
**PLAN DOCUMENT AND
SUMMARY PLAN DESCRIPTION
FOR**

JUNIATA COLLEGE EMPLOYEE BENEFIT PLAN

SPD Restated: June 1, 2012

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INTRODUCTION

This document is a description of Juniata College Employee Benefit Plan (the Plan). No oral interpretations can change this Plan. The Plan described is designed to protect Plan Participants against certain catastrophic health expenses.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Claim Provisions. Explains the rules for filing Claims and the Claim Appeal process.

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

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

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

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

LEGISLATIVE NOTICES

IMPORTANT NOTICE FOR MASTECTOMY PATIENTS

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

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

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

Preauthorization is required.

NOTICE OF GRANDFATHERED HEALTH PLAN STATUS

This Employer Sponsored Health Plan believes this Plan is a “grandfathered health plan” under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that Your Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of Lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Administrator. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

NOTICE FOR MEDICARE ELIGIBLE PARTICIPANTS

Important Notice About Your Prescription Drug Coverage and Medicare

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

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

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

When Can You Join A Medicare Drug Plan

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

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

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

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

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

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

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

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

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

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

For More Information About Your Options Under Medicare Prescription Drug Coverage

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

For more information about the Medicare Prescription Drug coverage:

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

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

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

SCHEDULE OF BENEFITS

Verification of Eligibility: 1-800-252-5742

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

MEDICAL BENEFITS

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

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

HealthAmerica
P.O. Box 67103
Harrisburg, PA 17106-7103
1-800-252-5742
www.healthamerica.cvty.com

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

If the Plan generally requires or allows the designation of a primary care Provider, a Covered Person has the right to designate any primary care Provider who is a Participating Provider and who is available to accept the Covered Person. For Children, a Covered Person may designate a pediatrician as the primary care Provider if the pediatrician is a Participating Provider and is available to accept the Child as a patient.

The Plan is a Preferred Provider Organization (PPO).

This Plan has entered into an agreement with certain Hospitals, Physicians and other health care Providers, which are called Participating Providers. Because these Participating Providers have agreed to charge reduced fees to persons covered under the Plan, the Plan can afford to reimburse a higher percentage of their fees.

Therefore, when a Covered Person uses a Participating Provider, that Covered Person will receive better benefits from the Plan than when a Non-Participating Provider is used. It is the Covered Person's choice as to which Provider to use.

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

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

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

Additional information about this option will be given to Covered Persons, at no cost, and updated as needed. The most current listing of Network Providers is available online at www.healthamerica.cvty.com.

Please note: Coinsurance and other payments to Network Providers may be based on an approved rate schedule, but a Network Provider's compensation ultimately is determined on the basis of each particular Network Provider's agreement with the Claims Administrator and may be an amount less than the approved rate. The Claims

Administrator may receive a retrospective discount or rebate from a Network Provider or vendor related to the volume of services, supplies, equipment or pharmaceuticals purchased by persons enrolled in health care plans offered or administered by the Claims Administrator and its affiliates. Neither the Plan nor the Covered Person shall share in such retrospective volume-based discounts or rebates, except as provided for under the context of the fees the Plan pays to the Claims Administrator for its services.

Deductibles/Copayments payable by Plan Participants

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

A Deductible is an amount of money that is paid once a Benefit Year per Covered Person. Typically, there is one Deductible amount per Plan and it must be paid before any money is paid by the Plan for any Covered Charges. Each January 1st, a new Deductible amount is required. Deductibles do not accrue toward the 100% maximum out-of-pocket payment.

A Copayment is the amount of money that is paid each time a particular service is used. Typically, there may be Copayments on some services and other services will not have any Copayments. Copayments do not accrue toward the 100% maximum out-of-pocket payment.

JUNIATA COLLEGE PREMIER PPO PLAN

DEDUCTIBLES AND MAXIMUMS	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
Annual Deductible (per <u>Calendar Year</u>)		
Individual	None	\$300
Family (aggregate)	None	\$600
Out-of-Pocket Maximum (<u>excludes</u> Deductible & Copays)		
Individual	None	\$2,000
Family (aggregate)	None	\$4,000
OUTPATIENT SERVICES	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
Physician Services (for Illness or Injury)		
Primary Care Visit (PCP)	\$10 Copay	20% Allowable Charges (after annual Deductible)
Specialist Visit (SCP)	\$10 Copay	20% Allowable Charges (after annual Deductible)
Preventive Services*		
Gynecological Exam (PCP/SCP)	\$10 Copay	20% Allowable Charges (after annual Deductible)
Routine PAP Test	0%	20% Allowable Charges (after annual Deductible)
Routine Mammograms	0%	20% Allowable Charges (after annual Deductible)
Routine Prostate Exam & PSA Test	0%	20% Allowable Charges (after annual Deductible)
Routine Adult Physical Exam	\$10 Copay	20% Allowable Charges (after annual Deductible)
Routine Pediatric Exam	\$10 Copay	20% Allowable Charges (after annual Deductible)
Well Pediatric Visits	\$10 Copay	20% Allowable Charges (after annual Deductible)
Routine Pediatric Immunizations	\$10 Copay	20% Allowable Charges Deductible Waived
Hearing Exams (<u>under age 18</u>)	0%	20% Allowable Charges (after annual Deductible)
Routine Hearing Aids (\$1,000 Lifetime maximum)	0%	20% Allowable Charges (after annual Deductible)
Routine Colonoscopy Screenings***	0%	20% Allowable Charges (after annual Deductible)
Foreign Travel Immunizations	0%	20% Allowable Charges (after annual Deductible)
Allergy Testing & Allergy Serum	0%	20% Allowable Charges (after annual Deductible)
Chemotherapy, Radiation, Infusion Therapy, Dialysis	0%	20% Allowable Charges (after annual Deductible)
Chiropractic Care (x-rays are subject to Deductible) (maximum 25 visits , per Calendar Year)	\$10 Copay (per visit)	20% Allowable Charges (after annual Deductible)
Podiatric Care	\$10 Copay (per visit)	20% Allowable Charges (after annual Deductible)
Outpatient Surgery	\$10 Copay (per procedure)	20% Allowable Charges (after annual Deductible)
Lab Services	0%	20% Allowable Charges (after annual Deductible)
Diagnostic X-ray	0%	20% Allowable Charges (after annual Deductible)

Radiology (CAT, MRI, Ultrasound, PET)	0%	20% Allowable Charges (after annual Deductible)
HOSPITAL SERVICES	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
Hospital Care	\$25 Copay (per admission)	
Semi-private room (private room if <u>Medically Necessary</u>)	0%	20% Allowable Charges (after annual Deductible)
Physician and Surgeon Fees	0%	20% Allowable Charges (after annual Deductible)
Surgery	0%	20% Allowable Charges (after annual Deductible)
Lab and X-ray services	0%	20% Allowable Charges (after annual Deductible)
All Medically Necessary Ancillary Services	0%	20% Allowable Charges (after annual Deductible)
Anesthesia	0%	20% Allowable Charges (after annual Deductible)
Administration of Blood	0%	20% Allowable Charges (after annual Deductible)
Blood Products	0%	20% Allowable Charges (after annual Deductible)
Therapy Services (Chemotherapy & Radiation Therapy)	0%	20% Allowable Charges (after annual Deductible)
MATERNITY SERVICES	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
Pregnancy Care (PCP or SCP) (Copay for the first office visit ONLY)	\$10 Copay	20% Allowable Charges (after annual Deductible)
Delivery	0%	20% Allowable Charges (after annual Deductible)
FAMILY PLANNING	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
Infertility Counseling/Testing/Services (<u>excludes</u> artificial insemination)	0%	20% Allowable Charges (after annual Deductible)
Tubal Ligation/Vasectomy	0%	20% Allowable Charges (after annual Deductible)
PRESCRIPTION DRUGS	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
(Includes oral contraceptives & Rx" Freedom" Formulary)	Rx "Freedom" Formulary provisions <u>apply</u>.	
Restrictive Generic Substitution	<u>DEDUCTIBLE: \$50 – Brand ONLY</u> (per person/per Calendar Year)	
▪ 90-day supply of Plan-approved 'Maintenance Medications' available at network retail pharmacies ▪	<u>RETAIL: \$3.00 'Select' Generics/ \$10 Generic/ 10%</u> (min. \$20 - max. \$100 Copay) <u>Brand Name/10%</u> (min. \$40 Copay - max. \$100 Copay)	
Tier 1A & Tier 1 generics ONLY!	Non-Formulary <u>MAIL ORDER: \$6.00 'Select' Generics/\$20 Generic/ \$40 Brand Name/ \$80 Non-Formulary</u>	
	Over-the-Counter Medications (approved medications with a doctor's prescription)	
	COVERED ONLY AT PARTICIPATING PHARMACIES (Refer to our website @ www.healthamerica.cvty.com)	

EMERGENCY CARE		
	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
Urgent Care Center	\$10 Copay (per visit)	
Non-Emergency Visit to ER	\$25 Copay (per visit)	20% Allowable Charges (after annual Deductible)
Emergency Room Services (not subject to Deductible)	\$25 Copay (waived if admitted)	
Ambulance Services	0% (Medically Necessary)	
REHABILITATION SERVICES		
	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
Occupational, Speech, Physical Therapy Outpatient	\$10 Copay (per visit) (60 Outpatient visits, per type, per Calendar Year)	20% Allowable Charges (after annual Deductible)
Inpatient	\$25 Copay (per admission) (45 Inpatient days, per Calendar Year)	20% Allowable Charges (after annual Deductible)
MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES		
	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
General Mental Health:	(Inpatient Mental Health services must be Preauthorized)	
Inpatient	\$25 Copay (per admission)	20% Allowable Charges (after annual Deductible)
Physician Services (Outpatient)	\$10 Copay (per visit)	20% Allowable Charges (after annual Deductible)
Serious Mental Health:		
Inpatient	\$25 Copay (per admission)	20% Allowable Charges (after annual Deductible)
Physician Services (Outpatient)	\$10 Copay (per visit)	20% Allowable Charges (after annual Deductible)
Substance Abuse:		
Inpatient Detoxification	\$25 Copay (per admission)	20% Allowable Charges (after annual Deductible)
Inpatient Rehabilitation	\$25 Copay (per admission)	20% Allowable Charges (after annual Deductible)
Transitional Partial hospitalization	\$10 Copay (per visit)	20% Allowable Charges (after annual Deductible)
OTHER BENEFITS		
	Participating MEMBER RESPONSIBILITY	Non-Participating MEMBER RESPONSIBILITY
Claim Forms Required	No	Yes
Durable Medical Equipment (DME) – (repair & replacement when Medically Necessary & due to normal use or change in condition)	0%	20% Allowable Charges (after annual Deductible)
Corrective Appliances	0%	20% Allowable Charges (after annual Deductible)
Orthotic Devices (excludes shoes/corrective shoes unless integral part of brace)	0%	20% Allowable Charges (after annual Deductible)
Home Health Care Services (includes home health aide services)	0% (120 visits, per Calendar Year) (120 visits combined, per Calendar Year)	20% Allowable Charges (after annual Deductible) (60 visits, per Calendar Year)
Hospice Care	0%	20% Allowable Charges (after annual Deductible)
Private Duty Nursing	0%	20% Allowable Charges (after annual Deductible)
Skilled Nursing Facility	\$25 Copay (per admission) (90 days combined maximum; per Calendar Year)	20% Allowable Charges (after annual Deductible)

Dental Services		
Repair due to Injury (must begin within <u>365 days</u> of date of Injury)	0%	20% Allowable Charges (after annual Deductible)
Removal of third molars	0%	20% Allowable Charges (after annual Deductible)
Vision Services	Vision One Eyecare Program®: Receive immediate savings on all eyecare needs--discounts on frames, lenses, and even LASIK surgery--at Participating Providers through the EyeMed Vision Care network.	
Health Education	Members receive reimbursement of the cost of approved wellness programs offered through local Hospitals and organizations.**	
PREAUTHORIZATION REQUIREMENT	By Physician	By Patient
When using a Non-Participating Provider, the member must obtain Preauthorization of non-emergency Hospital and other facility (e.g., Skilled Nursing Facilities, rehabilitation facilities, drug and alcohol treatment facilities) admissions, Outpatient surgery and certain other services as stated in the Summary Plan Description. If these services or admissions are not Preauthorized and the service is not Medically Necessary, the member may be responsible for 100% of the cost of the services.		
LIFETIME MAXIMUM	UNLIMITED	
Autism Spectrum Disorders	(\$36,000 Calendar Year maximum)	
<p>Autism Spectrum Disorders are covered pursuant to state mandates for groups with 51 or more Employees. This is not a contract. It is intended solely to provide You with an overview of the Plan. Complete details of benefits, terms and exclusions are governed by Your Summary Plan Document. This managed care plan may not cover all Your health care expenses. Read Your Summary Plan Document carefully to determine which health care services are covered. If You have questions call us at 800.788.8445 in Central/Eastern Pennsylvania. Benefits are administered on a Calendar Year basis. Coinsurance is based on Allowable Charges as defined in Your Summary Plan Document. For Non-Participating Providers, Allowable Charges are based on the lesser of the Provider's billed charges or our Out-of-Network Rate, which is defined in Your Summary Plan Document. In addition to Your Copay or Coinsurance, You are responsible for paying Non-Participating Providers the difference between our Out-of-Network rate and their actual charge for non-Emergency Services. Your out-of-pocket costs for non-emergency care from Non-Participating Providers may be substantial. Dependent coverage age limit is 26. *** The Physician must bill the Claim with a preventive diagnosis code in order to apply under preventive benefits coverage. **Reimbursement for Weight Management programs is limited to \$350 per Calendar Year, per member.</p>		

***Non-Participating Providers –Maximum Allowable Charge**

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

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

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

1. For non facility Claims, the lesser of the Non-Participating Provider's billed charges or the current (updated no later than April 1 of each year) Medicare rate, as set forth below. If there is no corresponding Medicare rate for the particular service, the Claim Administrator's Mental Disorders and Substance Abuse vendor shall pay the average amount the Mental Disorders and Substance Abuse vendor pays its Participating Providers for the same service(s). The Out-of-Network Rate (ONR) under Your Plan is 100% of the regionally adjusted Medicare rate based on the Non-Participating Provider's location.
2. For all other Claims, the lesser of the Non-Participating Provider's billed charges or the average amount the Mental Disorders and Substance Abuse vendor pays its Participating Providers for the same service(s). In addition to Your Copay or Coinsurance, You are responsible for paying Non-Participating Providers the difference between the Out-of-Network Rate and their actual charge for non-emergency services. **Your Out-of-Pocket costs for non-emergency care from Non-Participating Providers may be substantial.**

ELIGIBILITY, FUNDING, EFFECTIVE DATE AND TERMINATION PROVISIONS

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

ELIGIBILITY

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

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

- (1) is a Full-Time, Active Employee of the Employer. An Employee is considered to be Full-Time if he or she normally works at least 32 hours per week and is on the regular payroll of the Employer for that work. This does not include temporary or seasonal Employees.
- (2) is a Retired Employee of the Employer. Retired Employees may continue coverage up to age 65 by paying the applicable contribution for Employee and/or Dependent coverage. While the Employer expects Retiree coverage to continue, the Employer reserves the right to modify or discontinue Retiree coverage or any other provision of the Plan at any time.
- (3) is in a class eligible for coverage.
- (4) completes the employment Waiting Period as an Active Employee. A "Waiting Period" is the time between the first day of employment as an eligible Employee and the first day of coverage under the Plan. Eligible Employees are covered under the Plan on the first day of the month. If the Employee is hired on the first of the calendar month the Employee will be eligible on their date of hire. If the Employee is hired on any other date, they will be eligible on the first day of the following calendar month.

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

- (1) A covered Employee's Spouse.

The term "Spouse" shall mean the person recognized as the covered Employee's husband or wife under the laws of the state where the covered Employee lives or was married, and shall include common law marriages. The term "Spouse" shall include partners of the same sex who were legally married under the laws of the State in which they were married. The Plan Administrator may require documentation proving a legal marital relationship.

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

Domestic Partners, meeting the eligibility requirements of the Plan, are also considered eligible Dependents. The Plan Administrator may require documentation proving a legal marital relationship.

The term "Domestic Partner" is defined as a person of the same or opposite sex who:

- shares Your permanent address;
- has resided with You for no less than one year;
- is no less than 18 years of age;
- is financially interdependent with You and has proven such interdependence by providing documentation of at least two of the following arrangements: common ownership of real property or a common leasehold interest in such property; community ownership of a motor vehicle; a joint bank account or a joint credit account; designation as a beneficiary for life insurance or retirement benefits or under Your partner's will; assignment of a durable power of attorney or health care power of attorney; or such other proof as is considered by the Employer to be sufficient to establish financial interdependency under the circumstance of Your particular case;

- is not a blood relative any closer than would prohibit legal marriage; and
- has signed jointly with You, a notarized affidavit which can be made available to the Employer upon request.

In addition, You and Your Domestic Partner will be considered to have met the term of this definition as long as neither You nor Your Domestic Partner:

- has signed a Domestic Partner affidavit or declaration with any other person within twelve months prior to designating each other as Domestic Partners hereunder;
- is currently legally married to another person; or
- has any other Domestic Partner, Spouse or Spouse equivalent of the same or opposite sex.

You and Your Domestic Partner must have registered as Domestic Partners, if You reside in a state that provides for such registration. The section entitled "Continuation of Coverage under COBRA" will apply to Your Domestic Partner and his or her Dependents.

An Employee must file an Affidavit of Domestic Partnership for coverage hereunder for his or her eligible Domestic Partner. Employees should contact their Human Resources Department for additional information regarding completion of an Affidavit of Domestic Partnership.

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

An Employee's "Child" includes his natural Child, stepchild, adopted Child, a Child for whom the Employee is a Legal Guardian, or a Child placed with the Employee for adoption. An Employee's Child will be an eligible Dependent until reaching the limiting age of 26, without regard to student status, marital status, financial dependency or residency status with the Employee or any other person. When the Child reaches the applicable limiting age, coverage will end on the last day of the Child's birth month.

Stepchildren and Children of a Domestic Partner may be included as long as a natural parent remains married to the Employee.

However, for Plan Years beginning before January 1, 2014, an Employee's Child is not an eligible Child if the Child is eligible to enroll in an Employer-sponsored health plan other than the group health plan of a parent of the Child.

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

(3) A covered Employee's Qualified Dependents.

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

When a Qualified Dependent reaches the applicable limiting age, coverage will end the last day of the Qualified Dependent's birth month.

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

The Plan Administrator reserves the right to have such Dependent examined by a Physician of the Plan Administrator's choice, at the Plan's expense, to determine the existence of such incapacity.

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

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

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

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

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

FUNDING

Cost of the Plan. Juniata College shares the cost of Employee and Dependent coverage under this Plan with the covered Employees. The enrollment application for coverage will include a payroll deduction authorization. This authorization must be completed in a manner set forth by the Plan Administrator.

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

PRE-EXISTING CONDITIONS

There are no Pre-Existing Condition limitations.

A **Pre-Existing Condition** is a condition for which medical advice, diagnosis, care or treatment was recommended or received within six months prior to the person's Enrollment Date under this Plan. Genetic Information is not, by itself, a condition. Treatment includes receiving services and supplies, consultations, diagnostic tests or prescribed medicines. In order to be taken into account, the medical advice, diagnosis, care or treatment must have been recommended by, or received from, a Physician.

ENROLLMENT

Genetic Information Nondiscrimination Act of 2008 Genetic. In compliance with the Genetic Information Nondiscrimination Act of 2008, effective **January 1, 2010**, the Plan does not request, require, purchase or consider Genetic Information in connection with enrollment.

The term "Genetic Information" includes:

- genetic tests of a Participant;
- genetic tests of the Participant's family members;
- any request for or receipt of genetic services or participation in clinical research which includes genetic services by a Participant or a family member;
- the manifestation of a disease or disorder in family members of the Participant;
- the Genetic Information of the fetus carried by a pregnant woman; or
- with respect to a Participant or family member utilizing assisted reproductive technology, the Genetic Information of any embryo legally held by the Participant or family member.

The term "genetic test" means an analysis of human DNA, RNA, chromosomes, proteins, or metabolites that detects genotypes, mutations, or chromosomal changes. "Genetic test" does not include an analysis of proteins or metabolites that does not detect genotypes, mutations, or chromosomal changes, or an analysis of proteins or metabolites is directly

related to a manifested disease, disorder or pathological condition that could reasonably be detected by a health care professional with appropriate training and expertise in the field of medicine involved.

The term "genetic services" means a genetic test, genetic counseling (including obtaining, interpreting or assessing Genetic Information), or genetic education.

Enrollment Requirements. An Employee must enroll for coverage by filling out and signing an enrollment application along with the appropriate payroll deduction authorization within thirty-one (31) days of becoming eligible for coverage. The covered Employee is required to enroll for Dependent coverage within thirty-one (31) days of marriage or the acquiring of Children.

Enrollment Requirements for Newborn Children.

A newborn Child of a covered Employee is automatically covered under this Plan for 31 days. Newborn coverage for the first 31 days excludes grandchildren. Charges for covered nursery and routine Physician care during the first 31 days will be applied toward the Plan of the covered newborn. If the newborn Child is not enrolled in this Plan on a timely basis, as defined in the section "Timely Enrollment" following this section, there will be no payment from the Plan beyond the first 31 days and the parents will be responsible for all other costs.

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

TIMELY OR LATE ENROLLMENT

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

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

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

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

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

SPECIAL ENROLLMENT RIGHTS

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

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

The Special Enrollment rules are described in more detail below. To request Special Enrollment or obtain more detailed information of these portability provisions, contact the Plan Administrator, Juniata College, 1700 Moore Street, Huntingdon, Pennsylvania, 16652-2196, 814-641-3197.

SPECIAL ENROLLMENT PERIODS

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

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

 - (a)** The Employee or Dependent was covered under a group health plan or had health insurance coverage at the time coverage under this Plan was previously offered to the individual.
 - (b)** If required by the Plan Administrator, the Employee stated in writing at the time that coverage was offered that the other health coverage was the reason for declining enrollment.
 - (c)** The coverage of the Employee or Dependent who had lost the coverage was under COBRA and the COBRA coverage was exhausted, or was not under COBRA and either the coverage was terminated as a result of loss of eligibility for the coverage or because Employer contributions towards the coverage were terminated. Coverage will begin no later than the first day of the first calendar month following the date the completed enrollment form, or its equivalent, is received.
 - (d)** The Employee or Dependent requests enrollment in this Plan not later than thirty-one (31) days after the date of exhaustion of COBRA coverage or the termination of non-COBRA coverage due to loss of eligibility or termination of Employer contributions, described above. Coverage will begin no later than the first day of the first calendar month following the date the completed enrollment form, or its equivalent, is received.
- (2)** For purposes of these rules, a loss of eligibility occurs if one of the following occurs:

 - (a)** The Employee or Dependent has a loss of eligibility on the earliest date a Claim is denied that would meet or exceed a Lifetime limit on all benefits. This provision shall no longer apply for Plan Years starting after September 22, 2010.
 - (b)** The Employee or Dependent has a loss of eligibility due to the plan no longer offering any benefits to a class of similarly situated individuals (i.e.: part-time Employees).
 - (c)** The Employee or Dependent has a loss of eligibility as a result of legal separation, divorce, cessation of Dependent status (such as attaining the maximum age to be eligible as a Dependent Child under the plan), death, termination of employment, or reduction in the number of hours of employment or contributions towards the coverage were terminated.
 - (d)** The Employee or Dependent has a loss of eligibility when coverage is offered through an HMO, or other arrangement, in the individual market that does not provide benefits to individuals who no longer reside, live or work in a service area, (whether or not within the choice of the individual).
 - (e)** The Employee or Dependent has a loss of eligibility when coverage is offered through an HMO, or other arrangement, in the group market that does not provide benefits to individuals who no longer reside, live or work in a service area, (whether or not within the choice of the individual), and no other benefit package is available to the individual.

If the Employee or Dependent lost the other coverage as a result of the individual's failure to pay premiums or required contributions or for cause (such as making a fraudulent Claim or an intentional misrepresentation of a material fact in connection with the plan), that individual does not have a Special Enrollment right.

The addition of coverage for a Domestic Partner or Children of a Domestic Partner shall not constitute a Special Enrollment under this provision.

(3) Dependent beneficiaries. If:

- (a)** The Employee is a Participant under this Plan (or has met the Waiting Period applicable to becoming a Participant under this Plan and is eligible to be enrolled under this Plan but for a failure to enroll during a previous Enrollment Period), and
- (b)** A person becomes a Dependent of the Employee through marriage, registration of Domestic Partnership, birth, adoption or placement for adoption,

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

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

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

- (a)** in the case of marriage, the date of marriage when a completed request for enrollment is received; or
- (b)** in the case of a Dependent's birth, as of the date of birth; or
- (c)** in the case of a Dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.

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

- (a) Termination of Medicaid or SCHIP Coverage.** The eligible Employee or Dependent may enroll if the eligible Employee or Dependent is covered under a Medicaid plan under Title XIX of the Social Security Act, or under the State Children's Health Insurance Program ("SCHIP") under Title XXI of the Social Security Act, and coverage of the eligible Employee or Dependent under either the Medicaid or SCHIP plan is terminated as a result of loss of eligibility under such plan.
- (b) Eligibility for Premium Assistance Under Medicaid or SCHIP.** The eligible Employee or Dependent may enroll if the eligible Employee or Dependent becomes eligible for premium or other assistance with respect to coverage under this Plan, pursuant to a Medicaid plan or SCHIP plan (including any waiver or demonstration product conducted under or related to such Medicaid or SCHIP plan).

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

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

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

ENROLLMENT OF DEPENDENT PURSUANT TO A QUALIFIED MEDICAL CHILD SUPPORT ORDER

If the Plan Administrator receives a Qualified Medical Child Support Order (QMCSO), as determined by the Plan Administrator, for an eligible Dependent, the effective date shall be the later of (a) the date of the QMCSO, or (b) thirty (30) days prior to the date the QMCSO was received by the Plan Administrator. If the Employee is not enrolled in the Plan, the Plan Administrator shall enroll the Employee as of the same effective date as the eligible Dependent and the Employee shall be responsible for any required Employee contributions.

EFFECTIVE DATE

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

- (1) The Eligibility Requirement.
- (2) The Active Employee Requirement.
- (3) The Enrollment Requirements of the Plan.

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

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

TERMINATION OF COVERAGE

When coverage under this Plan stops, Plan Participants will receive a certificate that will show the period of Creditable Coverage under this Plan. The Plan maintains written procedures that explain how to request this certificate.

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

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

- (1) The date the Plan is terminated.
- (2) The last day of the calendar month in which the covered Employee ceases to be in one of the eligible classes. This includes death or termination of Active Employment of the covered Employee. (See the section entitled Continuation Coverage Rights under COBRA.) It also includes an Employee on disability, leave of absence or other leave of absence, unless the Plan specifically provides for continuation during these periods.
- (3) The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due.

- (4) If an Employee commits fraud or makes an intentional misrepresentation of material fact in applying for or obtaining coverage, or obtaining benefits under the Plan, then the Employer or Plan may either void coverage for the Employee and covered Dependents for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage. If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the Plan will provide at least 30 days' advance written notice of such action
- (5) If an Employee misuses the Plan Identification Card or allows persons other than the one specifically named on the ID card to attempt to obtain benefits, then coverage will be terminated for the Employee and covered Dependents upon thirty (30) days written notice from the Plan.
- (6) If a Network Provider, after Plan's reasonable efforts to provide this opportunity to the Employee, is unable to establish and maintain a satisfactory Provider-patient relationship with an Employee, Plan may terminate the coverage of the Employee and all other family members covered on that same policy. This can be done with thirty (30) days written notice to the Employee. Repeatedly seeking and receiving services that are not Medically Necessary as determined by the Plan and the Provider in question shall also be considered the inability to establish and maintain a satisfactory Provider-patient relationship.

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

For disability leave or layoff only: Coverage may be continued for a limited time, contingent upon payment of any required contributions for employees and/or dependents, when the employee is on an authorized leave of absence from the employer.

For leave of absence with pay: Coverage may be continued for a limited time, contingent upon payment of any required contributions for Employees and/or Dependents, when the Employee is on an authorized leave of absence from the Employer.

For leave of absence without pay: Coverage is not continued unless in case of qualified FMLA, workers comp or disability.

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

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

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

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

Dependent Continuation for Retirees Reaching Age 65

Medical care coverage for all Dependents which is in force at the time of the Retiree's loss of coverage due to reaching age 65, will continue until the earliest of the following dates:

- (1) The date the Employer terminates the Plan and offers no other group health plan.
- (2) The last day of the month in which the Dependent ceases to meet the eligibility requirements of the Plan.
- (3) The date the Dependent becomes eligible for Medicare due to age.

- (4) The date the Dependent becomes a full-time, active member of the armed forces of any country.
- (5) The date the Dependent ceases to make any required contributions.

Rehiring a Terminated Employee. A terminated Employee who is rehired will be treated as a new hire and be required to satisfy all Eligibility and Enrollment requirements.

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

- (1) The maximum period of coverage of a person and the person's Dependents under such an election shall be the lesser of:
 - (a) The 24 month period beginning on the date on which the person's absence begins; or
 - (b) The day after the date on which the person was required to apply for or return to a position of employment and fails to do so.
- (2) A person who elects to continue health plan coverage must pay up to 102% of the full contribution under the Plan, except a person on active duty for 30 days or less cannot be required to pay more than the Employee's share, if any, for the coverage.
- (3) An exclusion or Waiting Period may not be imposed in connection with the reinstatement of coverage upon reemployment if one would not have been imposed had coverage not been terminated because of service. However, an exclusion or Waiting Period may be imposed for coverage of any Illness or Injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of uniformed service.

If the Employee wishes to elect this coverage or obtain more detailed information, contact the Plan Administrator Juniata College, 1700 Moore Street, Huntingdon, Pennsylvania, 16652-2196, 814-641-3197. The Employee may also have continuation rights under COBRA. In general, the Employee must meet the same requirements for electing USERRA coverage as are required under COBRA continuation coverage requirements. Coverage elected under these circumstances is concurrent not cumulative. The Employee may elect USERRA continuation coverage for the Employee and their Dependents. Only the Employee has election rights. Dependents do not have any independent right to elect USERRA health plan continuation.

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

- (1) The date the Plan or Dependent coverage under the Plan is terminated.
- (2) The date that the Employee's coverage under the Plan terminates for any reason including death. (See the section entitled Continuation Coverage Rights under COBRA.)
- (3) The date a covered Spouse loses coverage due to loss of eligibility status. (See the section entitled Continuation Coverage Rights under COBRA.)
- (4) Coverage on the last day of the month in which a covered Spouse loses coverage due to loss of dependency status. (See the section entitled Continuation Coverage Rights under COBRA.)
- (5) Coverage will end on the last day of the month in which a person ceases to be a Dependent as defined by the Plan. (See the section entitled Continuation Coverage Rights under COBRA.)

- (6)** The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due.
- (7)** If a Dependent commits fraud or makes an intentional misrepresentation of material fact in applying for or obtaining coverage, or obtaining benefits under the Plan, or fails to notify the Plan Administrator that he or she has become ineligible for coverage, then the Employer or Plan may either void coverage for the Dependent for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage.
- (8)** If a Dependent misuses the Plan Identification Card or allows persons other than the one specifically named on the ID card to attempt to obtain benefits, then coverage will be terminated for the Dependent upon thirty (30) days written notice from the Plan.
- (9)** If a Network Provider, after Plan's reasonable efforts to provide this opportunity to the Dependent, is unable to establish and maintain a satisfactory Provider-patient relationship with a Dependent, Plan may terminate the coverage of Dependent. This can be done with thirty (30) days written notice to the Dependent. Repeatedly seeking and receiving services that are not Medically Necessary as determined by the Plan and the Provider in question shall also be considered the inability to establish and maintain a satisfactory Provider-patient relationship.

OPEN ENROLLMENT

OPEN ENROLLMENT

Open enrollment is the period designated by the Employer during which the Employee may change benefit plans or enroll in the Plan if he did not do so when first eligible or does not qualify for a Special Enrollment Period. An open enrollment will be permitted once in each Calendar Year during the month of November.

During this open enrollment period, an Employee and his Dependents who are covered under this Plan or covered under any employer sponsored health plan may elect coverage or change coverage under this Plan for himself and his eligible Dependents. An Employee must make written application (or electronic, if applicable) as provided by the Employer during the open enrollment period to change benefit plans.

The effective date of coverage as the result of an open enrollment period will be the following January 1st.

Except for a status change listed below, the open enrollment period is the only time an Employee may change benefit options or modify enrollment. Status changes include:

- (1) Change in family status. A change in family status shall include only;
 - a. Change in Employee's legal marital status;
 - b. Change in number of Dependents;
 - c. Termination or commencement of employment by the Employee, Spouse or Dependent;
 - d. Change in work schedule;
 - e. Dependent satisfies (or ceases to satisfy) Dependent eligibility requirements;
 - f. Change in residence or worksite of Employee, Spouse or Dependent.
- (2) Change in the cost of coverage under the Employer's group medical plan.
- (3) Cessation of required contributions.
- (4) Taking or returning from a leave of absence under the Family and Medical Leave Act of 1993.
- (5) Significant change in the health coverage of the Employee or Spouse attributable to the Spouse's employment.
- (6) A Special Enrollment Period as mandated by the Health Insurance Portability and Accountability Act of 1996.
- (7) A court order, judgment or decree.
- (8) Entitlement to Medicare or Medicaid, or enrollment in a state Child health insurance program (CHIP).
- (9) A COBRA qualifying event.

MEDICAL BENEFITS

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

DEDUCTIBLE

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

This amount will not accrue toward the 100% maximum out-of-pocket payment.

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

Deductible Three Month Carryover.

Effective January 1, 2013: Covered Charges incurred in, and applied toward the Deductible in October, November and December will be applied toward the Deductible in the next Calendar Year.

COPAYMENT

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

COINSURANCE

Coinsurance means the percentage stated in the Schedule of Benefits, if any, that You must pay to the In-Network or Out-of-Network Provider. The Plan calculates Coinsurance based on the negotiated rate between the Claims Administrator and the In-Network Provider or the Plan's Out-of-Network Rate, whichever is applicable.

BENEFIT PAYMENT

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

OUT-OF-POCKET LIMIT/MAXIMUM

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

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

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

MAXIMUM BENEFIT AMOUNT

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

COVERED CHARGES

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

- (1) **Hospital Care.** The medical services and supplies furnished by a Hospital or Ambulatory Surgical Center or a Birthing Center. Covered Charges for room and board will be payable as shown in the Schedule of Benefits. After 23 observation hours, a confinement will be considered an Inpatient confinement.

A semi-private room and general nursing care when part of a covered Inpatient stay are covered. A private room is only covered if Medically Necessary or if a semi-private room is not available.

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

- (2) **Coverage of Pregnancy.** Charges for the care and treatment of Pregnancy are covered the same as any other Sickness.

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 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, plans and issuers may not, under Federal law, require that a Provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Pregnancy or Complications of Pregnancy is covered for female Employees, a covered female Spouse and Dependent female Children.

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

- (a) the patient is confined as a bed patient in the facility; and
- (b) the attending Physician certifies that the confinement is needed for further care of the condition that caused the Hospital confinement; and
- (c) the attending Physician completes a treatment plan which includes a diagnosis, the proposed course of treatment and the projected date of discharge from the Skilled Nursing Facility.

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

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

Charges for **multiple surgical procedures** will be a Covered Charge subject to the following provisions:

- (a) If bilateral or multiple surgical procedures are performed by one (1) surgeon, benefits will be determined based on the charge that is allowed for the primary procedures; 50% of the charge will be allowed for each additional procedure performed through the same incision. Any

procedure that would not be an integral part of the primary procedure or is unrelated to the diagnosis will be considered "incidental" and no benefits will be provided for such procedures;

- (b) If multiple unrelated surgical procedures are performed by two (2) or more surgeons on separate operative fields, benefits will be based on the charge for each surgeon's primary procedure. If two (2) or more surgeons perform a procedure that is normally performed by one (1) surgeon, benefits for all surgeons will not exceed the percentage allowed for that procedure; and
- (c) If an assistant surgeon is required, the assistant surgeon's Covered Charge will not exceed 20% of the surgeon's allowance.
- (d) Surgical assistance provided by a Physician or professional Provider if it is determined that the condition of the Covered Person or the type of surgical procedure requires such assistance.
- (e) Surgical treatment. Separate payment will not be made for Inpatient pre-operative or post-operative care normally provided by a surgeon as part of the surgical procedure.
- (f) Consultations requested by the attending Physician during a Hospital confinement. Consultation do not include staff consultations that are required by a Hospital's rules and regulations.

Benefits for a second surgical opinion will be payable as another Sickness if an elective surgical procedure (non-emergency surgery) is recommended by the Physician.

The Physician rendering the second opinion regarding the Medical Necessity of such surgery must be a board certified specialist in the treatment of the Covered Person's Illness or Injury and must not be affiliated in any way with the Physician who will be performing the actual surgery.

In the event of conflicting opinions, a third opinion may be obtained. The Plan will consider payment for a third opinion the same as a second surgical opinion.

- (5) **Private Duty Nursing Care.** The private duty nursing care by a licensed nurse (R.N., L.P.N. or L.V.N.). Covered Charges for this service will be included to this extent:
 - (a) **Inpatient Nursing Care.** Charges are covered only when care is Medically Necessary or not Custodial in nature and the Hospital's Intensive Care Unit is filled or the Hospital has no Intensive Care Unit.
 - (b) **Outpatient Nursing Care.** Charges are covered only when care is Medically Necessary and not Custodial in nature. The only charges covered for Outpatient nursing care are those shown below, under Home Health Care Services and Supplies. Outpatient private duty nursing care on a 24-hour-shift basis is not covered.

Charges for Private Duty Nursing Care are payable as described in the Schedule of Benefits.

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

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

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

Nutritional guidance by a registered dietitian and nutritional supplements such as diet substitutes administered intravenously or through hyperalimentation as determined to be Medically Necessary.

No home health care benefits will be provided for dietitian services (except as may be specifically provided herein), homemaker services, maintenance therapy, dialysis treatment, food or home delivered meals, rental or purchase of Durable Medical Equipment or Prescription or non-Prescription Drugs or biologicals.

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

Covered Charges for Hospice Care Services and Supplies are payable and shall include:

- (a) Confinement in a hospice to include ancillary charges and room and board.
- (b) Services, supplies and treatment provided by a hospice to a Covered Person in a home setting.
- (c) Physician services and/or nursing care by a nurse.
- (d) Physical therapy, occupational therapy, speech therapy or respiratory therapy.
- (e) Nutrition services to include nutritional advice by a registered dietitian, and nutritional supplements such as diet substitutes administered intravenously or through hyperalimentation as determined to be Medically Necessary.
- (f) Counseling services provided through the hospice.
- (g) As described in the Schedule of Benefits.
- (h) Bereavement counseling services by a licensed social worker or a licensed pastoral counselor for the patient's immediate family (covered Spouse and/or other covered Dependents).

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

- (a) **Abortion.** Services, supplies, care or treatment in connection with an abortion are not covered except in the case of rape or incest or when the life of the mother is endangered by continued Pregnancy or when the fetus has a known condition incompatible with life.
- (b) **Alcohol.** Services, supplies, care or treatment to a Covered Person for an Injury or Sickness which occurred as a result of that Covered Person's illegal use of alcohol.
- (c) **Allergy** testing consisting of percutaneous, intracutaneous and patch tests and allergy injections.
- (d) Local Medically Necessary professional land or air **ambulance** service. A charge for this item will be a Covered Charge only if the service is to the nearest Hospital or Skilled Nursing Facility where necessary treatment can be provided unless a longer trip was Medically Necessary.

Ambulance service is covered in a non-emergency situation only to transport the Covered Person to or from a Hospital or between Hospitals for required treatment when such transportation is authorized by the attending Physician as Medically Necessary. Such transportation is covered only from the initial Hospital to the nearest Hospital qualified to render the special treatment.

Emergency Services actually provided by an advance life support unit, even though the unit does not provide transportation.

If the Covered Person is admitted to a Non-Participating Hospital after emergency treatment, ambulance service is covered to transport the Covered Person from the Non-Participating Hospital to a Participating Hospital after the patient's condition has been stabilized, provided such transport is authorized by the attending Physician as Medically Necessary.

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

Furnishing or administering anesthetics, other than local infiltration anesthesia, by other than the surgeon or his assistant. However, benefits will be provided for anesthesia services administered by oral and maxillofacial surgeons when such services are rendered in the surgeon's office.

Blood, when Medically Necessary, including;

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

- (f) Treatment of **Autism Spectrum Disorders** for Dependent Children under age 21. The following terms apply to the Covered Services of Autism Spectrum Disorders.

Diagnostic Assessment shall mean Medically Necessary assessments, evaluations or tests performed by a licensed Physician, licensed Physician assistant, licensed psychologist or certified nurse practitioner to diagnose whether an individual has Autism Spectrum Disorder.

Rehabilitative Care shall mean professional services and treatment programs, including Applied Behavioral Analysis (defined below), provided by an autism service Provider to produce socially significant improvements in human behavior or to prevent loss of attained skill or function.

Applied Behavioral Analysis shall mean the design, implementation and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior or to prevent loss of attained skill or function, including the use of direct observation, measurement and functional analysis of the relations between environment and behavior.

Therapeutic Care shall mean services provided by speech language pathologists, occupational therapists or physical therapists.

Covered Service are subject to the following guidelines:

- All treatment of Autism Spectrum Disorders must be specified in a treatment plan Preauthorized by the Claims Administrator or its designee. The treatment plan must be developed by a licensed Physician or licensed psychologist pursuant to a comprehensive evaluation. The evaluation must be performed in a manner consistent with the most recent clinical report or recommendations of the American Academy of Pediatrics.
- The Claims Administrator may review a treatment plan once every six (6) months to determine compliance with utilization review requirements. A different review schedule for the treatment plan can be established if mutually agreeable to the Claims Administrator and the licensed Physician or licensed psychologist who developed the plan.
- Diagnostic Assessment shall be covered not more often than once every twelve (12) months, unless a licensed Physician or licensed psychologist determines that an earlier assessment is necessary.
- The Covered Services under a treatment plan include any of the following when Medically Necessary and specified in the Covered Person's Preauthorized treatment plan: pharmacy care, psychiatric care, psychological care, rehabilitative care and therapeutic care that is prescribed by an appropriately licensed medical practitioner, provided by an autism service Provider, or provided by a person, entity or group that works under the direction of an autism service Provider.

Covered Services are subject to the benefit maximums shown in the Schedule of Benefits.

- (g) **Birth center.** Covered Charges shall include services, supplies and treatments rendered at a birthing center provided the Physician in charge is acting within the scope of his license and the birthing center meets all legal requirements. Services of a midwife acting within the scope of his license or registration are a Covered Charge provided that the state in which such service is performed has legally recognized midwife delivery.
- (h) **Cardiac rehabilitation** as deemed Medically Necessary provided services are rendered (a) under the supervision of a Physician; (b) in connection with a myocardial infarction, coronary occlusion or coronary bypass surgery; (c) initiated within 12 weeks after other treatment for the medical condition ends; and (d) in a Medical Care Facility as defined by this Plan. Coverage includes Phase I and Phase II. Phase III cardiac rehabilitation services are not covered.
- (i) Radiation or **chemotherapy** and treatment with radioactive substances. The materials and services of technicians are included.
- (j) Initial **contact lenses** or glasses required following cataract surgery.
- (k) **Contraceptives.** Covered Charges shall include charges for medical procedures or supplies related to contraception, including contraceptive devices, contraceptive injections and the surgical implantation and removal of contraceptive devices.

Charges for oral contraceptives (birth control pills) shall be covered under the Prescription Drug Benefits section of this Plan Document.

- (l) **Cosmetic surgery** or reconstructive surgery shall be a Covered Charge provided:
 - (a) A Covered Person receives an Injury as a result of an accident and as a result requires surgery. Cosmetic or reconstructive surgery and treatment must be for the purpose of restoring the Covered Person to his normal function immediately prior to the accident.
 - (b) It is required to correct a congenital anomaly, for example, a birth defect, for a Child.
- (m) **Dental services.** Covered Charges shall include repair of sound natural teeth or surrounding tissue provided it is the result of an Injury. Treatment must begin within three hundred sixty five (365) days of the date of such Injury. Damage to the teeth as a result of chewing or biting shall not be considered an Injury under this benefit.

Oral surgery includes excision of partially or completely unerupted impacted teeth, closed or open reduction of fractures or dislocations of the jaw, and excision of cysts or tumors of the mouth.

Inpatient facility charges for oral surgery or dental treatment that ordinarily could be performed in the Provider's office will be covered only if the Covered Person has a concurrent hazardous medical condition that prohibits performing the treatment safely in a Outpatient setting.

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

Diabetes equipment, supplies, and self-management training and education must comply with the Claims Administrator's Utilization Management policies and procedures.
- (p) **Diabetes treatment** and counseling is covered for in-person Outpatient self-management training and education, including medical nutritional therapy required for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes, and non-insulin using diabetes. This coverage is provided if: (i) prescribed by a Provider legally authorized to prescribe such services under law and (ii) provided by a Provider who is a certified, registered, or licensed health

care professional.

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

- (q) Peritoneal **dialysis** and hemodialysis. Hemodialysis is covered if deemed Medically Necessary and when provided at: (i) an Outpatient or Inpatient facility in an acute general Hospital; (ii) an Outpatient dialysis unit; or (iii) at home.
- (r) Rental of **durable medical or surgical equipment** if deemed Medically Necessary. These items may be bought rather than rented, with the cost not to exceed the fair market value of the equipment at the time of purchase, but only if Preauthorized in advance.

Benefit includes ostomy supplies, oxygen and respiratory equipment. Equipment rental for Negative Pressure Wound Therapy is covered under the Durable Medical Equipment benefit.

Equipment containing features of an aesthetic nature or features of a medical nature which are not required by the Covered Person's condition, or where there exists a reasonably feasible and medically appropriate alternative piece of equipment which is less costly than the equipment furnished, will be covered based on the usual charge for the equipment which meets the Covered Person's medical needs.

- (s) Diagnosis and Medically Necessary treatment of diseases and Injuries of the **eye** to include the first pair of cataract lenses, sclera shells or glasses following cataract removal surgery or lenses for the treatment of Keratoconus.
- (t) **Foreign travel immunizations.**
- (u) **Health education.** Covered Services includes instructions on achieving and maintaining physical and mental health, and preventing Illness and Injury. Covered Charges shall include Medically Necessary patient education programs including, but not limited to diabetic education and ostomy care.
- (v) Care, supplies and services for the diagnosis of **Infertility**. Covered Charges shall include expenses for Infertility testing for Employees and their covered Spouse. Infertility is the inability to conceive after one year of intercourse without contraception. Covered Charges for Infertility testing are limited to the actual testing for a diagnosis of Infertility. Any outside intervention procedures (e.g. artificial insemination) will not be considered a Covered Charge.
- (w) **Inhalation therapy.**
- (x) **Laboratory tests** are covered when obtained at the office of a Physician or through a laboratory.
- (y) **Maternity** including obstetrical care, prenatal, delivery and postpartum care in an Inpatient setting and/or a home visit or visits in accordance with the medical criteria prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists is covered. A nurse midwife may provide obstetrical care. Obstetrical care does not include services for elective childbirth performed in a home setting.
- (z) A **Medical Emergency** is a sudden onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent layperson to result in (i) serious jeopardy to the mental or physical health of the Covered Person; (ii) danger of serious impairment of the Covered Person's bodily functions; (iii) serious dysfunction of any of the Covered Person's bodily organs; or (iv) in the case of a pregnant woman, serious jeopardy to the health of the fetus. Screening and stabilization services provided in a Hospital emergency room for a Medical Emergency may be received from either In-Network or Out-of-Network Providers.

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

The Claims Administrator reviews all information and documentation with respect to these Claims in accordance with established medical criteria and guidelines. Claims resulting from a Medical Emergency are eligible for payment at the In-Network level of benefits. If a Claim is denied or paid at the Out-of-Network benefit level for being considered as non-emergent when You believe a Medical Emergency existed, contact the Customer Service Department.

Emergency accident care must begin within twenty-four (24) hours of the Injury in order to be eligible for coverage.

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

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

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

Deductibles shall not apply to coverage for nutritional supplements.

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

- (dd) **Organ transplant** limits. Services related to Medically Necessary organ transplants are covered when approved by the Claims Administrator and performed within the Coventry Transplant Network. Charges otherwise covered under the Plan that are incurred for the care and treatment due to an organ or tissue (including bone marrow) transplant are subject to these limits:

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

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

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

The cost of any care, including complications, arising from an organ donation by a Covered Person when the recipient is not a Covered Person is excluded.

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

Transplant services rendered by a Provider not in the Coventry Transplant Network. The Plan uses a transplant Network. Facilities in this Network are contracted to perform specific transplant services. Transplant services rendered by a Provider not in the Coventry Transplant Network are not covered. Specifically, even if the transplant services are rendered by a Network Provider, unless such Network Provider is also a Coventry Transplant Network Participating Facility, there is no coverage for such services. The Plan reserves the right to require a Covered Person to obtain services from a contracted Provider who may be outside of the Network service area if the services are to be covered by the Plan at the In-Network benefit level.

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

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

- (ff) **Ostomy supplies** accrue toward the medical supplies benefit.
- (gg) **Oxygen** when Medically Necessary and prescribed by a Physician.
- (hh) **Physical therapy** by a licensed physical therapist. The therapy must be in accord with a Physician's exact orders as to type, frequency and duration and for conditions which are subject to significant improvement through short-term therapy. Physical therapy rendered by a chiropractor is covered.
- (ii) **Prescription Drugs** approved by the Food and Drug Administration for a specific use, which can, under federal or state law, be dispensed only pursuant to a Prescription Order (i.e. a Legend Medication) and has not been excluded from coverage by the Claims Administrator.
- (jj) Routine **preventive care**. Covered Services under Medical Benefits are payable for routine preventive care as described in the Schedule of Benefits.

The Claims Administrator, on behalf of the Plan, has adopted preventive health recommendations to promote preventive health services. These guidelines are based on the recommendations of national medical associations and leading health organizations and have been approved by independent Physicians who participate on the Claims Administrator's Clinical Quality Improvement Committee. Covered Persons have access to these guidelines through the Claims Administrator's website and are sent a copy of these guidelines upon request.

When Medically Necessary, the following preventive, diagnostic and treatment services are covered:

Colorectal cancer screening: Specific screening with an annual fecal occult blood test, flexible sigmoidoscopy or colonoscopy, or in appropriate circumstances radiologic imaging in accordance with the most recently published recommendations established by the American College of Gastroenterology, in consultation with the American Cancer Society, for the ages, family histories, and frequencies referenced in such recommendations.

Genetic testing and genetic counseling: Genetic testing, screenings, counseling, and subsequent prophylactic procedures when Medically Necessary, Preauthorized and not specifically excluded by the Claims Administrator.

Hearing and vision screenings:

For Children up to age eighteen (18) when performed by a general practitioner, family practice Physician, pediatrician, or internist.

Newborn infant hearing screenings and all necessary audiological examinations provided in a Hospital. The infant hearing screenings and all necessary audiological examinations must use FDA approved technology that is recommended by the Joint Committee on Infant Hearing in its most current position statement addressing early hearing detection and intervention programs. Follow-up audiological examinations as recommended by the infant's Physician or audiologist and performed by a licensed audiologist to confirm the existence or absence of hearing loss are also covered.

Immunizations: Routine and necessary immunizations and boosters including, but not limited to: diphtheria, pertussis, tetanus, polio, hepatitis B, measles, mumps, rubella, HiB, varicella and other such immunizations.

Mammogram: One (1) mammogram every year over the age of 40 and one mammogram between the ages of 35 and 39 as routine, or as determined to be Medically Necessary by a Physician.

Pap smear: Annual testing performed by any FDA-approved gynecologic cytology screening technologies.

PSA (Prostate Specific Antigen) test: One test in a twelve (12)-month period and digital rectal examinations, all in accordance with American Cancer Society guidelines for (i) persons age fifty (50) and over and (ii) persons age forty (40) and over who are at high risk for prostate cancer, according to the most recent published guidelines of the American Cancer Society.

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

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

- (kk) **Podiatry services.** Covered Charges shall include surgical podiatry services, including incision and drainage of infected tissues of the foot, removal of lesions of the foot, removal or debridement of infected toenails, surgical removal of nail root, and treatment of fractures or dislocations of bones of the foot.
- (ll) The initial purchase, fitting and repair of fitted **prosthetic devices** (other than dental) which (i) replace all or part of a missing body organ and its adjoining tissue or all or part of the function of a permanently useless or malfunctioning body organ; and (ii) be an implantable prosthetic appliance or equivalent external device.

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

A prosthetic device that is received/delivered after the termination date of a Covered Person's coverage under this Plan is not covered.

- (mm) **Reconstructive surgery.** Reconstructive surgery or procedures when performed to correct deformity caused by disease, trauma, or a previous therapeutic process that is considered a

Covered Service. In the event a Covered Person is undergoing a multi-stage reconstruction or fulfilling a specific Waiting Period that is medically indicated, then the Provider must submit a treatment plan for approval.

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

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

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

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

- (i) Nipple and areola reconstruction.
- (ii) Medical complications resulting from the rupture of the prostheses/implant, and appropriate treatment, including removal of the prostheses/implant, upon Preauthorization.

- (nn) **Self-inflicted.** Any loss due to an intentionally self-inflicted Injury.
- (oo) **Special Equipment and Supplies.** Covered Charges shall include Medically Necessary special equipment and supplies including, but not limited to: casts; splints; braces; trusses; surgical and orthopedic appliances; colostomy and ileostomy bags and supplies required for their use; catheters; allergy serums; crutches; electronic pacemakers; oxygen and the administration thereof; support stockings, such as Jobst stockings; surgical dressing and other medical supplies ordered by a professional Provider in connection with medical treatment, but not common first aid supplies.
- (pp) **Speech therapy** by a licensed speech therapist. Therapy must be ordered by a Physician and follow either: (i) surgery for correction of a congenital condition of the oral cavity, throat or nasal complex (other than a frenectomy) of a person; (ii) an Injury; or (iii) a Sickness that is other than a learning or Mental Disorder.
- (qq) **Spinal Manipulation/Chiropractic services** by a licensed M.D., D.O. or D.C. Covered Charges include initial consultation, x-rays and treatment (including maintenance care), subject to the maximum benefits shown in the Schedule of Benefits.
- (rr) **Sterilization** procedures. Covered Charges shall include elective surgical sterilization procedures for the covered Employee or covered Spouse. Reversal of sterilization is not covered.
- (ss) **Surcharges.** Any excise tax, sales tax, surcharge (by whatever name called) imposed by a governmental entity for services, supplies and/or treatments rendered by a professional Provider; Physician, Hospital; facility or any other health care Provider shall be a Covered Charge under the terms of the Plan.
- (tt) **Surgery.** Any surgical operations (major or minor) which are Medically Necessary, not otherwise excluded or limited under the Medical Benefits and Preauthorized for payment by the Claims Administrator (unless Emergency Services).
- (uu) **Surgical dressings,** casts and other devices used in the reduction of fractures and dislocations, or as prescribed and determined to be Medically Necessary.
- (vv) **Surgical hose, stump socks, and mastectomy bras.** Covered Services for surgical hose, stump socks and mastectomy bras as determined to be Medically Necessary and as approved by the Claims Administrator.

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

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

- (xx) Charges for Illnesses or Injuries** suffered by a Covered Person due to the action or inaction of any party if the Covered Person fails to provide information as specified in the section, **Third Party Recovery Provision**.

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

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

- (zz) Coverage of well newborn nursery/Physician care.**

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

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

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

Charges for covered routine nursery care will be applied toward the Plan of the covered parent.

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 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, plans and issuers may not, under Federal law, require that a Provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

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

Charges for covered routine Physician care will be applied toward the Plan of the covered parent.

- (aaa) Charges associated with the initial purchase of a wig after chemotherapy,** surgery or burns, limited to one (1) while covered by this Plan.

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

UTILIZATION MANAGEMENT SERVICES

Preauthorization

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

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

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

General Policies

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

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

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

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

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

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

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

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

OBTAINING PREAUTHORIZATION FOR VISITS TO OUT-OF-NETWORK PROVIDERS AT THE IN-NETWORK BENEFIT LEVEL

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

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

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

UTILIZATION REVIEW

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

The program consists of:

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

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

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

Note: The services mentioned above must be Preauthorized or reimbursement from the Plan may be reduced. TO PREAUTHORIZE MEDICAL SERVICES CALL 1-800-755-1135 AND 1-866-369-8362 TO PREAUTHORIZE MENTAL HEALTH AND SUBSTANCE ABUSE TREATMENT:

- (b) Retrospective review of the Medical Necessity of the listed services provided on an emergency basis;
- (c) Concurrent review, based on the admitting diagnosis, of the listed services requested by the attending Physician; and
- (d) Certification of services and planning for discharge from a Medical Care Facility or cessation of medical treatment.

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

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

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

Here's how the program works.

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

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

- The name of the patient and relationship to the covered Employee,
- The name, member ID number and address of the covered Employee,
- The name of the Employer,
- The name and telephone number of the attending Physician,
- The name of the Medical Care Facility, proposed date of admission, and proposed length of stay,
- The diagnosis and/or type of surgery, and
- The proposed rendering of listed medical services.

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

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

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

Concurrent Care Benefit Determinations

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

Notifications of Benefit Determinations

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

Admission/Continued Stay Review

In the event of an emergency hospitalization or Outpatient surgery or procedure, the Claims Administrator must be contacted at the number provided on the member ID card must be contacted within 24 hours after the Medical Emergency or as soon as reasonably possible following the receipt of the services.

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

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

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

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

CASE MANAGEMENT

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

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

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

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

PRESCRIPTION DRUG BENEFITS

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

The Plan Administrator understands and agrees that Coventry Prescription Management Services, Inc. may receive a retrospective discount or rebate from a vendor or manufacturer related to the aggregate volume of services, supplies, equipment or pharmaceuticals purchased by persons enrolled in health care plans offered or administered by the Claims Administrator and its affiliates. Covered Persons shall not share in such retrospective volume-based discounts or rebates. However, such rebates will be considered by the Plan Administrator, in the aggregate, when determining prospective premium calculations for health care plans offered and/or administered by the Plan Administrator.

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

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

DEFINITIONS

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

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

Authorized Prescriber means any:

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

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

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

Contraceptive Drugs and/or Devices that prevent unwanted Pregnancy, including, but not limited to:

- Oral contraceptives;
- IUD's;
- Contraceptive implants; or
- Any similar drug, device or method.

Copayment means the flat dollar amount as specified in the Schedule of Benefits that will be charged to the Covered Person by the Network Retail, Mail Order, or Specialty Pharmacy to dispense any Prescription Order or Refill. The Covered Person is required to pay one (1) Copayment per each Prescription Order or Refill to a Network Retail, Mail Order, or Specialty Pharmacy at the time of service. Copayment amounts are not applied to:

- Pharmacy Deductible;
- Annual Maximum.

Covered Drugs means Prescription Drugs that are:

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

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

- Restricted Generic substitution means when a Generic is available, but the pharmacy dispenses the Brand Name Drug for any reason other than a Physician DAW (Dispense as Written) or equivalent instructions, the Covered Person is to pay the difference between the calculated Average Wholesale Price (AWP) cost of the Brand Name Drug and the calculated AWP of the Generic Drug in addition to the Brand Name Copayment and/or Coinsurance.

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

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

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

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

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

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

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

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

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

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

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

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

Medical Necessity

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

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

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

In-Network/Network/Participating Pharmacy means a Participating Retail Pharmacy, Mail Order Pharmacy or Specialty Pharmacy, as applicable.

In-Network/Network/Participating Prescriber means any Physician, Dentist or other In-Network health care Provider who is duly licensed to prescribe Prescription Drugs in the ordinary course of his or her professional practice, and has contracted with the Claims Administrator to provide medical services, including prescribing Prescription Drugs to Covered Persons.

Non-Network/Non-Participating/Out-of-Network Pharmacy means any registered, licensed pharmacy with which the Claims Administrator has not contracted to dispense Prescription Drugs to Covered Persons.

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

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

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

Pharmacy Deductible means the amount, if any, that a Covered Person must pay for Prescription Drugs each Benefit Year before a Covered Person may receive coverage for Prescription Drugs under this Plan. When the Pharmacy Deductible is met, the Covered Person is responsible for the Copayment and/or Coinsurance per

Prescription Order or Refill. The Pharmacy Deductible does not include Copayments, Coinsurance or any DAW Charges.

Prescription Drug means a drug approved by the FDA for a specific Outpatient use and that is dispensed only pursuant to a Prescription Order or Refill (a Legend Medication) under applicable law. Prescription Drugs include contraceptive drugs and devices, Self-Administered Injectable Drugs and some Over-the-Counter medications or disposable medical supplies specified by the Plan (for example, insulin, certain diabetic supplies, and select Over-the-Counter drugs). This does not extend to drugs or products that are not FDA approved prescription medications, such as those without an approved FDA application (NDA, ANDA or BLA).

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

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

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

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

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

Specialty Pharmacy means a pharmacy that:

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

Tier 0 (Value Formulary)

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

Tier 1 (Preferred Generic)

The group of Preferred which includes:

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

Tier 2 (Preferred Brand Name)

The group of Preferred medications which includes:

- Brand Name Prescription Drugs which are made by only one manufacturer, do not have a Generic equivalent and which the Plan has designated as Tier 2;
- Brand Name contraceptives which the Plan has designated as Tier 2;
- Brand Name Prescription Drugs which have a Narrow Therapeutic Index (those for which the dose must be monitored through laboratory tests) which the Plan has designated as Tier 2;
- Newly-introduced Generic Drugs which the Plan has designated as Tier 2; and
- Drugs designated as "Drug Efficacy Study Implementation (DESI) drugs" by the U.S. Food and Drug Administration ("FDA") which the Plan has designated as Tier 2. ("Drug Efficacy Study Implementation

(DESI) drugs” are being reviewed for their effectiveness by the FDA because they were approved solely on the basis of their safety prior to 1962.)

Tier 3 (Non-Preferred)

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

COVERED SERVICES

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

More information on the Mail Order benefit and any exclusions, as determined by the Claims Administrator, is available online. **Please allow at least a fourteen (14) day turnaround time to receive Mail Order Prescriptions.**

Retail Maintenance Benefit.

At Participating retail pharmacies, for Maintenance Medications, You will pay:

- Two Copayments for up to a 60-day supply (or the appropriate prescribing unit);
- Three Copayments for up to a 90-day supply (or the appropriate prescribing unit).

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

Specialty Drugs and Medications require Preauthorization.

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

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

- Coinsurance;
- DAW Order or Refill.

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

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

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

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

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

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

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

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

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

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

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

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

Qualified Covered Persons are those that meet the “Plan Criteria” applicable to each Tier 0 Drug, as designated by the Claims Administrator to promote effective and efficient drug therapy. Covered Persons who are on or have recently received **certain Prescription Drugs**, or who receive a new Prescription Order for **certain Prescription Drugs, as designated by the Claims Administrator**, may qualify for Tier 0 benefit coverage.

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

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

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

Example Value Formulary Tier 0 Drug Formulary:

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

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

Smoking Cessation Program.

The Plan covers Generic Over-the-Counter (OTC) nicotine replacement products at the Tier 1 (Generic) benefit provided You obtain a prescription from a doctor. A 31-day supply is available per prescription and is covered with an annual limit of 12 weeks therapy, per treatment type, per Benefit Year.

Products include:

- Nicotine patch (Generic equivalent of NicoDermCQ®)
- Nicotine gum (Generic equivalent of Nicorette®)
- Nicotine lozenges (Generic equivalent of Commit®).

Patients should talk with their doctor about the method that is right for them. This program excludes Brand Name Drugs. The Mail Order and Retail Maintenance benefits do not apply.

LIMITATIONS & EXCLUSIONS

The following limitations and exclusions apply to the Plan:

- (a) A pharmacy shall not dispense a Prescription Order or Refill which, in the pharmacist's professional judgment, should not be filled.
- (b) Authorized Refills will be provided for the lesser of:
 1. twelve (12) months from the original date on the Prescription Order or Refill unless limited by state or federal law; or
 2. the number of Refills indicated by the Authorized Prescriber.
- (c) Some medications are subject to quantity limits. Specific Quantity Limits can be obtained through the Customer Service Department and by searching the online Prescription Drug Formulary.
- (d) Coverage of injectable drugs is limited to Self-Administered Injectable Drugs and injectable diabetes agents, bee sting kits, injectable migraine agents and injectable contraceptives that are commonly and customarily administered by the Covered Person.
- (e) Except when the Claims Administrator determines the situation to be urgent, Self-Administered Injectable Drugs and Specialty Medications are available only from a Specialty Pharmacy unless otherwise Preauthorized by the Claims Administrator.
- (f) The Claims Administrator reserves the right to include only one manufacturer's product on the Formulary when the same or similar drug (that is, a drug with the same active ingredient), supply or equipment is made by two or more different manufacturers. The product that is listed on the Formulary will be covered

at the applicable benefit. The product or products not listed on the Formulary will be excluded from coverage.

- (g) The Claims Administrator reserves the right to include only one dosage or form of a drug on the Formulary when the same drug (that is, a drug with the same active ingredient) is available in different dosages or forms (for example, but not limited to, dissolvable tablets, capsules, etc.) from the same or different manufacturers. The product in the dosage or form that is listed on the Formulary will be covered at the applicable benefit. The product or products in other forms or dosages that are not listed on the Formulary will be excluded from coverage.
- (h) Coverage of therapeutic devices or supplies requiring a Prescription Order or Refill and prescribed by an Authorized Prescriber is limited to Plan-approved diabetic test strips and lancets.
- (i) Plan-approved blood glucose meters, asthma holding chambers and peak flow meters are Covered Charges, but are limited to one (1) Prescription Order per Benefit Year.
- (j) Unless this Summary Plan Description (SPD) indicates that Preauthorization is not required, Preauthorization is required for selected products with a Narrow Therapeutic Index, potential for misuse and/or abuse, and a narrow or limited range of FDA-approved indications. These products may not be available from the Mail Order Pharmacy. Information about which drugs require Preauthorization can be obtained through the Customer Service Department or the Claims Administrator's searchable Formulary on the website.
- (k) Coverage through the Mail Order Pharmacy is not available for drugs that are not Maintenance Medications as defined by the Claims Administrator, drugs that cannot be shipped by mail due to state or federal laws or regulations, or when the Claims Administrator considers shipment through the mail to be unsafe.
- (l) Contraceptive diaphragms, oral contraceptives and time-released injectable contraceptives, including but not limited to birth control pills, are Covered Charges unless specifically excluded as described by the Plan. Implantable time-released contraceptives are not Covered Charges.
- (m) The Claims Administrator reserves the right to limit the location at which a Covered Person can fill a covered Prescription Order or Refill to a pharmacy that is mutually agreeable to both the Claims Administrator and the Covered Person. Such limitation may be enforced in the event that the Claims Administrator identifies an unusual pattern of Claims for Covered Charges.
- (n) Certain vaccines are covered when obtained and administered in a pharmacy by a certified immunizing pharmacist and billed through the online Claims adjudication system.
- (o) Immunizations for foreign travel are covered.

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

- (a) Any Prescription Drugs, injectables, supplies, devices or other items covered under the Medical Benefits.
- (b) Prescription Drugs dispensed by Non-Network Pharmacies, except as described by the Plan.
- (c) Devices or supplies of any type, even though requiring a Prescription Order unless otherwise specified as a Covered Charge. These include, but are not limited to: therapeutic devices, support garments, corrective appliances, non-disposable hypodermic needles, or other devices, regardless of their intended use.
- (d) Drugs prescribed and administered in the Physician's office, or during or as part of an Inpatient or ambulatory surgery procedure or admission.
- (e) Implantable time-released medication, including, but not limited to implantable contraceptives.
- (f) Drugs which do not require a Prescription by federal or state law, unless specifically designated for coverage by the Claims Administrator. For example, but not limited to: Over-the-Counter drugs or Over-the-Counter equivalents, behind-the-counter drugs, nutraceuticals, medical foods (except when coverage is required by law), and dietary supplements.
- (g) Drugs, oral or injectable, used for the primary purpose of, or in connection with, treating Infertility, fertilization and/or artificial insemination, unless coverage is specifically listed in the Schedule of Benefits.
- (h) Experimental or Investigational drugs.

- (i) Drugs used for athletic performance enhancement or cosmetic purposes, including, but not limited to: anabolic steroids, tretinoin for aging skin, and minoxidil lotion.
- (j) Vitamins and minerals, both Over-the-Counter and Legend, except Legend prenatal vitamins for pregnant or nursing females, liquid or chewable Legend pediatric vitamins for Children under age thirteen (13), and potassium supplements to prevent/treat low potassium.
- (k) Oral dental preparations and fluoride rinses, fluoride supplements, except fluoride tablets or drops.
- (l) Refill Prescriptions resulting from loss or theft.
- (m) Growth hormones and insulin-like growth hormone factor-1, when not Medically Necessary to treat an Illness or Injury.
- (n) Pharmacological therapy for weight reduction.
- (o) Prescriptions for which the Covered Person is entitled to receive coverage without charge under any Workers' Compensation Law, or occupational disease statute, or any law or regulation.
- (p) Compounded Prescriptions are excluded unless all of the following apply:
 1. there is no suitable commercially-available alternative; and
 2. the main active ingredient is a covered Prescription Drug; and
 3. the purpose is solely to prepare a dose form that is Medically Necessary and is documented by the Authorized Prescriber; and
 4. the Claim is submitted electronically.
- (q) Prescriptions directly related to non-Covered Charges, as further described in the Medical Benefits section of the Plan Document.
- (r) Non-Preferred Drugs unless Tier 3 Drugs are specifically covered as described in the Schedule of Benefits.
- (s) Medications to prevent infections related to foreign travel are excluded from coverage. Drugs prescribed for the purpose of facilitating travel, including but not limited to medications, devices and supplies for motion Sickness (e.g. Relief Bands).
- (t) Medications used for the treatment or ongoing maintenance care of non-congenital transsexualism, gender dysphoria, or sexual reassignment or change.
- (u) Medications used for travel prophylaxis.
- (v) Growth hormone for adults, except as Preauthorized by the Claims Administrator.
- (w) Pharmacologic therapy for sexual dysfunction.
- (x) Biological sera, blood or blood plasma, tretinoin (all doses) for Covered Persons up to age 26 and hemantinics.

GENERAL PROVISIONS

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

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

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

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

Unless the Covered Person is enrolled in a Health Savings Account plan, the following do not apply toward fulfillment of any Out-of-Pocket Maximum specified, if any, in the Schedule of Benefits:

- Copayments;
- Coinsurance; or
- Pharmacy Deductible.

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

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

VISION BENEFIT

A summary of the Covered Charges and the Covered Person's payment responsibility are shown on the Schedule of Benefits. Benefits do not apply to services received from ophthalmologists or other Specialists not considered vision Providers.

This section describes coverage for services for routine vision care. Coverage for diseases and Injuries of the eye is described in the Medical Benefits section of this Summary Plan Description.

What is covered

Complete refractive eye examinations, to include exams for the wearing of glasses, daily wear or extended wear hard or soft lenses and specialty lens exams. Charges are subject to the limits as stated in the Schedule of Benefits.

In addition, for Juniata College Employees, this benefit includes;

- Discounts on prescription and non-prescription glasses, and on all eye care needs, including LASIK surgery. This discount is available from any EyeMed Vision Care doctor.

To locate a vision Provider, visit www.healthamerica.cvty.com.

DEFINED TERMS

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

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

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

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

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

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

1. For non-facility Claims, the lesser of the Non-Participating Provider's billed charges or the current (updated no later than April 1 of each year) Medicare rate, as set forth below. If there is no corresponding Medicare rate for the particular service, the Claim Administrator's Mental Disorders and Substance Abuse vendor shall pay the average amount the Mental Disorders and Substance Abuse vendor pays its Participating Providers for the same service(s). The Out-of-Network Rate (ONR) under Your Plan is 100% of the regionally adjusted Medicare rate based on the Non-Participating Provider's location.
 2. For all other Claims, the lesser of the Non-Participating Provider's billed charges or the average amount the Mental Disorders and Substance Abuse vendor pays its Participating Providers for the same service(s).
- **Participating Rate/In-Network Rate:** The amount determined by the Claims Administrator that it will pay for a Covered Service. Allowable Charge is the amount that a Participating Provider has agreed to accept as payment in full pursuant to its agreement with the Claims Administrator and/or the Plan.

The examples below illustrate how ONR works:

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

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

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

Assume the Deductible has been met and the Plan covers In-Network Inpatient Hospital services at 80%, the Hospital bill is \$5,000 (actual charges), and the contracted rate for the Hospital is \$3,000. In this example, the Plan would **not** take into account \$2,000 of the \$5,000 Hospital bill, because it exceeds the \$3,000 contracted rate. The Plan would pay 80% of the \$3,000 contracted rate, which is \$2,400. The Covered Person would pay 20% of the \$3,000 contracted rate, which is \$600. The amount in excess of the contracted rate would **not** be the Covered Person's

responsibility.

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

Ambulatory Surgical Center is a licensed facility that is used mainly for performing Outpatient surgery, has a staff of Physicians, has continuous Physician and nursing care by registered nurses (R.N.s) and does not provide for overnight stays.

Autism Service Provider shall mean a person, entity or group that provides Treatment of Autism Spectrum Disorders under a treatment plan approved by the Claims Administrator that is:

- (i) appropriately licensed or certified in Pennsylvania to provide the service; or
- (ii) enrolled in Pennsylvania's Medical Assistance program on or before July 9, 2008.

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

Benefit Year means January through December.

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

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

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

Claims Administrator means HealthAmerica.

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

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

Complications of Pregnancy means a disease, disorder or condition which is diagnosed as distinct from Pregnancy, but is adversely affected by or caused by Pregnancy. Some examples are: intra-abdominal surgery (but not elective cesarean section), ectopic Pregnancy, toxemia with convulsions (eclampsia), pernicious vomiting (hyperemesis gravidarum), nephrosis, cardiac decompensations, missed abortion, miscarriage. These conditions are not included: false labor, occasional spotting, rest during Pregnancy even if prescribed by a Physician, morning Sickness, or like conditions that are not medically termed as Complications of Pregnancy.

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

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

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

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

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

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

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

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

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

Domestic Partner is a same or opposite sex partner of an Employee who:

1. Is engaged in a committed relationship of mutual caring and support with the Employee and is jointly responsible with the Employee for each others' common welfare and living expenses such as food, shelter and medical expenses and agrees that they share financial obligations; and
2. is at least eighteen (18) years of age and mentally competent to consent to a contract; and
3. is the sole Domestic Partner of the Employee and intends to remain so indefinitely; and
4. Is not married to or legally separate from anyone else; and
5. Is not related to the Employee by blood to a degree of closeness that would prohibit legal marriage in the state in which they reside; and
6. Has been residing with the Employee continuously for at least six (6) months, unless the previous Domestic Partnership terminated by death; and
7. Has not had a different Domestic Partner in the last six (6) months, unless the previous Domestic Partnership terminated by death; and
8. Is not in a Domestic Partnership with the Employee solely for the purpose of obtaining benefits coverage.

In addition to the above provisions, the Employee and his/her Domestic Partner must possess proof of at least three (3) of the following:

1. Common ownership of real property (joint deed or mortgage agreement) or a common leasehold interest in property;
2. Common ownership of a motor vehicle;
3. Driver's license listing a common address;
4. Proof of joint bank accounts or credit accounts;

5. Proof of designation as the primary beneficiary designation under a partner's will; or
6. Assignment of a durable property power of attorney or health care power of attorney.

Upon termination of a Domestic Partnership, the Employee is obligated to notify the company in writing within thirty (30) days. An Employee cannot elect to cover another Domestic Partner under the company health insurance plans or other company benefits for at least six (6) months unless a previous Domestic Partnership terminated by death.

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

Employee means a person directly involved in the regular business of and compensated for services, as reported on the individual's annual W-2 form, by the Employer, who is regularly scheduled to work not less than thirty-two (32) hours per work week on a Full-Time status basis.

Employer is Juniata College.

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

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

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

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

- (1) if the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or
- (2) if the drug, device, medical treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval; or
- (3) if reliable evidence shows that the drug, device, medical treatment or procedure is the subject of on-going Phase I or Phase II clinical trials, is the research, Experimental, study or Investigational arm of on-going Phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or any health product or service that is the subject of a clinical trial that meets criteria for Phase I, II, III or IV as set forth by FDA regulations, except as specifically covered;
- (4) if reliable evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

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

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

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

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

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

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

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

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

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

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

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

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

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

- A facility operating legally as a psychiatric Hospital or residential treatment facility for mental health and licensed as such by the state in which the facility operates.
- A facility operating primarily for the treatment of Substance Abuse if it meets these tests: maintains permanent and full-time facilities for bed care and full-time confinement of at least 15 resident patients; has a Physician in regular attendance; continuously provides 24-hour a day nursing service by a

registered nurse (R.N.); has a full-time psychiatrist or psychologist on the staff; and is primarily engaged in providing diagnostic and therapeutic services and facilities for treatment of Substance Abuse.

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

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

Infertility means a condition diagnosed by a Physician that:

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

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

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

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

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

Leave of Absence means a period of time during which the Employee does not work, but which is of a stated duration after which time the Employee is expected to return to active work.

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

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

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

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

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

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

- Broken bone;
- Chest pain;
- Seizures or convulsions;
- Severe or unusual bleeding;
- Severe burns;
- Suspected poisoning;

- Trouble breathing;
- Vaginal bleeding during Pregnancy.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Plan means Juniata College Employee Benefit Plan, which is a benefits plan for certain Employees of Juniata College and is described in this document.

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

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

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

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

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

Retired Employee is a former Active Employee of the Employer who was retired while employed by the Employer under the formal written plan of the Employer and elects to contribute to the Plan the contribution required from the Retired Employee. As used in this document, the term Employee shall include retirees covered under the Plan.

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

Sickness is a Covered Person's Illness, disease or Pregnancy (including complications).

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

- (1) It is licensed to provide professional nursing services on an Inpatient basis to persons convalescing from Injury or Sickness. The service must be rendered by a registered nurse (R.N.) or by a licensed practical nurse (L.P.N.) under the direction of a registered nurse. Services to help restore patients to self-care in essential daily living activities must be provided.
- (2) Its services are provided for compensation and under the full-time supervision of a Physician.
- (3) It provides 24 hour per day nursing services by licensed nurses, under the direction of a full-time registered nurse.
- (4) It maintains a complete medical record on each patient.
- (5) It has an effective utilization review plan.
- (6) It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, mentally disabled, Custodial or educational care or care of Mental Disorders.
- (7) It is approved and licensed by Medicare.

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

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

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

Temporomandibular Joint (TMJ) syndrome is the treatment of jaw joint disorders including conditions of structures linking the jaw bone and skull and the complex of muscles, nerves and other tissues related to the Temporomandibular Joint.

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

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

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

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

PLAN EXCLUSIONS

The services, supplies, equipment, facilities and related charges listed below are excluded from payment under this Plan unless covered under an amendment to this Plan. Covered Persons may contact the Plan Administrator or Customer Service at the number on the member ID card for assistance in determining whether Covered Services have been extended by an amendment or notice of material modification.

This Plan does not cover the following items:

- Any service or supply that is not Preauthorized in accordance with this Plan's Utilization Management policies and procedures; provided that Emergency Services or services received from an obstetrician or gynecologist may vary from these requirements to the extent expressly stated in this Plan;
- Any service or supply that is not Medically Necessary;
- Any service or supply that is not a Covered Charge or that is directly or indirectly a result of receiving a non-Covered Charge;
- Any service or supply for which a Covered Person has no financial liability or that was provided at no charge;
- Procedures and treatments that this Plan determines, in its sole and absolute discretion, to be Experimental or Investigational;
- Reconstruction or delayed procedures except as specified in the Schedule of Benefits and, in the case of traumatic Injury, when a significant anatomical or functional improvement can be anticipated;
- Charges for services, supplies or treatment from any Hospital owned or operated by the United States government or any agency thereof or any government outside the United States, or charges for services, treatment or supplies furnished by the United States government or any agency thereof or any government outside the United States, unless payment is legally required.
- Care rendered to a Covered Person by a relative or someone who ordinarily resides in the same household;
- Charges resulting from the Covered Person's failure to appropriately cancel a scheduled appointment;
- Claims not submitted within the Plan's filing limit deadlines as specified in the section, How to Submit a Claim.
- Services and or supplies rendered as a result of Injuries sustained during the commission of an illegal act or engagement in an illegal occupation; and
- Court-ordered services or services that are a condition of probation or parole, to the extent permitted by law.
- Charges incurred after coverage ends.

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

- (1) **Abortion.** Charges for services provided to a Covered Person for an elective abortion. For specifics regarding the coverage of abortions, please refer to the Covered Services section of this Plan Document.
- (2) Charges for expenses in connection with an Injury arising out of or relating to an **accident** involving the maintenance or use of a motor vehicle (other than a recreational vehicle not intended for highway use, motorcycle, motor-driven cycle, motorized pedal cycle or like type vehicle). This exclusion shall apply to those expenses up to the minimum amount required by law in the state of residence for any Injury arising out of an accident of the type for which benefits are or would be payable under automobile insurance, regardless of whether or not automobile insurance is in force and regardless of any benefit limits under such insurance. However, this exclusion does not apply to a Covered Person who is a non-driver when involved in an uninsured motor vehicle accident.

For purpose of this exclusion, a non-driver is defined as a Covered Person who does not have the obligation to obtain automobile insurance because he/she does not have a driver's license or because he/she is not responsible for a motor vehicle.

- (3) Charges for an Injury or Illness contracted while on **active duty** in military service, unless payment is legally required.
- (4) **Acupressure.**
- (5) **Acupuncture.** Services, supplies, care or treatment in connection with acupuncture (except when used in lieu of an anesthetic agent for covered surgery).
- (6) **Ambulance service** except as specifically stated as being covered.
- (7) **Autopsy.**
- (8) **Behavior modification.**
- (9) **Biofeedback.**
- (10) **Bionic devices** (microprocessor controlled prosthetics) to include, but not limited to, C-Leg.
- (11) Charges for **blood donors and blood donation**, except as specified as being covered. The drawing, preparation and storage of umbilical cord blood is not covered. Specifically, charges for procurement and storage of one's own blood, unless incurred within three (3) months prior to a scheduled surgery.
- (12) **Braces** and supports needed for athletic participation or employment.
- (13) **Care not approved by a Physician.** Treatment, services or supplies that are not recommended and approved by a Physician will not be covered.
- (14) **Career or legal counseling.**
- (15) **Chelation therapy** except for acute arsenic, gold, mercury or lead poisoning.
- (16) **Clinical trials.**
- (17) **Clothing** or shoes of any type, including, but not limited to: orthopedic shoes, Children's corrective shoes, shoes used in conjunction with leg braces, and shoe inserts, except for inserts and shoes for Covered Persons with diabetes or peripheral vascular disease.
- (18) **Cochlear implants**, dental implants and nanometric implants. No coverage is provided for repair, replacement, or duplicates, nor is coverage provided for services related to the repair or replacement of covered implants, except due to a change in the Covered Person's medical condition.
- (19) **Complications of non-covered treatments.** Care, services or treatment required as a result of complications from a treatment not covered under the Plan are not covered.
- (20) **Corrective appliances** that do not require prescription specifications and/or are used primarily for recreational sports. Also, corrective appliances used primarily for cosmetic purposes, including but not limited to cranial prostheses and molding helmets.
- (21) **Cosmetic** services and surgery and the complications incurred as a result of those services and surgeries except as otherwise outlined in the Covered Services section of this Plan Document.
- (22) **Court ordered treatment.** Any services mandated by court order, or as a condition of parole or probation, are excluded from coverage under this Plan.

- (23) **Custodial Care.** Services or supplies provided mainly as a rest cure, maintenance, domiciliary or Custodial Care.
- (24) Repair and maintenance of **Durable Medical Equipment and corrective appliances:**
- (a) Routine servicing such as testing, cleaning, regulating and checking of equipment is not covered unless specified as covered elsewhere in this document.
- (b) Unless otherwise specified under Medical Benefits, repair coverage is limited to:
- adjustment required by wear or by condition change when prescribed by a Physician; and
 - repairs necessary to make the equipment/appliance serviceable unless the repair costs exceed the cost of the equipment/appliance.
- (26) Except as specified as being covered elsewhere, replacement coverage for **Durable Medical Equipment** or corrective appliances. Repair, replacement, and duplication are not covered if due to loss, neglect, abuse of equipment, or for the convenience or personal preference of the Plan Participant.
- (27) **Educational or vocational testing.** Services for educational or vocational testing or training. Charges for self-help training or other forms of non-medical self care.
- (28) **Elective home delivery** for childbirth.
- (29) **Emergency care** related to an accident that is not sought within twenty-four (24) hours of the accident is not covered.
- (30) Charges for **environmental change** including Hospital or Physician charges connected with prescribing an environmental change.
- (31) **Equestrian therapy** (hippotherapy), llama therapy, pet therapy or similar services.
- (32) **Equipment or services** primarily used for altering air quality or temperature or used for non-medical purposes.
- (33) **Exams** for employment, school, camp, sports, insurance, licensing, adoption, marriage or those ordered by a third party.
- (34) **Excess charges.** The part of an expense for care and treatment of an Injury or Sickness that is in excess of the Allowable Charge.
- (35) **Exercise programs.** Exercise programs for treatment of any condition, except for Physician-supervised cardiac rehabilitation, occupational or physical therapy covered by this Plan.
- (36) **Experimental/Investigational or not Medically Necessary.** Care and treatment that is either Experimental/Investigational or not Medically Necessary.
- (37) **Eye care.** Radial keratotomy or other eye surgery to correct refractive disorders. Also, routine eye examinations, including refractions, lenses for the eyes and exams for their fitting. This exclusion does not apply to aphakic patients and soft lenses or sclera shells intended for use as corneal bandages or as may be covered under the well adult or well Child sections of this Plan.
- (38) **Failure to provide information** or any additional documentation as may be requested by the Claims Administrator may result in no coverage.
- (39) **Food supplements** including infant formula, tube feedings, medical foods, cosmetic dietary aids, vitamins or other nutritional and Over-the-Counter electrolyte supplements, except as specified as being covered.
- (40) **Foot care.** Except as Medically Necessary for the treatment of metabolic or peripheral-vascular illness, charges for routine, palliative or cosmetic foot care, including, but not limited to: treatment of weak,

unstable, flat, strained or unbalanced feet; subluxations of the foot; treatment of corns or calluses; non-surgical care of toenails.

- (41) **Foreign travel.** Care, treatment or supplies out of the U.S. if travel is for the sole purpose of obtaining medical services.
- (42) **Genetic counseling,** gene therapy and genetic studies that are not required for diagnosis or treatment of genetic abnormalities according to Plan guidelines.
- (43) **Government coverage.** Care, treatment or supplies furnished by a program or agency funded by any government. This does not apply to Medicaid or when otherwise prohibited by law.
- (44) **Growth hormones,** except that they are covered when used to treat a congenital anomaly such as Turner's Syndrome, but only if the growth hormone is approved by the FDA for treatment of the congenital anomaly.
- (45) **Hair analysis and hair transplants.**
- (46) **Hair loss.** Care and treatment for hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a Physician; except for wigs or hairpieces when required due to chemotherapy, surgery or burns, subject to the limitations in the Covered Services section of this Plan Document.
- (47) **Hearing aids and exams.** Charges for services or supplies in connection with hearing aids or exams for their fitting, except as may be covered under the well adult or well Child sections of this Plan.
- (48) **Holistic medicines or Providers of naturopathy.**
- (49) **Home services** to help meet personal/family/domestic needs.
- (50) **Hospital employees.** Professional services billed by a Physician or nurse who is an employee of a Hospital or Skilled Nursing Facility and paid by the Hospital or facility for the service.
- (51) **Hypnotherapy.**
- (52) **Illegal acts.** Charges for services received as a result of Injury or Sickness occurring directly or indirectly, as a result of a Serious Illegal Act, or a riot or public disturbance. For purposes of this exclusion, the term "Serious Illegal Act" shall mean any act or series of acts that, if prosecuted as a criminal offense, a sentence to a term of imprisonment in excess of one year could be imposed. It is not necessary that criminal charges be filed, or, if filed, that a conviction result, or that a sentence of imprisonment for a term in excess of one year be imposed for this exclusion to apply. Proof beyond a reasonable doubt is not required. This exclusion does not apply if the Injury or Sickness resulted from an act of domestic violence or a medical (including both physical and mental health) condition.
- (53) Charges for **Inpatient room and board** in connection with a Hospital confinement primarily for diagnostic test, unless it is determined by the Plan that Inpatient care is Medically Necessary.
- (54) **Impotence.** Care, treatment, services, supplies such as sexual aids, vacuum devices and penile implants or medication in connection with treatment for impotence, unless as the result of Illness or Injury.
- (55) **Infertility.** Except as specified in the Schedule of Benefits. Infertility treatments, services and supplies, fetal reduction surgery, and artificial reproductive technology including but not limited to: egg harvest, sperm donation, donor sperm or donor eggs, in vitro and in vivo fertilization (IVF), gamete intrafallopian transfer (GIFT), and zygote intrafallopian transfer (ZIFT), embryo transplants and similar procedures, cryopreservation and storage of sperm unless Preauthorized, eggs and embryos, supplies, drug therapies, and drugs.
- (56) **Marital or pre-marital counseling.** Care and treatment for marital or pre-marital counseling.

- (57) **Massage therapy.**
- (58) **Milieu therapy**, the treatment of Mental Disorder or maladjustment by making substantial changes in a patient's immediate life circumstances and environment in a way that will enhance the effectiveness of other forms of therapy is not covered. Also known as "situation therapy".
- (59) **Naprapathic services** provided by a practitioner of Naprapathy (a "Naprapath") are not covered. Naprapathy is a system of treatment by manipulation of connective tissue and adjoining structures and by dietary measures that is held to facilitate the recuperative and regenerative processes of the body.
- (60) Elective **newborn home deliveries** and associated well newborn care.
- (61) **No charge.** Care and treatment for which there would not have been a charge if no coverage had been in force.
- (62) **Non-emergency Hospital admissions.** Care and treatment billed by a Hospital for non-Medical Emergency admissions on a Friday or a Saturday. This does not apply if surgery is performed within 24 hours of admission.
- (63) **Non-medical expenses** such as preparing medical reports, itemized bills or charges for mailing; for training, educational instructions or materials, even if they are performed or prescribed by a Physician; for legal fees and expenses incurred in obtaining medical treatment.
- (64) **No obligation to pay.** Charges incurred for which the Plan has no legal obligation to pay; or for which no charge would usually be made; or for which such charge, if made, would not usually be collected if no coverage existed; or to the extent the charge for the care exceeds the charge that would have been made and collected if no coverage existed.
- (65) **No Physician recommendation.** Care, treatment, services or supplies not recommended and approved by a Physician; or treatment, services or supplies when the Covered Person is not under the regular care of a Physician. Regular care means ongoing medical supervision or treatment which is appropriate care for the Injury or Sickness.
- (66) **Not specified as covered.** Non-traditional medical services, treatments and supplies which are not specified as covered under this Plan.
- (67) **Obesity.** Care and treatment of obesity, weight loss or dietary control whether or not it is, in any case, a part of the treatment plan for another Sickness. Specifically excluded are charges for bariatric surgery, including but not limited to, gastric bypass, stapling and intestinal bypass, and lap band surgery, including reversals. Medically Necessary surgical and non-surgical charges for Morbid Obesity are not covered. See Weight reduction exclusion for further information.
- (68) **Occupational.** Care and treatment of an Injury or Sickness that is occupational -- that is, arises from work for wage or profit including self-employment provided the Employer provides, or is required to provide Workers' Compensation or similar type coverage for such services.
- (69) Except as specified in the Schedule of Benefits, **oral surgery** and related services and supplies including, but not limited to:
- Services and supplies related to dental care, dental appliances, dental prostheses, dental implants, or dental x-rays;
 - Orthodontics, periodontics, endodontics, prosthodontics, preventive, cosmetic or restorative dentistry.
 - Oral surgery that is required as part of an orthodontic treatment program;
 - Oral surgery that is required for the correction of an occlusal defect, unless Medically Necessary;
 - Oral surgery that encompasses orthognathic, prosthodontics or prognathic surgical procedures;
 - Charges for Physicians' services or x-ray examinations involving one or more teeth, the tissue or structure around them, the alveolar process or the gums. This applies even if a condition requiring any of these services involves a part of the body other than the mouth, such as the

treatment of Temporomandibular Joint disorder or malocclusion involving joints or muscles by methods including, but not limited to: crowning, wiring, or repositioning of teeth.

- (70) **Orthodontia** and related services.
- (71) Charges in connection with **orthotics**, heel lifts and arch supports.
- (72) **Out-of-Network** charges in excess of the Out-of-Network Rate.
- (73) **Over-the-Counter supplies** such as ACE wraps/elastic supports/finger splints, neoprene sleeves, shoe inserts, heel cups, and orthotics, except for orthotics necessary for the treatment of diabetes.
- (74) **Penile prostheses**.
- (75) **Personal comfort items**. Charges for services, supplies or treatment which constitute personal comfort or beautification items, whether or not recommended by a Physician, such as, but not limited to, televisions, telephones, air conditioners, air-purification units, humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, elastic bandages or stockings, exercise equipment, scales, non-Prescription Drugs and medicines, and first-aid supplies and non-Hospital adjustable beds.
- (76) **Phone consultations**. This includes but is not limited to, e-mail consultations, and completion of Claims forms.
- (77) **Plan design exclusions**. Charges excluded by the Plan design as mentioned in this document.
- (78) Charges for **Prescription Drugs** or for the Prescription Drug Copay applicable to the Prescription Drug benefit. Outpatient Prescription Drugs are paid under the Prescription Drug benefit and under no other provision of this Plan.
- (79) Charges for or related to the following types of treatment: **primal therapy**, rolfing, psychodrama, megavitamin therapy, visual perception therapy.
- (80) **Private Inpatient room**, unless Medically Necessary or if a semi-private room is unavailable.
- (81) **Prolotherapy**, the use of injections to strengthen tendons and ligaments.
- (82) **Rehabilitation services**, including but not limited to cognitive therapy, physical therapy, occupational therapy, and speech therapy for developmental delay, school-related problems, apraxic disorders (unless caused by accident or episodic illness), stuttering, speech delay, articulation disorder, functional dysphonia, or speech problems resulting from psychoneurotic or personality disorders. Long-term rehabilitation therapy, cardiac rehabilitation therapy, and pulmonary rehabilitation are not covered by the Plan. However, the initial examination, office and diagnostic testing to determine the illness shall be a Covered Charge.
- (83) **Relative giving services**. Professional services performed by a person who ordinarily resides in the Covered Person's home or is related to the Covered Person as a Spouse, parent, Child, brother or sister, whether the relationship is by blood or exists in law.
- (84) **Replacement braces**. Replacement of braces of the leg, arm, back, neck, or artificial arms or legs, unless there is sufficient change in the Covered Person's physical condition to make the original device no longer functional.
- (85) Charges for **room and board** in a facility for days on which the Covered Person is permitted to leave (a weekend pass, for example).
- (86) **Sensory integration therapy**, reintegration therapy and kinetic therapy.

- (87) **Services before or after coverage.** Care, treatment or supplies for which a charge was incurred before a person was covered under this Plan or after coverage ceased under this Plan.
- (88) **Services that are not Preauthorized when Preauthorization is required.**
- (89) **Sex changes.** Care, services or treatment for non-congenital transsexualism, gender dysphoria or sexual reassignment or change. This exclusion includes medications, implants, hormone therapy, surgery, medical or psychiatric treatment. However, treatment of congenital hermaphroditism is a Covered Charge.
- (90) **Sex therapy, diversional therapy or recreational therapy.**
- (91) **Sleep disorders.** Care and treatment for sleep disorders unless deemed Medically Necessary.
- (92) **Smoking cessation.** Care and treatment programs for smoking cessation. Smoking cessation products and medications are not covered, except as specified in the Prescription Drug Benefits section of this Plan Document.
- (93) Therapy for snoring, such as but not limited to **somnoplasty**.
- (94) **Speech therapy** for fluency disorders, such as but not limited to stuttering.
- (95) **Sports medicine treatment** plans, surgery, corrective appliances, or artificial aids primarily intended to enhance athletic functions.
- (96) Charges for **structural changes** to a house or vehicle.
- (97) **Surgical sterilization reversal.** Care and treatment for reversal of surgical sterilization.
- (98) **Surgery** performed solely to address psychological or emotional factors.
- (99) **Surrogate motherhood services and supplies**, including, but not limited to, all services and supplies relating to the conception and Pregnancy of a Covered Person acting as a surrogate mother.
- (100) **Take home disposable** or consumable Outpatient supplies, such as sheaths, bags, elastic garments and bandages, syringes, needles, blood or urine testing supplies, home testing kits, vitamins, dietary supplements and replacements, food, food supplements, food replacements, and special food items, unless they are specified as covered.
- (101) **Temporomandibular Joint (TMJ) syndrome.** All diagnostic and treatment services related to the treatment of jaw joint problems including Temporomandibular Joint (TMJ) syndrome.
- (102) **Testicular implants.**
- (103) **Transplant services**, screening tests, and any related conditions or complications related to organ donation when a Covered Person is donating organ or tissue to a non-Covered Person.
- (104) Except as otherwise Preauthorized by this Plan, **transplant services** and all related services and supplies when received from any Provider not designated by this Plan as an In-Network Coventry Transplant Network facility.
- (105) **Travel or accommodations.** Charges for travel or accommodations, whether or not recommended by a Physician, except for ambulance charges or transplant travel as defined as a Covered Charge.
- (106) **Treatment of drug abuse or alcoholism** provided by halfway houses, boot camps and wilderness programs.
- (107) **Treatment of teeth**, charges for or in connection with: treatment of Injury or disease of the teeth; treatment of gums or structures directly supporting or attached to the teeth; removal or replacement of teeth; dental implants; or the nerves or roots of the teeth (excepted as stated under "Medical Benefits").

- (108) **Vision care** and optometry services except as specified in the Schedule of Benefits, except the following vision care and optometry services are never covered under this Plan:
- Lenses not requiring a prescription from a vision care Provider;
 - Sunglasses available with or without a prescription;
 - Industrial (3mm) safety lenses and safety frames with side shields;
 - Replacement of lost, stolen, broken or damaged lenses, contact lenses or frames
 - Replacement of current lenses, contact lenses or frames when there is not a prescription change of ½ diopter or more;
 - Services or supplies in connection with:
 - § examinations to determine the need for or change in prescription or other examination related to wearing eyeglasses or lenses of any type;
 - § eyeglasses or lenses of any type, except as specified in the Schedule of Benefits;
 - § eye surgery, such as radial keratotomy, laser corneal resurfacing, or other surgery, when the primary purpose is to correct myopia (nearsightedness), hyperopia (farsightedness) or astigmatism (blurring); or
 - § vision training, vision therapy or orthoptics.
- (110) Charges for methods of treatment to alter **vertical dimension**.
- (111) **Vocational therapy**.
- (112) **War**. Any loss that is due to a declared or undeclared act of war. War means declared or undeclared war, whether civil or international, or any substantial armed conflict between organized forces of a military nature.
- (113) **Weight reduction**. Charges for services, supplies or treatment primarily for weight reduction or treatment of obesity, including, but not limited to: exercise programs or use of exercise equipment; special diets or diet supplements, appetite suppressants; Nutri/System, Weight Watchers or similar programs; and Hospital confinements for weight reduction programs. However, office visits in connection with weight reduction shall be a Covered Charge.
- (114) **Work hardening programs** regardless of diagnosis or symptoms.
- (115) **Work related** Injuries or Illnesses. Charges for or in connection if an Illness or Injury for which the Employee or Dependent is entitled to benefits under any Workers' Compensation or similar law.

HOW TO SUBMIT A CLAIM

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

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

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

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

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

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

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

WHEN CLAIMS SHOULD BE FILED

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

- (a) it's not reasonably possible to submit the Claim in that time; and
- (b) the Claim is submitted within one year from the date incurred. This one year period will not apply when the person is not legally capable of submitting the Claim.

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

CLAIMS REVIEW AND APPEALS

Informal Inquiry Process

Most Complaints begin as an informal inquiry. Covered Persons should direct informal inquiries to the Plan via the Customer Service Department Monday through Friday from 8:00 a.m. to 5:00 p.m. Eastern Time at the telephone number listed below:

Toll-free 1-800-735-4404 or 1-800-788-8445
HealthAmerica
P.O. Box 67103
Harrisburg, PA 17106-7103

A Customer Service Associate will review, research and resolve the inquiry. The Covered Person will be informed of the resolution within thirty (30) days. At the time of resolution, if the decision is adverse to the Covered Person, the Covered Person will be advised of his/her right to request a formal Complaint. Covered Persons also have the right to bypass the informal inquiry procedures and immediately file a formal Complaint.

The Plan has an Appeal process with two (2) levels of review and an expedited internal Appeal process for Urgent Care Appeals.

The Covered Person or Authorized Representative may file a written or oral Appeal by contacting the Claims Administrator at the appropriate address and telephone number. If the Covered Person consents to the filing of an Appeal by an Authorized Representative under this section, the Covered Person may not file a separate Appeal. Appeals will be handled by an Appeal coordinator who may involve other staff of the Claims Administrator or Network Providers. The objective is to review all the facts and to handle the Appeal as quickly and as courteously as possible. If the solution is satisfactory to the Covered Person or Authorized Representative and the Plan, the matter ends.

First Level Appeal Process (Non-Urgent)

The Covered Person or Authorized Representative has one hundred and eighty (180) days after receipt of the initial notice of Adverse Benefit Determination to file an Appeal with the Plan. Requests received after one hundred and eighty (180) days will not be eligible for the Appeal process. The first level Appeal may be submitted in writing or orally. If submitted in writing, it should be sent to HealthAmerica, P.O. Box 67103, Harrisburg, PA 17106-7103, Attention: Appeal Process.

Each first level Appeal review includes an investigation of the Appeal and a review by an initial review committee. The committee consists of one or more individuals chosen by the Plan who were not involved in the event that caused the Appeal. When appropriate, the committee will include a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment for which the Covered Person is seeking coverage, or will include his or her consultative report in their deliberations. The Covered Person or Authorized Representative may submit written data or other information for the committee's review.

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

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

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

Second Level Appeal Process (Non-Urgent)

If the Covered Person or Authorized Representative is not satisfied with the decision of the first level Appeal committee, a request for a second level review of the Appeal may be submitted orally or in writing. If submitted in writing, it should be sent to HealthAmerica, P.O. Box 67103, Harrisburg, PA 17106-7103, Attention: Appeal Process. A Covered Person has forty-five (45) days from receipt of the notice of the review committee's decision to request the second level Appeal review.

Each second level Appeal review includes the following:

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

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

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

This notification shall include the basis and clinical rationale for the decision and is binding.

The Covered Person or Authorized Representative is not entitled to further Appeal under the Plan's Appeal processes after the Plan's final decision regarding payment for a service that is the subject of a second level Appeal.

Urgent Care Appeal Process

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

Autism Expedited Internal Appeal Process

The Covered Person has the right to an expedited (faster) internal Appeal of a denied Claim or partially denied Claim related to Autism Spectrum Disorders. The requirements for an expedited review are explained below. If the Covered Person prefers a non-expedited review, or if miss the deadlines explained are missed for an expedited review, the Appeal will follow the standard internal review procedures as explained in this Plan Document.

A Covered Person or Authorized Representative may request an expedited review of a denied Claim or partially denied Claim related to Autism Spectrum Disorders. The expedited autism Appeal may be submitted in writing or orally. If submitted in writing, it should be sent to: **HealthAmerica, P.O. Box 67103, Harrisburg, PA 17106-7103, Attention: Autism Expedited Appeal Process.**

A Covered Person or Authorized Representative has one hundred eighty (180) days in which to file the autism Appeal with the Claims Administrator. Requests received after one-hundred eighty (180) days will not be eligible for the autism expedited Appeal process.

Each autism expedited review includes an investigation of the Appeal and a review by a committee. This committee consists of one or more Employees of the Claims Administrator who were not involved in the event that caused the Appeal. At least one of the individuals on the committee will be a Physician or, when appropriate, a licensed psychologist, in the same or similar specialty that typically manages or consults on the health care service in question. The Covered Person or Authorized Representative may submit written data or other information for the committee review.

The autism Appeal review will be completed and written notification of the committee's decision will be sent to the

Covered Person and/or Authorized Representative within forty-eight (48) hours of the filing of the autism Appeal. This notification shall include the basis and clinical rationale for the decision and the procedure to file a request for a second level review of the decision.

Autism External Appeal Process

If the Covered Person is not satisfied with the committee's decision regarding the autism internal Appeal, the Covered Person may request an independent external review through the process established and administered by the Pennsylvania Department of Insurance ("PID"). In order to request an external Appeal review, the Covered Person must have completed the Claims Administrator's internal Appeal process.

The Covered Person has the right to an expedited (faster) external Appeal of a denied Claim or partially denied Claim related to Autism Spectrum Disorders. If the Covered Person prefers a non-expedited review, or if the Covered Person misses the deadlines explained below for an expedited review, the Appeal will follow the non-expedited external Appeal process. The requirements for both expedited and non-expedited external reviews are explained below.

All external autism Appeal requests must be submitted in writing. The request should be sent to the Claims Administrator's address **HealthAmerica, P.O. Box 67103, Harrisburg, PA 17106-7103, Attention: Autism Expedited Appeal Process**. The request should include justification for the request and all reasonably necessary supporting information. The Claims Administrator will coordinate the external autism Appeal with the PID, following all guidelines established by it.

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

- Non-expedited Appeals - within fifteen (15) days following receipt of the notice of the internal review committee's decision.
- Expedited Appeals - within two (2) business days following receipt of the notice of the internal review committee's decision

The Claims Administrator will notify the Covered Person and/or Authorized Representative and the PID of the external Appeal request within the following time periods:

- Non-expedited Appeals - five (5) business days of receiving the Covered Person or Authorized Representative's request for an independent external review.
- Expedited Appeals – twenty-four (24) hours of receiving the Covered Person or Authorized Representative's request for an independent external review.
- The PID will assign a utilization review entity (URE) to conduct the external review within two (2) business days of receiving the request for external review. In the absence of an assigned URE by the PID, the Claims Administrator will designate and notify a URE. (Note that URE selection will not occur on weekends or on holidays observed by the Commonwealth of Pennsylvania.)

The Claims Administrator will notify the Covered Person or Authorized Representative of the name, address and telephone number of the URE assigned for the external review within the following time periods:

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

The Claims Administrator shall forward to the URE conducting the external review copies of all written documentation regarding the Appeal, including the decisions, all reasonably necessary supporting information, a summary of applicable issues and the basis and clinical rationale for the decisions. The Covered Person may also submit any additional written information by sending it to both the Claims Administrator and the URE. All information must be submitted within the following time periods:

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

The URE conducting the external Appeal shall review all information considered in reaching any prior decisions and any other written submission by the Covered Person or Authorized Representative. The URE conducting the external Appeal shall issue a written decision, including the basis and clinical rationale for the decision to the Claims Administrator, the Covered Person, and Authorized Representative. The written decision will be sent within the following time periods:

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

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

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

COORDINATION OF BENEFITS

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

The plan that pays first according to the rules will pay as if there were no other plan involved. The secondary and subsequent plans will pay the balance due up to 100% of the total Allowable Charges.

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

- (1) Group or group-type plans, including franchise or blanket benefit plans.
- (2) Blue Cross and Blue Shield group plans.
- (3) Group practice and other group prepayment plans.
- (4) Federal government plans or programs. This includes, but is not limited to, Medicare and Tricare.
- (5) Other plans required or provided by law. This does not include Medicaid or any benefit plan like it that, by its terms, does not allow coordination.
- (6) No Fault Auto Insurance, by whatever name it is called, when not prohibited by law.

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

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

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

Automobile limitations. When medical payments are available under vehicle insurance, the Plan shall always be considered the secondary carrier regardless of the individual's election under PIP (personal Injury protection) coverage with the auto carrier.

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

- (1) Plans that do not have a coordination provision, or one like it, will pay first. Plans with such a provision will be considered after those without one.
- (2) Plans with a coordination provision will pay their benefits up to the Allowable Charge:
 - (a) The benefits of the plan which covers the person directly (that is, as an Employee, member or subscriber) ("Plan A") are determined before those of the plan which covers the person as a Dependent ("Plan B").
 - (b) The benefits of a benefit plan which covers a person as an Employee who is neither laid off nor retired are determined before those of a benefit plan which covers that person as a laid-off or Retired Employee. The benefits of a benefit plan which covers a person as a Dependent of an Employee who is neither laid off nor retired are determined before those of a benefit plan which covers a person as a Dependent of a laid off or Retired Employee. If the other benefit plan does

not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.

- (c)** The benefits of a benefit plan which covers a person as an Employee who is neither laid off nor retired or a Dependent of an Employee who is neither laid off nor retired are determined before those of a plan which covers the person as a COBRA beneficiary.
- (d)** When a Child is covered as a Dependent and the parents are not separated or divorced, these rules will apply:

 - (i)** The benefits of the benefit plan of the parent whose birthday falls earlier in a year are determined before those of the benefit plan of the parent whose birthday falls later in that year;
 - (ii)** If both parents have the same birthday, the benefits of the benefit plan which has covered the parent for the longer time are determined before those of the benefit plan which covers the other parent.
- (e)** When a Child's parents are divorced or legally separated, these rules will apply:

 - (i)** This rule applies when the parent with custody of the Child has not remarried. The benefit plan of the parent with custody will be considered before the benefit plan of the parent without custody.
 - (ii)** This rule applies when the parent with custody of the Child has remarried. The benefit plan of the parent with custody will be considered first. The benefit plan of the stepparent that covers the Child as a Dependent will be considered next. The benefit plan of the parent without custody will be considered last.
 - (iii)** This rule will be in place of items (i) and (ii) above when it applies. A court decree may state which parent is financially responsible for medical and dental benefits of the Child. In this case, the benefit plan of that parent will be considered before other plans that cover the Child as a Dependent.
 - (iv)** If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the Child, the plans covering the Child shall follow the order of benefit determination rules outlined above when a Child is covered as a Dependent and the parents are not separated or divorced.
 - (v)** For parents who were never married to each other, the rules apply as set out above as long as paternity has been established.
- (f)** If there is still a conflict after these rules have been applied, the benefit plan which has covered the patient for the longer time will be considered first. When there is a conflict in coordination of benefit rules, the Plan will never pay more than 50% of Allowable Charges when paying secondary.
- (3)** Medicare will pay primary, secondary or last to the extent stated in federal law. When Medicare would be the primary payer if the person had enrolled in Medicare, this Plan will base its payment upon benefits that would have been paid by Medicare under Parts A and B regardless of whether or not the person was enrolled under any of these parts. The Plan reserves the right to coordinate benefits with respect to Medicare Part D. The Plan Administrator will make this determination based on the information available through CMS. If CMS does not provide sufficient information to determine the amount Medicare would pay, the Plan Administrator will make reasonable assumptions based on published Medicare fee schedules.
- (4)** If a Plan Participant is under a disability extension from a previous benefit plan, that benefit plan will pay first and this Plan will pay second.

(5) The Plan will pay primary to Tricare and a State Child health plan to the extent required by federal law.

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

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

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

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

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

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

THIRD PARTY RECOVERY PROVISION

RIGHT OF SUBROGATION AND REIMBURSEMENT

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

1. In the event that benefits are provided under this Plan, the Plan shall be subrogated to all of the Covered Person's (the term Covered Person includes any person receiving benefits hereunder including all Dependents) rights of Recovery against any person or organization to the extent of the benefits provided. The Covered Person shall execute and deliver instruments and papers and do whatever else is necessary to secure such rights. The Covered Person shall do nothing after loss to prejudice such rights. The Covered Person hereby agrees to cooperate with the Plan and/or any representatives of the Plan in completing such forms and in giving such information surrounding any accident as the Plan or its representatives deem necessary to fully investigate the incident.
2. The Plan is also granted a right of reimbursement from the proceeds of any Recovery whether by settlement, judgment, or otherwise. This right of reimbursement is cumulative with and not exclusive of the Subrogation right granted in paragraph 1, but only to the extent of the benefits provided by the Plan.
3. The Plan, by providing benefits hereunder, is hereby granted a lien on the proceeds of any settlement, judgment or other payment intended for, payable to, or received by the Covered Person or his/her representatives, and the Covered Person hereby consents to said lien and agrees to take whatever steps are necessary to help the company secure said lien. The Covered Person agrees that said lien shall constitute a charge upon the proceeds of any Recovery and the Plan shall be entitled to assert security interest thereon. By the acceptance of benefits under the Plan, the Covered Person and his/her representatives agree to hold the proceeds of any settlement in trust for the benefit of the Plan to the extent of 100% of all benefits paid on behalf of the Covered Person.
4. By accepting benefits hereunder, the Covered Person hereby grants a lien and assigns to the Plan an amount equal to the benefits paid against any Recovery made by or on behalf of the Covered Person. This assignment is binding on any attorney who represents the Covered Person whether or not an agent of the Covered Person and on any insurance company or other financially responsible party against whom a Covered Person may have a Claim provided said attorney, insurance carriers or others have been notified by the Plan or its agents.
5. The Subrogation and reimbursement rights and liens apply to any Recoveries made by the Covered Person as a result of the Injuries sustained, including but not limited to the following:
 - a. Payments made directly by the third party tortfeasor, or any insurance company on behalf of the third party tortfeasor, or any other payments on behalf of the third party tortfeasor.
 - b. Any payments or settlements or judgment or arbitration awards paid by any insurance company under an uninsured or underinsured motorist coverage, whether on behalf of a Covered Person or other person.
 - c. Any other payments from any source designed or intended to compensate a Covered Person for Injuries sustained as the result of negligence or alleged negligence of a third party.
 - d. Any worker's compensation award or settlement.
 - e. Any Recovery made pursuant to no-fault insurance.

- f. Any medical payments made as a result of such coverage in any automobile or homeowners insurance policy.
6. No adult Covered Person hereunder may assign any rights that it may have to Recover medical expenses from any tortfeasor or other person or entity to any minor Child or Children of said adult Covered Person without the prior express written consent of the Plan. The Plan's right to Recover (whether by Subrogation or reimbursement) shall apply to decedents', minors', and incompetent or disabled persons' settlements or Recoveries.
7. No Covered Person shall make any settlement, which specifically reduces or excludes, or attempts to reduce or exclude the benefits provided by the Plan.
8. The Plan's right of Recovery shall be a prior lien against any proceeds Recovered by the Covered Person, which right shall not be defeated nor reduced by the application of any so-called "Made-Whole Doctrine", "Rimes Doctrine", or any other such doctrine purporting to defeat the Plan's Recovery rights by allocating the proceeds exclusively to non-medical expense damages.
9. No Covered Person hereunder shall incur any expenses on behalf of the Plan in pursuit of the Plan's rights hereunder, specifically, no court costs nor attorneys fees may be deducted from the Plan's Recovery without the prior express written consent of the Plan. This right shall not be defeated by any so-called "Fund Doctrine", or "Common Fund Doctrine", or "Attorney's Fund Doctrine".
10. The Plan shall Recover the full amount of benefits provided hereunder without regard to any Claim of fault on the part of any Covered Person, whether under comparative negligence or otherwise.
11. The benefits under this Plan are secondary to any coverage under no-fault or similar insurance.

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

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

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

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

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

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

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

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

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

CONTINUATION COVERAGE RIGHTS UNDER COBRA

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

The Plan Administrator is Juniata College, 1700 Moore Street, Huntingdon, Pennsylvania, 16652-2196, 814-641-3197. COBRA continuation coverage for the Plan is administered by Ameriflex, 3000 Internet Blvd., Suite 200, Frisco, Texas 75034,. Complete instructions on COBRA, as well as election forms and other information, will be provided by the Plan Administrator or its designee to Plan Participants who become Qualified Beneficiaries under COBRA.

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

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

- (1) Any individual who, on the day before a Qualifying Event, is covered under a Plan by virtue of being on that day either a covered Employee, the Spouse of a covered Employee, or a Dependent Child of a covered Employee. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.
- (2) Any Child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, and any individual who is covered by the Plan as an alternate recipient under a qualified medical support order. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.
- (3) A covered Employee who retired on or before the date of substantial elimination of Plan coverage which is the result of a bankruptcy proceeding under Title 11 of the U.S. Code with respect to the Employer, as is the Spouse, surviving Spouse or Dependent Child of such a covered Employee if, on the day before the bankruptcy Qualifying Event, the Spouse, surviving Spouse or Dependent Child was a beneficiary under the Plan.

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

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

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

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

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

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

- (1) The death of a covered Employee.
- (2) The termination (other than by reason of the Employee's gross misconduct), or reduction of hours, of a covered Employee's employment.
- (3) The divorce or legal separation of a covered Employee from the Employee's Spouse. If the Employee reduces or eliminates the Employee's Spouse's Plan coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a Qualifying Event even though the Spouse's coverage was reduced or eliminated before the divorce or legal separation.
- (4) A covered Employee's enrollment in any part of the Medicare program.
- (5) A Dependent Child's ceasing to satisfy the Plan's requirements for a Dependent Child (for example, attainment of the maximum age for dependency under the Plan).
- (6) A proceeding in bankruptcy under Title 11 of the U.S. Code with respect to an Employer from whose employment a covered Employee retired at any time.

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

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

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

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

What is the election period and how long must it last? The election period is the time period within which the Qualified Beneficiary must elect COBRA continuation coverage under the Plan. The election period must begin no later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event and ends 60 days after the later of the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event or the date notice is provided to the Qualified Beneficiary of her or his right to elect COBRA continuation coverage. If coverage is not elected within the 60 day period, all rights to elect COBRA continuation coverage are forfeited.

Note: If a covered Employee who has been terminated or experienced a reduction of hours qualifies for a trade readjustment allowance or alternative trade adjustment assistance under a federal law called the Trade Act of 2002, and the Employee and his or her covered Dependents have not elected COBRA coverage within the normal election period, a second opportunity to elect COBRA coverage will be made available for themselves and certain family members, but only within a limited period of 60 days or less and only during the six months immediately after their group health plan coverage ended. Any person who qualifies or thinks that he and/or his family members may qualify for assistance under this special provision should contact the Plan Administrator for further information about the special second election period.

The Trade Act of 2002 also created a tax credit for certain TAA-eligible individuals and for certain retired Employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) (eligible individuals). Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. If You have questions about these new tax provisions, You may call the Health Coverage Tax Credit Consumer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact.

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

- (1) the end of employment or reduction of hours of employment,
- (2) death of the Employee,
- (3) commencement of a proceeding in bankruptcy with respect to the Employer, or
- (4) entitlement of the Employee to any part of Medicare.

IMPORTANT:

For the other Qualifying Events (divorce, termination of Domestic Partnership or legal separation of the Employee and Spouse or a Dependent Child's losing eligibility for coverage as a Dependent Child), You or someone on Your behalf must notify the Plan Administrator or its designee in writing within 60 days after the

Qualifying Event occurs, using the procedures specified below. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator or its designee during the 60-day notice period, any Spouse or Dependent Child who loses coverage will not be offered the option to elect continuation coverage. You must send this notice to the COBRA Administrator.

NOTICE PROCEDURES:

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

Ameriflex
3000 Internet Blvd., Suite 200
Frisco, Texas 75034

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

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

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

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

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

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

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

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

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

- (2) The first day for which Timely Payment is not made to the Plan with respect to the Qualified Beneficiary.
- (3) The date upon which the Employer ceases to provide any group health plan (including a successor plan) to any Employee.
- (4) The date, after the date of the election, that the Qualified Beneficiary first becomes covered under any other Plan that does not contain any exclusion or limitation with respect to any pre-existing condition, other than such an exclusion or limitation that does not apply to, or is satisfied by, the Qualified Beneficiary.
- (5) The date, after the date of the election, that the Qualified Beneficiary first becomes entitled to Medicare (either part A or part B, whichever occurs earlier). The Qualified Beneficiary must immediately notify the Plan Administrator of any such enrollment in Medicare. The notice must be provided as described in the Notice Procedures above.
- (6) In the case of a Qualified Beneficiary entitled to a disability extension, the later of:
 - (a) (i) 29 months after the date of the Qualifying Event, or (ii) the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier; or
 - (b) the end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension.

The Plan can terminate for cause the coverage of a Qualified Beneficiary on the same basis that the Plan terminates for cause the coverage of similarly situated non-COBRA beneficiaries, for example, for the submission of a fraudulent Claim.

In the case of an individual who is not a Qualified Beneficiary and who is receiving coverage under the Plan solely because of the individual's relationship to a Qualified Beneficiary, if the Plan's obligation to make COBRA continuation coverage available to the Qualified Beneficiary ceases, the Plan is not obligated to make coverage available to the individual who is not a Qualified Beneficiary.

What are the maximum coverage periods for COBRA continuation coverage? The maximum coverage periods are based on the type of the Qualifying Event and the status of the Qualified Beneficiary, as shown below:

- (1) In the case of a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period ends 18 months after the Qualifying Event if there is not a disability extension and 29 months after the Qualifying Event if there is a disability extension.
- (2) In the case of a covered Employee's enrollment in the Medicare program before experiencing a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period for Qualified Beneficiaries ends on the later of:
 - (a) 36 months after the date the covered Employee becomes enrolled in the Medicare program. This extension does not apply to the covered Employee; or
 - (b) 18 months (or 29 months, if there is a disability extension) after the date of the covered Employee's termination of employment or reduction of hours of employment.
- (3) In the case of a bankruptcy Qualifying Event, the maximum coverage period for a Qualified Beneficiary who is the covered retiree ends on the date of the retiree's death. The maximum coverage period for a Qualified Beneficiary who is the covered Spouse, surviving Spouse or Dependent Child of the retiree ends on the earlier of the Qualified Beneficiary's death or 36 months after the death of the retiree.
- (4) In the case of a Qualified Beneficiary who is a Child born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, the maximum coverage period is the

maximum coverage period applicable to the Qualifying Event giving rise to the period of COBRA continuation coverage during which the Child was born or placed for adoption.

- (5) In the case of any other Qualifying Event than that described above, the maximum coverage period ends 36 months after the Qualifying Event.

Under what circumstances can the maximum coverage period be expanded? If a Qualifying Event that gives rise to an 18-month or 29-month maximum coverage period is followed, within that 18- or 29-month period, by a second Qualifying Event that gives rise to a 36-months maximum coverage period, the original period is expanded to 36 months, but only for individuals who are Qualified Beneficiaries at the time of and with respect to both Qualifying Events. In no circumstance can the COBRA maximum coverage period be expanded to more than 36 months after the date of the first Qualifying Event. The Plan Administrator must be notified of the second Qualifying Event within 60 days of the second Qualifying Event. This notice must be sent to the COBRA Administrator in accordance with the procedures above.

How does a Qualified Beneficiary become entitled to a disability extension? A disability extension will be granted if an individual (whether or not the covered Employee) who is a Qualified Beneficiary in connection with the Qualifying Event that is a termination or reduction of hours of a covered Employee's employment, is determined under Title II or XVI of the Social Security Act to have been disabled at any time during the first 60 days of COBRA continuation coverage. To qualify for the disability extension, the Qualified Beneficiary must also provide the Plan Administrator with notice of the disability determination on a date that is both within 60 days after the date of the determination and before the end of the original 18-month maximum coverage. This notice should be sent to the COBRA Administrator in accordance with the procedures above.

Does the Plan require payment for COBRA continuation coverage? For any period of COBRA continuation coverage under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. Qualified beneficiaries will pay up to 102% of the applicable premium and up to 150% of the applicable premium for any expanded period of COBRA continuation coverage covering a disabled Qualified Beneficiary due to a disability extension. The Plan will terminate a Qualified Beneficiary's COBRA continuation coverage as of the first day of any period for which timely payment is not made.

Must the Plan allow payment for COBRA continuation coverage to be made in monthly installments? Yes. The Plan is also permitted to allow for payment at other intervals.

What is Timely Payment for payment for COBRA continuation coverage? Timely Payment means a payment made no later than 30 days after the first day of the coverage period. Payment that is made to the Plan by a later date is also considered Timely Payment if either under the terms of the Plan, covered Employees or Qualified Beneficiaries are allowed until that later date to pay for their coverage for the period or under the terms of an arrangement between the Employer and the entity that provides Plan benefits on the Employer's behalf, the Employer is allowed until that later date to pay for coverage of similarly situated non-COBRA beneficiaries for the period.

Notwithstanding the above paragraph, the Plan does not require payment for any period of COBRA continuation coverage for a Qualified Beneficiary earlier than 45 days after the date on which the election of COBRA continuation coverage is made for that Qualified Beneficiary. Payment is considered made on the date on which it is postmarked to the Plan.

If Timely Payment is made to the Plan in an amount that is not significantly less than the amount the Plan requires to be paid for a period of coverage, then the amount paid will be deemed to satisfy the Plan's requirement for the amount to be paid, unless the Plan notifies the Qualified Beneficiary of the amount of the deficiency and grants a reasonable period of time for payment of the deficiency to be made. A "reasonable period of time" is 30 days after the notice is provided. A shortfall in a Timely Payment is not significant if it is no greater than the lesser of \$50 or 10% of the required amount.

IF YOU HAVE QUESTIONS

If You have questions about Your COBRA continuation coverage, You should contact the COBRA Administrator. For more information about Your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office

of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

KEEP YOUR PLAN ADMINISTRATOR INFORMED OF ADDRESS CHANGES

In order to protect Your family's rights, You should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for Your records, of any notices You send to the Plan Administrator.

RESPONSIBILITIES FOR PLAN ADMINISTRATION

PLAN ADMINISTRATOR. Juniata College Employee Benefit Plan is the benefit plan of Juniata College, the Plan Administrator, also called the Plan Sponsor. It is to be administered by the Plan Administrator in accordance with the provisions of ERISA. An individual or committee may be appointed by Juniata College to be Plan Administrator and serve at the convenience of the Employer. If the Plan Administrator or a committee member resigns, dies or is otherwise removed from the position, Juniata College shall appoint a new Plan Administrator as soon as reasonably possible.

The Plan Administrator shall administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits, to decide disputes which may arise relative to a Plan Participant's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator will be final and binding on all interested parties.

Should any provision of this Plan help to be unlawful, or be unlawful as to any person or instance, such fact will not adversely affect the other provisions herein contained or the application of said programs to any other person or instance, unless such illegality will make impossible the functioning of this Plan.

Service of legal process may be made upon the Plan Administrator.

DUTIES OF THE PLAN ADMINISTRATOR.

- (1) To administer the Plan in accordance with its terms.
- (2) To interpret the Plan, including the right to remedy possible ambiguities, inconsistencies or omissions.
- (3) To decide disputes which may arise relative to a Plan Participant's rights.
- (4) To prescribe procedures for filing a Claim for benefits and to review Claim denials.
- (5) To keep and maintain the Plan documents and all other records pertaining to the Plan.
- (6) To appoint a Claims Administrator to pay Claims.
- (7) To perform all necessary reporting as required by ERISA.
- (8) To establish and communicate procedures to determine whether a medical Child support order is qualified under ERISA Sec. 609.
- (9) To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate.

PLAN ADMINISTRATOR COMPENSATION. The Plan Administrator serves **without** compensation; however, all expenses for plan administration, including compensation for hired services, will be paid by the Plan.

FIDUCIARY. A fiduciary exercises discretionary authority or control over management of the Plan or the disposition of its assets, renders investment advice to the Plan or has discretionary authority or responsibility in the administration of the Plan.

FIDUCIARY DUTIES. A fiduciary must carry out his or her duties and responsibilities for the purpose of providing benefits to the Employees and their Dependent(s), and defraying reasonable expenses of administering the Plan. These are duties which must be carried out:

- (1) with care, skill, prudence and diligence under the given circumstances that a prudent person, acting in a like capacity and familiar with such matters, would use in a similar situation;
- (2) by diversifying the investments of the Plan so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so; and

- (3) in accordance with the Plan documents to the extent that they agree with ERISA.

THE NAMED FIDUCIARY. A "named fiduciary" is the one named in the Plan. A named fiduciary can appoint others to carry out fiduciary responsibilities (other than as a trustee) under the Plan. These other persons become fiduciaries themselves and are responsible for their acts under the Plan. To the extent that the named fiduciary allocates its responsibility to other persons, the named fiduciary shall not be liable for any act or omission of such person unless either:

- (1) the named fiduciary has violated its stated duties under ERISA in appointing the fiduciary, establishing the procedures to appoint the fiduciary or continuing either the appointment or the procedures; or
- (2) the named fiduciary breached its fiduciary responsibility under Section 405(a) of ERISA.

CLAIMS ADMINISTRATOR IS NOT A FIDUCIARY. A Claims Administrator is **not** a fiduciary under the Plan by virtue of paying Claims in accordance with the Plan's rules as established by the Plan Administrator.

CLAIMS ADMINISTRATOR DISCRETION. The Plan Administrator has designated to the Claims Administrator the authority to construe and interpret the terms and provisions of the Plan for purposes of making Claims determinations, to decide disputes which may arise relative to a Plan Participant's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan.

COMPLIANCE WITH HIPAA PRIVACY STANDARDS. Certain members of the Employer's workforce perform services in connection with administration of the Plan. In order to perform these services, it is necessary for these Employees from time to time to have access to Protected Health Information (as defined below).

Under the Standards for Privacy of Individually Identifiable Health Information (45 CFR Part 164, the "Privacy Standards"), these Employees are permitted to have such access subject to the following:

- (1) **General.** The Plan shall not disclose Protected Health Information to any member of the Employer's workforce unless each of the conditions set out in this HIPAA Privacy section is met. "Protected Health Information" shall have the same definition as set out in the Privacy Standards but generally shall mean individually identifiable health information about the past, present or future physical or mental health or condition of an individual, including information about treatment or payment for treatment.
- (2) **Permitted Uses and Disclosures.** Protected Health Information disclosed to members of the Employer's workforce shall be used or disclosed by them only for purposes of Plan administrative functions. The Plan's administrative functions shall include all Plan payment and health care operations. The terms "payment" and "health care operations" shall have the same definitions as set out in the Privacy Standards, but the term "payment" generally shall mean activities taken with respect to payment of premiums or contributions, or to determine or fulfill Plan responsibilities with respect to coverage, provision of benefits, or reimbursement for health care. "Health care operations" generally shall mean activities on behalf of the Plan that are related to quality assessment; evaluation, training or accreditation of health care Providers; underwriting, premium rating and other functions related to obtaining or renewing an insurance contract, including stop-loss insurance; medical review; legal services or auditing functions; or business planning, management and general administrative activities. Genetic information will not be used or disclosed for underwriting purposes.
- (3) **Authorized Employees.** The Plan shall disclose Protected Health Information only to members of the Employer's workforce who are designated and are authorized to receive such Protected Health Information, and only to the extent and in the minimum amount necessary for these persons to perform duties with respect to the Plan. For purposes of this HIPAA Privacy section, "members of the Employer's workforce" shall refer to all Employees and other persons under the control of the Employer.
 - (a) **Updates Required.** The Employer shall amend the Plan promptly with respect to any changes in the members of its workforce who are authorized to receive Protected Health Information.

- (b) **Use and Disclosure Restricted.** An authorized member of the Employer's workforce who receives Protected Health Information shall use or disclose the Protected Health Information only to the extent necessary to perform his or her duties with respect to the Plan.
- (c) **Resolution of Issues of Noncompliance.** In the event that any member of the Employer's workforce uses or discloses Protected Health Information other than as permitted by the Privacy Standards, the incident shall be reported to the privacy official. The privacy official shall take appropriate action, including:
 - (i) Investigation of the incident to determine whether the breach occurred inadvertently, through negligence, or deliberately; whether there is a pattern of breaches; and the degree of harm caused by the breach;
 - (ii) Applying appropriate sanctions against the persons causing the breach, which, depending upon the nature of the breach, may include, oral or written reprimand, additional training, or termination of employment;
 - (iii) Mitigating any harm caused by the breach, to the extent practicable; and
 - (iv) Documentation of the incident and all actions taken to resolve the issue and mitigate any damages.
- (4) **Certification of Employer.** The Employer must provide certification to the Plan that it agrees to:
 - (a) Not use or further disclose the Protected Health Information other than as permitted or required by the Plan documents or as required by law;
 - (b) Ensure that any agent or subcontractor, to whom it provides Protected Health Information received from the Plan, agrees to the same restrictions and conditions that apply to the Employer with respect to such information;
 - (c) Not use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other benefit or Employee benefit plan of the Employer;
 - (d) Report to the Plan any use or disclosure of the Protected Health Information of which it becomes aware that is inconsistent with the uses or disclosures hereunder or required by law;
 - (e) Make available Protected Health Information to individual Plan members in accordance with Section 164.524 of the Privacy Standards;
 - (f) Make available Protected Health Information for amendment by individual Plan members and incorporate any amendments to Protected Health Information in accordance with Section 164.526 of the Privacy Standards;
 - (g) Make available the Protected Health Information required to provide any accounting of disclosures to individual Plan members in accordance with Section 164.528 of the Privacy Standards;
 - (h) Make its internal practices, books and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Department of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Standards;
 - (i) If feasible, return or destroy all Protected Health Information received from the Plan that the Employer still maintains in any form, and retain no copies of such information when no longer needed for the purpose of which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information unfeasible; and

- (j) Ensure the adequate separation between the Plan and member of the Employer's workforce, as required by Section 164.504(f)(2)(iii) of the Privacy Standards.

The following members of Juniata College's workforce are designated as authorized to receive Protected Health Information from Juniata College Employee Benefit Plan ("the Plan") in order to perform their duties with respect to the Plan: Plan Administrator.

COMPLIANCE WITH HIPAA ELECTRONIC SECURITY STANDARDS. Under the Security Standards for the Protection of Electronic Protected Health Information (45 CFR Part 164.300 et. seq., the "Security Standards"), the Employer agrees to the following:

- (1) The Employer agrees to implement reasonable and appropriate administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of Electronic Protected Health Information that the Employer creates, maintains or transmits on behalf of the Plan. "Electronic Protected Health Information" shall have the same definition as set out in the Security Standards, but generally shall mean Protected Health Information that is transmitted by or maintained in electronic media.
- (2) The Employer shall ensure that any agent or subcontractor to whom it provides Electronic Protected Health Information shall agree, in writing, to implement reasonable and appropriate security measures to protect the Electronic Protected Health Information.
- (3) The Employer shall ensure that reasonable and appropriate security measures are implemented to comply with the conditions and requirements set forth in Compliance With HIPAA Privacy Standards provisions (3) Authorized Employees and (4) Certification of Employers described above.

FUNDING THE PLAN AND PAYMENT OF BENEFITS

The cost of the Plan is funded as follows:

For Employee and Dependent Coverage: Funding is derived from the funds of the Employer and contributions made by the covered Employees.

The level of any Employee contributions will be set by the Plan Administrator. These Employee contributions will be used in funding the cost of the Plan as soon as practicable after they have been received from the Employee or withheld from the Employee's pay through payroll deduction.

Benefits are paid directly from the Plan through the Claims Administrator.

PLAN IS NOT AN EMPLOYMENT CONTRACT

The Plan is not to be construed as a contract for or of employment.

CLERICAL ERROR

Any clerical error by the Plan Administrator or an agent of the Plan Administrator in keeping pertinent records or a delay in making any changes will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered.

If, an overpayment occurs in a Plan reimbursement amount, the Plan retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money. In the case of a Plan Participant, the amount of overpayment may be deducted from future benefits payable.

AMENDING AND TERMINATING THE PLAN

If the Plan is terminated, the rights of the Plan Participants are limited to expenses incurred before termination.

The Employer reserves the right, at any time, to amend, suspend or terminate the Plan in whole or in part. This includes amending the benefits under the Plan or the Trust agreement (if any).

CERTAIN PLAN PARTICIPANTS RIGHTS UNDER ERISA

Plan Participants in this Plan are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA specifies that all Plan Participants shall be entitled to:

Examine, without charge, at the Plan Administrator's office, all Plan documents and copies of all documents governing the Plan, including a copy of the latest annual report (form 5500 series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.

Continue health care coverage for a Plan Participant, Spouse, or other Dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event. Employees or Dependents may have to pay for such coverage.

Review this summary plan description and the documents governing the Plan or the rules governing COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for Pre-Existing Conditions under this group health Plan, if an Employee or Dependent has Creditable Coverage from another plan. The Employee or Dependent should be provided a certificate of Creditable Coverage, free of charge, from the group health plan or health insurance issuer when coverage is lost under the plan, when a person becomes entitled to elect COBRA continuation coverage, when COBRA continuation coverage ceases, if a person requests it before losing coverage, or if a person requests it up to 24 months after losing coverage. Without evidence of Creditable Coverage, a Plan Participant may be subject to a Pre-Existing Conditions exclusion for 12 months (18 months for Late Enrollees) after the Enrollment Date of coverage.

If a Plan Participant's Claim for a benefit is denied or ignored, in whole or in part, the Participant has a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to Appeal any denial, all within certain time schedules.

Under ERISA, there are steps a Plan Participant can take to enforce the above rights. For instance, if a Plan Participant requests a copy of Plan documents or the latest annual report from the Plan and does not receive them within 31 days, he or she may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and to pay the Plan Participant up to \$110 a day until he or she receives the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If the Plan Participant has a Claim for benefits which is denied or ignored, in whole or in part, the Participant may file suit in state or federal court.

In addition, if a Plan Participant disagrees with the Plan's decision or lack thereof concerning the qualified status of a medical Child support order, he or she may file suit in federal court.

In addition to creating rights for Plan Participants, ERISA imposes obligations upon the individuals who are responsible for the operation of the Plan. The individuals who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of the Plan Participants and their beneficiaries. No one, including the Employer or any other person, may fire a Plan Participant or otherwise discriminate against a Plan Participant in any way to prevent the Plan Participant from obtaining benefits under the Plan or from exercising his or her rights under ERISA.

If it should happen that the Plan fiduciaries misuse the Plan's money, or if a Plan Participant is discriminated against for asserting his or her rights, he or she may seek assistance from the U.S. Department of Labor, or may file suit in a federal court. The court will decide who should pay court costs and legal fees. If the Plan Participant is successful, the court may order the person sued to pay these costs and fees. If the Plan Participant loses, the court may order him or her to pay these costs and fees, for example, if it finds the Claim or suit to be frivolous.

If the Plan Participant has any questions about the Plan, he or she should contact the Plan Administrator. If the Plan Participant has any questions about this statement or his or her rights under ERISA, including COBRA or the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, that Plan Participant should contact either the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) or visit the EBSA website at www.dol.gov/ebsa/. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

GENERAL PLAN INFORMATION

TYPE OF ADMINISTRATION

The Plan is a self-funded group health Plan and the administration is provided through a Third Party Claims Administrator. The funding for the benefits is derived from the funds of the Employer and contributions made by covered Employees. The Plan is not insured.

PLAN NAME

Juniata College Employee Benefit Plan

PLAN NUMBER: 501

TAX ID NUMBER: 23-1352652

PLAN EFFECTIVE DATE: January 1, 2003; Restated June 1, 2012

PLAN YEAR ENDS: December 31st

EMPLOYER INFORMATION

Juniata College
1700 Moore Street
Huntingdon, Pennsylvania 16652-2196
814-641-3197

PLAN ADMINISTRATOR

Juniata College
1700 Moore Street
Huntingdon, Pennsylvania 16652-2196
814-641-3197

NAMED FIDUCIARY

Juniata College
1700 Moore Street
Huntingdon, Pennsylvania 16652-2196

AGENT FOR SERVICE OF LEGAL PROCESS

Juniata College
1700 Moore Street
Huntingdon, Pennsylvania 16652-2196

CLAIMS ADMINISTRATOR

HealthAmerica
P.O. Box 67103
Harrisburg, PA 17106-7103
1-800-252-5742
www.healthamerica.cvtv.com

BY THIS AGREEMENT, Juniata College Employee Benefit Plan is hereby adopted as shown.

IN WITNESS WHEREOF, this instrument is executed for Juniata College on or as of the day and year first below written.

By _____
Juniata College

Date _____

Witness _____

Date _____

PREAUTHORIZATION EXHIBIT
Preauthorization phone lines: toll free EPA 1-800-755-1135

The following health care services require Preauthorization for Medical Necessity Review under the Utilization Management Procedures:

1. Inpatient Hospital Admissions (Acute, Skilled, Sub-acute, or Rehab)
2. Outpatient Surgeries (Hospital or freestanding surgical centers) with the exception of the following procedures: Cataract Removal, Tonsillectomy & Adenoidectomy, Myringotomy and Myringotomy with Tubes, Knee Arthroscopy, Shoulder Arthroscopy, Carpal Tunnel Release, Colonoscopy and Cardiac Catheterization.
3. Home Health/Hospice Care
4. Durable Medical Equipment (includes orthotics and prosthetics, but excludes routine items such as ostomy supplies, cock-up wrist splints, bedside commodes, canes, crutches, walkers, cervical collars, pneumatic walking splints, clavicle straps, slings, breast adhesive skin supports (post-mastectomy), pneumatic walking boots, pneumatic full leg splints, and pneumatic knee splints)
5. Out-of-Network Referral Requests including Hospital Admissions
6. Experimental/Investigational Care Needs
7. Transplant Requests
8. Pain Management Programs (structured Inpatient or Outpatient comprehensive programs), excludes individual episodic treatments such as trigger point injections or epidurals
9. Injectable Medication Requests (excludes medications administered from office stock, i.e. immunizations, Insulin)
10. Chronic Care Requests (Dialysis, Chemotherapy)

The following health care services require Preauthorization for benefit review due to limitations, exclusions, and/or Medical Necessity review:

1. Infertility Treatment (including genetic counseling)
2. TMJ
3. Autism Spectrum Disorders

The following health care services do not require Preauthorization for Medical Necessity:

1. PCP referral to a Network medical/surgical Physician specialist for office visit consultation and follow-up
2. Routine laboratory services with Network Providers
3. Routine radiology testing including ultrasounds with Network Providers
4. Women's health services, routine and preventative care (e.g. pap smears and mammograms)
5. Emergency room care follows prudent layperson legislation, no Plan Preauthorization is required

Mental Health Care Services:

When seeing an In-Network Mental Health Provider, the Covered Person is not required to obtain a Preauthorization as this is the responsibility of the Provider. The Claims Administrator encourages all Covered Persons to contact the Mental Health Vendor at 1-866-369-8362 to ensure appropriate referral.

All Mental Health and Substance Abuse services require Preauthorization with the exception of the below:

- All routine outpatient services
- Psychological testing
- Intensive Outpatient services