SUMMARY OF MATERIAL MODIFICATIONS
TO THE
MEDICAL PLAN OF
DICKINSON COLLEGE PREFERRED PROVIDER ORGANIZATION HEALTH PLAN

To: All Plan Participants and Beneficiaries of the Dickinson College Preferred Provider Organization Health Plan

This notice, called a "Summary of Material Modifications," advises you of changes to your coverage under the Plans listed above. Please read this notice carefully, and if you have any questions, please contact the Plan Administrator.

Keep this notice with your Plan Document/Summary Plan Description and make a note in your Plan Document/Summary Plan Description as to what sections have been changed so that when you go to look up information you will be reminded that certain information has changed.

Effective July 1, 2015

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

1. **The Section entitled "ELIGIBILITY, FUNDING, EFFECTIVE DATE AND TERMINATION PROVISIONS", sub-section "ELIGIBILITY", number (1) under "Eligibility Requirements for Employee Coverage" is hereby amended by the addition of the following:**

   An Employee's status as a Full-Time Employee will be determined on the basis of the average number of hours worked during an initial or standard look back measurement period, as applicable, as established by the Plan in accordance with applicable law. The Employee's eligibility (or lack of eligibility) for Plan coverage on the basis of his or her Full-Time or Part-Time status will extend through the stability period established by the Plan in accordance with applicable law. In calculating the average hours worked, the Plan will count hours paid and hours for which the Employee is entitled to payment (such as paid holidays, vacation, pay, etc.). For Plan Years beginning before January 1, 2015, an Employee's status as a Full-Time or Part-Time Employee will be determined on the basis of the Employer's standard employment practices. For these purposes, a "look back measurement period" is defined as the period established by the Employer of at least three (3) but not more than twelve (12) consecutive months for purposes of determining an Employee's initial or ongoing eligibility for coverage. The initial look back measurement period and the standard look back measurement period for ongoing eligibility are not required to be of the same length. The "stability period" means the period chosen by the Employer for purposes of establishing the period of eligibility that follows an initial or standard look back measurement period (including any administrative period established by the Employer which may follow those look back periods).

2. **The Section entitled "ELIGIBILITY, FUNDING, EFFECTIVE DATE AND TERMINATION PROVISIONS", sub-section "ELIGIBILITY", number (1) under "Eligible Class of Dependents", the first paragraph is hereby amended by the addition of the following:**

   The term "Spouse" does not include common law marriages.

3. **The Section entitled "ELIGIBILITY, FUNDING, EFFECTIVE DATE AND TERMINATION PROVISIONS", sub-section "TERMINATION OF COVERAGE" the first paragraph is hereby deleted in its entirety.**

4. **The Section entitled "MEDICAL BENEFITS", sub-section "COVERED CHARGES", number (7) (dd) "Routine Preventive Care" is hereby deleted in its entirety and replaced with the following:**

   (dd) Routine **preventive care.** Covered Charges under Medical Benefits are payable for routine preventive care as described in the Schedule of Benefits. Additional preventive care shall be provided as required by applicable law. Standard preventive care shall be provided as required

by applicable law if provided by a Participating Provider. Standard preventive care for adults includes services with an "A" or "B" rating from the United States Preventive Services Task Force. Examples of standard preventive care include:

- Screenings for: breast cancer, cervical cancer, colorectal cancer, high blood pressure, Type 2 Diabetes Mellitus, cholesterol, and obesity.
- Immunizations for adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; and
- Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration, including the following:
  - Women's Contraceptives, sterilization procedures, and counseling.
  - Breastfeeding support, supplies, and counseling.
  - Gestational diabetes screening.

The list of services included as standard preventive care may change from time to time depending upon government guidelines. A current listing of required preventive care can be accessed at:

- www.HealthCare.gov/center/regulations/prevention.html. and
- www.cdc.gov/vaccines/recs/acip/

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. Standard preventive care shall be provided as required by applicable law if provided by a Participating Provider. Standard preventive care for Children includes services with an "A" or "B" rating from the United States Preventive Services Task Force. Examples of standard preventive care include:

- Immunizations for Children and adolescents recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. These may include:
  - Diphtheria,
  - Pertussis,
  - Tetanus,
  - Polio,
  - Measles,
  - Mumps,
  - Rubella,
  - Hemophilus influenza b (Hib),
  - Hepatitis B, and
  - Varicella.
- Preventive care and screenings for infants, Children and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.

The list of services included as standard preventive care may change from time to time depending upon government guidelines. A current listing of required preventive care can be accessed at:

- www.HealthCare.gov/center/regulations/prevention.html. and
- www.cdc.gov/vaccines/recs/acip/

5. The Section entitled "PRESCRIPTION DRUG BENEFITS", sub-section "COVERED SERVICES", the second paragraph under "Preventive Care Services" is hereby amended by the addition of the following:

Coverage is limited to those preventive and contraceptive drug products, as designated by the Claims Administrator, and to any applicable benefit maximums, as specified by Federal law.

6. The Section entitled "PRESCRIPTION DRUG BENEFITS", sub-section "LIMITATIONS & EXCLUSIONS", under "The following are not Covered Charges under this Plan" is hereby amended by the deletion of the following:

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

7. The Section entitled "DEFINED TERMS" the first paragraph of the definition of "Hospital" is hereby deleted in its entirety and replaced with:

Hospital is an institution which is engaged primarily in providing Inpatient diagnostic and therapeutic services at the patient's expense and which fully meets these tests: it is accredited as a Hospital by the Joint Commission, the American Osteopathic Association, or other accreditation program approved by the Centers for Medicare and Medicaid Services; it maintains diagnostic and therapeutic facilities on the premises which are provided by or under the supervision of a staff of Physicians; and it continuously provides on the premises 24-hour-a-day nursing services by or under the supervision of registered nurses (R.N.s). The Plan Administrator may accept accreditation of a Hospital by an organization other than those specifically listed, provided that the designation of an alternative accreditation body is consistently applied across institutions.

8. The Section entitled "DEFINED TERMS" is hereby amended by the addition of the following:

Residential Treatment is care received in a licensed, extended-stay facility that specializes in sub-acute care 24-hours-a-day. Care includes treatment with a range of diagnostic and therapeutic behavioral health services administered by a multidisciplinary team of Providers.

9. The Section entitled "PLAN EXCLUSIONS", exclusion number (19) "cosmetic" is hereby deleted in its entirety and replaced with the following:

(19) **Cosmetic** procedures, except as may be required by law. Any surgery or procedure, the primary purpose of which is to improve or change the appearance of any portion of the body, but which does not restore bodily function, correct a disease state, or improve a physiological function. Cosmetic procedures include cosmetic surgery, reconstructive surgery, pharmacological services, nutritional regimens or other services for beautification, or treatment relating to the consequences of, or as a result of, cosmetic surgery (including reimplantation). This exclusion includes, but is not limited to, surgery to correct gynecomastia and breast augmentation procedures, and otoplasties. This exclusion does not apply to surgery to restore function if the body area has been altered by Injury, disease, trauma, congenital/developmental anomalies, or previous covered therapeutic processes.

10. The Section entitled "PLAN EXCLUSIONS", exclusion number (88) "Smoking cessation" is hereby deleted in its entirety and replaced with the following:

(88) **Smoking cessation.** Care, medications and treatment for smoking cessation, including smoking deterrent products, except as required by Federal law.

11. The Section entitled "CLAIMS REVIEW AND APPEALS", the fifth paragraph is hereby deleted in its entirety and replaced with the following:

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 for a Claim denied based on medical judgment, 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.

12. The Section entitled "CLAIMS REVIEW AND APPEALS", sub-section "Urgent Care Claims", the third

paragraph is hereby deleted in its entirety and replaced with the following:

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 for a Claim denied based on medical judgment.

13. The Section entitled "CLAIMS REVIEW AND APPEALS", sub-section "Notice to Claimant of Adverse Benefit Determinations", number (1) is hereby deleted in its entirety and replaced with the following:

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

14. The Section entitled "CLAIMS REVIEW AND APPEALS", sub-section "Appeals", under "First Level Internal Appeal Process (Non-Urgent)", the first paragraph is hereby deleted in its entirety and replaced with the following:

When a Claimant receives notification of an Adverse Benefit Determination, the Claimant has one hundred eighty (180) days following receipt of the notification in which to file a request for an Appeal of the decision. For an Adverse Benefit Determination based on a rescission of coverage, the Claimant must file the Appeal within thirty (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:

15. The Section entitled "CLAIMS REVIEW AND APPEALS", sub-section "Appeals", under "Second Level Internal Appeal Process (Non-Urgent)", the second, third and fourth paragraphs are hereby deleted in their entirety and replaced with:

A Claimant has sixty (60) 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:

(1) An investigation of the Appeal; and

(2) A review of the adverse determination by 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, 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.

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

16. The Section entitled "CLAIMS REVIEW AND APPEALS", sub-section "Appeals", "Urgent Care Internal Appeal Process" is hereby deleted in its entirety and replaced with:

Urgent Care Internal Appeal Process

A Covered Person or Authorized Representative may request an expedited review of an Urgent Care Claim which involves a medical condition for which the timeframe for completion of an standard Appeal would seriously jeopardize Your life or health or would jeopardize Your ability to regain maximum function by providing the Plan with clinical rationale and facts to support the request. The Urgent Care Appeal determination will be completed and written notification of the decision of the Plan will be sent to the Covered Person and/or Authorized Representative within thirty six (36) hours of the filing of the Urgent Care Appeal at each of the two levels of available internal Appeal.

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 received 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.

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). The diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning are available upon request.

(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) A statement that if a rule, guideline, protocol, or criterion was relied upon in making the Adverse Benefit Determination, 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.

17. The Section entitled "CLAIMS REVIEW AND APEALS", sub-section "External Review Process", the first paragraph is hereby deleted in its entirety and replaced with the following:

If 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. The External Review process is available only where the Final Adverse Benefit Determination is denied on the basis of (1) a medical judgment (which includes but is not limited to, Plan requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit), (2) a determination that a treatment is experimental or investigational, or (3) a rescission of coverage. The request for External Review must be filed in writing within four (4) months after receipt of the Final Adverse Benefit Determination.

18. The Section entitled "CONTINUATION COVERAGE RIGHTS UNDER COBRA" is hereby deleted in its entirety and replaced with the following:

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.

There may be other options available when You lose group health coverage. For example, You may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, You may qualify for lower costs on Your monthly premiums and lower out-of-pocket costs. Additionally, You may qualify for a 30-day special enrollment period for another group health plan for which You are eligible (such as a Spouse's plan), even if that plan generally doesn't accept late enrollees.

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 and his or her Children are treated as Qualified Beneficiaries if they are covered under the Plan on the day before a Qualifying Event. This gives the Domestic Partner and Children the contractual rights outlined in this Section but does not extend statutory provisions to the Domestic Partner or Child.

Federal law does not recognize a Domestic Partner or his or her Children as Qualified Beneficiaries. However, the Plan will treat a Domestic Partner and his or her Children or Qualified Dependents as Qualified Beneficiaries if they are covered under the Plan on the day before a Qualifying Event. For purposes of interpreting this Section, the Domestic Partner will be treated as the Spouse of the Employee, and a divorce will be deemed to have occurred on the first date that one or more of the eligibility requirements for a Domestic Partner ceases to be met. This gives the Domestic Partner, Children and Qualified Dependents the contractual rights outlined in this Section but does not extend statutory remedies to them.

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 twelve (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, as amended ("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. For non-FMLA leaves of absence, the COBRA Qualifying Event date will be the day after the leave ends, if the Employee does not return to work in an Eligible Class.

What factors should be considered when determining to elect COBRA continuation coverage? When considering options for health coverage, Qualified Beneficiaries should consider:

- **Premiums:** This Plan can charge up to 102% of total plan premiums for COBRA coverage. Other options, like coverage on a Spouse's plan or through the Marketplace, may be less expensive. Qualified Beneficiaries have special enrollment rights under federal law (HIPAA). They have the right to request special enrollment in another group health plan for which they are otherwise eligible (such as a plan sponsored by a Spouse's employer) within thirty (30) days after Plan coverage ends due to one of the Qualifying Events listed above.

- **Provider Networks:** If a Qualified Beneficiary is currently getting care or treatment for a condition, a change in health coverage may affect access to a particular health care Provider. You may want to check to see if Your current health care Providers participate in a Network in considering options for health coverage.

- **Drug Formularies:** For Qualified Beneficiaries taking medication, a change in health coverage may affect costs for medication – and in some cases, the medication may not be covered by another plan. Qualified beneficiaries should check to see if current medications are listed in drug Formularies for other health coverage.

- **Severance payments:** If COBRA rights arise because the Employee has lost his job and there is a severance package available from the employer, the former employer may have offered to pay some or all of the Employee's COBRA payments for a period of time. This can affect the timing of coverage available in the Marketplace. In this scenario, the Employee may want to contact the Department of Labor at 1-866-444-3272 to discuss options.

- **Service Areas:** If benefits under the Plan are limited to specific service or coverage areas, benefits may not be available to a Qualified Beneficiary who moves out of the area.

- **Other Cost-Sharing:** In addition to premiums or contributions for health coverage, the Plan requires Participants to pay Copayments, Deductibles, Coinsurance, or other amounts as benefits are used. Qualified beneficiaries should check to see what the cost-sharing requirements are for other health coverage options. For example, one option may have much lower monthly premiums, but a much higher Deductible and higher Copayments.

Are there other coverage options besides COBRA Continuation Coverage? Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for Qualified Beneficiaries through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a Spouse's plan) through what is called a "Special Enrollment Period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

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 no later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event and ends sixty (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 sixty (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) entitlement of the Employee to any part of Medicare.

IMPORTANT:

For the other Qualifying Events (divorce, termination of domestic partnership 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 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 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 Pre-Existing 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 becomes entitled to Medicare (either part A or part B, whichever occurs earlier).

(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 ends on the later of:

(a) thirty-six (36) months after the date the covered Employee becomes enrolled in the Medicare program. This extension does not apply to the covered Employee; 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 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.

(4) 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.

(5) 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.

Under what circumstances can the maximum coverage period be expanded? If a Qualifying Event that gives rise to an 18-month or 29-month maximum coverage period is followed, within that 18- or 29-month period, by a second Qualifying Event that gives rise to a 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 Sponsor or its designee 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 18-month maximum coverage. This notice should be sent to the Plan Sponsor or its designee 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 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.

IF YOU HAVE QUESTIONS
If You have questions about Your COBRA continuation coverage, You should contact the Plan Sponsor. 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.

19. **The Section entitled "CERTAIN PLAN PARTICIPANTS RIGHTS UNDER ERISA", the sixth paragraph is hereby deleted in its entirety.**

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