means any health care Provider that has entered into an agreement with the Plan to furnish Covered Services to Covered Persons.

Infertility means a condition diagnosed by a Physician that:

1. After unprotected sexual intercourse for at least twelve (12) months prior to the diagnosis, results in the inability of a woman to conceive a pregnancy or carry a pregnancy to a live birth; or
2. After six (6) trials of artificial insemination within at least the past twelve (12) months prior to the diagnosis, results in the inability of a woman to conceive a pregnancy or carry a pregnancy to a live birth.

Injury means an accidental physical Injury to the body caused by unexpected external means.

Inpatient means a confinement of a Covered Person in a Hospital, hospice, or Skilled Nursing Facility as a registered bed patient, for twenty-three (23) or more consecutive hours and for whom charges are made for room and board.

Intensive Care Unit is defined as a separate, clearly designated service area which is maintained within a Hospital solely for the care and treatment of patients who are critically ill. This also includes what is referred to as a "coronary care unit" or an "acute care unit." It has: facilities for special nursing care not available in regular rooms and wards of the Hospital; special life saving equipment which is immediately available at all times; at least two beds for the accommodation of the critically ill; and at least one registered nurse (R.N.) in continuous and constant attendance 24 hours a day.

Late Enrollee means a Covered Person who enrolls under the Plan other than during the first 31-day period in which the individual is eligible to enroll under the Plan or during a Special Enrollment Period.

Legal Guardian means a person recognized by a court of law as having the duty of taking care of the person and managing the property and rights of a minor child.

Lifetime is a word that appears in this Plan in reference to benefit maximums and limitations. Lifetime is understood to mean while covered under this Plan. Under no circumstances does Lifetime mean during the lifetime of the Covered Person.

Medical Care Facility means a Hospital, a facility that treats one or more specific ailments or any type of Skilled Nursing Facility.

Medical Emergency means the sudden and acute onset of a medical condition manifesting itself by symptoms of sufficient severity (including pain) such as a prudent person, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn Child, or
- serious impairment to bodily functions, or
- serious dysfunction of any bodily organ or part.

Some examples of a Medical Emergency include but are not limited to:

- Broken bone;
- Chest pain;
- Seizures or convulsions;
- Severe or unusual bleeding;
- Severe burns;
- Suspected poisoning;
- Trouble breathing;
- Vaginal bleeding during Pregnancy.

Medical Non-Emergency Care means care which can safely and adequately be provided other than in a Hospital.

Medically Necessary means those services, supplies, equipment and facilities charges that are not expressly excluded under this Plan and determined by the Claims Administrator to be:

1. Medically appropriate, so that expected health benefits (such as, but not limited to, increased life expectancy, improved functional capacity, prevention of complications, relief of pain) materially exceed the expected health risks;
2. Necessary to maintain the Covered Person's health, improve physiological function and required for a reason other than improving appearance;
3. Rendered in the most cost-efficient manner and setting appropriate for the delivery of the health service;
4. Consistent in type, frequency and duration of treatment with scientifically-based guidelines of national medical research, professional medical specialty organizations or governmental agencies who are generally accepted as national authorities on the services, supplies, equipment or facilities for which coverage is requested;
5. Consistent with the diagnosis of the condition at issue;
6. Required for reasons other than the Covered Person's comfort or the comfort and convenience of the Physician or Medical Facility; and
7. Not Experimental or Investigational as determined by the Claims Administrator.

All of these criteria must be met; merely because a Physician recommends or approves certain care does not mean that it is Medically Necessary.

The Plan Administrator or its designee has the discretionary authority to decide whether care or treatment is Medically Necessary.

Medicare is the Health Insurance For The Aged and Disabled program under Title XVIII of the Social Security Act, as amended.

Mental Disorder means any disease or condition, regardless of whether the cause is organic, that is classified as a Mental Disorder in the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services or is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association.

Morbid Obesity is a diagnosed condition in which the body weight exceeds the medically recommended weight by either 100 pounds or is twice the medically recommended weight for a person of the same height, age and mobility as the Covered Person.

Network Provider, Network Hospital, Network Pharmacy, Network Physician or Other Network Health Care Provider means any health care Provider that has entered into an agreement with the Claims Administrator and/or the Plan to furnish Covered Services to Covered Persons.

No-Fault Auto Insurance is the basic reparations provision of a law providing for payments without determining fault in connection with automobile accidents.

Non-Participating Provider, Non-Participating Hospital, Non-Participating Physician or Other Non-Participating Health Care Provider means any health care Provider that has NOT entered into an agreement with the Claims Administrator or the Plan to furnish Covered Services to Covered Persons.

Out-of-Network (Provider, Hospital, Pharmacy, Physician or Other Health Care Provider) means any health care Provider that has NOT entered into an agreement with the Claims Administrator or the Plan to furnish Covered Services to Covered Persons.

Out-of-Pocket Limit/Maximum means the limit on the amount a covered Employee and covered Dependents must pay out of their pocket for specified Covered Charges in a Benefit Year.

Outpatient care and/or services is treatment including services, supplies and medicines provided and used at a Hospital under the direction of a Physician to a person not admitted as a registered bed patient; or services rendered in a Physician's office, laboratory or X-ray facility, an Ambulatory Surgical Center, or the patient's home.

Participating Provider, Participating Hospital, Participating Pharmacy, Participating Physician or Other Participating Health Care Provider means any health care Provider that has entered into an agreement with the Claims Administrator and/or the Plan to furnish Covered Services to Covered Persons.

Physician means a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), Audiologist, Certified Nurse Anesthetist, Licensed Professional Counselor, Licensed Professional Physical Therapist, Master of Social Work (M.S.W.), Midwife, Occupational Therapist, Physiotherapist, Psychiatrist, Psychologist (Ph.D.), Speech Language Pathologist and any other practitioner of the healing arts who is licensed and regulated by a state or federal agency and is acting within the scope of his or her license.

Plan means Dickinson College Preferred Provider Organization Health Plan, which is a benefits plan for certain Employees of Dickinson College and is described in this document.

Plan Administrator means Dickinson College.

Plan Participant is any Employee, Retiree or Dependent who is covered under this Plan.

Plan Year is the 12-month period beginning on either the effective date of the Plan or on the day following the end of the first Plan Year which is a short Plan Year.

Preauthorization means a determination by the Claims Administrator that a medical services, supplies or medications have been reviewed and based upon the information provided, the prescribed treatment satisfies the Plan's requirements for Covered Charges.

Pregnancy is childbirth and conditions associated with Pregnancy, including complications.

Provider(s) include Physicians, pharmacies, Hospitals, and other caregivers who provide services.

Retired Employee is a former Active Employee of the Employer who was retired while employed by the Employer under the formal written Plan of the Employer and elects to contribute to the Plan the contribution required from the Retired Employee.

Serious Mental Illness is schizophrenia, bipolar disorder, obsessive-compulsive disorder, major depressive disorder, panic disorder, anorexia nervosa, bulimia nervosa, schizo-affective disorder, and delusional disorder.

Sickness is: For a covered Employee, covered Spouse, and covered Dependent: Illness, disease or Pregnancy.

Skilled Nursing Facility is a facility that fully meets all of these tests:

(1) It is licensed to provide professional nursing services on an inpatient basis to persons convalescing from Injury or Sickness. The service must be rendered by a registered nurse (R.N.) or by a licensed practical nurse (L.P.N.) under the direction of a registered nurse. Services to help restore patients to self-care in essential daily living activities must be provided.

(2) Its services are provided for compensation and under the full-time supervision of a Physician.

(3) It provides 24 hour per day nursing services by licensed nurses, under the direction of a full-time registered nurse.

(4) It maintains a complete medical record on each patient.

(5) It has an effective utilization review plan.

(6) It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, mentally disabled, Custodial or educational care or care of Mental Disorders.

(7) It is approved and licensed by Medicare.

This term also applies to charges incurred in a facility referring to itself as an extended care facility, convalescent nursing home, rehabilitation hospital, long-term acute care facility or any other similar nomenclature.

Spinal Manipulation/Chiropractic Care means skeletal adjustments, manipulation or other treatment in connection with the detection and correction by manual or mechanical means of structural imbalance or subluxation in the human body. Such treatment is done by a Physician to remove nerve interference resulting from, or related to, distortion, misalignment or subluxation of, or in, the vertebral column.

Substance Abuse is regular excessive compulsive drinking of alcohol and/or physical habitual dependence on drugs. This does not include dependence on tobacco and ordinary caffeine-containing drinks.

Temporomandibular Joint (TMJ) syndrome is the treatment of jaw joint disorders including conditions of structures linking the jaw bone and skull and the complex of muscles, nerves and other tissues related to the temporomandibular joint. Care and treatment shall include, but are not limited to orthodontics, crowns, inlays, physical therapy and any appliance that is attached to or rests on the teeth.

Total Disability (Totally Disabled) means: In the case of a Dependent child, the complete inability as a result of Injury or Sickness to perform the normal activities of a person of like age and sex in good health.

Urgent Care services means care for an unforeseen Illness, Injury or condition that requires immediate attention to prevent serious deterioration is covered when services are provided in an Urgent Care center or in a Physician's office.

Waiting Period is the period that must pass, when applicable, with respect to the Covered Person before the Covered Person is eligible to be covered for services under this Plan.

You or Your means an individual who is covered under the Plan.

PLAN EXCLUSIONS

The services, supplies, equipment, facilities and related charges listed below are excluded from payment under this Plan unless covered under an amendment to this Plan. Covered Persons may contact the Claims Administrator to assist in determining whether Covered Services have been extended by an amendment or notice of material modification.

This Plan does not cover the following items:

1. Any service or supply that is not Preauthorized in accordance with this Plan's Utilization Management policies and procedures; provided that Emergency Services or services received from an obstetrician or gynecologist may vary from these requirements to the extent expressly stated in this Plan;

2. Any service or supply that is not Medically Necessary;

3. Any service or supply that is not a Covered Charge or that is directly or indirectly a result of receiving a non-Covered Charge;

4. Any service or supply for which a Covered Person has no financial liability or that was provided at no charge;

5. Procedures and treatments that this Plan determines, in its sole and absolute discretion, to be Experimental or Investigational;

6. Reconstruction or delayed procedures except as specified in the Schedule of Benefits and, in the case of traumatic Injury, when a significant anatomical or functional improvement can be anticipated;

7. Any services to the extent that payment for such services is, by law, covered by any governmental agency as a primary plan;

8. Care rendered to a Covered Person by a relative or someone who ordinarily resides in the same household;

9. Charges resulting from the Covered Person’s failure to appropriately cancel a scheduled appointment;

10. Services and or supplies rendered as a result of Injuries sustained during the commission of an illegal act or engagement in an illegal occupation; and

11. Court-ordered services or services that are a condition of probation or parole, to the extent permitted by law.

12. Charges incurred after coverage ends.

For all Medical Benefits shown in the Schedule of Benefits, a charge for the following is not covered:

1. **Abortion.** Services, supplies, care or treatment in connection with an abortion unless the life of the mother is endangered by the continued Pregnancy or the Pregnancy is the result of rape or incest.

2. **Acupressure**.

3. **Acupuncture**.

4. **Alcohol.** Services, supplies, care or treatment to a Covered Person for an Injury or Sickness which occurred as a result of that Covered Person's illegal use of alcohol. The arresting officer's determination of inebriation will be sufficient for this exclusion. Expenses will be covered for injured Covered Persons other than the person illegally using alcohol and expenses will be covered for Substance Abuse treatment as specified in this Plan. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

5. **Ambulance service** except as outlined in the Schedule of Benefits.

6. **Audiometric services.** Audiometric testing and expenses for hearing aids (including, but not limited to, cochlear implants) are excluded from coverage for any member eighteen (18) years of age or older.

7. **Autopsy**.

8. **Behavior modification**.

9. **Biofeedback** except as Preauthorized.

10. **Bionic devices** (microprocessor controlled prosthetics) to include, but not limited to, C-Leg.

11. Charges for **blood donors and blood donation**, except as specified as being covered. The drawing, preparation and storage of umbilical cord blood is not covered.

12. **Braces** and supports needed for athletic participation or employment.

13. **Chelation therapy** except for acute arsenic, gold, mercury or lead poisoning.

14. **Clinical Trials,** except as otherwise stated as being covered and only to the extent permitted by Federal law. Routine patient care of a qualified individual participating in a clinical trial, as defined under the Patient Protection and Affordable Care Act of 2010, is covered.

15. **Clothing** or shoes of any type, including but not limited to orthopedic shoes, Children's corrective shoes, shoes used in conjunction with leg braces, and shoe inserts except for inserts and shoes for Covered Persons with diabetes or peripheral vascular disease.

16. **Cochlear implants, dental implants** and **nanometric implants**. No coverage is provided for repair, replacement, or duplicates, nor is coverage provided for services related to the repair or replacement of covered implants, except due to a change in the Covered Person's medical condition.

17. **Complications of non-covered treatments**. Care, services or treatment required as a result of complications from a treatment not covered under the Plan are not covered.

18. **Corrective appliances** that do not require prescription specifications and/or are used primarily for recreational sports. Also, corrective appliances used primarily for cosmetic purposes, including but not limited to cranial prostheses and molding helmets.

19. **Cosmetic** services and surgery and the complications incurred as a result of those services and surgeries.

20. **Court ordered treatment.** Any services mandated by court order, or as a condition of parole or probation, are excluded from coverage under this Plan.

21. **Custodial Care** and domiciliary care, residential care, protective and supportive care including but not limited to, educational services, rest cures, and convalescent care.

22. Repair and maintenance of **Durable Medical Equipment and corrective appliances**:

    (a) Routine servicing such as testing, cleaning, regulating and checking of equipment is not covered unless specified as covered elsewhere in this document.

    (b) Unless otherwise specified under Medical Benefits, repair coverage is limited to:
    - adjustment required by wear or by condition change when prescribed by a Physician; and
    - repairs necessary to make the equipment/appliance serviceable unless the repair costs exceed the cost of the equipment/appliance.

    Except as specified as being covered elsewhere, replacement coverage for Durable Medical Equipment or corrective appliances. Repair, replacement, and duplication are not covered if due to loss, neglect, abuse of equipment, or for the convenience or personal preference of the Plan Participant.

23. **Educational or vocational testing.** Services for educational or vocational testing or training.

24. **Elective home delivery** for childbirth.

25. **Emergency facility services.** Services that do not meet the definition of Medical Emergency and are provided in an emergency facility are excluded from coverage under this Plan.

26. **Equestrian therapy** (hippotherapy), llama therapy, pet therapy or similar services.

27. **Equipment or services** primarily used for altering air quality or temperature, or used for non-medical purposes.

28. **Exams** for employment, school, camp, sports, licensing, insurance, adoption, marriage, driver's license, foreign travel, passports, or those ordered by a third party.

29. **Excess charges**. The part of an expense for care and treatment of an Injury or Sickness that is in excess of the Allowable Amount.

30. **Exercise programs and equipment**. Exercise programs for treatment of any condition, except for Physician-supervised cardiac rehabilitation, occupational or physical therapy covered by this Plan.

31. **Experimental or Investigational.** Care and treatment that is either Experimental or Investigational. For Plan Years beginning on or after January 1, 2014, this exclusion shall not apply to the extent that the charge is for a qualified individual who is a participant in an approved clinical trial with respect to the treatment of cancer or another life-threatening disease or condition. The Plan shall not deny, limit or impose additional conditions on routine patient costs for items and services furnished in connection with participation in the clinical trial. However, this provision does not require the Plan to pay charges for services or supplies that are not otherwise Covered Charges (including, without limitation, charges which the qualified individual would not be required to pay in the absence of this coverage) or prohibit the Plan from imposing all applicable cost sharing and reasonable Utilization Management provisions. For these purposes, a qualified individual is a Covered Person who is eligible to participate in an approved clinical trial according to the trial protocol with respect to the treatment of cancer or another life-threatening disease or condition, and either: (1) the referring health care professional is a Participating Provider and has concluded that the individual's participation in such trial would be appropriate; or (2) the Covered Person provides medical and scientific information establishing that the individual's participation in such trial would be appropriate.

32. **Eye care.** Radial keratotomy or other eye surgery to correct refractive disorders. Also, routine eye examinations, including refractions, lenses for the eyes and exams for their fitting. This exclusion does not apply to aphakic patients and soft lenses or sclera shells intended for use as corneal bandages or as may be covered under the well adult or well Child Sections of this Plan.

33. **Failure to provide information**. Failure to provide any additional documentation or information as may be requested by the Claims Administrator may result in no coverage.

34. **Family counseling** services are not covered.

35. **Food supplements** including infant formula, tube feedings, medical foods, vitamins or other nutritional and Over-the-Counter electrolyte supplements, except as specified as being covered.

36. **Foot care**, except for foot care required to treat manifestations of systematic disease causing circulatory problems, such as diabetes or peripheral vascular disease. Foot care excluded from coverage under this Plan includes, but is not limited to: removal or reduction of warts, removal of toenails (except Medically Necessary surgery for ingrown toenails), treatment of corns, calluses, flat feet, weak feet, chronic foot strain, symptomatic complaints of the feet, or bunions, unless Medically Necessary.

37. **Foreign travel**. Care, treatment or supplies outside of the U.S. if travel is for the sole purpose of obtaining medical services.

38. **Genetic counseling**, gene therapy and genetic studies that are not required for diagnosis or treatment of genetic abnormalities according to the guidelines used by the Claims Administrator.

39. **Government coverage**. Care, treatment or supplies furnished by a program or agency funded by any government. This does not apply to Medicaid or when otherwise prohibited by law.

40. **Growth hormones**, except that they are covered when used to treat a congenital anomaly such as Turner's Syndrome, but only if the growth hormone is approved by the FDA for treatment of the congenital anomaly.

41. **Habilitative Services** that are not Medically Necessary, do not meet the medical criteria of the Claims Administrator or that is determined to be long term care where no significant improvement in the Plan Participant's condition is expected, are not covered.

42. **Hair analysis and hair transplants**.

43. **Hair loss**. Care and treatment for hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a Physician, except for wigs after chemotherapy or radiation.

44. **Hearing aids and exams**. Charges for services or supplies in connection with hearing aids or exams for their fitting, except as may be covered under the well adult or well Child sections of this Plan.

45. **Home services** to help meet personal/family/domestic needs.

46. **Hospital employees**. Professional services billed by a Physician or nurse who is an employee of a Hospital or Skilled Nursing Facility and paid by the Hospital or facility for the service.

47. **Hypnotherapy**.

48. **Illegal acts**. Charges for services received as a result of Injury or Sickness occurring directly or indirectly, as a result of a Serious Illegal Act, or a riot or public disturbance. For purposes of this exclusion, the term "Serious Illegal Act" shall mean any act or series of acts that, if prosecuted as a criminal offense, a sentence to a term of imprisonment in excess of one (1) year could be imposed. It is not necessary that criminal charges be filed, or, if filed, that a conviction result, or that a sentence of imprisonment for a term in excess of one (1) year be imposed for this exclusion to apply. Proof beyond a reasonable doubt is not required. This exclusion does not apply if the Injury or Sickness resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

49. **Immunizations** specifically required for travel or employment.

50. **Impotence**. Care, treatment, services, supplies or medication in connection with treatment for impotence, unless as the result of illness or Injury sustained while covered under the Plan.

51. **Infertility**. Except as specified in the Schedule of Benefits, Infertility treatments, services and supplies, fetal reduction surgery, and artificial reproductive technology including but not limited to: egg harvest, sperm donation, donor sperm or donor eggs, in vitro and in vivo fertilization (IVF), gamete intrafallopian transfer (GIFT), and zygote intrafallopian transfer (ZIFT), embryo transplants and similar procedures, cryopreservation and storage of sperm unless preauthorized, eggs and embryos, supplies, drug therapies, and drugs.

52. **Marital or pre-marital counseling.** Care and treatment for marital or pre-marital counseling.

53. **Massage therapy.**

54. **Milieu therapy**, the treatment of Mental Disorder or maladjustment by making substantial changes in a patient's immediate life circumstances and environment in a way that will enhance the effectiveness of other forms of therapy is not covered. Also known as "situation therapy".

55. **Military service.** Care for military service-connected conditions or disabilities for which the Covered Person is legally entitled to receive Veteran's Administration Services and for which facilities are available is excluded from coverage under this Plan.

56. **Motorized equipment.** The purchase or rental of motorized transportation equipment, escalators or elevators, saunas or swimming pools, and motorized professional medical equipment such as blood pressure kits will not be covered.

57. **Napropathic services.** therapy to restore normal muscoskeletal and nerve function by realignment of spiral and other ligaments, muscles and soft tissue.

58. Elective **newborn home deliveries** and associated well newborn care.

59. **No charge**. Care and treatment or portions of charges for care or treatment for which there would not have been a charge if no coverage had been in force.

60. **Non-emergency Hospital admissions**. Care and treatment billed by a Hospital for non-Medical Emergency admissions on a Friday or a Saturday. This does not apply if surgery is performed within 24 hours of admission.

61. **Non-medical expenses** such as preparing medical reports, itemized bills or charges for mailing; for training, educational instructions or materials, even if the are performed or prescribed by a Physician; for legal fees and expenses incurred in obtaining medical treatment.

62. **Non-traditional medical services.** Non-traditional medical treatments, services and supplies are not covered under the Plan unless specifically covered elsewhere in this Summary Plan Description.

63. **No obligation to pay.** Charges incurred for which the Plan has no legal obligation to pay.

64. **No Physician recommendation**. Care, treatment, services or supplies not recommended and approved by a Physician; or treatment, services or supplies when the Covered Person is not under the regular care of a Physician. Regular care means ongoing medical supervision or treatment which is appropriate care for the Injury or Sickness.

65. **Not specified as covered**. Non-traditional medical services, treatments and supplies which are not specified as covered under this Plan.

66. **Occupational**. Care and treatment of an Injury or Sickness that is occupational -- that is, arises from work for wage or profit including self-employment provided the employer provides, or is required to provide Workers' Compensation or similar type coverage for such services.

67. Except as specified in the Schedule of Benefits, **oral surgery** and related services and supplies including, but not limited to:

- Services and supplies related to dental care, dental appliances, dental prostheses, dental implants, or dental x-rays;
- Orthodontics, periodontics, endodontics, prosthodontics, preventive, cosmetic or restorative dentistry, even when associated with congenital anomalies;
- Oral surgery that is required as part of an orthodontic treatment program;
- Oral surgery that is required for the correction of an occlusal defect, unless Medically Necessary;
- Oral surgery that encompasses orthognathic, prosthodontics or prognathic surgical procedures;
- Charges for Physicians' services or x-ray examinations involving one or more teeth, the tissue or structure around them, the alveolar process or the gums. This applies even if a condition requiring any of these services involves a part of the body other than the mouth, such as the treatment of Temporomandibular Joint disorder or malocclusion involving joints or muscles by methods including, but not limited to: crowning, wiring, or repositioning of teeth.

68. **Orthodontia** and related services.

69. Charges in connection with **orthotics**, heel lifts and arch supports. Foot orthotics are not covered, except for a diagnosis of diabetes.

70. **Out-of-Network** charges in excess of the Out-of-Network Rate

71. **Over-the-Counter supplies** such as ACE wraps/elastic supports/finger splints, and orthotics**,** except for orthotics necessary for the treatment of diabetes.

72. **Penile prostheses.**

73. **Personal comfort items**. Personal comfort items or other equipment, such as, but not limited to: air conditioners, air-purification units, humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, nonprescription drugs and medicines, television and telephone, first-aid supplies and non-hospital adjustable beds.

74. **Phone consultations**.

75. **Plan design exclusions**. Charges excluded by the Plan design as mentioned in this document.

76. **Private duty nursing**. Charges in connection with care, treatment or services of a private duty nurse, except as stated in the Medical Benefits section of this document.

77. **Private inpatient room**, unless Medically Necessary or if a semi-private room is unavailable.

78. **Prolotherapy,** the use of injections to strengthen tendons and ligaments.

79. **Rehabilitation services**, including but not limited to cognitive therapy, physical therapy, occupational therapy, and speech therapy for developmental delay, school-related problems, apraxic disorders (unless caused by accident or episodic illness), stuttering, autism, speech delay, articulation disorder, functional dysphonia, or speech problems resulting from psychoneurotic or personality disorders.

80. **Relative giving services**. Professional services performed by a person who ordinarily resides in the Covered Person's home or is related to the Covered Person as a Spouse, parent, child, brother or sister, whether the relationship is by blood or exists in law.

81. **Replacement braces**. Replacement of braces of the leg, arm, back, neck, or artificial arms or legs, unless there is sufficient change in the Covered Person's physical condition to make the original device no longer functional.

82. **Self-Inflicted**. Any loss due to an intentionally self-inflicted Injury. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

83. **Sensory integration therapy**, reintegration therapy and kinetic therapy.

84. **Services before or after coverage**. Care, treatment or supplies for which a charge was incurred before a person was covered under this Plan or after coverage ceased under this Plan.

85. **Services that are not Preauthorized when Preauthorization is required.**

86. **Sex changes**. Care, services or treatment for non-congenital transsexualism, gender dysphoria or sexual reassignment or change. This exclusion includes medications, implants, hormone therapy, surgery, medical or psychiatric treatment.

87. **Sleep disorders**. Care and treatment for sleep disorders unless deemed Medically Necessary.

88. **Smoking cessation**. Care and treatment for smoking cessation programs, including smoking deterrent patches, unless Medically Necessary due to a severe active lung Illness such as emphysema or asthma.

89. Therapy for snoring, such as but not limited to **somnoplasty.**

90. **Speech therapy** for fluency disorders, such as but not limited to stuttering.

91. **Sports medicine treatment** plans, surgery, Corrective Appliances, or artificial aids primarily intended to enhance athletic functions.

92. Jobst **stockings**, elastic hose and graduated compression (TED) hose, except as Preauthorized by the Claims Administrator.

93. **Surgery** performed solely to address psychological or emotional factors.

94. **Surgical sterilization reversal**. Care and treatment for reversal of surgical sterilization.

95. **Surrogate motherhood services and supplies**, including, but not limited to, all services and supplies relating to the conception and pregnancy of a Covered Person acting as a surrogate mother.

96. **Take home disposable** or consumable Outpatient supplies, such as sheaths, bags, elastic garments and bandages, syringes, needles, blood or urine testing supplies, home testing kits, vitamins, dietary supplements and replacements, food, food supplements, food replacements, and special food items, unless they are specified as covered.

97. **Temporomandibular Joint syndrome (TMJ)**. All diagnostic and treatment services related to the treatment of jaw joint problems including Temporomandibular Joint (TMJ) syndrome.

98. **Testicular implants.**

99. **Transplant services**, screening tests, and any related conditions or complications related to organ donation when a Covered Person is donating organ or tissue to a non-Covered Person.

100. Except as otherwise Preauthorized by this Plan, **transplant services** and all related services and supplies when received from any Provider not designated by this Plan as a Participating Coventry Transplant Network facility.

101. **Travel or accommodations.** Charges for travel or accommodations, whether or not recommended by a Physician, except for ambulance and transplant travel charges as defined as a Covered Charge.

102. **Treatment of drug abuse or alcoholism** provided by halfway houses, boot camps and wilderness programs.

103. **Treatment of teeth**, the nerves or roots of the teeth (excepted as stated under “Medical Benefits”) or for the repair or replacement of a denture.

104. **Vision care** and optometry services except as specified in the Schedule of Benefits, except the following vision care and optometry services are never covered under this Plan:

- Lenses not requiring a prescription from a vision care Provider;
- Sunglasses available with or without a prescription;
- Industrial (3mm) safety lenses and safety frames with side shields;
- Services or supplies in connection with:
  - § examinations to determine the need for or change in prescription or other examination related to wearing eyeglasses or lenses of any type;
  - § eyeglasses or lenses of any type, except as specified in the Schedule of Benefits;
  - § eye surgery, such as radial keratotomy, laser corneal resurfacing, or other surgery, when the primary purpose is to correct myopia (nearsightedness), hyperopia (farsightedness) or astigmatism (blurring); or
  - § vision training or orthotics.

105. **Vocational Therapy.**

106. **War**. Any loss that is due to a declared or undeclared act of war.

107. **Work hardening programs.**

108. **Work related** Injuries or illnesses. Charges for or in connection if an Illness or Injury for which the Employee or Dependent is entitled to benefits under any Workers' Compensation or similar law.

HOW TO SUBMIT A CLAIM

Benefits under this Plan shall be paid only if the Plan Administrator decides in its discretion that a Covered Person is entitled to them.

Claims for services rended by Out-of-Network Providers should be sent to:

HealthAmerica
Claims Department
P.O. Box 7089
London, KY 40742-7089

If a charge is made to a Participant for any service that is reimbursable under this Plan, written proof of such charge shall include an itemized statement and diagnosis and must be submitted to Claims Administrator within 365 days after the delivery of the service. Such services must have been provided in accordance with the Plan's Utilization Management and Preauthorization policies and procedures. Failure to furnish such documentation within the specified period shall invalidate or reduce any such claim unless for good reason, as determined by the Plan, it was not possible to submit the claim within the specified period, provided such proof is produced in a timely basis.

The Plan may make payment to the person or institution providing the services, or at the Plan's discretion may make payment directly to the Covered Employee. However, if the Covered Employee furnishes evidence satisfactory to the Plan that payment has been made to such person or institution for the service covered, Reimbursement will be made to the Covered Employee after deducting any payment made by the Plan before receipt of such evidence. The Plan will reimburse up to the Out-of-Network Rate for services rendered.

The Plan at its own expense shall have the right to require that a Participant whose Sickness or Injury is the basis of a claim under this Summary Plan Description, be examined by a Network Physician or other health care Provider of the Plan’s choosing when and as often as the Plan may reasonably require.

No legal action for Reimbursement of a claim for payment for services may be initiated prior to the exhaustion of the Plan's Appeals procedures. No legal action for Reimbursement of a claim for payment for services may be initiated more than three (3) years after the expiration of the date of service of the claim at issue.

WHEN CLAIMS SHOULD BE FILED

Claims should be filed with the Claims Administrator within three hundred-sixty-five (365) days of the date charges for the service were incurred. Benefits are based on the Plan's provisions at the time the charges were incurred. Claims filed later than that date may be declined or reduced unless:

(a) it's not reasonably possible to submit the claim in that time; and

(b) the claim is submitted within one (1) year from the date incurred. This one (1) year period will not apply when the person is not legally capable of submitting the claim.

The Claims Administrator will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested from the Claimant. The Plan reserves the right to have a Plan Participant seek a second medical opinion.

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, or if the Plan does not follow the Appeal procedures properly, 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 shown in the timetable. 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 shown on the timetable. Once the Claim is complete, the Plan Administrator must make its decision as shown in the timetable. 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 shown on the timetable. The time periods shown in the timetable 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 listed in the timetables below. 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 or it's designee shall provide written or electronic notification of the Adverse Benefit Determination. The notice will state in a culturally and linguistically appropriate manner and 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 an Adverse Benefit Determination based on a rescission of coverage, the Claimant must file the Appeal within 30 days of notification. A Claimant may submit written comments, documents, records, and other information relating to the Appeal. If submitted in writing, it should be sent to;

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

The Appeal review will be completed and written notification will be sent to the Claimant 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 Claimant 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
Attn: Appeal Process

A Claimant 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 Claimant or Authorized Representative that they have the right to, 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 determination. 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 or its designee 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 a Claimant receives a Final Adverse Benefit Determination under the Plan's internal claims and Appeals Procedures, he or she may request that the claim be reviewed under the Plan's External Review process. This request must be filed in writing within four (4) months after receipt of the Final Adverse Benefit Determination.

The Plan Administrator or its designee will determine whether the claim is eligible for review under the External Review process. This determination is based on whether:

(1) The Claimant is or was covered under the Plan at the time the claim was made or incurred;

(2) The denial relates to the Claimant's failure to meet the Plan's eligibility requirements;

(3) The Claimant has exhausted the Plan's internal claims and Appeal Procedures or the Plan has not followed the Appeal procedures properly; and

(4) The Claimant has provided all the information required to process an External Review.

Within one business day after completion of this preliminary review, the Plan Administrator or its designee will provide written notification to the Claimant of whether the claim is eligible for External Review.

If the request for review is complete but not eligible for External Review, the Plan Administrator or its designee will notify the Claimant of the reasons for its ineligibility. The notice will include contact information for the United States Department of Labor Employee Benefits Security Administration at its toll free number (866-444-3272).

If the request is not complete, the notice will describe the information needed to complete it. The Claimant will have forty-eight (48) hours or until the last day of the four (4) month filing period, whichever is later, to submit the additional information.

If the request is eligible for the External Review process, the Plan will assign it to a qualified independent review organization ("IRO"). The IRO is responsible for notifying the Claimant, in writing, that the request for External Review has been accepted. The notice should include a statement that the Claimant may submit in writing, within ten (10) business days, additional information the IRO must consider when conducting the review. The IRO will share this information with the Plan. The Plan may consider this information and decide to reverse its denial of the claim. If the denial is reversed, the Plan will notify the Claimant in writing and the External Review process will end.

If the Plan does not reverse the denial, the IRO will make its decision on the basis of its review of all of the information in the record, as well as additional information where appropriate and available, such as:

(1) The Claimant's medical records;

(2) The attending health care professional's recommendation;

(3) Reports from appropriate health care professionals and other documents submitted by the Plan or issuer, Claimant, or the Claimant's treating Provider;

(4) The terms of the Plan;

(5) Appropriate practice guidelines;

(6) Any applicable clinical review criteria developed and used by the Plan; and

(7) The opinion of the IRO's clinical reviewer.

The IRO must provide written notice to the Plan and the Claimant of its final decision within 45 days after the IRO receives the request for the External Review. The IRO's decision notice must contain:

(1) A general description of the reason for the External Review, including information sufficient to identify the Claim;

(2) The date the IRO received the assignment to conduct the review and the date of the IRO's decision;

(3) References to the evidence or documentation the IRO considered in reaching its decision;

(4) A discussion of the principal reason(s) for the IRO's decision;

(5) A statement that the determination is binding and that judicial review may be available to the Claimant; and

(6) Contact information for any applicable office of health insurance consumer assistance or ombudsman established under the PPACA.

Generally, a Claimant must exhaust the Plan's Claims and Procedures in order to be eligible for the External Review process. However, in some cases the Plan provides for an expedited External Review if:

(1) The Claimant receives an Adverse Benefit Determination that involves a medical condition for which the time for completion of the Plan's internal Claims and Appeal Procedures would seriously jeopardize the Claimant's life or health or ability to regain maximum function and the Claimant has filed a request for an expedited internal review; or

(2) The Claimant receives a Final Adverse Benefit Determination that involves a medical condition where the time for completion of a standard External Review process would seriously jeopardize the Claimant's life or health or the Claimant's ability to regain maximum function, or if the Final Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which the Claimant received Emergency Services, but has not been discharged from a facility.

Immediately upon receipt of a request for expedited External Review, the Plan must determine and notify the Claimant whether the request satisfies the requirements for expedited review, including the eligibility requirements for External Review listed above. If the request qualifies for expedited review, it will be assigned to an IRO. The IRO must make its determination and provide a notice of the decision as expeditiously as the Claimant's medical condition or circumstances require, but in no event more than seventy-two (72) hours after the IRO receives the request for an expedited External Review. If the original notice of its decision is not in writing, the IRO must provide written confirmation of the decision within forty-eight (48) hours to both the Claimant and the Plan.

COORDINATION OF BENEFITS

Coordination of the benefit plans. Coordination of benefits sets out rules for the order of payment of Covered Charges when two or more plans -- including Medicare -- are paying. When a Covered Person is covered by this Plan and another plan, or the Covered Person's Spouse is covered by this Plan and by another plan or the couple's covered Children are covered under two or more plans, the plans will coordinate benefits when a claim is received.

The plan that pays first according to the rules will pay as if there were no other plan involved. The secondary and subsequent plans will pay the balance up to each one's plan formula minus whatever the primary plan paid. This is called non-duplication of benefits. The total reimbursement will never be more than the amount that would have been paid if the secondary plan had been the primary plan -- 50% or 80% or 100% -- whatever it may be. The balance due, if any, is the responsibility of the Covered Person.

Benefit plan. This provision will coordinate the medical benefits of a benefit plan. The term benefit plan means this Plan or any one of the following plans:

(1) Group or group-type plans, including franchise or blanket benefit plans.

(2) Group practice and other group prepayment plans.

(3) Federal government plans or programs. This includes Medicare.

(4) Other plans required or provided by law. This does not include Medicaid or any benefit plan like it that, by its terms, does not allow coordination.

(5) No Fault Auto Insurance, by whatever name it is called, when not prohibited by law.

Allowable Charge. For a charge to be allowable it must be within the Plan's definition of an Allowable Charge and at least part of it must be covered under this Plan.

In the case of HMO (Health Maintenance Organization) or other In-Network only plans: This Plan will not consider any charges in excess of what an HMO or Participating Provider has agreed to accept as payment in full. Also, when an HMO or network plan is primary and the Covered Person does not use an HMO or Participating Provider, this Plan will not consider as an Allowable Charge any charge that would have been covered by the HMO or network plan had the Covered Person used the services of an HMO or Participating Provider.

In the case of service type plans where services are provided as benefits, the reasonable cash value of each service will be the Allowable Charge.

Automobile limitations. When medical payments are available under vehicle insurance, the Plan shall pay excess benefits only, without reimbursement for vehicle plan deductibles. This Plan shall always be considered the secondary carrier regardless of the individual's election under PIP (personal Injury protection) coverage with the auto carrier.

Benefit plan payment order. When two or more plans provide benefits for the same Allowable Charge, benefit payment will follow these rules:

(1) Plans that do not have a coordination provision, or one like it, will pay first. Plans with such a provision will be considered after those without one.

(2) Plans with a coordination provision will pay their benefits up to the Allowable Charge:

(a) The benefits of the plan which covers the person directly (that is, as an Employee, member or subscriber) ("Plan A") are determined before those of the plan which covers the person as a Dependent ("Plan B").

(b) The benefits of a benefit plan which covers a person as an Employee who is neither laid off nor retired are determined before those of a benefit plan which covers that person as a laid-off or Retired Employee. The benefits of a benefit plan which covers a person as a

Dependent of an Employee who is neither laid off nor retired are determined before those of a benefit plan which covers a person as a Dependent of a laid off or Retired Employee. If the other benefit plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.

(c) The benefits of a benefit plan which covers a person as an Employee who is neither laid off nor retired or a Dependent of an Employee who is neither laid off nor retired are determined before those of a plan which covers the person as a COBRA beneficiary.

(d) When a Child is covered as a Dependent and the parents are not separated or divorced, these rules will apply:

(i) The benefits of the benefit plan of the parent whose birthday falls earlier in a year are determined before those of the benefit plan of the parent whose birthday falls later in that year;

(ii) If both parents have the same birthday, the benefits of the benefit plan which has covered the parent for the longer time are determined before those of the benefit plan which covers the other parent.

(e) When a child's parents are divorced or legally separated, these rules will apply:

(i) This rule applies when the parent with custody of the Child has not remarried. The benefit plan of the parent with custody will be considered before the benefit plan of the parent without custody.

(ii) This rule applies when the parent with custody of the Child has remarried. The benefit plan of the parent with custody will be considered first. The benefit plan of the stepparent that covers the Child as a Dependent will be considered next. The benefit plan of the parent without custody will be considered last.

(iii) This rule will be in place of items (i) and (ii) above when it applies. A court decree may state which parent is financially responsible for medical and dental benefits of the child. In this case, the benefit plan of that parent will be considered before other plans that cover the Child as a Dependent.

(iv) If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the Child shall follow the order of benefit determination rules outlined above when a Child is covered as a Dependent and the parents are not separated or divorced.

(v) For parents who were never married to each other, the rules apply as set out above as long as paternity has been established.

(f) If there is still a conflict after these rules have been applied, the benefit plan which has covered the patient for the longer time will be considered first. When there is a conflict in coordination of benefit rules, the Plan will never pay more than 50% of Allowable Charges when paying secondary.

(3) Medicare will pay primary, secondary or last to the extent stated in federal law. When Medicare is to be the primary payer, this Plan will base its payment upon benefits that would have been paid by Medicare under Parts A, B and D, regardless of whether or not the person was enrolled under any of these parts. The Plan reserves the right to coordinate benefits with respect to Medicare Part D. The Plan Administrator will make this determination based on the information available through CMS.

(4) If a Covered Person is under a disability extension from a previous benefit plan, that benefit plan will pay first and this Plan will pay second.

Claims determination period. Benefits will be coordinated on a Benefit Year basis. This is called the claims determination period.

Right to receive or release necessary information. To make this provision work, this Plan may give or obtain needed information from another insurer or any other organization or person. This information may be given or obtained without the consent of or notice to any other person. A Covered Person will give this Plan the information it asks for about other plans and their payment of Allowable Charges.

Facility of payment. This Plan may repay other plans for benefits paid that the Claims Administrator determines it should have paid. That repayment will count as a valid payment under this Plan.

Right of recovery. This Plan may pay benefits that should be paid by another benefit plan. In this case this Plan may recover the amount paid from the other benefit plan or the Covered Person. That repayment will count as a valid payment under the other benefit plan.

Further, this Plan may pay benefits that are later found to be greater than the Allowable Charge. In this case, this Plan may recover the amount of the overpayment from the source to which it was paid.

Exception to Medicaid. In accordance with ERISA, the Plan shall not take into consideration the fact that an individual is eligible for or is provided medical assistance through Medicaid when enrolling an individual in the Plan or making a determination about the payments for benefits received by a Covered Person under the Plan.

RIGHT OF SUBROGATION AND REIMBURSEMENT

The benefits payable hereunder as a result of any Injuries which give rise to a claim by any participant, beneficiary or any other covered person, hereinafter individually and collectively "Participant", against a third party tortfeasor or against any person or entity as the result of the actions of a third party are excluded from coverage under this plan. This Plan also does not provide benefits to the extent that there is other coverage under non-group medical payments (including auto) or medical expense type coverage to the extent of that coverage. However, this Plan will provide benefits, otherwise payable under this Plan, to or on behalf of said Participant only on the following terms and conditions:

1. In the event that benefits are provided under this Plan, the Plan shall be subrogated to all of the Participant's (the term Participant includes any person receiving benefits hereunder including all dependents) rights of recovery against any person or organization to the extent of the benefits provided. The Participant shall execute and deliver instruments and papers and do whatever else is necessary to secure such rights. The Participant shall do nothing after loss to prejudice such rights. The Participant hereby agrees to cooperate with the Plan and/or any representatives of the Plan in completing such forms and in giving such information surrounding any accident as the Plan or its representatives deem necessary to fully investigate the incident.

2. The Plan is also granted a right of reimbursement from the proceeds of any recovery whether by settlement, judgment, or otherwise. This right of reimbursement is cumulative with and not exclusive of the subrogation right granted in paragraph 1, but only to the extent of the benefits provided by the Plan.

3. The Plan, by providing benefits hereunder, is hereby granted a lien on the proceeds of any settlement, judgment or other payment intended for, payable to, or received by the Participant or his/her representatives, and the Participant hereby consents to said lien and agrees to take whatever steps are necessary to help the company secure said lien. The Participant agrees that said lien shall constitute a charge upon the proceeds of any recovery and the Plan shall be entitled to assert security interest thereon. By the acceptance of benefits under the Plan, the Participant and his/her representatives agree to hold the proceeds of any settlement in trust for the benefit of the Plan to the extent of 100% of all benefits paid on behalf of the participant.

4. By accepting benefits hereunder, the Participant hereby grants a lien and assigns to the Plan an amount equal to the benefits paid against any recovery made by or on behalf of the Participant. This assignment is binding on any attorney who represents the Participant whether or not an agent of the Participant and on any insurance company or other financially responsible party against whom a Participant may have a claim provided said attorney, insurance carriers or others have been notified by the Plan or its agents.

5. The subrogation and reimbursement rights and liens apply to any recoveries made by the Participant as a result of the Injuries sustained, including but not limited to the following:

    a. Payments made directly by the third party tortfeasor, or any insurance company on behalf of the third party tortfeasor, or any other payments on behalf of the third party tortfeasor.

    b. Any payments or settlements or judgment or arbitration awards paid by any insurance company under an uninsured or underinsured motorist coverage, whether on behalf of a Participant or other person.

    c. Any other payments from any source designed or intended to compensate a Participant for Injuries sustained as the result of negligence or alleged negligence of a third party.

    d. Any worker's compensation award or settlement.

    e. Any recovery made pursuant to no-fault insurance.

    f. Any medical payments made as a result of such coverage in any automobile or homeowners insurance policy.

6. No adult Participant hereunder may assign any rights that it may have to recover medical expenses from any tortfeasor or other person or entity to any minor Child or Children of said adult Participant

without the prior express written consent of the Plan. The Plan's right to recover (whether by subrogation or reimbursement) shall apply to decedents', minors', and incompetent or disabled persons' settlements or recoveries.

7. No Participant shall make any settlement, which specifically reduces or excludes, or attempts to reduce or exclude the benefits provided by the Plan.

8. The Plan's right of recovery shall be a prior lien against any proceeds recovered by the Participant, which right shall not be defeated nor reduced by the application of any so-called "Made-Whole Doctrine", "Rimes Doctrine", or any other such doctrine purporting to defeat the Plan's recovery rights by allocating the proceeds exclusively to non-medical expense damages.

9. No Participant hereunder shall incur any expenses on behalf of the Plan in pursuit of the Plan's rights hereunder, specifically, no court costs nor attorneys fees may be deducted from the Plan's recovery without the prior express written consent of the Plan. This right shall not be defeated by any so-called "Fund Doctrine", or "Common Fund Doctrine", or "Attorney's Fund Doctrine".

10. The Plan shall recover the full amount of benefits provided hereunder without regard to any claim of fault on the part of any Participant, whether under comparative negligence or otherwise.

11. The benefits under this Plan are secondary to any coverage under no-fault or similar insurance.

In the event that a Participant shall fail or refuse to honor its obligations hereunder, then the Plan shall be entitled to recover any costs incurred in enforcing the terms hereof including but not limited to attorney's fees, litigation, court costs, and other expenses. The Plan shall also be entitled to offset the reimbursement obligation against any entitlement to future medical benefits hereunder until the Participant has fully complied with his reimbursement obligations hereunder, regardless of how those future medical benefits are incurred.

Any reference to state law in any other provision of this policy shall not be applicable to this provision, if the Plan is governed by ERISA. By acceptance of benefits under the Plan, the Participant agrees that a breach hereof would cause irreparable and substantial harm and that no adequate remedy at law would exist. Further, the Plan shall be entitled to invoke such equitable remedies as may be necessary to enforce the terms of the Plan, including, but not limited to, specific performance, restitution, the imposition of an equitable lien and/or constructive trust, as well as injunctive relief.

Defined terms: "Covered Person" means anyone covered under the Plan, including minor dependents.

"Recover," "Recovered," "Recovery" or "Recoveries" means all monies paid to the Covered Person by way of judgment, settlement, or otherwise to compensate for all losses caused by the Injury or Sickness, whether or not said losses reflect medical or dental charges covered by the Plan. "Recoveries" further includes, but is not limited to, recoveries for medical or dental expenses, attorneys' fees, costs and expenses, pain and suffering, loss of consortium, wrongful death, lost wages and any other recovery of any form of damages or compensation whatsoever.

"Refund" means repayment to the Plan for medical or dental benefits that it has paid toward care and treatment of the Injury or Sickness.

"Subrogation" means the Plan's right to pursue and place a lien upon the Covered Person's claims for medical or dental charges against the other person.

"Third Party" means any Third Party including another person or a business entity.

Recovery from another plan under which the Covered Person is covered. This right of Refund also applies when a Covered Person Recovers under an uninsured or underinsured motorist plan (which will be treated as Third Party coverage when reimbursement or Subrogation is in order), homeowner's plan, renter's plan, medical malpractice plan or any liability plan.

Rights of Plan Administrator. The Plan Administrator has a right to request reports on and approve of all settlements.

CONTINUATION COVERAGE RIGHTS UNDER COBRA

Under federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), certain Employees and their families covered under Dickinson College Preferred Provider Organization Health Plan (the Plan) will be entitled to the opportunity to elect a temporary extension of health coverage (called "COBRA continuation coverage") where coverage under the Plan would otherwise end. This notice is intended to inform Plan Participants and beneficiaries, in summary fashion, of their rights and obligations under the continuation coverage provisions of COBRA, as amended and reflected in final and proposed regulations published by the Department of the Treasury. This notice is intended to reflect the law and does not grant or take away any rights under the law.

The Plan Administrator is Dickinson College, 55 N. West Street, PO Box 1773, Carlisle, Pennsylvania, 17013, 1-717-245-1503. The Plan Administrator is responsible for administering COBRA continuation coverage. Complete instructions on COBRA, as well as election forms and other information, will be provided by the Plan Administrator or its designee to Plan Participants who become Qualified Beneficiaries under COBRA.

What is COBRA continuation coverage? COBRA continuation coverage is the temporary extension of group health plan coverage that must be offered to certain Plan Participants and their eligible family members (called "Qualified Beneficiaries") at group rates. The right to COBRA continuation coverage is triggered by the occurrence of a life event that results in the loss of coverage under the terms of the Plan (the "Qualifying Event"). The coverage must be identical to the Plan coverage that the Qualified Beneficiary had immediately before the Qualifying Event, or if the coverage has been changed, the coverage must be identical to the coverage provided to similarly situated Active Employees who have not experienced a Qualifying Event (in other words, similarly situated non-COBRA beneficiaries).

Who can become a Qualified Beneficiary? In general, a Qualified Beneficiary can be:

(1) Any individual who, on the day before a Qualifying Event, is covered under a Plan by virtue of being on that day either a covered Employee, the Spouse of a covered Employee, or a Dependent Child of a covered Employee. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

(2) Any Child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, and any individual who is covered by the Plan as an alternate recipient under a qualified medical support order. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

(3) A covered Employee who retired on or before the date of substantial elimination of Plan coverage which is the result of a bankruptcy proceeding under Title 11 of the U.S. Code with respect to the Employer, as is the Spouse, surviving Spouse or Dependent Child of such a covered Employee if, on the day before the bankruptcy Qualifying Event, the Spouse, surviving Spouse or Dependent Child was a beneficiary under the Plan.

The term "covered Employee" includes any individual who is provided coverage under the Plan due to his or her performance of services for the employer sponsoring the Plan (e.g., common-law employees (full or part-time), self-employed individuals, independent contractor, or corporate director). However, this provision does not establish eligibility of these individuals. Eligibility for Plan Coverage shall be determined in accordance with Plan Eligibility provisions.

An individual is not a Qualified Beneficiary if the individual's status as a covered Employee is attributable to a period in which the individual was a nonresident alien who received from the individual's Employer no earned income that constituted income from sources within the United States. If, on account of the preceding reason, an individual is not a Qualified Beneficiary, then a Spouse or Dependent Child of the individual will also not be considered a Qualified Beneficiary by virtue of the relationship to the individual. A domestic partner is treated as

a Qualified Beneficiary. This gives the domestic partner the contractual rights outlined in this document but does not extend statutory provisions to the domestic partner.

Each Qualified Beneficiary (including a Child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage) must be offered the opportunity to make an independent election to receive COBRA continuation coverage.

What is a Qualifying Event? A Qualifying Event is any of the following if the Plan provided that the Plan participant would lose coverage (i.e.: cease to be covered under the same terms and conditions as in effect immediately before the Qualifying Event) in the absence of COBRA continuation coverage:

(1) The death of a covered Employee.

(2) The termination (other than by reason of the Employee's gross misconduct), or reduction of hours, of a covered Employee's employment.

(3) The divorce or legal separation of a covered Employee from the Employee's Spouse. If the Employee reduces or eliminates the Employee's Spouse's Plan coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a Qualifying Event even though the Spouse's coverage was reduced or eliminated before the divorce or legal separation.

(4) A covered Employee's enrollment in any part of the Medicare program.

(5) A Dependent child's ceasing to satisfy the Plan's requirements for a Dependent Child (for example, attainment of the maximum age for dependency under the Plan).

(6) A proceeding in bankruptcy under Title 11 of the U.S. Code with respect to an Employer from whose employment a covered Employee retired at any time.

If the Qualifying Event causes the covered Employee, or the covered Spouse or a Dependent Child of the covered Employee, to cease to be covered under the Plan under the same terms and conditions as in effect immediately before the Qualifying Event (or in the case of the bankruptcy of the Employer, any substantial elimination of coverage under the Plan occurring within 12 months before or after the date the bankruptcy proceeding commences), the persons losing such coverage become Qualified Beneficiaries under COBRA if all the other conditions of COBRA are also met. For example, any increase in contribution that must be paid by a covered Employee, or the Spouse, or a Dependent Child of the covered Employee, for coverage under the Plan that results from the occurrence of one of the events listed above is a loss of coverage.

The taking of leave under the Family and Medical Leave Act of 1993 ("FMLA") does not constitute a Qualifying Event. A Qualifying Event will occur, however, if an Employee does not return to employment at the end of the FMLA leave and all other COBRA continuation coverage conditions are present. If a Qualifying Event occurs, it occurs on the last day of FMLA leave and the applicable maximum coverage period is measured from this date (unless coverage is lost at a later date and the Plan provides for the extension of the required periods, in which case the maximum coverage date is measured from the date when the coverage is lost.) Note that the covered Employee and family members will be entitled to COBRA continuation coverage even if they failed to pay the employee portion of premiums for coverage under the Plan during the FMLA leave.

What factors should be considered when determining to elect COBRA continuation coverage? You should take into account that a failure to continue your group health coverage will affect your rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied by other group health plans if there is more than a 63-day gap in health coverage and election of COBRA continuation coverage may help you avoid such a gap. (These Pre-Existing Condition exclusions will only apply during Plan Years that begin before January 1, 2014.) Second, if you do not elect COBRA continuation coverage and pay the appropriate premiums for the maximum time available to you, you will lose the right to convert to an individual health insurance policy, which does not impose such pre-existing condition exclusions. Finally, you should take into account that you have special enrollment rights under federal law (HIPAA). You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your Spouse's employer) within 30 days after Plan coverage ends due to a Qualifying Event listed

above. You will also have the same special right at the end of COBRA continuation coverage if you get COBRA continuation coverage for the maximum time available to you.

What is the procedure for obtaining COBRA continuation coverage? The Plan has conditioned the availability of COBRA continuation coverage upon the timely election of such coverage. An election is timely if it is made during the election period.

What is the election period and how long must it last? The election period is the time period within which the Qualified Beneficiary must elect COBRA continuation coverage under the Plan. The election period must begin not later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event and ends 60 days after the later of the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event or the date notice is provided to the Qualified Beneficiary of her or his right to elect COBRA continuation coverage. If coverage is not elected within the 60 day period, all rights to elect COBRA continuation coverage are forfeited.

Is a covered Employee or Qualified Beneficiary responsible for informing the Plan Administrator of the occurrence of a Qualifying Event? The Plan will offer COBRA continuation coverage to Qualified Beneficiaries only after the Plan Administrator or its designee has been timely notified that a Qualifying Event has occurred. The Employer (if the Employer is not the Plan Administrator) will notify the Plan Administrator of the Qualifying Event within thirty (30) days following the date coverage ends when the Qualifying Event is:

(1) the end of employment or reduction of hours of employment,

(2) death of the Employee,

(3) commencement of a proceeding in bankruptcy with respect to the Employer, or

(4) enrollment of the Employee in any part of Medicare.

IMPORTANT:

For the other Qualifying Events (divorce or legal separation of the Employee and Spouse or a Dependent child's losing eligibility for coverage as a Dependent child), you or someone on your behalf must notify the Plan Administrator or its designee in writing within sixty (60) days after the Qualifying Event occurs, using the procedures specified below. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator or its designee during the sixty (60) day notice period, any Spouse or Dependent Child who loses coverage will not be offered the option to elect continuation coverage. You must send this notice to the Plan Sponsor.

NOTICE PROCEDURES:

Any notice that you provide must be ***in writing***. Oral notice, including notice by telephone, is not acceptable. You must mail, fax or hand-deliver your notice to the person, department or firm listed below, at the following address:

Dickinson College
55 N. West Street, PO Box 1773
Carlisle, Pennsylvania 17013

If mailed, your notice must be postmarked no later than the last day of the required notice period. Any notice you provide must state:

- the **name of the plan or plans** under which you lost or are losing coverage,
- the **name and address of the Employee** covered under the plan,
- the **name(s) and address(es) of the Qualified Beneficiary(ies)**, and
- the **Qualifying Event** and the **date** it happened.

If the Qualifying Event is a **divorce or legal separation**, your notice must include **a copy of the divorce decree or the legal separation agreement**.

Be aware that there are other notice requirements in other contexts, for example, in order to qualify for a disability extension.

Once the Plan Administrator or its designee receives *timely notice* that a Qualifying Event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA continuation coverage. Covered Employees may elect COBRA continuation coverage for their Spouses, and parents may elect COBRA continuation coverage on behalf of their Children. For each Qualified Beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that plan coverage would otherwise have been lost. If you or your Spouse or Dependent Children do not elect continuation coverage within the sixty (60) day election period described above, the right to elect continuation coverage will be lost.

Is a waiver before the end of the election period effective to end a Qualified Beneficiary's election rights? If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of COBRA continuation coverage. However, if a waiver is later revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent to the Plan Administrator or its designee, as applicable.

Is COBRA coverage available if a Qualified Beneficiary has other group health plan coverage or Medicare? Qualified beneficiaries who are entitled to elect COBRA continuation coverage may do so even if they are covered under another group health plan or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, a Qualified Beneficiary's COBRA coverage will terminate automatically if, after electing COBRA, he or she becomes entitled to Medicare or becomes covered under other group health plan coverage (but only after any applicable preexisting condition exclusions of that other plan have been exhausted or satisfied).

When may a Qualified Beneficiary's COBRA continuation coverage be terminated? During the election period, a Qualified Beneficiary may waive COBRA continuation coverage. Except for an interruption of coverage in connection with a waiver, COBRA continuation coverage that has been elected for a Qualified Beneficiary must extend for at least the period beginning on the date of the Qualifying Event and ending not before the earliest of the following dates:

(1) The last day of the applicable maximum coverage period.

(2) The first day for which Timely Payment is not made to the Plan with respect to the Qualified Beneficiary.

(3) The date upon which the Employer ceases to provide any group health plan (including a successor plan) to any employee.

(4) The date, after the date of the election, that the Qualified Beneficiary first becomes covered under any other Plan that does not contain any exclusion or limitation with respect to any pre-existing condition, other than such an exclusion or limitation that does not apply to, or is satisfied by, the Qualified Beneficiary.

(5) The date, after the date of the election, that the Qualified Beneficiary first enrolls in the Medicare program (either part A or part B, whichever occurs earlier). The Qualified Beneficiary must immediately notify the Plan Administrator of any such enrollment in Medicare. The notice must be provided as described in the Notice Procedures above.

(6) In the case of a Qualified Beneficiary entitled to a disability extension, the later of:

(a) (i) Twenty-nine (29) months after the date of the Qualifying Event, or (ii) the first day of the month that is more than thirty (30) days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier; or

(b) the end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension.

The Plan can terminate for cause the coverage of a Qualified Beneficiary on the same basis that the Plan terminates for cause the coverage of similarly situated non-COBRA beneficiaries, for example, for the submission of a fraudulent claim.

In the case of an individual who is not a Qualified Beneficiary and who is receiving coverage under the Plan solely because of the individual's relationship to a Qualified Beneficiary, if the Plan's obligation to make COBRA continuation coverage available to the Qualified Beneficiary ceases, the Plan is not obligated to make coverage available to the individual who is not a Qualified Beneficiary.

What are the maximum coverage periods for COBRA continuation coverage? The maximum coverage periods are based on the type of the Qualifying Event and the status of the Qualified Beneficiary, as shown below:

(1) In the case of a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period ends (eighteen) 18 months after the Qualifying Event if there is not a disability extension and (twenty-nine) 29 months after the Qualifying Event if there is a disability extension.

(2) In the case of a covered Employee's enrollment in the Medicare program before experiencing a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period for Qualified Beneficiaries other than the covered Employee ends on the later of:

(a) Thirty-six (36) months after the date the covered Employee becomes enrolled in the Medicare program; or

(b) Eighteen (18) months (or twenty-nine (29) months, if there is a disability extension) after the date of the covered Employee's termination of employment or reduction of hours of employment.

(3) In the case of a Qualified Beneficiary who is a Child born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, the maximum coverage period is the maximum coverage period applicable to the Qualifying Event giving rise to the period of COBRA continuation coverage during which the Child was born or placed for adoption.

(4) In the case of any other Qualifying Event than that described above, the maximum coverage period ends thirty-six (36) months after the Qualifying Event.

(5) In the case of a bankruptcy Qualifying Event, the maximum coverage period for a Qualified Beneficiary who is the covered Retiree ends on the date of the Retiree's death. The maximum coverage period for a Qualified Beneficiary who is the covered Spouse, surviving Spouse or Dependent Child of the Retiree ends on the earlier of the Qualified Beneficiary's death or thirty-six (36) months after the death of the Retiree.

Under what circumstances can the maximum coverage period be expanded? If a Qualifying Event that gives rise to an eighteen (18) month or twenty-nine (29) month maximum coverage period is followed, within that eighteen (18) or twenty-nine (29) month period, by a second Qualifying Event that gives rise to a thirty-six (36) months maximum coverage period, the original period is expanded to thirty-six (36) months, but only for individuals who are Qualified Beneficiaries at the time of and with respect to both Qualifying Events. In no circumstance can the COBRA maximum coverage period be expanded to more than thirty-six (36) months after the date of the first Qualifying Event. The Plan Administrator must be notified of the second Qualifying Event within sixty (60) days of the second Qualifying Event. This notice must be sent to the Plan Administrator in accordance with the procedures above.

How does a Qualified Beneficiary become entitled to a disability extension? A disability extension will be granted if an individual (whether or not the covered Employee) who is a Qualified Beneficiary in connection with the Qualifying Event that is a termination or reduction of hours of a covered Employee's employment, is determined under Title II or XVI of the Social Security Act to have been disabled at any time during the first sixty (60) days of COBRA continuation coverage. To qualify for the disability extension, the Qualified Beneficiary must also provide the Plan Administrator with notice of the disability determination on a date that is both within sixty (60) days after the date of the determination and before the end of the original eighteen (18) month maximum coverage. This notice should be sent to the Plan Administrator in accordance with the procedures above.

Does the Plan require payment for COBRA continuation coverage? For any period of COBRA continuation coverage under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. Qualified beneficiaries will pay up to 102% of the applicable premium and up to 150% of the applicable premium for any expanded period of COBRA continuation coverage covering a disabled Qualified Beneficiary due to a disability extension. The Plan will terminate a Qualified Beneficiary's COBRA continuation coverage as of the first day of any period for which timely payment is not made.

Must the Plan allow payment for COBRA continuation coverage to be made in monthly installments? Yes. The Plan is also permitted to allow for payment at other intervals.

What is Timely Payment for payment for COBRA continuation coverage? Timely Payment means a payment made no later than thirty (30) days after the first day of the coverage period. Payment that is made to the Plan by a later date is also considered Timely Payment if either under the terms of the Plan, covered employees or Qualified Beneficiaries are allowed until that later date to pay for their coverage for the period or under the terms of an arrangement between the Employer and the entity that provides Plan benefits on the Employer's behalf, the Employer is allowed until that later date to pay for coverage of similarly situated non-COBRA beneficiaries for the period.

Notwithstanding the above paragraph, the Plan does not require payment for any period of COBRA continuation coverage for a Qualified Beneficiary earlier than forty-five (45) days after the date on which the election of COBRA continuation coverage is made for that Qualified Beneficiary. Payment is considered made on the date on which it is postmarked to the Plan.

If Timely Payment is made to the Plan in an amount that is not significantly less than the amount the Plan requires to be paid for a period of coverage, then the amount paid will be deemed to satisfy the Plan's requirement for the amount to be paid, unless the Plan notifies the Qualified Beneficiary of the amount of the deficiency and grants a reasonable period of time for payment of the deficiency to be made. A "reasonable period of time" is thirty (30) days after the notice is provided. A shortfall in a Timely Payment is not significant if it is no greater than the lesser of $50 or 10% of the required amount.

Is COBRA continuation coverage available to Domestic Partners and Children of Domestic Partners? A Domestic Partner is treated as a Qualified Beneficiary. This gives the Domestic Partner the contractual rights outlined in this document but does not extend statutory provisions to the Domestic Partner.

IF YOU HAVE QUESTIONS

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

KEEP YOUR PLAN ADMINISTRATOR INFORMED OF ADDRESS CHANGES

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

RESPONSIBILITIES FOR PLAN ADMINISTRATION

PLAN ADMINISTRATOR. Dickinson College Preferred Provider Organization Health Plan is the benefit plan of Dickinson College, the Plan Administrator, also called the Plan Sponsor. It is to be administered by the Plan Administrator in accordance with the provisions of ERISA. An individual may be appointed by Dickinson College to be Plan Administrator and serve at the convenience of the Employer. If the Plan Administrator resigns, dies or is otherwise removed from the position, Dickinson College shall appoint a new Plan Administrator as soon as reasonably possible.

The Plan Administrator shall administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits, to decide disputes which may arise relative to a Covered Person's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator will be final and binding on all interested parties.

Should any provision of this Plan be held to be unlawful, or be unlawful as to any person or instance, such fact will not adversely affect the other provisions herein contained or the application of said programs to any other person or instance, unless such illegality will make impossible the functioning of this Plan.

DUTIES OF THE PLAN ADMINISTRATOR.

(1) To administer the Plan in accordance with its terms.

(2) To interpret the Plan, including the right to remedy possible ambiguities, inconsistencies or omissions.

(3) To decide disputes which may arise relative to a Covered Person's rights.

(4) To prescribe procedures for filing a claim for benefits and to review claim denials.

(5) To keep and maintain the Plan documents and all other records pertaining to the Plan.

(6) To appoint a Claims Administrator to pay claims.

(7) To perform all necessary reporting as required by ERISA.

(8) To establish and communicate procedures to determine whether a medical Child support order is qualified under ERISA Sec. 609.

(9) To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate.

PLAN ADMINISTRATOR COMPENSATION. The Plan Administrator serves **without** compensation; however, all expenses for plan administration, including compensation for hired services, will be paid by the Plan.

FIDUCIARY. A fiduciary exercises discretionary authority or control over management of the Plan or the disposition of its assets, renders investment advice to the Plan or has discretionary authority or responsibility in the administration of the Plan.

FIDUCIARY DUTIES. A fiduciary must carry out his or her duties and responsibilities for the purpose of providing benefits to the Employees and their Dependent(s), and defraying reasonable expenses of administering the Plan. These are duties which must be carried out:

(1) with care, skill, prudence and diligence under the given circumstances that a prudent person, acting in a like capacity and familiar with such matters, would use in a similar situation;

(2) by diversifying the investments of the Plan so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so; and

(3) in accordance with the Plan documents to the extent that they agree with ERISA.

THE NAMED FIDUCIARY. A "named fiduciary" is the one named in the Plan. A named fiduciary can appoint others to carry out fiduciary responsibilities (other than as a trustee) under the Plan. These other persons become fiduciaries themselves and are responsible for their acts under the Plan. To the extent that the named fiduciary allocates its responsibility to other persons, the named fiduciary shall not be liable for any act or omission of such person unless either:

(1) the named fiduciary has violated its stated duties under ERISA in appointing the fiduciary, establishing the procedures to appoint the fiduciary or continuing either the appointment or the procedures; or

(2) the named fiduciary breached its fiduciary responsibility under Section 405(a) of ERISA.

CLAIMS ADMINISTRATOR IS NOT A FIDUCIARY. A Claims Administrator is **not** a fiduciary under the Plan by virtue of paying claims in accordance with the Plan's rules as established by the Plan Administrator.

CLAIMS ADMINISTRATOR DISCRETION. The Plan Administrator has designated to the Claims Administrator the authority to construe and interpret the terms and provisions of the Plan for purposes of making claims determinations, and to decide questions of Plan interpretation and those of fact relating to the Plan.

COMPLIANCE WITH HIPAA PRIVACY STANDARDS. Certain members of the Employer's workforce perform services in connection with administration of the Plan. In order to perform these services, it is necessary for these employees from time to time to have access to Protected Health Information (as defined below).

Under the Standards for Privacy of Individually Identifiable Health Information (45 CFR Part 164, the "Privacy Standards"), these employees are permitted to have such access subject to the following:

(1) **General.** The Plan shall not disclose Protected Health Information to any member of the Employer's workforce unless each of the conditions set out in this HIPAA Privacy section is met. "Protected Health Information" shall have the same definition as set out in the Privacy Standards but generally shall mean individually identifiable health information about the past, present or future physical or mental health or condition of an individual, including information about treatment or payment for treatment.

(2) **Permitted Uses and Disclosures.** Protected Health Information disclosed to members of the Employer's workforce shall be used or disclosed by them only for purposes of Plan administrative functions. The Plan's administrative functions shall include all Plan payment and health care operations. The terms "payment" and "health care operations" shall have the same definitions as set out in the Privacy Standards, but the term "payment" generally shall mean activities taken with respect to payment of premiums or contributions, or to determine or fulfill Plan responsibilities with respect to coverage, provision of benefits, or reimbursement for health care. "Health care operations" generally shall mean activities on behalf of the Plan that are related to quality assessment; evaluation, training or accreditation of health care Providers; underwriting, premium rating and other functions related to obtaining or renewing an insurance contract, including stop-loss insurance; medical review; legal services or auditing functions; or business planning, management and general administrative activities.

(3) **Authorized Employees.** The Plan shall disclose Protected Health Information only to members of the Employer's workforce who are designated and are authorized to receive such Protected Health Information, and only to the extent and in the minimum amount necessary for these persons to perform duties with respect to the Plan. For purposes of this HIPAA Privacy section, "members of the Employer's workforce" shall refer to all employees and other persons under the control of the Employer.

(a) **Updates Required.** The Employer shall amend the Plan promptly with respect to any changes in the members of its workforce who are authorized to receive Protected Health Information.

(b) **Use and Disclosure Restricted.** An authorized member of the Employer's workforce who receives Protected Health Information shall use or disclose the Protected Health

Information only to the extent necessary to perform his or her duties with respect to the Plan.

(c) **Resolution of Issues of Noncompliance.** In the event that any member of the Employer's workforce uses or discloses Protected Health Information other than as permitted by the Privacy Standards, the incident shall be reported to the privacy official. The privacy official shall take appropriate action, including:

(i) Investigation of the incident to determine whether the breach occurred inadvertently, through negligence, or deliberately; whether there is a pattern of breaches; and the degree of harm caused by the breach;

(ii) Applying appropriate sanctions against the persons causing the breach, which, depending upon the nature of the breach, may include, oral or written reprimand, additional training, or termination of employment;

(iii) Mitigating any harm caused by the breach, to the extent practicable; and

(iv) Documentation of the incident and all actions taken to resolve the issue and mitigate any damages.

(4) **Certification of Employer.** The Employer must provide certification to the Plan that it agrees to:

(a) Not use or further disclose the Protected Health Information other than as permitted or required by the Plan documents or as required by law;

(b) Ensure that any agent or subcontractor, to whom it provides Protected Health Information received from the Plan, agrees to the same restrictions and conditions that apply to the Employer with respect to such information;

(c) Not use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer;

(d) Report to the Plan any use or disclosure of the Protected Health Information of which it becomes aware that is inconsistent with the uses or disclosures hereunder or required by law;

(e) Make available Protected Health Information to individual Plan members in accordance with Section 164.524 of the Privacy Standards;

(f) Make available Protected Health Information for amendment by individual Plan members and incorporate any amendments to Protected Health Information in accordance with Section 164.526 of the Privacy Standards;

(g) Make available the Protected Health Information required to provide any accounting of disclosures to individual Plan members in accordance with Section 164.528 of the Privacy Standards;

(h) Make its internal practices, books and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Department of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Standards;

(i) If feasible, return or destroy all Protected Health Information received from the Plan that the Employer still maintains in any form, and retain no copies of such information when no longer needed for the purpose of which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information unfeasible; and

(j) Ensure the adequate separation between the Plan and member of the Employer's workforce, as required by Section 164.504(f)(2)(iii) of the Privacy Standards.

The following members of Dickinson College's workforce are designated as authorized to receive Protected Health Information from Dickinson College Preferred Provider Organization Health Plan ("the Plan") in order to perform their duties with respect to the Plan: Dickinson College authorized employees.

COMPLIANCE WITH HIPAA ELECTRONIC SECURITY STANDARDS. Under the Security Standards for the Protection of Electronic Protected Health Information (45 CFR Part 164.300 et. seq., the "Security Standards"), the Employer agrees to the following:

(1) The Employer agrees to implement reasonable and appropriate administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of Electronic Protected Health Information that the Employer creates, maintains or transmits on behalf of the Plan. "Electronic Protected Health Information" shall have the same definition as set out in the Security Standards, but generally shall mean Protected Health Information that is transmitted by or maintained in electronic media.

(2) The Employer shall ensure that any agent or subcontractor to whom it provides Electronic Protected Health Information shall agree, in writing, to implement reasonable and appropriate security measures to protect the Electronic Protected Health Information.

(3) The Employer shall ensure that reasonable and appropriate security measures are implemented to comply with the conditions and requirements set forth in Compliance With HIPAA Privacy Standards provisions (3) Authorized Employees and (4) Certification of Employers described above.

FUNDING THE PLAN AND PAYMENT OF BENEFITS

The cost of the Plan is funded as follows:

For Employee and Dependent Coverage: Funding is derived from the funds of the Employer and contributions made by the covered Employees.

The level of any Employee contributions will be set by the Plan Administrator. These Employee contributions will be used in funding the cost of the Plan as soon as practicable after they have been received from the Employee or withheld from the Employee's pay through payroll deduction.

Benefits are paid directly from the Plan through the Claims Administrator.

PLAN IS NOT AN EMPLOYMENT CONTRACT

The Plan is not to be construed as a contract for or of employment.

CLERICAL ERROR

Any clerical error by the Plan Administrator or an agent of the Plan Administrator in keeping pertinent records or a delay in making any changes will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered.

If, due to a clerical error, an overpayment occurs in a Plan reimbursement amount, the Plan retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money. In the case of a Covered Person, if it is requested, the amount of overpayment will be deducted from future benefits payable.

AMENDING AND TERMINATING THE PLAN

If the Plan is terminated, the rights of the Covered Persons are limited to expenses incurred before termination.

The Employer intends to maintain this Plan indefinitely; however, it reserves the right, at any time, to amend, suspend or terminate the Plan in whole or in part. This includes amending the benefits under the Plan or the Trust agreement (if any).

CERTAIN PLAN PARTICIPANTS RIGHTS UNDER ERISA

Plan Participants in this Plan are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA specifies that all Plan Participants shall be entitled to:

Examine, without charge, at the Plan Administrator's office, all Plan documents and copies of all documents governing the Plan, including a copy of the latest annual report (form 5500 series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

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

Continue health care coverage for a Plan Participant, Spouse, or other dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event. Employees or dependents may have to pay for such coverage.

Review this summary plan description and the documents governing the Plan or the rules governing COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for Pre-Existing Conditions under this group health Plan, if an Employee or dependent has Creditable Coverage from another plan. The Employee or dependent should be provided a certificate of Creditable Coverage, free of charge, from the group health plan or health insurance issuer when coverage is lost under the plan, when a person becomes entitled to elect COBRA continuation coverage, when COBRA continuation coverage ceases, if a person requests it before losing coverage, or if a person requests it up to twenty-four (24) months after losing coverage. Without evidence of Creditable Coverage, a Plan Participant may be subject to a Pre-Existing Conditions exclusion for twelve (12) months (eighteen (18) months for Late Enrollees) after the Enrollment Date of coverage, but only for Plan Years that begin before January 1, 2014.

If a Plan Participant's claim for a benefit is denied or ignored, in whole or in part, the participant has a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to Appeal any denial, all within certain time schedules.

Under ERISA, there are steps a Plan Participant can take to enforce the above rights. For instance, if a Plan Participant requests a copy of Plan documents or the latest annual report from the Plan and does not receive them within thirty (30) days, he or she may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and to pay the Plan Participant up to $110 a day until he or she receives the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If the Plan Participant has a claim for benefits which is denied or ignored, in whole or in part, the participant may file suit in state or federal court.

In addition, if a Plan Participant disagrees with the Plan's decision or lack thereof concerning the qualified status of a medical Child support order, he or she may file suit in federal court.

In addition to creating rights for Plan Participants, ERISA imposes obligations upon the individuals who are responsible for the operation of the Plan. The individuals who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of the Plan Participants and their beneficiaries. No one, including the Employer or any other person, may fire a Plan Participant or otherwise discriminate against a Plan Participant in any way to prevent the Plan Participant from obtaining benefits under the Plan or from exercising his or her rights under ERISA.

If it should happen that the Plan fiduciaries misuse the Plan's money, or if a Plan Participant is discriminated against for asserting his or her rights, he or she may seek assistance from the U.S. Department of Labor, or may file suit in a federal court. The court will decide who should pay court costs and legal fees. If the Plan Participant is successful, the court may order the person sued to pay these costs and fees. If the Plan Participant loses, the court may order him or her to pay these costs and fees, for example, if it finds the claim or suit to be frivolous.

If the Plan Participant has any questions about the Plan, he or she should contact the Plan Administrator. If the Plan Participant has any questions about this statement or his or her rights under ERISA, including COBRA or

the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, that Plan Participant should contact either the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) or visit the EBSA website at www.dol.gov/ebsa/. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

GENERAL PLAN INFORMATION

TYPE OF ADMINISTRATION

The Plan is a self-funded group health Plan and the administration is provided through a Third Party Claims Administrator. The funding for the benefits is derived from the funds of the Employer and contributions made by covered Employees. The Plan is not insured.

PLAN NAME

Dickinson College Preferred Provider Organization Health Plan

PLAN NUMBER: 501

TAX ID NUMBER: 23-1365954

PLAN EFFECTIVE DATE: July 1, 2004 and Restated July 1, 2014

PLAN YEAR ENDS: June 30

EMPLOYER INFORMATION

Dickinson College
55 N. West Street, PO Box 1773
Carlisle, Pennsylvania 17013
1-717-245-1503

PLAN ADMINISTRATOR

Dickinson College
Director of Human Resources
55 N. West Street, PO Box 1773
Carlisle, Pennsylvania 17013
1-717-245-1503

NAMED FIDUCIARY

Dickinson College
55 N. West Street, PO Box 1773
Carlisle, Pennsylvania 17013

AGENT FOR SERVICE OF LEGAL PROCESS

Dickinson College
55 N. West Street, PO Box 1773
Carlisle, Pennsylvania 17013

CLAIMS ADMINISTRATOR

HealthAmerica
PO Box 7089
London, Kentucky 40742
1-866-347-2460

PLAN SPONSOR ACCEPTANCE OF RESPONSIBILITY

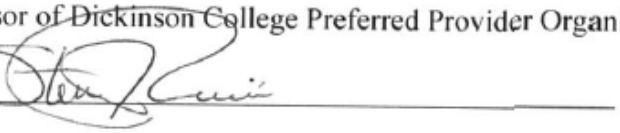
PLEASE SIGN BELOW TO ACKNOWLEDGE YOUR ACCEPTANCE OF RESPONSIBILITY FOR THE CONTENTS OF THIS DOCUMENT AND RETURN THIS SIGNED FORM TO:

HealthAmerica
P.O. Box 67103
Harrisburg, PA 17106

I, the authorized representative of the Plan Sponsor of Dickinson College Preferred Provider Organization Health Plan and fiduciary responsible for plan design, recognize that the Plan Sponsor has full responsibility for the contents of the plan documents for Dickinson College Preferred Provider Organization Health Plan and that while HealthAmerica., the Administrative Services Provider, its employees and subcontractors may have assisted in the preparation of the attached document, the Plan Sponsor is responsible for the final text and meaning.

I further certify that the attached document (Restated SPD 2014) is understood and accurately and completely describes Plan Sponsor's intent with regard to its employee welfare plan.

Plan Sponsor of ~~Dickinson~~ College Preferred Provider Organization Health Plan

By: 

Print Name: Steven J. Riccio

Print Title: Associate Vice President for Human Resource Services

Date: 2/20/15

PREAUTHORIZATION EXHIBIT
Administered by
HEALTHAMERICA
Preauthorization phone lines: toll free 1-800-755-1135

SERVICES REQUIRING PREAUTHORIZATION

Preauthorization is the process for authorizing the non-emergency use of facilities, diagnostic testing, and other health services before care is provided. All Inpatient admissions to a Hospital, Skilled Nursing Facility or Specialty Care Program such as Rehabilitation or Behavioral Health and Substance Abuse will require Preauthorization. For Outpatient services, the most current listing of services requiring Preauthorization may be obtained by contacting Customer Service at the number printed on the back of Your Plan ID card or by visiting the Claims Administrator's website at www.healthamerica.cvty.com.