

**SUMMARY PLAN DESCRIPTION**

**FOR**

**EARLHAM COLLEGE**

**GROUP MEDICAL BENEFIT PLAN**

As of July 1, 2007, this booklet and description of benefits replaces any previous booklet and description of group health benefits provided to employees of Earlham College, its affiliates and subsidiaries.

**SUMMARY OF MATERIAL MODIFICATION  
AND AMENDMENT 1-07  
to the  
Earlham College Group Medical Benefit Plan  
Amended and Restated as of July 1, 2007**

This Summary of Material Modification and Amendment describes changes to the Earlham College Group Medical Benefit Plan. **These changes are effective as of July 1, 2007** and will remain in effect until amended in writing by the Plan Sponsor.

You should read this document carefully and staple this Summary of Material Modification to your Plan Document and Summary Plan Description. Please contact your Plan Administrator identified in your Summary Plan Description if you have any questions regarding the changes described in this Summary of Material Modification.

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Earlham College (the "Plan Sponsor") wishes to amend the Earlham College Group Medical Benefit Plan (the "Plan") as follows:

- 1. The Plan excludes treatment of weight loss programs and obesity, except for prescription drugs. As such, the following section (qq) weight loss programs and obesity is added under Section 7.01 Exclusions:**

**Section 7.01 Exclusions**

Except as specifically provided, the Plan does not provide Major Medical benefits for:

- (qq) Weight loss programs and treatment of obesity, including morbid obesity or obesity which is aggravating a diagnosed medical condition, except for weight loss prescription drugs covered under the Prescription Drug Program.

All other provisions of this Plan shall remain unchanged.

Dated this 12<sup>th</sup> day of January, 2009

BY



TITLE

Asst. VP for Business

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# Section 1

## Introduction

This booklet is designed to summarize the Earlham College Group Medical Benefit Plan (the "Plan").

As of July 1, 2007, the group health plan has been restated. As before, the Plan is designed to provide you and your covered dependents with major medical and prescription drug coverage, to help protect your family's financial security if a significant sickness or injury occurs. We urge you to carefully read this summary of your coverage.

Claims are administered by the "Plan Supervisor", Meritain Health. The Plan Supervisor is responsible for processing claims based on the terms of the Plan. The "Plan Administrator", Earlham College, is responsible for deciding the terms of the Plan and for providing funds to pay benefits.

Although this booklet explains the Plan in nontechnical language it does contain terms which may be new to you. A Definitions Section has been included at the back of this booklet to assist you. (Words that are capitalized have special meanings which are described in the Definitions section.) If you have any questions concerning your Plan, please contact the Plan Administrator.

This booklet provides a summary of the benefits provided by your Plan. If you have a question as to whether a specific drug, procedure or supply is covered, contact the Plan Supervisor at the number shown on your Plan ID card; there is no charge for this information.

***Your rights are governed by the Plan itself and not by the descriptions in this booklet. If there are any inconsistencies between this description and the actual provisions of the Plan, the Plan document will govern.***

**IMPORTANT INFORMATION FOR ALL PARTICIPANTS:** In an effort to control rising health care costs and provide better care, your Plan contains utilization review/care management procedures. You should read the Utilization Review/Care Management section of this summary carefully. Briefly, you must contact the Plan's Care Manager at the number shown on your Plan ID card before you obtain certain medical services, or benefits for those services will be reduced. See Section 5 of this Summary for details.

**IMPORTANT INFORMATION:** The Plan pays greater benefits for services from a Preferred Provider ("PPO"). Normally these PPO benefits apply only to services and supplies provided by a Preferred Provider, so make sure you determine the provider's status (by calling the provider's office or the PPO network office, at the number shown on your Plan ID card) before you obtain treatment. Providers join and leave the network from time to time, or a PPO Provider may refer you to a Non-PPO Provider. In some situations, benefits for services and supplies provided by the Non-Preferred Provider may be paid at the Preferred Provider rate. See Section 6.05 of this Summary for details.

Your PPO network is shown on your Plan ID card. A listing of the providers in your PPO network is available on the PPO's website. You can access this website through the Plan Supervisor's website ([www.mymeritain.com](http://www.mymeritain.com)). You are also entitled to receive a paper copy of the Preferred Provider directory free of charge. Contact the Plan Administrator if you would like a printed directory.

## **Statement of Rights Under the Women's Health and Cancer Rights Act of 1998**

Under federal law, group health plans that provide medical and surgical benefits with respect to a mastectomy are required to provide to a Covered Person who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with the mastectomy, benefits for:

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

Deductibles and Co-benefit Rates, and pre-certification requirements, may be applied as long as they are consistent with the provisions that apply to other types of surgical procedures. Plans may not deny coverage to mastectomy patients.

## **Statement of Rights Under the Newborns' and Mothers' Health Protection Act**

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 48 hours following a vaginal delivery, or less than 96 hours following a delivery by 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 48 hours (or 96 hours, as applicable). In any case, a plan or issuer may not, under Federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours, as applicable).

## **Continuation Coverage Rights under COBRA**

### **Introduction**

This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.**

COBRA continuation coverage can become available to you and to other members of your family who are covered under the Plan when you would otherwise lose your group health coverage. This notice gives only a summary of your COBRA continuation coverage rights. For more information about your rights and obligations under the Plan and under federal law, you should either review the COBRA Coverage provisions under the Continuation of Coverage Section of this Summary Plan Description or contact the Plan Administrator.

The Plan Administrator is shown on the last page of this booklet, under "Other Information." The Plan Administrator is responsible for administering COBRA continuation coverage.

## **COBRA Continuation Coverage**

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse and your dependent children could become qualified beneficiaries under the Plan if coverage is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because either one of the following qualifying events happens:

- (1) Your hours of employment are reduced; or
- (2) Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because any of the following qualifying events happens:

- (1) Your spouse dies;
- (2) Your spouse's hours of employment are reduced;
- (3) Your spouse's employment ends for any reason other than his or her gross misconduct;
- (4) Your spouse becomes entitled to (is actually enrolled in) Medicare (under Part A, Part B, or both); or
- (5) You become divorced or legally separated (with court approval) from your spouse.

Your dependent children will become qualified beneficiaries if they will lose coverage under the Plan because any of the following qualifying events happens:

- (1) The parent-employee dies;
- (2) The parent-employee's hours of employment are reduced;
- (3) The parent-employee's employment ends for any reason other than his or her gross misconduct;
- (4) The parent-employee becomes entitled to (is actually enrolled in) Medicare (Part A, Part B, or both);
- (5) The parents become divorced or legally separated (with court approval); or
- (6) The child stops being eligible for coverage under the plan as a "dependent child."

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to Earlham College, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee is a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse,

surviving spouse, and dependent children will also be qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, commencement of a proceeding in bankruptcy with respect to the employer, or enrollment of the employee in Medicare (Part A, Part B, or both), the employer does not need specific notice of the qualifying event.

**For the other qualifying events (divorce or court-approved legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must send this notice to: Earlham College's Human Resources Department. Your notice may be written or e-mailed, and must include the employee's name, the name(s) of the individual(s) who are losing eligibility, the reason for the loss of eligibility (such as divorce or end of full-time student status), and the date eligibility is lost.**

Once the Plan Administrator receives 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 on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, enrollment of the employee in Medicare (Part A, Part B, or both), your divorce or legal separation, or a dependent child losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

#### **Disability extension of 18-month period of continuation coverage**

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family can receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. You must make sure that the Plan Administrator is notified of the Social Security Administration's determination within 60 days of the date of the determination (or within 60 days after the COBRA qualifying event occurs) and before the end of the 18-month period of COBRA continuation coverage. This notice should be sent to the Human Resources Department of Earlham College. You will need to include a copy of the Social Security Disability determination letter.

## **Second qualifying event extension of 18-month period of continuation coverage**

If your family experiences another qualifying event while receiving COBRA continuation coverage, the spouse and dependent children in your family can get additional months of COBRA continuation coverage, up to a maximum of 36 months, if notice of the second qualifying event is properly given. This extension may be available to the spouse and any dependent children receiving continuation coverage if the former employee dies, enrolls in Medicare (Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred. **In all of these cases, you must make sure that the Plan Administrator's representative is notified of the second qualifying event within 60 days of the second qualifying event. This notice must be sent to the Human Resources Department of Earlham College. Your notice may be written, e-mailed or made by telephone. You must provide the name of the qualified beneficiaries, the new qualifying event, and the date of the new qualifying event.**

### **If You Have Questions**

If you have questions about your Plan or your COBRA continuation coverage, you should contact the Human Resources Department of Earlham College. 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) in your area or visit the EBSA website at [www.dol.gov/ebsa](http://www.dol.gov/ebsa). (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

### **Keep Your Plan 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.

## Section 2

### Schedule of Benefits

#### Earlham College Group Medical Benefit Plan

#### Section 2.01 Major Medical Benefit

	Preferred Providers	Reid Hospital Providers	Non-Preferred Providers
(A) <b>Deductible</b> – per calendar year (See Sections 6.02 and 6.04 for details) Per Covered Person Per Family		\$500 \$1,000	
(B) <b>Out-of-Pocket Maximum<sup>1</sup></b> - per calendar year (See Section 6.04 for details) Per Covered Person Per Family		\$1,800 \$3,000	
(C) <b>Plan Lifetime Maximum<sup>2</sup></b>		\$1,000,000	
(D) <b>Inpatient Hospital Services</b> (billed by Hospital) Room and Board	90% (Deductible applies)	80% (Deductible applies)	70% (Deductible applies)
Ancillary Services	90% (Deductible applies)	80% (Deductible applies)	70% (Deductible applies)
Pre-admission Testing	90% (Deductible applies)	80% (Deductible applies)	70% (Deductible applies)
(E) <b>Outpatient Hospital/Ambulatory Surgical Center Service</b> (billed by Facility) Surgery	90% (Deductible applies)	80% (Deductible applies)	70% (Deductible applies)
Ancillary Services	90% (Deductible applies)	80% (Deductible applies)	70% (Deductible applies)

<sup>1</sup> Out-of-Pocket Maximum includes Deductible and excludes amounts paid under the Prescription Drug Vendor Benefit and Utilization Review penalties. Once the Out-of-Pocket Maximum is met, the Co-benefit Rate will increase to 100% of Covered Charges for the rest of the calendar year, except that the Co-benefit Rate for care of Mental and Nervous Disorders (including Chemical Dependency) will never exceed the Co-benefit Rate shown above. Employee Co-payments and Utilization Review/Care Management penalties apply even if the Out-of-Pocket Maximum has been met.

<sup>2</sup> Lesser lifetime maximums apply to certain benefits; see below for details.

		<b>Preferred Providers</b>	<b>Reid Hospital Providers</b>	<b>Non-Preferred Providers</b>
(F)	<b>Emergency Room Services</b> (billed by Facility) Emergency Care	90% (Deductible applies)	90% (Deductible applies)	90% (Deductible applies)
	Non-Emergency Care	80% (Deductible applies)	80% (Deductible applies)	80% (Deductible applies)
(G)	<b>Ambulance</b>	90% (Deductible applies)	80% (Deductible applies)	70% (Deductible applies)
(H)	<b>Urgent/Convenient Care Centers</b> Physician Charges	90% (Deductible applies)	80% (Deductible applies)	70% (Deductible applies)
	Related Charges	90% (Deductible applies)	80% (Deductible applies)	70% (Deductible applies)
(I)	<b>Wellness/Routine Care</b> All Covered Persons Calendar Year Maximum of \$400 (Charges over maximum subject to the Deductible and Co-benefit Rate as shown in Section 2.01(Z))	100% (Deductible waived)	100% (Deductible waived)	100% (Deductible waived)
(J)	<b>Routine Mammograms</b>	100% (Deductible waived)	100% (Deductible waived)	100% (Deductible waived)
(K)	<b>Allergy Injections</b>	90% (Deductible applies)	80% (Deductible applies)	70% (Deductible applies)

		<b>Preferred Providers</b>	<b>Reid Hospital Providers</b>	<b>Non-Preferred Providers</b>
(L)	<b>Physician Services</b>			
	Inpatient	90% (Deductible applies)	80% (Deductible applies)	70% (Deductible applies)
	Emergency Room Emergency Care	90% (Deductible applies)	80% (Deductible applies)	70% (Deductible applies)
	Non-Emergency Care	80% (Deductible applies)	80% (Deductible applies)	80% (Deductible applies)
	Office Visits (MD charge only)	90% (Deductible applies)	80% (Deductible applies)	70% (Deductible applies)
	Second Opinions (MD charge only)	90% (Deductible applies)	80% (Deductible applies)	70% (Deductible applies)
	Pathology & Radiology – Inpatient	90% (Deductible applies)	80% (Deductible applies)	70% (Deductible applies)
	Pathology & Radiology – Outpatient	90% (Deductible applies)	80% (Deductible applies)	70% (Deductible applies)
	Pathology & Radiology – Office	90% (Deductible applies)	80% (Deductible applies)	70% (Deductible applies)
	Surgery (including Anesthesia) – Inpatient	90% (Deductible applies)	80% (Deductible applies)	70% (Deductible applies)
	Surgery (including Anesthesia) – Outpatient	90% (Deductible applies)	80% (Deductible applies)	70% (Deductible applies)
	Surgery (including Anesthesia) – Office	90% (Deductible applies)	80% (Deductible applies)	70% (Deductible applies)
(M)	<b>Radiation/Chemotherapy/Dialysis</b> (Inpatient, Outpatient and Office)	90% (Deductible applies)	80% (Deductible applies)	70% (Deductible applies)
(N)	<b>Speech/Physical/Occupational Therapy</b>			
	Inpatient	90% (Deductible applies)	80% (Deductible applies)	70% (Deductible applies)
	Outpatient	90% (Deductible applies)	80% (Deductible applies)	70% (Deductible applies)
	Office	90% (Deductible applies)	80% (Deductible applies)	70% (Deductible applies)

		<b>Preferred Providers</b>	<b>Reid Hospital Providers</b>	<b>Non-Preferred Providers</b>
(O)	<b>Mental and Nervous Disorders</b> Inpatient/Intensive Outpatient (Facility and Physician) Calendar Year Maximum of 30 days Outpatient/Office Treatment Calendar Year Maximum of 50 Treatment Visits Diagnostic Services	80% (Deductible applies)  80% (Deductible applies)  80% (Deductible applies)	80% (Deductible applies)  80% (Deductible applies)  80% (Deductible applies)	80% (Deductible applies)  80% (Deductible applies)  80% (Deductible applies)
(P)	<b>Chemical Dependency</b>	See Mental and Nervous Disorders		
(Q)	<b>Spinal Manipulations</b> Calendar Year Maximum of 30 visits	80% (Deductible applies)	80% (Deductible applies)	80% (Deductible applies)
(R)	<b>TMJ</b> Lifetime Maximum of \$1,000 Inpatient  Outpatient  Office	90% (Deductible applies)  90% (Deductible applies)  90% (Deductible applies)	80% (Deductible applies) 80% (Deductible applies) 80% (Deductible applies)	70% (Deductible applies)  70% (Deductible applies)  70% (Deductible applies)
(S)	<b>Infertility</b>	Not Covered		
(T)	<b>Organ Transplants</b> Inpatient  Outpatient  Office	90% (Deductible applies)  90% (Deductible applies)  90% (Deductible applies)	80% (Deductible applies) 80% (Deductible applies) 80% (Deductible applies)	70% (Deductible applies)  70% (Deductible applies)  70% (Deductible applies)
(U)	<b>Home Health Care</b>	90% (Deductible applies)	80% (Deductible applies)	70% (Deductible applies)
(V)	<b>Skilled Nursing Facility</b>	90% (Deductible applies)	80% (Deductible applies)	70% (Deductible applies)
(W)	<b>Hospice</b>	90% (Deductible applies)	80% (Deductible applies)	70% (Deductible applies)
(X)	<b>Prosthetics/Orthotics/Durable Medical Equipment</b>	90% (Deductible applies)	80% (Deductible applies)	70% (Deductible applies)

		<b>Reid Hospital Providers</b>	<b>Non-Preferred Providers</b>
(Y) <b>Wigs</b> (if Medically Necessary) Lifetime Maximum of \$150	90% (Deductible applies)	80% (Deductible applies)	70% (Deductible applies)
(Z) <b>All Other Covered Services and Supplies</b> (See Section 6.05 for situations in which PPO benefits may apply to Non-Preferred Provider services)	90% (Deductible applies)	80% (Deductible applies)	70% (Deductible applies)
(AA) <b>Utilization Review/Care Management</b> Applies to: Inpatient Hospital Outpatient Surgery	Penalty per failure to comply: \$500		

**Maximum benefits shown above apply to all services and supplies provided to the Covered Person, whether by Preferred Providers, Reid Hospital Providers, Non-Preferred Providers or any types of providers, unless otherwise specifically provided. All maximums are per Covered Person, unless otherwise specifically provided.**

## Section 2.02 Prescription Drug Vendor Benefit

	<b>Generic</b>	<b>Preferred Name Brand (Formulary)</b>	<b>Non-Preferred Name Brand (Non-Formulary)</b>
(A) <b>Prescription Drug Card</b> 30 day supply	100% (\$10 Employee Co-payment applies <sup>3</sup> )	100% (\$25 Employee Co-payment applies <sup>3</sup> )	100% (\$40 Employee Co-payment applies <sup>3</sup> )
(B) <b>Mail Order</b> 90 day supply	100% (\$20 Employee Co-payment applies <sup>3</sup> )	100% (\$50 Employee Co-payment applies <sup>3</sup> )	100% (\$80 Employee Co-payment applies <sup>3</sup> )

<sup>3</sup> Or actual cost of drug, if less.

## **Section 3**

### **Effective Dates**

#### **Section 3.01 Employee Coverage**

You are eligible for coverage under the Plan if:

- (a) You are scheduled to work at least 30 hours per week, 36 weeks per year; or
- (b) You meet the definition of a Retiree.

If you are an hourly Employee of Earlham College or the Earlham School of Religion, coverage will begin on the day you begin to work for the Employer, provided you are properly enrolled and have made (or agree to make) any required contribution. If you do not enroll within 31 days after you become eligible for coverage, coverage will not begin unless and until you satisfy the requirements for a Late Applicant, explained below.

If you are a salaried Employee of Earlham College or the Earlham School of Religion, coverage will begin on the date specified in your employment contract.

#### **Section 3.02 Dependent Coverage**

Your spouse and children are eligible for coverage if you are covered by the Plan and they meet the definition of a Dependent.

Coverage for Dependents who are eligible will begin on the date your coverage is effective, provided the Dependent is properly enrolled and you have made (or agreed to make) any required contribution.

If a person becomes a Dependent spouse or child after your coverage is effective, coverage will begin on the date the person becomes a Dependent if the needed level of Dependent coverage (such as family or employee plus children) is already in effect or you request Dependent coverage within 31 days after the person becomes a Dependent. If the needed level of Dependent coverage is not added within that 31-day period, coverage for the Dependent spouse or child will not begin unless and until you satisfy the requirements for a Late Applicant, described below.

A newborn child of a Covered Person, who qualifies as a Dependent, will automatically be covered from birth until the child is 31 days old. Coverage will continue after the 31st day only if the needed level of Dependent coverage is in effect and any required contribution is paid or authorized within 31 days after birth.

#### **Section 3.03 Late Applicant**

- (a) If you do not enroll yourself and/or any eligible Dependents for coverage within 31 days of becoming eligible, or you discontinue coverage, you may later obtain coverage to be effective as of the date of your request. (An 18-month pre-existing condition limitation period will apply to late applicants.)
- (b) A child who is becoming a Covered Person under the terms of a Qualified Medical Child Support Order (QMCSO) will not be considered a late applicant,

and the standard 12-month pre-existing condition limitation period will apply. Coverage will begin on the date a medical child support order was initially issued, regardless of the date it is determined to be "qualified". (If you did not previously have coverage under the Plan, you will be enrolled, too.)

- (c) You (and your eligible Dependents) may enter the Plan during a special enrollment period. You (and your eligible Dependent spouse and children) may enter the Plan as "special enrollees" (without proof of good health and subject to the standard 12-month pre-existing condition limitation period) if you are eligible for coverage under the Plan, but previously declined that coverage and:
- (1) You have a new Dependent spouse or child, if you request coverage within 31 days after the marriage, birth or adoption. All eligible individuals may enroll in the Plan at this time. Coverage will begin on the date of the marriage, birth or adoption; or
  - (2) You or a Dependent spouse or child declined coverage under this Plan because you (or a Dependent) had other coverage, and that coverage is no longer available. You must request coverage under this Plan within 31 days after coverage ends under the other Plan. All eligible individuals may enroll in the Plan at this time. Coverage is considered unavailable if:
    - (A) COBRA coverage which was in effect when you declined coverage under this Plan is exhausted;
    - (B) The individual has become ineligible for the other coverage due, for example, to death, divorce or legal separation, termination of employment (whether termination is voluntary or involuntary), or reduction in hours below the number needed to be eligible for the Plan (whether the reduction in hours is voluntary or involuntary); or
    - (C) The individual's employer has ceased contributions for the coverage.
    - (D) The individual has lost coverage because he or she no longer resides, lives, or works in an HMO service area (whether or not within the choice of the individual) and no other benefit package is available to the individual; or
    - (E) The individual incurs a claim that would meet or exceed a lifetime limit on all benefits; or
    - (F) The individual is included in a class of similarly situated individuals to whom the Plan no longer offers any benefits.

(You are not eligible for special enrollment if COBRA or other coverage ended because you failed to pay a required contribution or the coverage was ended for cause, such as fraud.)

Coverage will begin on the date of the request (or the date the other coverage ends, if later).

If an individual materially misrepresents his status in a late applicant request, the Plan may rescind coverage for up to 3 years following the date of the misrepresentation.

**Note:** Retirees and their eligible Dependents may enter the Plan as special enrollees if there is a new spouse or child, or they declined coverage under this Plan because they had other coverage and that coverage is no longer available. Retirees and their Dependents who discontinue or decline coverage are not eligible to re-enroll in the Plan for any other reason.

**IMPORTANT:** A Pre-Existing Condition Limitation may apply to newly added individuals and Late Applicants. See Section 7.02 for details.

#### **Section 3.04 Change in Dependents**

You must notify the Plan Administrator of any changes in your family status that may affect your health coverage, such as marriage, divorce, birth, and death. You also need to advise the Plan Administrator of name and address changes.

#### **Section 3.05 Change in Coverage**

Any change in benefits under the Plan will apply to all Covered Persons, regardless of their medical condition on the date of the change.

#### **Section 3.06 Contributions and Funding**

- (a) Your Employer will tell you the amount of your contribution to the Plan. This contribution amount may change from time to time. Your contributions will be collected by payroll deduction. Contribution levels are based on expected claims and administrative expenses.
- (b) Your Employer sponsors a Section 125 plan, which allows you to make your contributions on a pre-tax basis. If you make contributions on a pre-tax basis, you may not change your level of coverage (payroll deduction amount) during the year unless you have a Change in Family Status and your requested change in coverage is consistent with the Change in Family Status.
- (c) Your Plan is self-funded. This means that benefits are paid from Plan assets, and not by an insurance company.

#### **Section 3.07 Qualified Medical Child Support Orders or QMCSO's**

- (a) The Plan Administrator will establish procedures to determine the qualified status of a medical child support order. Copies of the full procedures are available on request. If benefits are payable while the status of the order is being determined, they will be put in suspense. Upon qualification of the order, benefits will be paid to the person designated as alternate recipient in the order, unless benefits were assigned to the provider by the Participant or the alternate recipient.
- (b) Upon receipt of a National Medical Support Notice ("Notice"), these procedures will be followed:

- (1) The Employer will complete Parts A and B, and provide the requested information to the issuing agency as soon as reasonably possible, but in no event more than 40 business days after receipt.
  - (2) If the Notice is not qualified, if you are not eligible for coverage, or if the Employer determines that withholding of the Employee contribution would violate federal or state rules, it will so advise the issuing agency.
  - (3) If you are not currently enrolled in the Plan, you will be enrolled in the Plan as of the issue date of the Notice (or upon completion of the Eligibility Waiting Period, if later). The issuing agency will be advised if the Plan offers benefit options. If the agency has not elected a benefit option within 20 business days after notice of the option is mailed, you and your children covered by the order will be enrolled in the Major Medical Benefits Option with the smallest employee contribution.
  - (4) If the child is currently covered under the Plan, the Employer will so advise the issuing agency.
  - (5) The Plan will provide the custodial parent with a copy of the Summary Plan Description, contribution amounts, and details on PPO choices (if any) and Service Area within 20 business days after receiving the Notice.
- (c) Upon receiving a private medical child support order, the Plan Administrator promptly will notify you and any alternate recipient named in the order, in writing, of the receipt of the order and the Plan's procedures for determining the qualified status of the order. Within a reasonable period of time after receiving the order, the Plan Administrator will determine the qualified status of the order and notify you and each alternate recipient, in writing, of its determination. If the order is determined to be qualified, the Plan Administrator will provide the custodial parent with a copy of the Summary Plan Description, contribution amounts, and details on PPO choices (if any). The Plan Administrator will provide notice under this paragraph by mailing to the individual's address specified in the medical child support order, or in a manner consistent with federal regulations.

## **Section 4**

### **Termination Dates**

#### **Section 4.01 Employee Termination**

Unless continued under the Continuation of Coverage provisions, your coverage will end when the first of these events occurs:

- (a) The date your employment terminates for any reason, unless you are eligible for coverage as a Retiree or under the terms of a Severance Incentive Plan sponsored by the Employer;
- (b) The Plan is terminated;
- (c) The date you are no longer in a class of employees eligible to participate in this Plan (including failing to be an "Employee" or reaching the end of the severance incentive period);
- (d) The date you are temporarily or permanently laid off;
- (e) You fail to make any required contribution;
- (f) You request that your coverage end (if permitted under the rules of the Section 125 plan);
- (g) Your death.

#### **Section 4.02 Dependent Termination**

Unless continued under the Continuation of Coverage provisions, a Dependent's coverage will end when the first of these events occurs:

- (a) Your coverage terminates;
- (b) The date a spouse no longer meets the definition of a Dependent spouse;
- (c) The end of the month in which the child no longer meets the definition of a Dependent child;
- (d) You fail to make any required contribution;
- (e) You request termination of Dependent coverage (if permitted under the rules of the Section 125 plan).

#### **Section 4.03 Certificates of Coverage**

The Plan, or its designated representative, will automatically issue a certificate of coverage within 14 days after being advised that a Covered Person's Plan coverage or COBRA coverage has terminated. The Plan will also issue a certificate of coverage within a reasonable period of time after a former Covered Person requests a certificate, if the request is made within 24 months after coverage ended.

Certificates of coverage are used to show the amount of "Creditable Coverage" the person had under their prior health coverage, because this can reduce or eliminate the length of time that any pre-existing condition limitation period in a new plan will apply to the person. See Section 7.02 for more information. If a former health plan does not automatically provide you with a certificate you should request one. If you continue to have difficulties obtaining a certificate, contact the Plan Supervisor's Eligibility Department.

## Section 5

### Utilization Review/Care Management

#### Section 5.01 Pre-certification of Services

(a) In order for full benefits to be paid, the services and supplies listed below must be certified by the Care Manager. If certification is not obtained, Covered Charges will be reduced by \$500 per failure to certify. Pre-certification is not needed if this Plan is secondary to Medicare or another group health plan under the Non-Duplication of Benefits provision.

(1) Hospital Admissions. All Inpatient Hospital admissions must be certified except that a maternity stay does not need to be certified unless the mother or baby remains in the Hospital for more than 48 hours following a normal delivery, or for more than 96 hours following a cesarean section, and an admission for outpatient observation does not need to be certified unless the stay exceeds 48 hours.

(A) Elective/planned admissions must be certified at least 7 days prior to admission. An admission is considered elective if delaying admission to a hospital would not present a risk to the patient's health.

(B) Emergency Inpatient admissions must be certified within two working days after admission.

Certification includes utilization review, concurrent stay review, and discharge planning.

(2) Outpatient Surgery. An Outpatient surgical cutting or laser procedure (including biopsy and laparoscopy) which requires use of an operating room or a surgical suite must be pre-certified. Non-cutting procedures (such as an endoscopic examination) and urgent or emergency correction of a fracture or dislocation, even if followed by a cutting procedure, do not need to be pre-certified. (A scheduled outpatient surgery to correct a fracture or dislocation must be pre-certified.)

(b) Covered Persons are encouraged, but not required, to obtain pre-certification of the services and supplies listed below from the Care Manager:

(1) Home Health Care. All home health care services (including home infusion therapy) should be pre-certified.

(2) Durable Medical Equipment. Rentals and purchases of Durable Medical Equipment which cost more than \$200 should be pre-certified.

(3) Skilled Nursing Facility. All admissions to a Skilled Nursing Facility should be pre-certified.

(4) Hospice. All Hospice care should be pre-certified.

- (5) Pregnancy Screening. To help prevent premature births, all pregnant Covered Persons should contact the Care Manager by the end of the first trimester of pregnancy (or within 30 days after the pregnancy is diagnosed, if later). The Care Manager will review the patient's status to allow better management of potentially high risk pregnancies.

## **Section 5.02 Request for Pre-Certification**

- (a) To obtain needed Pre-certification of Services, the Covered Person must contact the Care Manager at the number or website shown on the Covered Person's Plan ID card. The Covered Person must provide the name of the Participant/Insured, the name of the Covered Person/Patient, the Social Security Number or other identifying number of the Participant, the recommended procedure, and the proposed date of the procedure. If the Covered Person believes this request is "urgent", he should indicate this to the Care Manager. A Provider may call on behalf of the Covered Person, and the Provider also may indicate urgency to the Care Manager.
- (b) If a request for pre-certification is "urgent", the Care Manager will advise whether the request is approved or denied within 72 hours. A request is considered "urgent" if application of the time frame for making non-urgent care determinations:
  - (1) could, applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine, seriously jeopardize the life or health of the Covered Person or the ability of the Covered Person to regain maximum function; or
  - (2) in the opinion of a Physician with knowledge of the Covered Person's medical condition, would subject the Covered Person to severe pain that cannot be adequately managed without the care or treatment for which pre-certification is requested.
- (c) If a request for pre-certification is not "urgent", the Care Manager will advise whether the request is approved or denied within 15 days.
- (d) A Covered Person (or the parent or guardian of a Covered Person who is a minor or otherwise legally incapacitated) may designate an authorized representative for purposes of requesting Pre-certification of Services or appealing a denial involving Care Management by completing a form prescribed by the Care Manager. Except that, if a request is "urgent", the Provider may serve as the Covered Person's authorized representative without completion of any form.
- (e) The Care Manager will approve a requested procedure, service or supply only if it finds it to be medically necessary and medically appropriate, based on the severity and complexity of the Covered Person's Sickness or Injury, the Covered Person's age and general health, and medical necessity/appropriateness guidelines. However, a determination by the Care Manager that a requested procedure, service or supply is medically necessary and/or medically appropriate does not mean that the procedure, service or supply is a Covered Charge under this Plan.

## Section 5.03 Appeals

### (a) Expedited and First Level Appeals

- (1) A Covered Person (or the designated representative of the Covered Person) may appeal any whole or partial denial of Pre-certification of Services by filing an appeal with the Care Manager. An "expedited appeal" may be filed if pre-certification is denied for "urgent" care. The appeal may be requested, and additional information may be provided, by telephone, facsimile transfer, or electronic mail. It must be filed within 72 hours of the initial denial, and may be made by the Provider.

A "standard appeal" may be filed if pre-certification is denied for care that is not "urgent", or if an expedited appeal is denied. The appeal may be made in writing or by telephone. A standard appeal must be filed within 180 days after receipt of the written notification of denial, and explain why the Covered Person believes the denial is incorrect.

- (2) The Covered Person (or the designated representative of the Covered Person) may submit written comments, documents, medical records and other relevant information, even if that information was not previously provided.
- (3) Upon request, the Covered Person (or the designated representative of the Covered Person) will be given reasonable access to, and/or copies of, all documents, records and other information relevant to the Covered Person's request (even if that information was not considered by the Care Manager when the denial was made). Access and copies will be provided free of charge.
- (4) The expedited appeal and/or First Level Appeal shall take into account all comments, documents, records and other information relating to the request, without regard to whether that information was submitted or considered in the initial denial and/or expedited appeal. The review will not provide deference to the initial denial or expedited appeal. Neither the individual who made the initial determination(s) nor a subordinate of those individuals will perform the review.
- (5) Each appeal will be reviewed by a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, and who is neither an individual who was consulted in connection with the initial denial or expedited appeal or a subordinate of that individual; the identity of any such health care professional will be disclosed to the Covered Person whether or not the professional's advice was followed, if the Covered Person requests that information in writing.
- (6) The Care Manager will provide a written determination within 15 days after a standard appeal is received, and within 72 hours of an expedited appeal.

(b) Second Level Appeal

- (1) If the Covered Person is adversely affected by the standard appeal, the Covered Person (or the designated representative of the Covered Person) may appeal any whole or partial denial of Pre-certification of Services by filing an appeal with the Plan Administrator. This Second Level Appeal must be filed within 60 days after receipt of the written standard First Level Appeal denial, and explain why the Covered Person believes the denial is incorrect.
- (2) The Covered Person (or the designated representative of the Covered Person) may submit written comments, documents, medical records and other relevant information.
- (3) Upon request, the Covered Person (or the designated representative of the Covered Person) will be given reasonable access to, and/or copies of, all documents, records and other information relevant to the Covered Person's request (even if that information was not considered by the Care Manager previously). Access and copies will be provided free of charge.
- (4) The review shall take into account all comments, documents, records and other information relating to the request, without regard to whether that information was submitted or considered in the initial denial, expedited appeal or First Level Appeal determination. The review will not provide deference to the initial denial, expedited appeal or First Level Appeal determination. Neither the individual who made the initial determination(s) nor a subordinate of that individual will perform the review.
- (5) The request will be reviewed by a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, and who is neither an individual who was consulted in connection with the initial denial or First Level Appeal or a subordinate of that individual; the identity of any such health care professional will be disclosed to the Covered Person whether or not the professional's advice was followed, if the Covered Person requests that information in writing.
- (6) The Plan Administrator will provide a written determination within 15 days after the appeal is received. No further administrative appeals are available under the Plan, but the Covered Person may file suit under Section 502 of ERISA.

**Section 5.04 Negotiated Rate**

Durable Medical Equipment purchases and rentals which exceed \$200 and all Home Health Care services must be reported to the Care Manager if obtained from a Non-Preferred Provider. The Care Manager will conduct service searches in connection with these services, to obtain the highest quality product at the most cost effective price. The Covered Person and his Physician will have full authority to determine which services and supplies will be used, whether or not the vendor is suggested by the Care Manager; however, Covered Charges will not exceed the price for the provider or

facility recommended by the Care Manager. If the Covered Person disagrees with the Care Manager's determination, the decision may be appealed as described above.

### **Section 5.05 Medical Case Management**

The Care Manager will review the medical care provided to Covered Persons and may recommend alternative, cost-efficient programs of treatment. Such programs will be implemented only with the consent of the Covered Person, his Physician, and the Plan Administrator (or its designee) and may, in appropriate cases, provide for payment of benefits that would not otherwise be covered by the Plan, if payment of such benefits is expected to accelerate recovery or reduce overall expenses. The cost of such program, including any fees of the Care Manager, will be Covered Charges.

**IMPORTANT:** You and your doctor determine whether and for how long to hospitalize, whether to perform a procedure, and which provider to use. The Plan's role is simply to determine to what extent benefits are to be paid.

## Section 6

### Major Medical Benefits

On receipt of satisfactory proof of claim, the Plan will pay benefits up to the maximums shown in the Schedule of Benefits. Payments will be made at the Co-benefit Rate for Covered Charges incurred by a Covered Person for care of an Injury or Sickness and for specified Routine Care which:

- (a) Exceed the Deductible or Employee Co-payment; and
- (b) Are not otherwise excluded or limited by the Plan.

#### Section 6.01 First-Dollar Benefits

Routine Care. The Deductible is waived and 100% Co-benefit Rate applies to Routine Care of any Covered Person, including a physical examination and related tests such as pap smears, EKG's, bloodwork, PSA's, and chest x-rays. Immunizations (including those for foreign travel) and flu shots are covered. Annual mammograms are covered, but are not subject to the benefit limit.

Charges in excess of the benefit maximum shown in the Schedule of Benefits will be covered under the Major Medical Benefit, subject to the Deductible and applicable Co-benefit Rate.

#### Section 6.02 Deductible

The Deductible will be met when Covered Charges for Major Medical care on which the Deductible is not waived equal the Deductible amount shown in the Schedule of Benefits.

- (a) The Deductible must be met each Benefit Year.
- (b) The Deductible will be applied separately to each person's Covered Charges except when:
  - (1) the Family Deductible has been met; or
  - (2) two or more covered Family members are injured in the same accident. If this happens, only one individual Deductible will be applied to all Covered Charges incurred by Family members during the calendar year as a result of the accident. If a Covered Person injured in the accident incurs unrelated Covered Charges during the calendar year, charges incurred by the Covered Person as a result of the accident will not be applied to meet the Deductible.
- (c) Routine nursery care and related charges provided to a newborn child of any Covered Person will be considered the child's separate claim.

#### Section 6.03 Maximum Lifetime Benefit

The maximum benefit the Plan will pay for services and supplies provided to a person while covered by the Plan (including benefits under the prior plan sponsored by the

Employer) is shown in the Schedule of Benefits. Lesser lifetime maximum benefit amounts applicable to certain benefits also are shown in the Schedule of Benefits.

#### **Section 6.04 Coordination of Preferred Provider and Non-Preferred Provider Charges**

All charges will be applied to the lifetime and Benefit Year maximums regardless whether incurred through a Preferred Provider or a Non-Preferred Provider. Both PPO and Non-PPO charges will be applied to the Deductible and Out-of-Pocket Maximum.

#### **Section 6.05 Services Not Provided by Preferred Provider**

Services and supplies provided by a Non-Preferred Provider will be payable at the rate shown in the Schedule of Benefits for Non-Preferred Providers. However, the Preferred Provider benefit will be applied to services and supplies provided by a Non-Preferred Provider if:

- (a) The service is not available from a Preferred Provider;
- (b) The service or supply is provided to a Covered Person traveling or residing outside the PPO Service Area;
- (c) The service or supply is needed for Emergency Care of a Covered Person, including the services of an emergency room physician;
- (d) A Preferred Provider who is providing the primary service has ordered the related, ancillary services (including, but not limited to, radiology, anesthesia or pathology) and the Covered Person has no practical choice regarding the provider of the service;
- (e) The Plan Administrator has determined, in writing, that there are insufficient facilities or providers in the Participant's location to provide an adequate level of care.

#### **Section 6.06 Coordination with Prior Plan**

For all purposes, including, but not limited to, application of lifetime and Benefit Year maximum benefit amounts and the Deductible and Out-of-Pocket Maximum, this Plan is considered a continuation of the group health plan sponsored by the Employer on December 31, 2004.

#### **Section 6.07 Covered Charges**

Covered Charges are charges made for a service or supply furnished to a Covered Person while the person is covered under this Plan. The service or supply must be ordered by a Physician because of the Covered Person's Sickness or Injury. State-imposed surcharges and taxes on medical care are considered Covered Charges.

A charge is considered made ("incurred") on the date the service is given or the supply is purchased, and not on the date the charge is billed or paid.

Covered Charges are the actual charges, but not more than the Reasonable and Customary Charges, for:

- (a) Hospital room and board, including normal daily services and supplies furnished by the Hospital, for a semi-private room. Charges for a private room are Covered Charges to the extent they exceed the semi-private room rate only if confinement in a private room is Medically Necessary or the Hospital has only private rooms;
- (b) Charges for confinement in an intensive care unit, cardiac care unit, burn unit, or a similar critical care unit;
- (c) Other medical services and supplies billed by a Hospital;
- (d) Anesthetics and their administration;
- (e) Professional ambulance transport to and from the nearest facility equipped to care for the Covered Person's Sickness or Injury;
- (f) Physician's charges for:
  - (1) Office visits, consultations, home visits, second surgical opinions, and other medical care; and
  - (2) Surgery. If more than one procedure is performed during one operative session, the Covered Charge will be the full Reasonable and Customary Charge for the most costly procedure. The Covered Charges for secondary procedures, which add significant time and/or complexity, will be 50% of the Reasonable and Customary Charges for the additional procedures;
- (g) Medical services and supplies, including:
  - (1) oxygen;
  - (2) surgical dressings, casts, splints, trusses, cervical collars, orthopedic braces and ostomy supplies; and
  - (3) blood, plasma and related charges;
- (h) Speech Therapy, but only if the therapy is recommended by an M.D. Speech Therapy to correct developmental delays is not covered even if recommended by a Physician;
- (i) Physical and Occupational Therapy; however, materials used in Occupational Therapy are not covered;
- (j) Inhalation Therapy and rehabilitation therapy;
- (k) Drugs and medicines which are available only with a prescription if:
  - (1) provided on an Inpatient basis or as a take home drug from a Hospital or Ambulatory Surgical Facility; or

- (2) the drug or medicine is not covered under the Prescription Drug Vendor Benefit but is prescribed to treat a Sickness or Injury for which benefits are payable under the Plan;
- (l) Diabetic supplies not covered under the Prescription Drug Vendor Benefit;
- (m) Diagnostic x-ray and laboratory exams, including pregnancy tests if performed by a qualified laboratory on any Covered Person;
- (n) Radiation treatment and chemotherapy;
- (o) Use of an Ambulatory Surgical Facility;
- (p) Use of an Urgent (Convenient) Care Center;
- (q) Room and board including normal daily services and supplies furnished by a Skilled Nursing Facility;
- (r) Home health care provided by a Home Health Care Agency. The services must be ordered and supervised by the Covered Person's Physician as part of a written health care program. If the Home Health Care Agency is owned in whole or part by the Physician ordering the care (or the physician's group of which he is a part), benefits will only be paid to the extent an independent third party verifies the need for, and cost of, the care. Home health care services are:
  - (1) Part-time (not more than 8 hours in a day) or intermittent nursing care provided in the home by a Registered Nurse, Licensed Practical Nurse, or a licensed public health nurse, or by a licensed vocational nurse if acting under the supervision of a Registered Nurse;
  - (2) Part-time (not more than 8 hours in a day) or intermittent home health aide visits for the personal care of the patient (personal care includes bathing, dressing, securing safe surroundings and dispensing medication; it does not include transportation);
  - (3) Physical, Occupational, Inhalation or Speech Therapy when provided in the home;
  - (4) Supplies, prescription drugs (even if available through the Prescription Drug Vendor) and laboratory services provided by a Home Health Care Agency; supplies, drugs and laboratory services will not be applied to any Home Health Care limit shown in the Schedule of Benefits;
- (s) Hospice care, provided the Covered Person's Physician prescribes these services in place of Hospital confinement. Covered Hospice services are:
  - (1) Room and board including normal daily services and supplies while an Inpatient in a Hospice;
  - (2) Services and supplies furnished by a Hospice team member on an Outpatient basis;
  - (3) Part-time, intermittent or round-the-clock nursing by a Registered Nurse or a Licensed Practical Nurse;

- (4) Medical social services under the direction of a Physician;
  - (5) Physical and Occupational Therapy;
  - (6) Part-time (not more than 8 hours in one day) or intermittent care by a home health care aide;
  - (7) Medical supplies and prescription drugs; and
  - (8) Bereavement services provided to members of the Covered Person's Family. No more than 6 sessions will be covered per Family;
- (t) Treatment of Mental and Nervous Disorders (including Chemical Dependency), but not to exceed the limits shown in the Schedule of Benefits. The Mental and Nervous Disorder limit applies only to services by a psychiatrist, a psychologist or another mental health practitioner acting under the supervision of a psychiatrist or a psychologist (services by a Primary Care Physician will not be applied to the limits). For purposes of this benefit, visits to monitor drug levels are not considered treatment of a Mental or Nervous Disorder. Each 2 days of Intensive Outpatient Treatment will be considered 1 day of Inpatient treatment. Outpatient shock therapy is considered Intensive Outpatient Treatment. Outpatient diagnostic services are not applied to the Outpatient visit limit. Services of a social worker are covered whether or not provided under the supervision of a Physician or psychologist. Services of other mental health practitioners are covered if provided under the supervision of a Physician or a psychologist;
- (u) Prenatal, delivery and postnatal care for any Covered Person. Benefits will be paid for home births, for 48 hours of confinement in a Hospital or Birth Center following a normal, vaginal delivery, and for 96 hours of confinement in a Hospital or Birth Center following a cesarean section (unless the mother leaves the Hospital or Birth Center sooner, with her Physician's consent) even if confinement for that amount of time is not Medically Necessary. Benefits will be paid for a longer confinement if Medically Necessary;
- (v) Routine care of a newborn, including nursery care, routine tests, and related charges such as Physician's visits, if provided within 4 days of birth; charges for circumcision are covered if performed as soon as medically reasonable;
- (w) Elective sterilization, but not reversals;
- (x) The initial examination, one follow-up visit and one pair of eyeglasses, contact lenses or intraocular lenses, if purchased immediately following and because of cataract surgery or to treat keratoconus;
- (y) Organ and Tissue Transplants, including charges for tissue typing, procuring and transporting the organ and tissue, and facility and Provider services and supplies in connection with the transplant.

Donor expenses are covered only if the recipient is a Covered Person, but only to the extent not covered by the donor's health coverage. Donor expenses include, but are not limited to, procurement of a donor organ, evaluation, surgical removal, transportation, and storage of the donor organ or tissue. If a scheduled transplant is canceled because of the patient's medical condition or

death, and the organ cannot be used for someone else, donor benefits will still be paid. If an organ or tissue is sold rather than donated, the purchase price of the organ or tissue will not be covered by the Plan. The donor's charges will be considered to be furnished on account of the recipient's Sickness or Injury even if the donor is a Covered Person;

- (z) Services and supplies (including x-rays and other diagnostic procedures, office visits, manipulations, and any other type of non-surgical treatment or therapy including, but not limited to, massage, traction, physical therapy, ultrasound, infrared, diathermy and hydrotherapy) provided in connection with dislocations or subluxations of the spine or musculoskeletal manipulations, up to the limits shown in the Schedule of Benefits; Maintenance Treatment is not covered;
- (aa) Diagnosis and treatment of Temporomandibular Joint Disorders (TMJ), including all office visits, appliances, tests, and surgery, up to the limits shown in the Schedule of Benefits;
- (bb) Facility and Provider charges for:
  - (1) dental treatment if needed as a result of an accidental injury and both the damaged teeth and supporting tissue and other structures are natural and sound; treatment must be performed as soon as medically reasonable;
  - (2) treatment of a fracture, dislocation or wound of the mouth or jaw;
  - (3) removal or treatment of cysts, tumors or other diseased or infected tissue of the mouth or jaw;
  - (4) treatment of infections resulting from dental care;
  - (5) extraction of partially or completely unerupted or impacted teeth and of wisdom teeth;
- (cc) Facility, but not Provider, charges for dental treatment if treatment in a Hospital or an Ambulatory Surgical Facility is Medically Necessary due to the Covered Person's age or health;
- (dd) Dialysis, including rental (or purchase if more economical) of equipment for home kidney dialysis. Charges for training, supplies, materials and repairs necessary for the proper operation of this equipment also will be covered expenses;
- (ee) Fitting, initial purchase, and repair of Prosthetic Devices. Covered Charges for deluxe items are limited to the cost of standard items. Replacement devices are covered only if needed as a result of natural growth or pathological changes, to maintain functionality, or because the existing device is beyond repair;
- (ff) Rental up to the purchase price (or purchase of the equipment if more economical) of Durable Medical Equipment. Routine maintenance and repairs are covered if needed to keep the equipment functional. Covered Charges for deluxe items are limited to the cost of standard items. Replacement equipment is covered only if needed as a result of natural growth or pathological changes, to maintain functionality, or because the existing equipment is beyond repair;

- (gg) Fitting, initial purchase and repair of custom Orthotic Appliances if prescribed by a Physician, including the cost of any biomechanical exam, molds and casting. Replacement appliances are covered only if needed as a result of natural growth or pathological changes, to maintain functionality, or because the existing equipment is beyond repair;
- (hh) Diagnosis and medical and surgical treatment of disease of and injuries to the eye including cornea transplants;
- (ii) Orthoptic/Vision Therapy, if recommended by an ophthalmologist or an optometrist;
- (jj) Diagnosis and treatment of sleep disorders if caused by a medical condition;
- (kk) Education and training in connection with management of a Sickness or Injury for which benefits are payable under this Plan (such as diabetes or a cardiac condition);
- (ll) Surgical and non-surgical treatment of disorders of the foot, including, but not limited to, bunions, corns, calluses and weak arches;
- (mm) Mastectomy and breast reconstruction in connection with such mastectomy, to include:
  - (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; and
  - (3) prostheses and physical complications at all stages of mastectomy, including lymphedemas;
- (nn) Allergy tests consisting of percutaneous, intracutaneous and patch tests;
- (oo) Allergy injections;
- (pp) Complications from excluded procedures, except as specifically provided to the contrary;
- (qq) Wigs, up to the limit shown in the Schedule of Benefits, but only if prescribed by a Physician for hair loss resulting from Injury, Sickness or treatment of Sickness including, but not limited to, burns resulting in permanent hair loss, lupus, fungal infections not responding to treatment resulting in near or complete cranial hair loss, chemotherapy, radiation therapy and autoimmune disorders resulting in alopecia.

## Section 7

### Major Medical Benefit Exclusions and Limitations

#### Section 7.01 Exclusions

Except as specifically provided, the Plan does not provide Major Medical benefits for:

- (a) Services and supplies received while the recipient is not a Covered Person;
- (b) Services or supplies provided by the Covered Person, the Covered Person's spouse, a grandparent, parent, sibling, child, or grandchild of the Covered Person or his spouse, or a person who resides with the Covered Person;
- (c) Charges in excess of the Reasonable and Customary Charge;
- (d) Charges for injury or sickness resulting from:
  - (1) war, declared or undeclared, or any act of war;
  - (2) active participation in a riot;
  - (3) committing, or attempting to commit, an assault or felony (provided, however, that operation of a vehicle while intoxicated will not be considered committing or attempting to commit an assault or felony even if prosecution results);
- (e) Confinement, treatment, or services paid for or furnished by a government or one of its agencies (except as required by Medicaid or Medicare);
- (f) Services or supplies that are not prescribed by the attending Physician or Medically Necessary for treatment of the sickness or injury;
- (g) Confinement, treatment, or services that result from a sickness or injury arising out of or in the course of employment for wage or profit, whether or not the sickness or injury is covered by a Worker's Compensation, occupational disease, or similar law;
- (h) Charges that the Covered Person would not be required to pay in the absence of coverage;
- (i) Cosmetic Procedures, unless the procedure:
  - (1) results from an accidental Injury and is performed as soon as medically reasonable following the Injury;
  - (2) is to correct birth abnormalities of a child; or
  - (3) is designed to reconstruct following surgery and is performed as soon as medically reasonable following the surgery;

- (j) Charges for:
- (1) examinations to determine the need for contact lenses or eyeglasses, except as specifically provided;
  - (2) the fitting, adjustment, or purchase of contact lenses or eyeglasses, except as specifically provided;
  - (3) LASIK, radial keratotomy or any other surgical or laser procedure designed to correct errors in refraction;
- however, charges for the initial examination and one follow-up examination and the cost of one pair of eyeglasses, contact lenses, or intraocular lenses after cataract surgery are covered;
- (k) Charges for examinations to determine the need for hearing aids, hearing aids, hearing aid batteries, hearing aid repairs and replacements or cochlear implants;
- (l) Treatment, diagnosis, or x-rays of, on, or to the teeth, the nerves or roots of the teeth, gingival tissue, or alveolar processes, except as specifically provided;
- (m) Charges for an abortion, whether surgical or drug-induced, unless Medically Necessary to save the life of the mother; however, complications arising from any abortion are covered;
- (n) Genetic Testing;
- (o) Birth Control Care, devices, implants, injections or medications, unless Medically Necessary to manage a specific condition;
- (p) Diagnosis and the treatment of Infertility. All charges of a surrogate mother are excluded (even if the mother is a Covered Person);
- (q) Corrective or orthopedic shoes, unless an integral part of a brace;
- (r) Charges for the services of any health care provider not meeting the definition of a "Provider", except as specifically provided;
- (s) Travel or hospitalization for environmental change, even though prescribed by a Physician;
- (t) Donor charges in connection with an organ or tissue transplant, unless the recipient is a Covered Person;
- (u) Charges incurred in connection with transplantation of non-human, artificial or mechanical organs;
- (v) Provider charges for phone calls, missed appointments or for completion of routine claim forms required to file a claim under the Plan;
- (w) Custodial Care (unless provided under the hospice or home health care benefit), rest cures, or sanitarium care;

- (x) Charges for medical care or supplies which involve Experimental or Investigational Care;
- (y) Charges for Hospital confinement on a Friday, Saturday, or Sunday if the Covered Person is admitted on one of those days, unless the admission is Medically Necessary for Emergency Care, a need for observation, or to prepare for surgery to be performed on the following day;
- (z) Private duty nursing care, unless provided through a Hospice;
- (aa) Speech Therapy unless recommended by an M.D.; therapy to correct developmental delays is not covered even if recommended by an M.D.;
- (bb) Sterilization reversals and attempted reversals;
- (cc) Charges incurred in connection with a sex change or gender identification problem, or to treat sexual dysfunction;
- (dd) Items provided for comfort, personal hygiene, or convenience including, but not limited to, home blood pressure monitors, air conditioners, humidifiers, whirlpools, and exercise equipment, or for structural changes to a house or vehicle, even if prescribed by a Physician;
- (ee) Nutritional supplements even if prescribed by a Physician;
- (ff) Non-prescription drugs, even if prescribed by a Physician;
- (gg) Prescription drugs obtained from a retail pharmacy, except as specifically covered under the Prescription Drug Vendor or Major Medical Benefit;
- (hh) Biofeedback, encounter groups, and self-improvement groups;
- (ii) Counseling services unless provided in connection with a Sickness or Injury for which benefits are payable under the Plan including, but not limited to, marital, family, career and financial counseling;
- (jj) Acupuncture or acupressure, unless provided in connection with a surgical procedure for which benefits are payable under the Plan;
- (kk) Charges for services or supplies furnished by a Preferred Provider in excess of the amount the provider has agreed to charge individuals covered by this Plan;
- (ll) Materials used in connection with Occupational Therapy;
- (mm) Holistic and homeopathic therapies;
- (nn) Maintenance Care;
- (oo) Vocational rehabilitation;
- (pp) Services and supplies provided outside the United States or Canada, if the Covered Person traveled to the area primarily to receive medical care (unless provided in connection with an unrelated Sickness or Injury arising at the location).

## Section 7.02 Pre-existing Condition Limitation

A pre-existing condition is any sickness, injury or other physical or mental condition, regardless of the cause, for which medical advice, diagnosis, care or treatment was received (including the use of prescription medication) within the 6 month period immediately preceding the person's Enrollment Date. A genetic condition will not be considered a pre-existing condition unless a sickness or disease has been diagnosed and is under treatment.

- (a) Benefits for a pre-existing condition are limited to \$500 until 12 months have elapsed since the individual's Enrollment Date (18 months, for a Late Enrollee).

Provided, however, that the pre-existing condition limitation period will be reduced by the person's prior Creditable Coverage, if any. Each day of Creditable Coverage, determined without regard to the specific benefits included in the coverage, will reduce the pre-existing condition limitation period under this Plan by one day. Except that, if the person experienced a Significant Break in Coverage, only days after the break ended will be applied as Creditable Coverage. For purposes of this Section, time under a leave of absence covered by the Family and Medical Leave Act or a military leave covered by the Uniformed Services Employment and Reemployment Rights Act also will be applied to reduce the pre-existing condition limitation period.

- (b) The Plan may not impose any limit on the amount of time that an individual has to present a certificate or other evidence of Creditable Coverage. This limitation will not apply to:

- (1) a newborn child who is enrolled in Creditable Coverage plan within 31 days after its birth and who has not had a Significant Break in Coverage;
- (2) a child who becomes a Covered Person within 31 days after he is "legally adopted," as described in the definition of a "Dependent" and who has not had a Significant Break in Coverage;
- (3) pregnancy, including complications, regardless when conception occurred or the amount of Creditable Coverage.
- (4) a condition based solely on genetic information.

- (c) This limitation will apply to all other individuals including those who enroll as a result of special enrollment.

- (d) If the Plan Supervisor determines that the pre-existing condition limitation period applies to a Covered Person, within a reasonable period of time following receipt of a certificate of Creditable Coverage (or other evidence of Creditable Coverage if a certificate is not reasonably available), the Plan will advise the Covered Person of the amount of time for which the limitation will apply, the basis on which it made its determination, and the individual's right to appeal the determination.

If the Plan later determines that an individual did not have the claimed Creditable Coverage, the Plan may modify its initial determination. In that case, the individual will be notified of the reconsideration by the provision of a notice of the new determination; however, until a final determination is reached, the

Plan will act in accordance with its initial determination in favor of the Participant or Dependent for the purpose of pre-certifying coverage for medical services.

## **Section 8**

### **Prescription Drug Vendor Benefit**

#### **Section 8.01 Employee Co-payment**

The Employee Co-payment for prescription drugs is shown in the Schedule of Benefits. The Employee Co-payment applies to each prescription filled under this benefit. The Employee Co-payment will not be applied to meet the Plan Deductible or Out-of-Pocket Maximum.

#### **Section 8.02 Benefit**

- (a) Benefits will be paid for:
  - (1) drugs and medicines which, under federal or state law, require a written prescription;
  - (2) insulin, syringes and needles prescribed for use with insulin, and certain diabetic supplies, such as chemstrips, lancets and Glucagon Emergency Kits;
  - (3) contraceptives; and
  - (4) prescription prenatal vitamins.
- (b) Benefits are subject to the rules and limitations of the provider, and any quantity limits imposed by the vendor or elected by the Plan Administrator.
- (c) The Plan may, in its sole discretion, authorize coverage of and pay benefits for a drug that is normally excluded under the Prescription Drug Vendor Benefit if it is provided evidence that the drug has been prescribed to treat a Sickness or Injury covered by the Plan.

#### **Section 8.03 Payment**

- (a) Prescription Drug Card. Benefits will be paid directly to the provider if the Covered Person presents the drug card when the prescription is filled. If the Covered Person fails to present the card or obtains a covered drug from a pharmacy not participating in the program, the Plan will reimburse the Covered Person (as if the drug card had been used) but only if the Covered Person demonstrates that failure to use the drug card was beyond his control.
- (b) Mail Order Drug. Benefits will be paid directly to the provider for maintenance drugs dispensed by an approved mail order drug provider.

## Section 9

### Prescription Drug Vendor Exclusions

#### Section 9.01 Exclusions

The Plan does not pay benefits under the Prescription Drug Vendor Benefit for:

- (a) Drugs administered or provided while confined to a Hospital or other institution;
- (b) More than a 30-day supply of a drug for drugs purchased with a drug card, or more than a 90-day supply for drugs purchased by mail;
- (c) Any prescription dispensed more than 12 months after issued (6 months after issued, if a federally controlled drug), or in excess of the quantity prescribed;
- (d) Therapeutic equipment for administration of any drug (other than syringes for approved uses), devices or appliances, support garments, and other non-medical substances;
- (e) Experimental or Investigational drugs including medicines for non-FDA approved use;
- (f) Fertility medications;
- (g) Minoxidil (Rogaine), Propecia, or any other drug used in connection with hair loss;
- (h) Contraceptive devices;
- (i) Cosmetic drugs such as Avita, Differin, Renova and Retin-A, for individuals age 26 or older;
- (j) Viagra, Levitra, Cialis and other male impotency drugs;
- (k) Fluoride products;
- (l) Injectables, unless otherwise covered under the program selected by the Plan Administrator, such as, but not limited to, insulin, Imitrex and beesting kits;
- (m) Immunization agents, biological sera, blood, or blood plasma;
- (n) Non-legend (over-the-counter) drugs other than insulin;
- (o) Any drug covered by any workers' compensation or federal, state or local government program;
- (p) Prescriptions filled while not a Covered Person;
- (q) Any other drug not covered under the program selected by the Plan Administrator.

## **Section 9.02 Other Coverage**

Drugs that are not submitted to the Prescription Drug Vendor because they are submitted to another plan are not covered under the Plan.

If a person is eligible for and covered by Medicare Part D and if Medicare is the primary plan, regular benefits under this Plan may be reduced by benefits paid by Medicare if the total of the benefits payable under both plans would exceed 100% of Allowable Expenses. In no event will this Plan pay more than the regular benefits payable in the absence of Medicare coverage.

## **Section 10**

### **CONTINUATION OF COVERAGE**

#### **Section 10.01 Leave of Absence**

If you are on a leave of absence under the Family and Medical Leave Act, you (and your covered Dependents) may continue coverage under this Plan by paying the usual employee contribution, during the leave. If you are on a military leave covered by the Uniformed Services Employment and Reemployment Rights Act, you (and your covered Dependents) may continue coverage under this Plan by paying the required contribution, during the leave. (You may be responsible for the full cost of coverage if your military leave is more than 30 days.) If you are receiving either Workmen's Compensation Disability Benefits or Long-Term Disability Benefits, you (and your covered Dependents) may continue coverage under this Plan, while receiving these benefits, by paying the required contribution during the leave. If you are on any other approved leave of absence, you (and your covered Dependents) may continue coverage under this Plan by paying the required contribution for up to:

- (a) 6 months if on a personal leave of absence;
- (b) 12 months if on a sabbatical;
- (c) 6 months if on a medical leave of absence (this may be increased by up to 3 months for every 5 years of service).

Coverage under this Section will not be applied to the maximum COBRA coverage period unless you are on a military leave which lasts over 30 days.

#### **Section 10.02 Retirement**

A former Employee who qualifies as an Early Retiree or a Medicare Retiree may continue coverage in effect at retirement by paying the required contribution to the Employer. (An individual classified as an Early Retiree will be reclassified as a Medicare Retiree when he or she becomes covered by Medicare.) Coverage will continue until:

- (a) The Retiree's death;
- (b) The required contribution is not made; or
- (c) Coverage would otherwise end under the terms of the Plan.

Your surviving spouse may continue coverage (even if your spouse has other coverage in effect at your death) by paying the required contribution. Coverage will continue until the spouse dies, remarries, first becomes eligible for other group health coverage or fails to pay the required contribution.

Coverage under this Section will be applied to the maximum COBRA coverage period.

### Section 10.03 COBRA Coverage

- (a) Federal law requires your Employer to offer continued medical and prescription drug coverage to you and your covered Dependents if coverage ends because of one of these "qualifying events":
  - (1) You die;
  - (2) Your employment ends (other than because of your gross misconduct), or your hours are reduced below the minimum hours needed to be eligible for coverage;
  - (3) You and your spouse are divorced or legally separated;
  - (4) You become entitled to Medicare;
  - (5) A Dependent child ceases to be eligible; or
  - (6) You are covered as a Retiree and your Employer files for bankruptcy under Chapter 11.
- (b) You and your covered Dependents may continue the coverage they have under this Plan by:
  - (1) Electing to continue coverage on a form supplied by the Plan Administrator (or its representative) within 60 days after a qualifying event occurs (or within 60 days after the election form is mailed to you if later. Your employer will provide you with information about COBRA and a form on which to elect COBRA continuation coverage within 44 days after is learns of the Qualifying Event); and
  - (2) Making the first contribution for coverage within 45 days after continuation coverage is elected and paying later contributions by the last day of each month for which COBRA coverage is desired.
- (c) If you or a covered dependent are covered by Medicare or another group health plan on the date of a qualifying event, you also may elect COBRA coverage under this plan if you wish. If you or a Dependent later become covered under Medicare or another plan which does not limit coverage for a pre-existing condition while you have COBRA coverage under this Plan, your COBRA coverage will end.
- (d) You must notify the Plan Administrator of a divorce or legal separation or of a Dependent child becoming ineligible within 60 days after the event occurs, or continuation rights will be lost. If a child is born to you or placed for adoption with you while you have COBRA coverage, the child also will be a covered Dependent if you request coverage within 60 days after the child's birth or placement.
- (e) If you wish to extend coverage because of disability, you must notify your Employer of the disability before the 18-month continuation coverage period ends and provide a copy of the Social Security disability determination letter within 60 days after you receive it (or within 60 days after your Qualifying Event, if later), or extension rights will be lost.

- (f) Each covered Dependent may separately choose to continue or waive coverage, and to change coverages during any open enrollment (change) period. Elections by parents will bind minor children.

Deductibles and plan limits will apply to the continuation coverage, with offsetting for claims submitted prior to the qualifying event.

- (g) Continuation coverage will continue:

- (1) For 18 months, if the qualifying event is termination of employment or reduction of hours, except that, if you became entitled to Medicare less than 18 months before your employment ended or your hours were reduced, your spouse and children may elect COBRA for a total of 36 months from the date you became entitled to COBRA;
- (2) For 29 months, if the Social Security Administration determines the Covered Person was disabled on the date of the qualifying event or within 60 days after the qualifying event occurred;
- (3) For 36 months, if the qualifying event is your death, divorce or entitlement to Medicare, or a Dependent child ceases to be eligible;
- (4) Until your death, if you are covered as a Retiree and your Employer files for bankruptcy under Chapter 11.

- (h) Coverage will end before these dates if:

- (1) The Covered Person, after electing COBRA coverage, becomes covered by another group health plan which does not limit coverage of a pre-existing condition;
- (2) The Covered Person, after electing COBRA coverage, becomes entitled to Medicare;
- (3) The Covered Person ceases to be disabled;
- (4) The Employer ceases to maintain any group health plan; or
- (5) You fail to make required contributions within 30 days after they are due.

- (i) If a second qualifying event occurs while 18 (or 29) months of continuation coverage is being provided, coverage may be continued for a total of 36 months if the second qualifying event would have been a qualifying event if the first qualifying event had not occurred. No more than 36 months of continuation coverage will ever be provided, except to a Retiree if the Employer is in Chapter 11 bankruptcy.

- (j) The contribution for continuation coverage will be 102% of the total cost of Plan coverage for the coverage year (150% for the disabled person's family unit during the extended coverage period). You will be required to pay the full cost yourself, even though your Employer paid all or part of the cost when you were employed.

- (k) Your election period will be extended if you are receiving trade adjustment assistance under the Trade Act of 2002.

## **Section 11**

### **Non-Duplication of Coverage**

#### **Section 11.01 Other Group Health Coverage**

If benefits are payable under more than one group health plan, benefits paid under this Plan (or the other Plan) may be reduced so that you are not reimbursed for more than your actual expenses.

In general, the plan that covers a person as an active employee will pay its benefits first, as the "primary plan". If a child is covered by both parents, and the parents are not divorced, the plan of the parent whose birthday is earliest in the year will pay its benefits first. If the parents are divorced, the plan of the parent with custody of the child will pay its benefits first, unless a divorce decree makes a different arrangement and a copy of the decree is provided to the Plan Supervisor.

If a Covered Person is covered by more than one plan, you should submit your claim to the primary plan first. After it has paid its benefits, submit another claim and evidence of how the primary plan paid benefits to the secondary plan. The secondary plan will then pay its benefits, taking into account amounts the primary plan already paid.

#### **Section 11.02 Automobile Coverage**

If a Covered Person has medical costs because of an automobile accident, this Plan will be secondary to the medical portion of any automobile insurance (including no-fault) that provides coverage.

#### **Section 11.03 Medicare**

If you or a Dependent become eligible for Medicare while covered by the Plan, you should contact Medicare for enrollment information. If you are covered by both this Plan and Medicare, normally this Plan will pay its benefits first as long as you are considered an active Employee. (You may elect to have Medicare coverage as primary, but if you do, this Plan may not pay any further benefits.)

If you are covered by both this Plan and Medicare, benefits may be reduced under this Plan so that you are not reimbursed for more than your actual expenses. It is very important that you enroll for Part B coverage if you are eligible, since the Plan will pay benefits as if you have this coverage, whether you actually have Part B or not.

## Section 12

### Claims

#### Section 12.01 Filing a Claim

- (a) To receive benefits under this Plan, you (or your named representative) must file a written "Claim for Benefits" with the Plan Supervisor within the Time Limits described below. You must also promptly provide all other information the Plan Administrator or Plan Supervisor may reasonably require to determine whether benefits are payable under the Plan. Claims should be submitted to the address shown on your Plan ID card.
- (b) A "Claim for Benefits" is an itemized bill which also includes the name of the Participant/Insured, the name of the Covered Person/Patient, the Social Security Number or other identifying number of the Participant/Insured, the date of service, proper ICD-9, CPT or other similar revenue coding, the amount of actual charges, any needed repricing from the Preferred Provider network, notice of pre-certification if required for the procedure, service or supply, the name of the Provider, and the Provider's taxpayer identification number.
- (c) Use of the Prescription Drug Vendor Benefit is not considered a Claim for Benefits if the drug is provided at a predetermined cost to Covered Persons to the extent the vendor exercises no discretion on behalf of the Plan.
- (d) An inquiry as to whether a procedure, service or supply is covered or a request to approve a procedure, service or supply prior to the time the procedure, service or supply is performed or provided is not a Claim for Benefits, except to the extent pre-certification is required under the Utilization Review/Care Management provisions of this Plan, in which case the Request and Appeals procedures of Section 5 will apply. However, the procedures described below (but not the time frames) will apply to any appeal of information given in response to this type of an inquiry.
- (e) An inquiry as to whether an individual is, was or could become a Covered Person will not be considered a Claim for Benefits unless payment is denied for incurred health care services as a direct result of the determination that the individual was not a Covered Person when the service was provided. However, the procedures described below (but not the time frames) will apply to any appeal of this information.
- (f) There is no charge to file a Claim for Benefits under the Plan. The Plan may require physical examinations by an independent Physician, at its expense, if it considers such an examination reasonably necessary to adequately evaluate a Claim for Benefits. If a Provider charges a fee for providing medical records, you may be responsible for paying those charges.

#### Section 12.02 Time Limits

- (a) You must submit a written Claim for Benefits, including any supporting information the Plan Supervisor or Plan Administrator may reasonably require, to the Plan Supervisor within 12 months after the charges were incurred. Expenses submitted after this time are not eligible for consideration, unless the

Plan Supervisor or the Plan Administrator determines, in its sole discretion, that it was not reasonably possible to submit proof within the required period of time. Except that, upon termination of the Plan itself, all Claims for Benefits must be submitted within 90 days after the termination date. Claims for Benefits will be paid promptly after approval.

- (b) If your Employer terminates its participation in this Plan, all Claims for Benefits must be submitted to the Plan Supervisor within 90 days after the termination date.
- (c) No legal action against the Plan for benefits may be commenced:
  - (1) less than 60 days or more than 3 years after the claim was incurred; and
  - (2) until all administrative remedies, as set forth in the Appeals section, have been exhausted.

### **Section 12.03 Payment of Claims**

- (a) The Plan Supervisor will approve, deny or pend all Claims for Benefits, based upon the terms of the Plan, within 30 days after receipt. Except that, if the Plan Supervisor is unable to make a benefit determination within that time period due to matters beyond its control, this time period may be extended for up to 15 days, provided the Plan provides a notice to you before the initial 30-day period ends explaining the circumstances causing the delay and the date by which a decision is anticipated. If additional information is needed from you, the claim may be pended, and the pend notice will describe what information is needed. The Plan will allow you 45 days to provide the needed information; the time periods which the Plan follows in making claims determinations will be tolled while the requested, needed information from you is pending. If you fail to provide the needed information by the due date described in the pend notice, the Claim for Benefits will be denied as of that missed due date.
- (b) Payment of an approved Claim for Benefits will be made as described below unless benefits are to be paid to an alternate recipient under the terms of a Qualified Medical Child Support Order.
  - (1) The Plan will pay benefits for covered services and supplies provided by Preferred Providers directly to Preferred Providers. Preferred Providers may seek payment from Covered Persons only for any Deductible, Employee Co-payments, amounts unpaid by the Plan due to the Co-benefit Rate, and services and supplies which are not covered by the Plan. Any discounts obtained from Preferred Providers will be shared with Covered Persons.
  - (2) The Plan will pay benefits for covered services and supplies provided by a Non-Preferred Provider to the Participant, unless otherwise directed by a written assignment or QMCSO. The Covered Person is responsible for charges in excess of the Reasonable and Customary Charge, as well as the Deductible, any Employee Co-payment, amounts unpaid due to the Co-benefit Rate, and services and supplies which are not covered by the Plan.

- (c) If a claim is not paid in full for any reason (an "initial denial" or "denied"), including but not limited to imposition of any pre-existing condition limitation, application of the Deductible, Employee Co- payments or the Co-benefit Rate, or a stated exclusion, the Plan Supervisor will furnish a notice to you:
  - (1) specifying the reason or reasons for the denial;
  - (2) stating the Plan provisions on which the determination was based;
  - (3) describing any additional information or material needed from you or the Covered Person to perfect the claim, and why that information or material is needed; and
  - (4) describing the Plan's review procedures and the time limits applicable to those procedures, including the right to file suit.
- (d) If a Claim for Benefits was denied wholly or partly because an internal rule, guideline or protocol was followed, you will be advised that a copy of the rule, guideline or protocol will be provided upon written request, at no charge. If you do request this information, it will be provided within 15 days after the written request is received.
- (e) If a Claim for Benefits was denied wholly or partly because Medical Necessity was not shown or because the treatment is considered "Experimental or Investigational", you will be advised that the claim was denied for that reason, and that an explanation of how the terms of the Plan apply to the patient's medical circumstances will be provided upon written request, at no charge. If you do request this information, it will be provided within 15 days after the written request is received.
- (f) All benefit determinations will be made according to the terms of the Plan in effect at the time the claim was incurred, and Plan provisions will be applied consistently to similarly situated Covered Persons.

#### **Section 12.04 Right of Recovery**

If benefits are paid by the Plan which were not properly payable, the Plan has the right to recover the amounts incorrectly paid from the person to whom the benefits were paid and/or the person who should have paid the benefits. This right includes the right to offset future benefit payments.

## **Section 13**

### **Subrogation And Reimbursement**

#### **Section 13.01 Applicability**

If a Covered Person is injured or becomes ill because of another person's negligence or wrongful act, the Plan will pay benefits on account of the injury or sickness while you work to obtain payment from the party who hurt you.

#### **Section 13.02 Obligations of the Covered Person**

- (a) If the Plan Sponsor or Plan Administrator believes that your injury or sickness may be the result of another person's actions, you may be required to complete a questionnaire and sign an agreement to reimburse the Plan if money is later recovered from the person who hurt you before the Plan will pay benefits in connection with the injury or sickness.
- (b) If you recover money from the person who caused your injury or sickness, you must reimburse the Plan for amounts it paid on your behalf. If you only recover a part of your monetary losses from that person, you must reimburse the Plan on a proportionate basis. The Plan is not responsible for any of your attorney's fees.
- (c) You may contact the Plan Administrator or Plan Supervisor for a copy of the Plan provisions that contain additional information about your obligations.

## Section 14

### Privacy Provisions

#### Section 14.01 Definitions

When used in this Section, the terms listed below will have the following meanings, unless another meaning is clearly required by the context in which the term is used.

- (a) "Business Associate" means a person who:
  - (1) Performs, or assists in the performance of a function or activity involving the use or disclosure of PHI, including claims processing or administration, data analysis, processing or administration, utilization review, quality assurance, billing, benefit management, practice management, and repricing, or any other function or activity regulated by the Regulations, or
  - (2) Provides legal, actuarial, accounting, consulting, data aggregation management, administrative, accreditation, or financial services to or for the Plan where the provision of the service involves the disclosure of PHI from the Plan, or from a Business Associate of the Plan, to the person.
- (b) "Covered Entity" means any of the following (as defined in the Regulations):
  - (1) A health plan, including the Plan;
  - (2) A health care clearinghouse;
  - (3) A health care provider;
- (c) "Health Care Operations" means any of the following activities of the Plan or other Covered Entity to the extent that the activities are related to covered functions:
  - (1) Conducting quality assessment and improvement activities, including outcomes evaluation and development of clinical guidelines, provided that the obtaining of generalized knowledge is not the primary purpose of any studies resulting from such activities, population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, contacting of health care providers and patients with information about treatment alternatives; and related functions that do not include treatment;
  - (2) Reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, health plan performance, conducting training programs in which students, trainees, or practitioners in areas of health care learn under supervision to practice or improve their skills as health care providers, training of non-health care professionals, accreditation, certification, licensing, or credentialing activities;

- (3) Underwriting, premium rating, and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing, or placing a contract for reinsurance of risk relating to claims for health care (including stop-loss insurance and excess loss insurance), provided that the information is not further used if the recipient does not provide services to the Plan;
  - (4) Conducting or arranging for medical review, legal services, and auditing functions, including fraud and abuse detection and compliance programs;
  - (5) Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the entity, including formulary development and administration, development or improvement of methods of payment or coverage policies; and
  - (6) Business management and general administrative activities of the entity, including, but not limited to:
    - (A) Management activities relating to implementation of and compliance with the requirements of this Section;
    - (B) Customer service, including the provision of data analyses for plan sponsors, or other customers, provided that Protected Health Information is not disclosed to such plan sponsor or customer;
    - (C) Resolution of internal grievances;
    - (D) The sale, transfer, merger, or consolidation of all or part of the Covered Entity with another Covered Entity, or an entity that following such activity will become a Covered Entity and due diligence related to such activity; and
    - (E) Creating de-identified health information or a limited data set.
- (d) "Individually Identifiable Health Information" is information, including demographic information collected from an individual, that:
- (1) Is created or received by a health care provider, health plan, employer, or health care clearinghouse; and
  - (2) Relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual; and
    - (A) That identifies the individual; or
    - (B) With respect to which there is a reasonable basis to believe the information can be used to identify the individual.

- (e) "Payment" means:
  - (1) The activities undertaken by:
    - (A) A health plan to obtain premiums or to determine or fulfill its responsibility for coverage and provision of benefits under the health plan; or
    - (B) A health care provider or health plan to obtain or provide reimbursement for the provision of health care; and
  - (2) The activities in paragraph (1) of this definition relate to the individual to whom health care is provided and include, but are not limited to:
    - (A) Determination of eligibility or coverage (including coordination of benefits or the determination of cost sharing amounts), and adjudication or subrogation of health benefit claims;
    - (B) Risk adjusting amounts due based on enrollee health status and demographic characteristics;
    - (C) Billing, claims management, collection activities, obtaining payment under a contract for reinsurance (including stop-loss insurance and excess loss insurance), and related health care data processing;
    - (D) Review of health care services with respect to medical necessity, coverage under a health plan, appropriateness of care, or justification of charges;
    - (E) Utilization review activities, including precertification and preauthorization of services, concurrent and retrospective review of services; and
    - (F) Disclosure to consumer reporting agencies of any of the following Protected Health Information relating to collection of premiums or reimbursement:
      - (i) Name and address;
      - (ii) Date of birth;
      - (iii) Social security number;
      - (iv) Payment history;
      - (v) Account number; and
      - (vi) Name and address of health care provider and/or health plan.

- (f) "PHI" or "Protected Health Information" means Individually Identifiable Health Information other than Individually Identifiable Health Information in:
  - (1) Education records covered by the Family Education Rights and Privacy Act, as amended, 20 U.S.C. 1232g;
  - (2) Records described at 20 U.S.C. 1232g(a)(4)(B)(iv); and
  - (3) Employment records held by a Covered Entity in its role as employer.
- (g) "Regulations" means the Rules on Standards for Privacy of Individually Identifiable Health Information (45 CFR Parts 160 and 164), as amended from time to time.
- (h) "Summary Health Information" means information, that may be Individually Identifiable Health Information, and:
  - (1) That summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom a plan sponsor has provided health benefits under a group health plan; and
  - (2) From which the information described below has been deleted:
    - (A) Names;
    - (B) All geographic subdivisions smaller than a 5 digit zip code,
    - (C) All elements of dates (except year) for dates directly related to an individual, including birth date, admission date, discharge date, date of death; and all ages over 89 and all elements of dates (including year) indicative of such age, except that such ages and elements may be aggregated into a single category of age 90 or older;
    - (D) Telephone numbers;
    - (E) Fax numbers;
    - (F) Electronic mail addresses;
    - (G) Social security numbers;
    - (H) Medical record numbers;
    - (I) Health plan beneficiary numbers;
    - (J) Account numbers; and
    - (K) Any other unique identifying number, characteristic, or code except as permitted by paragraph (c) of this section.
  - (3) The Covered Entity does not have actual knowledge that the information could be used alone or in combination with other information to identify an individual who is a subject of the information.

## **Section 14.02 Permitted Disclosure of General Information**

- (a) The Plan may disclose Summary Health Information to the Employer or a Business Associate if the Employer or Business Associate requests that information for the purpose of:
  - (1) Obtaining reinsurance or premium bids to provide coverage under the Plan; or
  - (2) Modifying, amending or terminating the Plan.
- (b) The Plan may disclose to the Employer, a Covered Entity or a Business Associate whether an individual is or was a Covered Person under the Plan.

## **Section 14.03 Permitted Disclosure of Individually Identifiable Health Information**

- (a) The Plan may use or disclose PHI for Treatment, Payment and Health Care Operations, as described in the Notice of Information Practices provided to the Participant or in a consent received from the Covered Person (or the representative of the Covered Person). The Plan will only use or disclose the minimum information needed to effectively accomplish the intended purpose of the use, disclosure or request.
- (b) The Plan may release information as provided in an authorization signed by the Covered Person (or a representative of the Covered Person if the Covered Person is a minor or otherwise unable to provide an authorization).
- (c) The Plan may disclose PHI to a Business Associate and may allow a Business Associate to create or receive PHI on its behalf, as long as the Plan has received satisfactory written assurances from the Business Associate that it will appropriately safeguard the PHI.
- (d) The Plan may release PHI as required or permitted by the Regulations, including, but not limited to, facially valid requests for PHI in connection with public health activities, law enforcement, health oversight activities, and judicial and administrative proceedings.
- (e) The Plan may release PHI in connection with data analysis.
- (f) The Plan will disclose PHI to the Employer if needed by the Employer to adequately administer or manage the Plan, whether in its role as Plan Administrator or plan sponsor, as described in the Notice of Privacy Practices.
  - (1) The Plan will disclose only the minimum necessary PHI to allow the Employer to complete the needed function.
  - (2) Disclosure of PHI will be limited to individuals in the Human Resources Department who are directly responsible for administration of the Plan (including Payment or Health Care Operations). The Employer will take all reasonable steps to ensure that access to and use of information by these individuals is limited to plan administration functions that the Employer provides for the Plan.

#### **Section 14.04 Right of Access to PHI**

The Covered Person may inspect or receive a copy of PHI contained in the individual's records; except that access may be denied if release may be harmful to the Covered Person or another person mentioned in the records, or as otherwise set forth in the Regulations. The request to inspect or obtain copies must be written. Access or copies will be provided within 30 days of receipt of the request if the records are maintained or accessible on-site, and within 60 days if they must be retrieved from another site. If it is not reasonably possible to meet these time frames, the Covered Person will be advised, and the Plan will produce the requested information within an additional 30 days. If access is denied, the Covered Person will be advised within 30 days. If only a portion of the requested information is accessible, that information will be provided, with an explanation regarding the information that is not available. The Covered Person will be advised of his right to, and the process for, an appeal of a full or partial denial. (A reasonable fee may be charged for copying, mailing or summarizing the PHI.)

#### **Section 14.05 Right to Amend PHI**

- (a) The Covered Person may amend the PHI contained in his records unless the Plan determines that the PHI or record that is the subject of the request:
  - (1) Was not created by the Plan, unless the individual provides a reasonable basis to believe that the originator of Protected Health Information is no longer available to act on the requested amendment;
  - (2) Is not part of its records;
  - (3) Would not be available for inspection under the Plan; or
  - (4) Is accurate and complete.
- (b) A request to amend must be written. The Plan will either make the requested amendment or provide notice of denial within 60 days after receiving the request to amend. If it is not reasonably possible to meet this time frame, the Covered Person will be advised of the delay, the reason for the delay, and the date by which the Plan will have completed its actions (but in no event more than 90 days from the date of the original request to amend).
- (c) If the Plan accepts the requested amendment to PHI, it will identify and note the records that are affected by the amendment. The Plan will advise the Covered Person that the amendment has been (or promptly will be) made, and provide an opportunity for the Covered Person to advise of the identity of relevant persons and entities with whom the amendment should be shared. The Plan will make reasonable efforts to provide the amendment to individuals identified by the Covered Person, as well as others, including Business Associates, that the Plan knows have the PHI that is the subject of the amendment and that may have relied, or foreseeably could rely, on the PHI to the detriment of the Covered Person.
- (d) If the request is denied, the Plan will provide a written notice of denial within 30 days. The denial will include the reason for the denial (as specified above), notice that the Covered Person has the right to file a statement of disagreement of the denial, and notice that if the Covered Person chooses not to file a

statement of disagreement, the person still may request that future disclosures of the PHI at issue include notice of the request to amend and denial of that request. If the Covered Person files a statement of disagreement, that statement will be appended or linked to the PHI at issue and included with all future disclosures of that PHI.

#### **Section 14.06 Right to an Accounting of Disclosures of PHI**

- (a) If requested in writing by the Covered Person, the Plan will provide an accounting of all PHI disclosures made by the Plan during the prior 6 years, except for disclosures of PHI:
  - (1) Made prior to the effective date of these Privacy Provisions, shown above;
  - (2) Made to carry out Payment, Treatment or Health Care Operations;
  - (3) Made incident to a use or disclosure otherwise permitted or required by the Regulations;
  - (4) Made to the Covered Person or the representative of the Covered Person;
  - (5) Made pursuant to a written authorization given by the Covered Person; or
  - (6) As otherwise specifically addressed in the Regulations (primarily with respect to law enforcement activities).
- (b) The accounting will include the date of the disclosure, the name (and address if known) of the recipient, a brief description of the PHI disclosed and a copy of the request for disclosure. The accounting will be provided within 60 days after the date of the request (one 30 day extension may apply if the Covered Person is advised of the delay and the reason for the delay). One accounting will be provided free of charge during any 12 month period; there may be a charge for additional accountings.

#### **Section 14.07 Complaints**

If the Covered Person believes PHI has been used inappropriately, a written complaint should be filed with the Privacy Officer for the Plan at the address shown in the Notice of Privacy Practices within 12 months after the date the questioned use or disclosure occurred. All complaints will be investigated, and a written response will be provided within 60 days after the complaint is received.

## **Section 15**

### **General Information**

#### **Section 15.01 The Plan Can Be Changed or Terminated**

The Plan has been established to provide long-term benefits with the objective of being maintained for an indefinite period of time. However, the Company reserves the right to terminate or amend the Plan at any time. Termination of the Plan must be approved by the governing body of the Company. Plan amendments must be signed by a designated officer of the Company.

Termination or amendment of the Plan will not prevent the Covered Person from receiving the benefits provided by the Plan immediately before termination or amendment, if the services were provided before the effective date of the termination or amendment.

#### **Section 15.02 Plan Administration**

The Plan Administrator is the named fiduciary of the Plan and has the power and duty to do all things necessary to carry out the intent and purposes of the Plan, including interpreting the Plan. Benefits will be paid under this Plan only if the Plan Administrator decides, in its discretion, that the Covered Person is entitled to them.

#### **Section 15.03 No Guarantee of Employment**

The existence or terms of this Plan do not in any way affect the Employer's right to terminate employment of Plan participants.

#### **Section 15.04 No Guarantee of Tax Consequences**

Neither the Plan Supervisor, the Plan Administrator nor the Employer makes any commitment or guarantee that any amounts paid under this Plan will be excludible from income for federal or state income tax purposes.

#### **Section 15.05 Choice of Provider**

You are responsible for choosing your medical providers. The Plan is not responsible for any act or omission of any provider.

#### **Section 15.06 Appeals**

(a) First Level Appeal

- (1) You (or your named representative) may appeal any whole or partial initial denial of a Claim for Benefits by filing a written appeal with the Plan Supervisor. This appeal must be filed within 180 days after receipt of the written notification of whole or partial initial denial of benefits, and explain why you believe the denial is incorrect.
- (2) You (or your named representative) may submit written comments, documents, records and other information relevant to the Claim for Benefits or appeal.

- (3) Upon request, you (or your named representative) will be given reasonable access to, and/or copies of, all documents, records and other information relevant to your Claim for Benefits (even if that information was not considered by the Plan Supervisor when the determination was made). Access and copies will be provided free of charge.
  - (4) The review will take into account all comments, documents, records and other information relating to the Claim for Benefits, without regard to whether that information was submitted or considered as part of the initial denial. The review will not provide deference to the initial denial. Neither the individual who made the initial denial nor a subordinate of that individual will perform the review.
  - (5) If the initial denial of the Claim for Benefits was based, in whole or in part, on a medical judgment, the reviewer will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, and who is neither an individual who was consulted in connection with the initial claim denial or a subordinate of that individual; the identity of any such health care professional will be disclosed to you whether or not the professional's advice was followed, if you request that information in writing.
  - (6) The Plan Supervisor will provide a written determination within 30 days after the written appeal is received.
- (b) Second Level Appeal
- (1) You (or your named representative) may appeal any whole or partial denial of a Claim for Benefits previously denied as a First Level Appeal by filing a written appeal with the Plan Administrator. This appeal must be filed within 60 days after receipt of the written First Level Appeal denial.
  - (2) You (or your named representative) may submit written comments, documents, records and other information relevant to the Claim for Benefits or appeal.
  - (3) Upon request, you (or your named representative) will be given reasonable access to, and/or copies of, all documents, records and other information relevant to the Covered Person's Claim for Benefits (even if that information was not considered by the Plan Supervisor as part of the initial denial or First Level Appeal). Access and copies will be provided free of charge.
  - (4) The review shall take into account all comments, documents, records and other information relating to the Claim for Benefits, without regard to whether that information was submitted or considered in the initial denial or at the First Level Appeal. The review will not provide deference to either the initial denial or First Level Appeal denial.
  - (5) If the denial of the Claim for Benefits was based, in whole or in part, on a medical judgment, the reviewer will consult with a health care

professional who has appropriate training and experience in the field of medicine involved in the medical judgment, and who is neither an individual who was consulted in connection with the initial denial or First Level Appeal or a subordinate of those individuals; the identity of the health care professional will be disclosed to you whether or not the professional's advice was followed, if you request that information in writing.

- (6) The Plan Administrator will provide a written, final determination within 30 days after the written Second Level Appeal is received. No further administrative appeals will be available under the Plan, but you may file suit under Section 502 of ERISA.

### **Section 15.07 Appointment of Representative**

You (or the parent or guardian of a Covered Person who is a minor or otherwise legally incapacitated) may designate an authorized representative for purposes of filing a Claim for Benefits or for appealing a denial of a Claim for Benefits by completing a form prescribed by the Plan Supervisor. Once a representative is named, all notices and communication will be with the representative, unless and until you terminate the representation in writing.

### **Section 15.08 Statement of ERISA Rights**

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

- **Receive Information About Your Plan and Benefits**

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing the plan and 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, upon written request to the Plan Administrator, copies of documents governing the operation of the plan and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

Receive a summary of the plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report if the Plan has 100 or more participants.

- **Continue Group Health Plan Coverage**

Continue health care coverage for yourself, spouse or dependent children if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

- **Prudent Actions by Plan Fiduciaries**

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

- **Enforce Your Rights**

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have 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 you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

- **Assistance With Your Questions**

If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your

telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

## Section 16

### Definitions

When used in this Summary, the terms listed below will have the following meanings, unless another meaning is clearly required by the context in which the term is used.

**Section 16.01 Actively at Work or Active Work** means the Employee is performing in the customary manner all of his normal job duties with the Employer at the Employer's place of business or at any other place that the Employer's business requires him to go.

An Employee will be considered to be Actively at Work if he is not at work solely because he is on a vacation or it is a scheduled non-working day, if he was Actively at Work on the last preceding regular working day.

**Section 16.02 Ambulatory Surgical Facility** means an establishment which may or may not be a part of a Hospital and which:

- (a) Is legally operated as an ambulatory surgical facility in the state in which it is located;
- (b) Is primarily engaged in performing surgical procedures;
- (c) Has permanent operating room(s), recovery room(s) and equipment for emergency care;
- (d) Has an organized medical staff, including Physicians and Registered Nurses, providing Services on a continuous basis; and
- (e) Does not provide services or accommodations for patients to remain overnight.

**Section 16.03 Benefit Year** means a calendar year. The Benefit Year is used to determine satisfaction of the Deductible and Out-of-Pocket Maximum, and application of annual benefit maximums.

**Section 16.04 Birth Center** means a facility which:

- (a) Is legally operated as a birth center in the state in which it is located;
- (b) Is primarily engaged in providing a comprehensive birth service program to patients who are considered normal low risk patients;
- (c) Has organized facilities for birth services on its premises;
- (d) Provides services by a Physician specializing in obstetrics, or, at his direction, by a licensed and certified nurse-midwife;
- (e) Has 24-hour-a-day Registered Nursing services; and
- (f) Maintains daily clinical records.

**Section 16.05 Birth Control** means a non-permanent method of contraception.

**Section 16.06 Board** means the Board of Trustees of the Company.

**Section 16.07 Care Manager** means the firm designated by the Plan Administrator to provide cost containment and medical care management services to the Plan.

**Section 16.08 Change in Family Status** means:

- (a) A change in legal marital status, including marriage, death of the spouse, divorce, legal separation, or annulment;
- (b) A change in the number of Dependents (as defined in Code section 152), including birth, adoption, placement for adoption (as defined in the regulations under Code section 9801), or death;
- (c) A change in employment status - termination or commencement of employment by the Participant, the Participant's spouse or a Dependent child, a strike or lockout, commencement of or return from an unpaid leave of absence (including an FMLA leave), or a change in employment status which affects eligibility for coverage, such as switching between hourly and salaried status or a reduction or increase in hours of employment;
- (d) A Dependent satisfying or ceasing to satisfy the requirements for dependent coverage due to attainment of age, student status, marriage or similar circumstances;
- (e) A change in the place of residence or work of the Participant, the Participant's spouse or a Dependent child (which affects health coverage options);
- (f) A HIPAA special enrollment event;
- (g) Entitlement to Medicare or Medicaid or loss of entitlement to Medicare, Medicaid or CHIP;
- (h) A court order, judgment or decree (including a QMCSO) requiring the Participant or the Participant's former spouse to provide health coverage for a Dependent child as long as the coverage is actually added;
- (i) A change in a Dependent's coverage under the plan sponsored by the Dependent's employer that either meets one of the criteria in (a) through (h) above or is made during that plan's open enrollment;
- (j) A severe curtailment in coverage available under this Plan or the Dependent's plan (such as a PPO or HMO leaving the area);
- (k) Any other change permitted under IRS rules.

**Section 16.09 Chemical Dependency** means alcohol or drug abuse or dependency, as described in category 303 or 304 of the International Classification of Diseases, U.S. Department of Health and Human Services.

**Section 16.10 Chemical Dependency Treatment Facility** means an institution which:

- (a) Is legally operated as such a facility in the state in which it is located;

- (b) Is primarily engaged in providing inpatient services (including room, board, and 24-hour-a-day nursing services) for treatment of alcoholism or drug addiction or dependency;
- (c) Is under the supervision of a Physician or a Registered Nurse; if not under the supervision of a Physician, a Physician must be available on a prearranged basis;
- (d) Maintains daily clinical records; and
- (e) Is not primarily a rest home, a home for the aged, or a Skilled Nursing Facility.

**Section 16.11 Co-benefit Rate** means the portion of Covered Charges that the Plan pays, as specified in the Schedule of Benefits, which is in excess of the Deductible or Employee Co-payment.

**Section 16.12 Code** means the Internal Revenue Code of 1986, as amended from time to time.

**Section 16.13 Company** means Earlham College or any successor company which adopts the Plan. Except as otherwise specifically provided in the Plan, the Company may act for and on behalf of each Participating Employer in any matter pertaining to the Plan and each such act will be effective and binding as though the act were that of the Employer.

**Section 16.14 Cosmetic Procedure** means surgery or any other procedure which is directed at improving the Covered Person's appearance and which does not meaningfully correct or improve a bodily function or treat or prevent a Sickness or Injury, including, but not limited to, a procedure to change the texture or appearance of the skin, or the relative size or position of any part of the body.

**Section 16.15 Covered Charge** means the actual expense incurred by a Covered Person, not in excess of the Reasonable and Customary Charge, for a service or supply which is covered by this Plan.

**Section 16.16 Covered Person** means a Participant or Dependent who has met the Eligibility and Effective Date requirements of this Plan and whose coverage has not terminated, or a person whose coverage is continuing under the Continuation of Coverage provisions of the Plan.

**Section 16.17 Creditable Coverage** means coverage of the individual for medical expenses under a group health plan, an individual health policy, COBRA, Medicare, Medicaid, Champus, S-CHIP, a state health benefits risk pool, a public health plan including health coverage provided under a Plan established or maintained by a foreign country or political subdivision, a health benefit plan under the Peace Corps or the Indian Health Service, or similar health coverage provided within the United States. Coverage under a plan or policy which provides benefits only for accidents, or which provides disability income, liability insurance, workers compensation coverage, automobile, or credit coverage is not considered Creditable Coverage. A stand alone program, which charges a discrete premium, for dental, vision, specified disease, hospital indemnity, and/or long term benefits also is not considered Creditable Coverage.

**Section 16.18 Custodial Care** means care provided by an institution or a provider mainly to assist an individual with the activities of daily living, and which is not expected to significantly improve a medical condition. Activities of daily living include bathing, feeding, toileting, transferring in and out of a bed or chair and taking oral medicine. Such care is

Custodial Care regardless of who recommends, provides or directs the care, where the care is provided and whether or not the patient can be or is being trained to care for himself or herself.

**Section 16.19 Deductible** means the amount of Covered Charges the Covered Person must pay each Benefit Year for services not subject to an Employee Co-payment before the Plan begins to pay benefits.

**Section 16.20 Dentist** means a person who is licensed to practice dentistry and who is acting within the scope of his license, including a Physician who is providing dental services within the scope of his license.

**Section 16.21 Dependent** means:

(a) The Participant's lawful spouse if the spouse:

- (1) is not a full-time member of the Armed Services of any country; and
- (2) is not covered under this Plan as an Employee.

In addition, an individual who qualifies as a "domestic partner" under the Employer's written policy, also will be considered a "spouse" as of the date enrolled as such, as long as the domestic partner is not a full-time member of the Armed Services of any country and is not covered under the Plan as an Employee.

(b) A child who:

- (1) is not a full-time member of the Armed Services of any country; and
- (2) is currently unmarried; and
- (3) has any of the following relationships with the Participant:
  - (A) is a natural child or legally adopted child of the Participant whether or not the child is living with the Participant; or
  - (B) is a stepchild who receives his principal support from the Participant and who lives with the Participant more than half the year (unless a student who lives at school or college during the school year, and who lives with the Participant during vacations); or
  - (C) is a child for whom the Participant is required to provide medical care or insurance under the terms of a court order; or
  - (D) is a child for whom the Participant is legal guardian; or
  - (E) is any other child who lives with the Participant in a parent-child relationship and who is claimed as a Dependent by the Participant on his federal income tax return; and

- (4) is less than 19 years old if not a full-time student, or is less than 25 years old if a full-time student at an accredited school and principally dependent on the Participant for support.

Full-time student status will be determined by the school's definition of a full-time student. Summer vacations will be considered a part of full-time attendance if the child was enrolled as a full-time student on the last day of the prior spring term (unless the child has graduated and has not enrolled at another institution for the fall term). Internships will be considered part of full-time attendance if the child intends to return to school at the start of the next grading period. A full-time student who withdraws from school during a grading period due to a Sickness or Injury will remain a "Dependent" until the end of the grading period.

A child will be considered "legally adopted" as of the date the Participant is legally obligated to provide total or partial financial support of the child, even if the adoption is not final, provided the child is less than 18 years old on the date of placement.

Provided, however, that if a Qualified Medical Child Support Order requires the Plan to cover a child who does not otherwise meet the definition of "Dependent," the child will be considered to be a "Dependent" until the earlier of termination of the order and the last day of the month in which the child's 25<sup>th</sup> birthday occurs.

In addition, a child over the age of 19 who is incapable of self-sustaining employment because of a long-term physical or mental incapacity will remain a Dependent while the incapacity and inability to be employed continue, provided:

- (A) the incapacity began before age 19 (age 25 for a full-time student);
- (B) the child is primarily dependent on the Participant for support;
- (C) proof of the incapacity is furnished to the Plan Administrator within 120 days after the date coverage would otherwise terminate; and
- (D) proof of continued incapacity, which may include a medical examination at the Plan's expense, is furnished upon request. The Plan may request additional proof annually.

If Employees are married to each other, one Employee-spouse may elect family coverage.

A person may not be covered as both a Participant and a Dependent, or as a Dependent of more than one Participant under this Plan.

The Plan may require proof of dependent status, such as a marriage or birth certificate, statement from the school regarding student status, and other similar items.

**Section 16.22 Diagnostic Services** means tests or procedures ordered by a Physician or other professional Provider because of specific symptoms. Diagnostic services must be directed toward determining a definite physical condition or disease and include:

- (a) X-ray and other radiology services;
- (b) Laboratory and pathology services;
- (c) Cardiographic, encephalographic and radioisotope tests;
- (d) Pathology;
- (e) Nuclear medicine;
- (f) Ultrasound;
- (g) MRI's and CAT scans.

**Section 16.23 Durable Medical Equipment** means medical equipment which is:

- (a) Prescribed by a Physician as essential in the treatment of an Injury or Sickness, and not just for temporary comfort or exercise;
- (b) Manufactured or distributed by a medical supply company;
- (c) Able to withstand repeated use; and
- (d) Not generally useful to an individual in the absence of an injury or sickness.

Durable Medical Equipment includes items like hospital beds, crutches, wheel chairs, and oxygen equipment.

**Section 16.24 Early Retiree** means an Employee who on his retirement date was a Covered Person under the Plan, had reached age 55, and was not eligible for Medicare.

**Section 16.25 Effective Date** means February 1, 1976 (the original effective date of the Plan).

**Section 16.26 Emergency Care** means medical care needed due to a sudden change in the Covered Person's physical or mental condition, that a prudent lay person who possesses an average knowledge of health and medicine would believe may have led to loss of life or ongoing medical problems if not provided within 24 hours following onset. Examples of conditions which might necessitate Emergency Care include, but are not limited to:

- (a) Chest pain;
- (b) Significant bleeding;
- (c) Difficulty in breathing;
- (d) Sudden onset of weakness or paralysis of a body part;
- (e) Unconsciousness;
- (f) Convulsions;

- (g) Severe burns;
- (h) Multiple injuries or trauma;
- (i) Ingestion of a poisonous substance;
- (j) Severe pain.

Any Sickness or Injury for which the Covered Person is admitted to the Hospital or transported by ambulance is considered a condition necessitating Emergency Care. In addition, a Sickness or Injury which is diagnosed or treated in an emergency room is considered a condition necessitating Emergency Care if adequate care was not available elsewhere in the area at the time and place it was needed. When determining whether Emergency Care is necessary, consideration will be given to items such as the patient's age, general health, and prior medical history as appropriate.

**Section 16.27 Employee** means any person who is regularly scheduled to work for the Employer at least 30 hours per week and 36 weeks per year. A temporary employee is not considered an "Employee".

**Section 16.28 Employee Co-payment** means the amount the Employee must pay for a specified benefit, generally in lieu of the Deductible. Employee Co-payments will not be applied to the Deductible or Out-of-Pocket Maximum, and are payable even if the Out-of-Pocket Maximum is met.

**Section 16.29 Employer or Participating Employer** means the Company, Earlham School of Religion, or any other company or a division thereof which is a member of the same controlled group of corporations [as defined in Sections 414(b), (c) or (m) of the Code] who is admitted to the Plan, or any successor which adopts this Plan.

**Section 16.30 Enrollment Date** means:

- (a) The date a Participant begins Active Work with the Employer, if the Participant enters the Plan when first eligible. (If a Participant is rehired, "Enrollment Date" is the date Active Work begins in connection with the most recent period of employment.)
- (b) The date an individual meets the definition of a "Dependent," if the Dependent enters the Plan when first eligible.
- (c) The date an individual becomes a Covered Person, if the individual enters the Plan during a special enrollment or an open enrollment.
- (d) If a Participant receiving benefits under a group health plan changes benefit packages, or if the Plan changes group health insurance issuers, the Participant's enrollment date remains the date determined pursuant to (a), (b) or (c) above.

(This definition applies only to the Pre-existing Condition Limitation.)

**Section 16.31 ERISA** means the Employee Retirement Income Security Act of 1974, as amended from time to time.

**Section 16.32 ERISA Plan Year or Plan Year** means the 12-month period beginning each July 1 and ending the following June 30.

**Section 16.33 Experimental or Investigational Care** means a drug, device, medical treatment or procedure that meets any of the following:

- (a) The drug, device treatment or procedure has not received the endorsement or approval of the U.S. Food and Drug Administration, American Medical Association or National Institute of Health for its intended use at the time the drug or device is furnished; or
- (b) 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
- (c) "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
- (d) "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.

For purposes of this definition, "Reliable Evidence" means 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, device, 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.

**Section 16.34 Family** means the Participant and all of the Participant's Dependents who are covered by the Plan.

**Section 16.35 FMLA** means the Family and Medical Leave Act, as amended from time to time.

**Section 16.36 Genetic Testing** means the examination of human DNA for an anomaly associated with a disease or disorder, with DNA taken from a sample of the patient's blood, body fluid or tissue.

**Section 16.37 HIPAA** means the Health Insurance Portability and Accountability Act, as amended from time to time.

**Section 16.38 Home Health Care Agency** means a provider which:

- (a) Is legally operated as a home health care agency in the jurisdiction in which it is located;
- (b) Is engaged primarily in providing skilled nursing and other therapeutic services;
- (c) Is supervised by a Physician or a Registered Nurse; and
- (d) Maintains a daily medical record.

**Section 16.39 Hospice** means a provider which may or may not be a part of a Hospital and which:

- (a) Is legally operated as a hospice in the jurisdiction in which it is located;
- (b) Is engaged in providing supportive and palliative, rather than curative, care to individuals who have a prognosis of 6 months or less to live, and supportive care to their families;
- (c) Provides skilled nursing, medical, and social services, and psychological and bereavement counseling;
- (d) Provides or arranges for other support services including Physician care, physical or occupational therapy, part-time home nursing services, and Inpatient care when needed for pain control or acute or chronic symptom management;
- (e) Has Registered Nursing care available 24-hours per day and at least one Physician on call at all times; and
- (f) Is not primarily a rest home.

**Section 16.40 Hospital** means an institution which:

- (a) Is legally operated as a hospital in the state in which it is located;
- (b) Is engaged primarily in providing Inpatient medical care and treatment to injured or sick individuals with medical and major surgical facilities on its premises;
- (c) Is supervised by a staff of Physicians and has 24-hour-a-day Registered Nursing services;

- (d) Is accredited by the Joint Commission on Accreditation of Healthcare Organizations or the American Osteopathic Association; and
- (e) Is not primarily a rest home, home for the aged, Skilled Nursing Facility, clinic, school, or Custodial Care facility.

"Hospital" includes any psychiatric hospital that would qualify under the above except that it lacks major surgical facilities and any Chemical Dependency Treatment Facility.

**Section 16.41 Infertility** means the failure to become pregnant after 12 months of unprotected intercourse. (Inability to carry the fetus to term is not considered Infertility.)

**Section 16.42 Inhalation Therapy** means the introduction of dry or moist gases into the lungs for treatment purposes.

**Section 16.43 Injury** means bodily harm sustained by a Covered Person as a result of a sudden and unforeseen event, and necessitating treatment by a Physician.

**Section 16.44 Inpatient** means services provided during confinement to a Hospital, Skilled Nursing Facility or Chemical Dependency Treatment Facility for 23 or more hours or for which a room and board charge is made.

**Section 16.45 Intensive Outpatient Treatment** means treatment of a Mental or Nervous Disorder or Chemical Dependency for 3 or more hours per day, but for which no room and board charge is made.

**Section 16.46 Late Enrollee** means an individual who declined coverage under the Plan when the person was first eligible for coverage, and who does not qualify as a special enrollee.

**Section 16.47 Licensed Practical Nurse** means a graduate practical nurse whose qualifications have been examined by the State Board of Nursing and who is legally authorized to practice as a licensed nurse.

**Section 16.48 Maintenance Care** means treatment intended to maintain, rather than improve, the patient's functional condition.

**Section 16.49 Medically Necessary** means any confinement, treatment, or service that is prescribed by a Physician and which is:

- (a) Consistent with the standards of good medical practice which are generally accepted by the medical-scientific community in the United States of America;
- (b) Consistent with the symptoms or diagnosis of the condition for which services or supplies are rendered;
- (c) Not provided solely for the convenience of the patient or provider; and
- (d) Necessary for the diagnosis or correction of a condition which is threatening to the life, health, or physical well being of the Covered Person, or the source of significant physical discomfort.

**Section 16.50 Medicare** means the programs established by Title I of Public Law 89-97, entitled "Health Insurance for the Aged Act," as amended, which includes Part A, Part B, and Part C.

**Section 16.51 Medicare Retiree** means an individual who has retired from the Employer, was a Covered Person under the Plan on his retirement date, and who is covered by Medicare.

**Section 16.52 Mental or Nervous Disorder** means a mental, emotional, or nervous disease or disorder, including Chemical Dependency, as described in categories 290 through 319 of the International Classification of Diseases, U.S. Department of Health and Human Services.

**Section 16.53 Morbidly Obese** means:

- (a) A weight of at least two (2) times the ideal weight for frame, age, height, and gender; or
- (b) A body mass index of at least 36 kilograms per meter squared, with comorbidity or coexisting medical conditions supporting medical necessity.

**Section 16.54 Non-Preferred Provider or Non-PPO** means a provider of a service or supply who has not been contracted by the Employer or the Plan to provide services or supplies to Covered Persons at an agreed cost.

**Section 16.55 Occupational Therapy** means the use of home and work-related skills through the device of practical projects to develop or restore an individual's ability to perform daily tasks.

**Section 16.56 Organ and Tissue Transplant** means the surgical transfer from one person to another of the kidney, heart, lung(s), heart and lung(s), liver, intestine or pancreas, or the surgical transfer from one person to another or from the patient to himself of bone marrow.

**Section 16.57 Orthoptic/Vision Therapy** means therapy to:

- (a) Encourage the eyes to work together simultaneously, equally and accurately, as a coordinated team; or
- (b) Improve visual skills, such as stereopsis, binocular coordination, binocular fusion, focusing, depth perception, visual memory, or visual motor integration.

**Section 16.58 Orthotic Appliance** means an appliance which is customized for the patient and designed to alleviate, correct, or accommodate a foot problem or mechanically control the foot.

**Section 16.59 Out-of-Pocket Charges** means Covered Charges not paid by the Plan due to the Co-Benefit and Deductible amounts. Charges covered under the Prescription Drug Vendor Benefit, and any penalty assessed for failure to comply with utilization review requirements will not be applied to the out-of-pocket maximum. Once the out-of-pocket maximum has been reached, the Plan will pay 100% of Covered Charges for the rest of the Benefit Year, unless otherwise specified, but never more than the applicable maximum specified in Section 2.

**Section 16.60 Outpatient** means services provided during confinement to a Hospital, Ambulatory Surgical Facility, or Chemical Dependency Treatment Facility of less than 23 hours and for which no room and board charge is made.

**Section 16.61 Participant** means:

- (a) An hourly Employee of the Earlham College or Earlham School of Religion who has elected to participate in this Plan;
- (b) A salaried Employee of Earlham College or Earlham School of Religion;
- (c) A Retiree who has elected to participate in this Plan;
- (d) A former Employee whose coverage is continuing under the terms of a severance incentive plan sponsored by an Employer;
- (e) A former Employee or a Retiree whose coverage is continuing under the Continuation of Coverage provisions of the Plan.

**Section 16.62 Physical Therapy** means the use of physical agents (such as massage, exercise, electricity, water, heat, cold, and infrared) to strengthen weak muscles, increase range of motion, improve coordination and endurance, decrease pain, reduce spasticity, decrease swelling, or otherwise improve functionality.

**Section 16.63 Physician** means a person who is a licensed medical doctor or osteopath, while acting within the scope of his license.

**Section 16.64 Plan** means Earlham College Group Medical Benefit Plan, as amended from time to time.

**Section 16.65 Plan Administrator** means the person designated by the Employer from time to time to administer the Plan. The Plan Administrator is the Company.

**Section 16.66 Plan Supervisor** means the firm designated by the Plan Administrator to provide claims administration services in connection with the operation of the Plan. The Plan Supervisor is Meritain Health.

**Section 16.67 PPO Service Area** means the area described in the applicable PPO Network booklet.

**Section 16.68 Preferred Provider or PPO** means a provider of a service or supply who has been contracted by the Employer or the Plan to provide services or supplies to Covered

Persons at an agreed cost and any provider who has been subcontracted by the PPO network to provide certain services.

**Section 16.69 Primary Care Physician** means a family physician, general practitioner, general internist, pediatrician or osteopath. An Urgent Care Center also is considered a Primary Care Physician.

**Section 16.70 Prosthetic Device** means a customized device which replaces an impaired or absent body part, or which performs a necessary bodily function.

**Section 16.71 Provider** means:

- (a) A Physician;
- (b) Any of the following, while acting within the scope of his license, if licensed or certified by the state in which the services were performed:
  - (1) Chiropractor;
  - (2) Dentist;
  - (3) Licensed Practical Nurse;
  - (4) Optometrist;
  - (5) Physical or Occupational Therapist;
  - (6) Podiatrist or Chiropodist;
  - (7) Psychologist, or a Health Service Provider in Psychology;
  - (8) Registered Nurse including an advanced practice nurse such as a certified nurse-anesthetist and a nurse-midwife;
  - (9) Physician's assistant;
  - (10) Social worker (including an individual who holds a Masters or PhD in social work);
  - (11) Mental health practitioner acting under the supervision of a Physician or a psychologist;
  - (12) Speech therapist or speech pathologist;
  - (13) Inhalation therapist; or
  - (14) Acupuncturist.

**Section 16.72 Qualified Medical Child Support Order or QMCSO** means a judgment, decree or order (including approval of a settlement agreement) issued by a court of competent jurisdiction or through an administrative process established under state law which has the force and effect of law under applicable state law:

- (a) Which provides for child support with respect to a child of the Participant or provides for health benefit coverage for such child, is made pursuant to a state domestic relations order, and relates to benefits under the Plan, or enforces a law relating to medical child support described in Section 1908 of the Social Security Act, with respect to the Plan; and
- (b) Which creates or recognizes the right of a child of the Participant to enroll in and receive benefits under the Plan; and
- (c) Which contains the following information:
  - (1) the name and the last known mailing address (if any) of the Participant and the name and mailing address of each child covered by the order, except that, to the extent provided by the order, the name and mailing address of an official of a state or political subdivision thereof may be substituted for the mailing address of the child;
  - (2) a reasonable description of the type of coverage to be provided by the plan to each such child, or the manner in which such type of coverage is to be determined; and
  - (3) the period to which such order applies; and
- (d) Which does not require the Plan to provide any type or form of benefit, or any option, not otherwise provided under the Plan, except to the extent necessary to meet the requirements of a law relating to medical child support described in Section 1908 of the Social Security Act.

A properly completed National Medical Support Notice is considered a Qualified Medical Child Support Order.

**Section 16.73 Reasonable and Customary Charge** means the amount that most Physicians or other health care providers charge for providing the same or similar treatment, service, or supplies to a person in similar health in the cost area (or a comparable cost area) where the treatment, service, or supply is provided.

**Section 16.74 Registered Nurse** means a graduate nurse registered and licensed to provide skilled nursing care by the State Board of Nurse Examiners or other state authority.

**Section 16.75 Retiree** means a Medicare Retiree or an Early Retiree.

**Section 16.76 Routine Care** means physician's services and related laboratory work, EKG's, and other screening tests performed for preventive purposes, and in the absence of any specific symptoms or diagnosis.

**Section 16.77 Sickness** means disease or illness sustained by a Covered Person requiring treatment by a Physician while covered by this Plan. Sickness includes Mental or Nervous Disorders. Sickness also includes pregnancy, childbirth and miscarriage of any Covered Person.

**Section 16.78 Significant Break in Coverage** means a period of 63 consecutive days during all of which the individual has no Creditable Coverage; neither an eligibility waiting period or an affiliation period will be considered in determining whether a Significant Break in Coverage has occurred.

In addition, for an individual who elects COBRA continuation coverage during the second election period provided under the Trade Act of 2002, the days between the date the individual lost group health plan coverage and the first day of the second COBRA election period are not taken into account in determining whether a Significant Break in Coverage has occurred.

**Section 16.79 Skilled Nursing Facility** means an institution, or distinct part thereof, which:

- (a) Is legally operated as a convalescent hospital, extended care facility, long term care facility, skilled nursing facility, or intermediate care facility in the state in which it is located;
- (b) Is supervised on a full-time basis by a Physician or Registered Nurse;
- (c) Is primarily engaged in providing for compensation inpatient skilled nursing care on its premises;
- (d) Maintains a daily medical record and is equipped to dispense and administer drugs;
- (e) Provides 24-hour nursing care by or under the supervision of a Registered Nurse; and
- (f) Is not primarily a home for the aged, a rest home, or a Custodial Care facility.

**Section 16.80 Speech Therapy** means remediation to disorders of articulation, language or voice resulting from Sickness, Injury, medical processes or congenital anomalies.

**Section 16.81 Surgery** means entering any bodily orifice, whether the orifice is natural or the result of a cutting procedure. Surgery includes, but is not limited to, use of specialized instrumentations, endoscopic examinations and other invasive procedures, and the correction of fractures and dislocations, including pre-operative and postoperative care. Obstetrical services are considered Surgery.

**Section 16.82 Temporomandibular Joint (TMJ) Disorder** means Temporomandibular Joint Syndrome and craniomandibular disorders, or any other condition of the joints linking the jawbone and skull, including the complex of muscles, nerves, and other tissues related to that joint.

**Section 16.83 Urgent (Convenient) Care Center** means an institution, or a distinct part thereof, which:

- (a) Is legally operated as such in the state in which it is located;
- (b) Is engaged primarily in providing Outpatient medical care and treatment to individuals suffering from acute sicknesses or injuries; and
- (c) Has a Physician and Registered Nurse on the premises at all times.



## **Section 17**

### **Other Information**

**Group Number**

375-7

**Plan Sponsor/Plan Administrator, Address and Phone Number**

Earlham College  
801 National Road West  
Richmond, IN 47374-4095  
(765) 983-1628

**ERISA Plan Information Number**

503

**Employer Identification Number of Plan Sponsor**

35-0868073

**Participating Employer**

Earlham School of Religion

**Agent for Service of Process**

Plan Administrator

**Type of Administration**

Contract

**Type of Plan**

Group Health (Medical and Prescription Drug)

**Plan Fiscal Year**

The Plan's fiscal year ends each June 30