MIDDLEBURY COLLEGE
HEALTH AND WELFARE BENEFITS PLAN

Summary Plan Description

Retiree Version

Effective as of January 1, 2014
Revised September 11, 2014
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INTRODUCTION

This Summary Plan Description ("SPD") is intended to provide you with an easily understandable description of the main provisions of the Middlebury College Health and Welfare Benefits Plan ("Plan"). To serve this purpose, the SPD cannot explain all of the details of the Plan. IF THERE ARE ANY INCONSISTENCIES BETWEEN THIS SPD AND THE PLAN DOCUMENT, THE PLAN DOCUMENT WILL GOVERN. Separate benefit summaries, booklets or pamphlets (collectively, "Summaries") are attached to this SPD which describe the different benefits that are offered as part of the Plan. These Summaries are intended to be read with, and considered part of, this SPD. If you have questions or would like to see or obtain a copy of the Plan document, please contact the Office of Human Resources of your Employer.

This SPD is intended to primarily describe those Plan benefits available to Eligible Retirees. A separate SPD has been prepared that also describes benefits available to Eligible Employees.

I. GENERAL INFORMATION

1.1 Plan Name and Effective Date. The full name of the Plan is the Middlebury College Health and Welfare Benefits Plan, effective as of January 1, 2011. This SPD reflects the terms of the Plan in effect as of January 1, 2014, unless otherwise noted. The Plan contains benefits provided by your Employer which previously had been treated as separate plans for reporting purposes.

1.2 Plan Number. The number assigned to the Plan is 501.

1.3 Employer Information.

The President and Fellows of Middlebury College ("College")
Room 200, Service Building
Middlebury, Vermont 05753
(802) 443-5465

EIN: 03-0179298

1.4 Plan Year. The Plan Year is generally the period from January 1 through December 31. However, certain benefits offered under the Plan are currently being run on a contract year basis pursuant to the terms of each individual benefit. The Plan’s records are kept on a Plan Year basis.

1.5 Plan Administrator. The Plan Administrator is the College, or its designee, and may be contacted at the address and telephone number given above. The College is the "named fiduciary" for the Plan within the meaning of Section 402(a) of the Employee Retirement Income Security Act of 1974, as amended ("ERISA").
Although this SPD references benefits provided by your specific “Employer,” the College is responsible for administration of the Plan.

1.6 **Agent for Service of Legal Process.** The designated agent for service of legal process is the Treasurer’s Office at the following address:

The President and Fellows of Middlebury College  
Treasurer’s Office  
Middlebury, Vermont 05753

Process may also be served upon the Plan Administrator.

1.7 **Type of Plan and Eligibility.** The Plan is an employee welfare benefit plan, within the meaning of Section 3(1) of ERISA, which offers the benefits described in Section 3.1 to eligible Retired Employees (as described in Section 2.2) and their beneficiaries. The Plan also offers certain benefits to Eligible Employees, which are described in a separate SPD. Eligibility for benefits varies depending upon the type of benefit being provided.

1.8 **Discretion of Plan Administrator.** Notwithstanding any other provision in the Plan and this SPD, and to the full extent permitted by ERISA and the Code, the Plan Administrator (and its designees and representatives) has the discretionary authority to construe any uncertain or disputed term or provision in the Plan and this SPD. The Plan Administrator’s exercise of this discretionary authority shall be binding and shall be given deference on any judicial (or other) review, to the fullest extent permitted by law. Notwithstanding the foregoing, to the extent an insurer exercises sole discretionary authority or discretionary responsibility over the benefit claims procedure, it shall be the only fiduciary for purposes of the Plan with authority and discretion to construe any uncertain or disputed term or provision in its contracts, booklets and certificates.

1.9 **COBRA Continuation Coverage.** Under a Federal law referred to as COBRA, your covered spouse and dependents, have the right, at your (or their) own expense, to continue coverage that otherwise would end for the Group Health Benefits described in 3.1(a) and the Vision benefits described in 3.2(b). These rules, which are very important for you, are explained in Article V. You may have other continuation coverage rights under state law. You should contact your Employer’s Office of Human Resources for further information.

1.10 **Other Special Statutory Rules - HIPAA, FMLA and USERRA.** The usual rules of the Plan will be modified when and as applicable to comply with: (i) the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"); (ii) the Family and Medical Leave Act of 1993 ("FMLA"); and (iii) the Uniform Services Employment and Reemployment Act of 1994 ("USERRA"); contact the Plan Administrator to obtain information about any of these rules.

**HIPAA Non-Discrimination Rules:** This Plan will not deny certain Group Health Benefits in accordance with the HIPAA non-discrimination rules.
Privacy of Your Protected Health Information: The College will use and disclose individually identifiable health information (“Protected Health Information” or “PHI”) as defined in 45 C.F.R. Parts 160 and 164 and specifically 45 C.F.R. section 164.504(f) (the “HIPAA Privacy Rule”), only to perform administrative functions on behalf of the sponsored group health plan. The College will not use or disclose such information for any purpose other than as permitted to administer the Plan or as permitted by applicable law.

The group health plan shall disclose PHI to the College only upon receipt of the certification by the College that the plan document has been amended to incorporate the provisions herein. The College will ensure that any agents, including subcontractors, to whom it provides PHI received from the Plan agree to the same restrictions and conditions that apply to the College with respect to such information. The College will not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plans. The College will report to the group health plan any use or disclosure of PHI that is inconsistent with the uses or disclosures provided for herein of which it becomes aware.

The College will make available PHI to the Plan for purposes of providing access to individual’s PHI in accordance with 45 CFR Section 164.524. The College will make available PHI to the Plan for amendment and incorporate any new amendments to PHI in accordance with 45 CFR Section 164.526 and shall make available PHI and any disclosures thereof to the Plan as required to provide an accounting of disclosures in accordance with 45 CFR Section 164.528.

The College will make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining compliance by the Plan with the HIPAA Privacy Rules and the College will notify the Plan of any such request by the Secretary prior to making such practices, books and records available. The College will, if feasible, return or destroy all PHI received from the Plan that it maintains in any form and retain no copies of such information when no longer needed for the purpose for which the disclosures were made, except if such return or destruction is not feasible, and shall limit further uses and disclosures to those purposes that make the return or destruction of the information unfeasible.

The College will also ensure that only its employees or other persons within its control that participate in administering the Plan will be given access to PHI, including those employees or persons who receive PHI relating to Payment, Health Care Operations (as defined in the HIPAA Privacy Rules), or other matters pertaining to the Plan in the ordinary course of the business and perform Plan administration functions. The College agrees to demonstrate to the satisfaction of the Plan that it has put in place effective procedures to address any issues of noncompliance with the privacy rules described in this section by its employees or other persons within its control.
HIPAA Privacy and Security Rules: This Plan will protect individually identifiable health information as required by the “Administrative Simplification” provisions of the HIPAA regulations.

1.11 Right to Amend and Terminate Plan. The College expressly reserves the unqualified right to amend or terminate the Plan at any time and for any reason, including, but not limited to the right to change any benefit provisions and required premium contributions, deductibles and co-payments. Notwithstanding any other provision in the Plan or this SPD to the contrary, no participant, spouse, dependent or other beneficiary shall have any right to benefits under the Plan or SPD which in any way interferes with your Employer's right to terminate the Plan or amend the Plan. There are no contractual rights to benefits under the Plan. YOUR EMPLOYER MAKES NO PROMISE TO CONTINUE PLAN BENEFITS IN THE FUTURE AND RIGHTS TO FUTURE BENEFITS DO NOT VEST. In particular, termination of employment or retirement does not in any manner confer upon any Participant or other beneficiary any irrevocable right to continued benefits under the Plan.

1.12 Funding and Type of Administration. Group Health Benefits under the Plan (including dental benefits) are self-funded by the College, and administered pursuant to a contract the College has with Comprehensive Benefits Administrator, Inc. dba CBABlue (“CBABlue”). Participants are required to contribute towards the cost of Group Health Benefits, as specified on a schedule maintained by your Employer’s Office of Human Resources (“Human Resources”).

Vision benefits are provided pursuant to a contract the College has with Vision Service Plan Insurance company (“VSP”). Retirees pay the entire cost of coverage elected.

Additional benefits are available to Eligible Employees, as described in a separate SPD.

Specific eligibility for the above-mentioned benefits is set forth in Article II and the applicable documents for each individual benefit. A schedule of required contributions is available from Human Resources.

1.13 Information To Be Furnished. You are required to provide the Plan Administrator and its designee(s) with such information and evidence, and to sign such documents, as may reasonably be requested from time to time for the purpose of Plan administration. If not so provided or signed, the Plan Administrator or its designee(s) may deny benefits until the requested information, evidence, and/or documents is/are furnished. If any false or misleading information concerning the Plan or any Plan benefit is provided to the Plan Administrator or its designee(s) by you, a covered spouse, a covered eligible domestic partner, or a covered dependent (collectively, “Covered Person”), or any person or entity acting on behalf of a Covered Person, the Plan Administrator (or, if applicable, a designee of the Plan Administrator) will have the discretionary authority, to the full extent permitted by law, to terminate the coverage of the Covered Person prospectively and to recoup, offset or otherwise recover any overpayment or other benefit that you, your
covered spouse or your covered dependent received as a result of such false or misleading information. In the case of fraud or an intentional misrepresentation of material fact made by a Covered Person, the Plan Administrator or its designee reserves the right to terminate a Covered Person’s coverage retroactively, to the extent permitted by law, and to recoup, offset or otherwise recover any overpayment or other benefit that the Covered Person received as a result of such fraudulent act or intentional misrepresentation.

II. ELIGIBILITY

2.1 Am I eligible to participate in the Plan if I am retired? You are generally eligible to participate in the Plan as an “Eligible Retiree” if you were an Eligible Employee (as that term is defined in the Plan) immediately prior to retirement from your Employer, and:

   (a) you were employed by your Employer for ten consecutive years following the attainment of age forty-five in a “benefits eligible” position; or

   (b) you were a Faculty Employee of your Employer, but resigned from a tenured position to take a part-time position, regardless of age or years of service.

Eligible Retirees may continue participation in the Plan upon retirement from the College for medical insurance, vision and dental insurance benefits only. If you are an Eligible Retiree and you do not continue participation immediately after retirement, you will not be allowed to re-enroll in the Plan (even if there is a change in the facts that caused you to stop participating in the Plan), unless federal law requires.

2.2 Are my spouse (including my same-sex spouse), dependent(s), domestic partner (including same-sex partner) or individual with whom I have entered into a civil union eligible for benefits under the Plan? Your same-sex or opposite-sex spouse, dependent(s), domestic partner (as determined by documents maintained by Human Resources) or any individual with whom you have entered into a civil union may be eligible for coverage under the specific benefit options you select to the extent they satisfy any additional eligibility requirements set forth for that specific benefit. Your spouse (same-sex or opposite-sex) is a person who is legally married to you under state law, regardless of your place of domicile.

To enroll your domestic partner, you must have either registered your domestic partnership in a jurisdiction that authorizes such domestic partnership, or complete the forms required by your Employer.
Your domestic partner must be enrolled for coverage at the time you are first eligible for coverage under the Plan or during any subsequent enrollment period. Your domestic partner (except a domestic partner registered in a jurisdiction that authorizes such domestic partnership, which will follow the same rules as spouses or civil union partners) will not be allowed to enroll for coverage under the Plan unless he or she has been identified as your domestic partner in the records of Human Resources for at least six months and he or she has lost coverage under another benefit plan OR he or she has been identified as your domestic partner in the records of Human Resources for at least six months prior to an open enrollment period.

**Please note:** The definition of who is your dependent may differ between the benefits provided under the Plan. Please refer to each specific benefit summary for the applicable dependent eligibility.

2.3 **When must I enroll for benefits?**

Eligible Retirees must be enrolled for benefits under the Plan immediately prior to your retirement. You may continue participation in the Plan immediately upon retirement by submitting an election form to the Office of Human Resources. Effective January 1, 2014, you also may elect to enroll in the retiree benefits offered under the Plan even if you did not enroll in such benefits immediately following your retirement. However, in order to enroll at a later date, you must provide the College with acceptable evidence of other medical coverage during the period following your retirement from employment with the College to the date of your enrollment (e.g., proof of coverage through your spouse’s employer or Marketplace coverage). If you are enrolling in the Plan following the loss of such other medical coverage, you must request enrollment within 30 days of the coverage loss.

Special enrollment will be allowed if you are required to provide Plan coverage for a child pursuant to a “qualified medical child support order,” or as otherwise required by federal law.

You may not be enrolled under the Plan (i) both as an Eligible Employee or Eligible Retiree and at the same time as a spouse, dependent or other beneficiary, or (ii) as a spouse, dependent or other beneficiary of more than one participant.

2.4 **When will my participation in the Plan terminate?** Participation in the Plan generally will terminate when the first of the following events occurs: (a) the date the Plan is terminated (b) the date you are no longer an Eligible Retiree, (c) the date you revoke an election form, (d) the first day for which any required contributions are not paid, or (e) the date otherwise provided in the documents for a specific benefit.

For your spouse, dependent(s), domestic partner or individual with whom you have entered into a civil union, participation will also end upon the date they no longer satisfy the eligibility requirements under the Plan. You are required to notify Human Resources
within 30 days of the date that your spouse, dependent(s), domestic partner or individual with whom you have entered a civil union no longer satisfies the Plan’s eligibility requirements (e.g., due to divorce, termination of domestic partner status or loss of dependent child status).

In certain circumstances, covered individuals will have the right to elect continuing coverage under a federal law known as "COBRA," after your participation in the Plan terminates (see Section 1.9 above and Article V). You may also have other continuation of coverage rights, and you should contact Human Resources for further information.

III. BENEFITS AND CONTRIBUTIONS

3.1 What benefits are offered by the Plan to Eligible Retirees?

(a) Group Health Benefits.

Your Employer offers medical and dental insurance benefits (collectively, “Group Health Benefits”) in accordance with the general terms stated in the attached Appendix C and Appendix D, respectively. Summaries of the different Group Health Benefits have been attached to this SPD, and additional copies may be obtained by contacting Human Resources. Contribution requirements are described in Appendix B.

The terms and conditions of these different plans, including but not limited to contracts and policies with insurers or third-party administrators, determine the benefits payable and the other conditions of coverage. The provisions of these documents, as amended from time to time, are incorporated by reference in the Plan and this SPD and are available for your inspection in Human Resources.

(b) Vision Benefits.

Your Employer offers vision benefits in accordance with the terms stated in Appendix E and the remainder of this SPD. A summary of the vision benefits has been attached as Appendix E of this SPD, and additional copies may be obtained by contacting Human Resources. Contribution requirements are described in Appendix B.

The terms and conditions of these benefits, including, but not limited to, contracts and policies with insurers, determine the benefits payable and the other conditions of coverage (for example, the definition of an Eligible Retiree and coverage limitations). The provisions of these documents, as amended from time to time, are incorporated by reference in the Plan and this SPD and are available for your inspection in Human Resources.

3.2 How is the cost of medical, dental and vision Plan benefits paid for by Eligible Retirees? Eligible Retirees are generally required to pay the entire cost of the coverage
elected, unless eligible for participation in some other program sponsored by the Employer. Please refer to Appendix B for a description of the cost sharing exceptions that may apply for certain Eligible Retirees. All retirees pay the full cost of the vision insurance.

3.3 **Is medical coverage provided under the Plan coordinated with other coverage?** Medical coverage provided by this Plan is coordinated with coverage available under another medical benefits program. The purpose of coordination of benefits is to avoid both programs paying medical benefits for the same services. When an individual has medical coverage under this Plan and another medical plan, the individual has “primary” and “secondary” coverage. The program that is required to pay its benefits first is considered “primary.” The program that pays its benefits second is considered “secondary.” Any coordination of benefits with respect to the Plan will be done in accordance with the rules described in Appendix F.

### IV. ELECTIONS

4.1 **When and how do I elect Retiree Benefits under the Plan?** When you first become an Eligible Retiree you may elect the benefits that you want by submitting the designated election form to the College’s Office of Human Resources within 30 days of the end of your active employment.

4.2 **When does my election become effective?** An election of benefits is generally made prior to the first day of coverage, and is effective as of the first day of the coverage period.

4.3 **What happens if I do not timely return an election form?** If you fail to return your election form when you first become eligible to participate in the Plan as a retiree, you will not be eligible to enroll in the retiree benefits under the Plan unless you have a “Change In Family Status,” as described in Section 4.4 below.

4.4 **May I change an election after I have enrolled in the Retiree Benefits under the Plan?** You generally are not allowed to add a spouse, dependent, domestic partner or individual with whom you have entered into a civil union once you have enrolled. However, you may change your election to add a spouse, dependent, domestic partner or individual with whom you have entered into a civil union after you have enrolled, if such a change is consistent with IRS rules that apply to changes in pre-tax premium elections, as described in the “Change In Family Status” section below (provided the change is also permitted by the Group Health Benefit). If you wish to make a change, be sure to ask Human Resources for the Plan's complete procedures that implement these IRS rules, if you have questions after reading the following summary. You must make your new election in writing within 30 days of the occurrence that permits the change. As a Participant in this Plan you must notify Human Resources of any change in family status affecting your own, or a dependent’s, eligibility for benefits. Failure to do so can result in serious consequences including, but not limited to, the requirement to
maintain your current election for the remainder of the applicable Period of Coverage, even if your coverage is reduced based on a change in family status (e.g., from family to single). These requirements will apply regardless of whether your change in family status involves a spouse, dependent, domestic partner, or individual with whom you have entered into a civil union.

Additionally, if you failed to enroll in the retiree benefits offered under the Plan, you may enroll in the Plan at a later date provided you have a qualifying “Change In Family Status” that is consistent with your late enrollment, as described below.

Cancellation of Coverage: You may cancel coverage for yourself, your spouse and/or your dependents at any time. Additionally, your coverage (and coverage for your spouse and/or dependents) will automatically be cancelled if you fail to timely pay required premiums. If coverage is cancelled, you, your spouse and/or your dependents will not be able to re-enroll in the retiree benefits under the Plan, unless otherwise required by federal law.

Special Enrollment Period for Medical Benefits under "HIPAA": Under special HIPAA rules, you may have a 30-day special enrollment period to elect certain benefits, if you or a dependent (including your spouse) loses other coverage, or when an individual becomes your dependent through marriage, birth, adoption or placement for adoption.

In addition, a 60-day special enrollment period applies for the health benefits provided under the Plan if you or a dependent (including your spouse) loses Medicaid or State Children’s Health Insurance Program coverage, or if you or a dependent becomes eligible for assistance from the State to purchase coverage under the Plan.

The “Special Enrollment” provisions will also allow you to make changes to your election of benefits to cover your domestic partner or individual with whom you have entered into a civil union, to the extent allowed by law.

Changes In Family Status: You may change an election after you have elected retiree benefits due to one of the following changes in family status, provided the election change is consistent with the change in family status:

(i) A change in legal marital status;

(ii) A change in number of dependents;

(iii) A situation in which a dependent satisfies or ceases to satisfy eligibility requirements (for example, ineligibility due to age);

(iv) A change in residence (for you, a spouse or a dependent); or
Any change in employment status, by you or another family member, with the consequence that you or that person becomes eligible, or ceases to be eligible, under an employer's cafeteria plan—or other plan offering benefits that could be offered through a cafeteria plan.

The “Change in Family Status” provisions will also allow you to make changes to your election of benefits for your domestic partner or individual with whom you have entered into a civil union, to the extent allowed by law.

**Consistency Requirement:** The consistency requirement for making an election change due to a change in family status normally is satisfied if, and only if, your election change is on account of and corresponds with a change in family status that affects eligibility for coverage under an employer's plan.

**Cost or Coverage Changes for Benefits:** You may change an election if the cost of a benefit changes, or if there is a change in benefit coverage. In part, these rules for benefits now allow an appropriate election change when another family member is making an election change under an employer plan with a different period of coverage.

**Changes Based on Medicare or Medicaid Entitlement:** You may make a change that is appropriate to reflect the fact that an individual has gained or lost Medicare or Medicaid coverage.

**Order Regarding Health Coverage for a Child:** You also may make a change to comply with a court order regarding health coverage for a child, including an order entered as a qualified medical child support order under special ERISA rules (see Section 4.6 below). You may obtain a copy of the Plan's procedures from your Employer's Office of Human Resources.

**4.5 Are there any circumstances in which I must choose benefits?** The Plan is legally required to comply with the provisions of any qualified child medical support order ("QMCSO") that relates to Plan benefits. A QMCSO is a medical child support order that may require a child (including a child born out of wedlock) to be covered by the Plan even if you would not otherwise have chosen to cover the child. You will be notified and provided with further information about the QMCSO rules if the Plan receives an order that applies to you. You may obtain a copy of the Plan’s QMCSO procedures from the Plan Administrator.

**4.6 What are the tax consequences of benefits offered under the Plan for your domestic partner or an individual with whom you have entered into a civil union?** The benefits provided to your same-sex spouse, domestic partner or an individual with whom you have entered into a civil union generally will be identical to those provided to your eligible spouse and eligible dependent child. In certain, limited circumstances, the Employer may contribute to the cost of your retiree benefits (these circumstances are described in Appendix B), including benefits provided to your domestic partner or an individual with
whom you have entered into a civil union. However, under the Internal Revenue Code, only the cost of coverage for your eligible opposite-sex spouse and eligible dependent child generally is excluded from income and is exempt from income taxes. Therefore, the cost for a domestic partner or an individual with whom you have entered into a civil union is not excludable from income taxes unless, among other requirements, such domestic partner or individual with whom you have entered into a civil union is considered your “dependent,” as defined in Section 152 of the Code.

If your domestic partner or individual with whom you have entered into a civil union is your dependent under the Code, and you have so informed your Employer by such means as is required by your Employer, you generally will be able to exclude from income the coverage for each eligible individual.

If your domestic partner or individual with whom you have entered into a civil union is not your dependent under the Code, you may still elect to provide such individual with benefits. However, payments for benefit coverage will be treated as follows:

- your Employer’s contribution for this coverage will be reported as additional compensation to you. Your Employer will be required to report applicable state and federal taxes based upon this additional compensation. (Please be advised that the value of coverage can be high. Therefore, the taxes you will be required to pay may be substantial.)

This information is not, nor is it a substitute for, professional tax advice. The Employer urges you to consult with your tax advisors about the treatment of particular benefits on your tax return.

Please note: In the event you notify the College or MIIS of an individual's tax dependent status, such individual will be treated as your tax dependent on a prospective basis, unless HIPAA Special Enrollment rules apply.

V. COBRA HEALTH CONTINUATION COVERAGE

5.1 When will my participation in the Plan terminate?

THERE IS NO CONTRACTUAL RIGHT TO BENEFITS UNDER THIS PLAN AND FUTURE BENEFITS WILL NEVER VEST. In particular, retirement does not in any manner confer upon you, your spouse, your dependents or other beneficiaries any right to continued benefits under this Plan or any benefit options offered through the Plan, other than those specifically mentioned.

Generally, your participation in the Plan will end on the earlier of the date on which the Plan terminates, you cease to be an Eligible Retiree, or you fail to pay any required premiums. However, under federal law, continued health coverage may be available for
your spouse and dependents ("Qualified Beneficiaries") at your (or their) own expense. These legal rights are known as "COBRA" rights and apply to group health plans.

The COBRA rights under the Plan are described in Section 5.2, below.

**Note:** Certain changes made by the Affordable Care Act may be relevant to your decision to elect COBRA.

First, there may be other coverage options for Qualified Beneficiaries other than COBRA coverage through the Plan. Beginning January 1, 2014, Qualified Beneficiaries will be able to buy coverage through the Health Insurance Marketplace. In the Marketplace, a Qualified Beneficiary may be eligible for a tax credit that lowers the monthly premium. Qualified Beneficiaries will be able to obtain information regarding applicable premiums, deductibles and out-of-pocket costs before making a decision to enroll in the Marketplace. Being eligible for COBRA does not limit eligibility for a tax credit through the Marketplace.

Second, health plans are prohibited from imposing preexisting condition exclusions beginning in plan years that commence on or after January 1, 2014. Because this requirement applies on a plan year basis, the exclusion may not apply immediately to all plans.

### 5.2 What are my COBRA rights under the Plan?

The term "COBRA" refers to the Consolidated Omnibus Budget Reconciliation Act of 1985, which, as amended, provides certain individuals with the rights to health continuation coverage described in this Section 5.2. A “Qualified Beneficiary” may elect “COBRA” coverage for either or both types of coverage upon the occurrence of a “Qualifying Event,” as explained below. **Please note** that although not required by law, your Employer will extend COBRA rights to your domestic partner or individual with whom you have entered into a civil union in the same manner as such COBRA rights are extended to a spouse, as specified below.

(a) **Qualified Beneficiary.** A "Qualified Beneficiary" may be your spouse or dependent child (individually, "spouse" or "dependent child"; collectively "family members") who has health continuation rights with respect to an event that is a Qualifying Event.

- An individual normally must have coverage on the day before a Qualifying Event in order to be a Qualified Beneficiary. (For example, if the Qualified Beneficiary only has medical coverage, there is no COBRA election for dental coverage.)
- However, a child who is born to or placed for adoption with you during a period that you have COBRA coverage also is considered a Qualified
Beneficiary. The COBRA period is measured from the same date as for other Qualified Beneficiaries with respect to the same Qualifying Event.

(b) **Qualifying Events For a Spouse To Elect COBRA Coverage.** Your spouse may elect health continuation coverage for himself or herself (and affected family members) if coverage would end due to one of the following Qualifying Events:

(i) your death;

(ii) your spouse's divorce or legal separation from you; or

(iii) your entitlement to Medicare.

(c) **Qualifying Events For a Dependent Child To Elect COBRA Coverage.** A dependent child may elect health continuation coverage if coverage otherwise would end due to any of the following five Qualifying Events:

(i) your death;

(ii) divorce or legal separation of you and your spouse;

(iii) your becoming entitled to Medicare; or

(iv) loss of dependent child status under the terms of the Plan.

(d) **Notice Provisions; Election of Coverage:**

(i) You (or a family member or a legal representative) must inform your Employer's Human Resource Office, in writing, within 60 days of the date that there is a divorce, a legal separation, or a loss of dependent child status. The written notice must describe the particular Qualifying Event triggering the COBRA coverage (e.g., identify whether the Qualifying Event was due to divorce, legal separation, or loss of dependent status) and the date on which the event occurred. **If notice is not given in a timely manner, the right to COBRA health continuation coverage will be lost.**

(ii) Subject to the requirement in (i), when applicable, the affected Qualified Beneficiary or Beneficiaries will be notified of the right to choose COBRA health continuation coverage if a Qualifying Event occurs. The election for COBRA coverage must be made within 60 days from the later of the date of notification about COBRA or the date of loss of coverage. If an election is not made timely, coverage under the Plan will end and there will be no further COBRA rights.
(e) **Cost of Continuation Coverage.** A Qualified Beneficiary who chooses to continue health coverage may be required to pay up to, but not more than, 102 percent of the full cost to the Plan for the health coverage. The first premium payment must be made, with any payments owed from the date health coverage ended, within 45 days from the date the Qualified Beneficiary chooses to continue health coverage.

(f) **Length of Continuation Coverage:**

A Qualified Beneficiary may continue health coverage for up to 36 months in the event of death, divorce or legal separation, entitlement to Medicare, or ineligibility for dependent coverage.

(g) **Notice of Unavailability of Continuation Coverage.** If the Plan Administrator is notified of a Qualifying Event, second Qualifying Event, or a determination of disability by the Social Security Administration, regarding a Qualified Beneficiary, and the Plan Administrator determines that such individual is not entitled to the COBRA continuation coverage being requested, the Plan Administrator will notify the individual of that fact within 14 days of the receipt of a request for COBRA continuation coverage.

(h) **Termination of COBRA Continuation Coverage.** The COBRA coverage will end before the end of the applicable maximum time period in case of any of the following:

- **A** your Employer ceases to provide health coverage to any employees or retirees;

- **B** the premium is not paid on a timely basis under the COBRA rules;

- **C** the Qualified Beneficiary becomes covered under another group health plan (not merely eligible) after the date on which COBRA coverage is elected for the Qualified Beneficiary and either: (i) the other plan does not contain any exclusion or limitation with respect to any preexisting condition of the Qualified Beneficiary; or (ii) the exclusion or limitation in the other plan either doesn’t apply to the Qualified Beneficiary or has been satisfied, based on applicable law; or

- **D** the Qualified Beneficiary becomes entitled to Medicare (not merely eligible) after the date on which the COBRA coverage under this Plan is elected; or

- **E** the maximum period of continuation coverage ends.
In the event that a Qualified Beneficiary’s COBRA continuation coverage is terminated prior to the end of the maximum period of continuation coverage applicable under COBRA, the Plan Administrator will notify the Qualified Beneficiary of the loss of COBRA continuation coverage as soon as is practicable following such determination.

VI. CLAIMS AND APPEAL PROCEDURES

6.1 How do I make a claim under the Plan? A claim for benefits under the Plan can be filed by a Plan Participant or beneficiary (a “claimant”), or by an authorized representative acting on behalf of the claimant, by contacting the insurer, HMO or claims administrator in the manner specified in the Summaries, booklets and/or contracts describing the coverage.

6.2 What are the procedures for Group Health Benefit claims? Each insurer, health maintenance organization and/or claims administrator for a Group Health Benefit will follow claims procedures that satisfy the requirements specified in this Section. For purposes of this procedure, the person who is responsible for making a claims decision is referred to as the “Claims Administrator.”

(a) Urgent Care. An “urgent care claim” is a claim for medical treatment or care that, if not provided quickly, could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function or, in the opinion of a physician with knowledge of the case, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment requested.

A decision on an urgent care claim will be made within 72 hours after the request is received. If the request is incomplete, the claimant will be notified within 24 hours of the submission (and will be told of the specific information necessary to complete the claim). The claimant then has 48 hours after the notice is received (unless the insurer or Claims Administrator allows a longer period) to provide the additional information. A decision will be made by the later of (a) 48 hours after the additional information is provided or (b) the expiration of the deadline to provide additional information.

An appeal of an adverse decision (denial) regarding an urgent care claim will be decided within 72 hours after the appeal request is filed.

(b) Concurrent Care. A “concurrent care claim” involves a decision by the Plan or an issuer to reduce or stop a course of treatment that has already begun.

Any reduction or termination of an ongoing course of treatment to be provided over a period of time or a specified number of treatments shall be treated as an “adverse benefit determination” (unless due to an amendment or termination of the
Plan). The claimant will be notified of the decision to reduce or terminate the course of treatment in sufficient time to allow an appeal (and a determination on the appeal) to take place before the benefit is reduced or terminated.

(c) **Pre-Service Claims.** A “pre-service claim” is any claim for a benefit where the terms of the Plan require approval prior to obtaining medical care.

An initial decision on a pre-service claim must be made in a reasonable time, but no later than 15 days after the submission of the claim. This time period can be extended for an additional 15 days if the Claims Administrator determines that the extension is necessary due to matters beyond its control and notifies the claimant, before the end of the initial 15-day period, of the circumstances requiring the extension and the date by which a decision is expected.

If an extension is necessary to allow the claimant to submit additional information, the claimant will have 45 days from receipt of the notice to provide the information required.

(d) **Post-Service Claims.** A “post-service claim” is any claim that is not a “pre-service claim” (in other words, you do not need approval before obtaining medical care).

The claimant will be notified of any adverse benefit determination of a post-service claim within a reasonable time, but not later than 30 days after receipt of the claim. The period for a decision may be extended for an additional 15 days if the Claims Administrator determines that the extension is necessary due to matters beyond its control and notifies the claimant, before the end of the initial 30-day period, of the circumstances requiring the extension and the date by which a decision is expected.

If an extension is necessary to allow the claimant to submit additional information, the claimant will have 45 days from receipt of the notice to provide the information required.

(e) **Manner and Content of Notification of Benefit Determination.** The Claims Administrator will provide the claimant with a written or electronic notification of any adverse benefit decision. The notification will state, in a manner calculated to be understood by the claimant:

(i) The specific reason for the adverse determination;

(ii) Reference to the specific Plan provisions on which the determination is based;
(iii) information sufficient to identify the health claim (if applicable) involved (including the date of service, the health care provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning);

(iv) A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;

(v) A description of the Plan’s review procedures (including both the available internal appeals and external appeals process) and time limits (including a statement of the claimant’s right to bring a civil suit under Section 502(a) of ERISA following an adverse benefit determination on review);

(vi) a statement regarding the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established to assist individuals with the internal claims and appeals and external review processes; and

(vii) If the claim is an urgent care claim, a description of the expedited review process.

If an internal rule, guideline, protocol or other similar criterion (collectively, “Internal Rule”) was relied upon in making the adverse determination, the notification will contain the Internal Rule, or a statement that such an Internal Rule was relied upon in making the determination and that a copy of the Internal Rule may be obtained free of charge upon request. Further, if the adverse determination is based on a medical necessity or experimental treatment or similar exclusion or limit, the notification will contain an explanation of the scientific or clinical judgment for the determination (applying the terms of the Plan to the claimant’s medical circumstances), or a statement that such explanation will be provided free of charge upon request.

(f) **Appeal of an Adverse Determination.** A claimant has 180 days following receipt of an adverse benefit determination to appeal that determination. (The appeal must be post-marked on or before the 180th day.) On appeal, a claimant has the opportunity to submit written comments and documents related to the claim for benefits and will be provided, upon request and free of charge, all documents, records and other information relevant to the claimant’s claim for benefits. A review will be conducted by a fiduciary who is neither the individual who made the initial determination nor a subordinate of that person. The review will take into account all information submitted by the claimant relating to the claim, regardless of whether such information was submitted in the initial benefit determination. If the adverse benefit determination was based, in whole or in part, on a medical
judgment (including whether a particular treatment, drug, etc., is experimental, investigational or not medically necessary or appropriate) the reviewer will consult with an appropriate health care professional who is neither an individual who was consulted in connection with the initial determination nor a subordinate of that person. Any expert whose advice was obtained in connection with the adverse benefit determination will be identified to the claimant. Additionally, the Plan must provide the claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan or issuer (or at the direction of the Plan or issuer) in connection with the claim, or any new rationale for issuing an adverse benefit, sufficiently in advance of the date that the notice of the final adverse benefit determination is required to give the claimant a reasonable opportunity to respond prior to that date.

6.3 **What are the procedures for disability claims?** A decision on a claim for benefits will be made no later than 45 days after receipt of the claim. This time period can be extended for two additional 30-day periods if, prior to the expiration of the determination period, the Claims Administrator determines that, due to matters beyond its control, a decision cannot be rendered within that determination period. If an extension of the initial 45-day claim period is necessary, the Claims Administrator will notify the claimant of the date it expects to render a decision. If a second 30-day extension becomes necessary, the Claims Administrator will inform the claimant of the standards on which entitlement to the benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues.

In any case where the Claims Administrator requests additional information, the claimant will have at least 45 days to provide the information.

If a disability claim is denied, a written request for review of the denial must be made within 180 days after receiving notice of the denial. A decision on appeal will be rendered within 45 days after the request for review. If an extension of time is required to process the claim, the Claims Administrator will notify the claimant in writing before the end of the initial 45-day period of the special circumstances requiring the extension and the date by which a decision is expected. The maximum extension period is 45 days. The claimant has at least 45 days to provide any additional information requested by the Claims Administrator.

6.4 **What are the procedures for all other claims?** A decision on all other claims for benefits shall be made no later than 90 days after receipt of the claim. If the Claims Administrator determines that an extension of time for processing the claim is required, the claimant will receive written notice of the extension prior to the end of the initial 90-day period. The maximum extension period is an additional 90 days. The extension notice will describe the special circumstances requiring the extension and the date by which a decision is expected.
If a claim is denied, the claimant has 60 days to make a written appeal to the adverse decision. Written comments, documents, records and any other information related to the claim may be submitted. You will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim.

6.5 **What are the requirements for notification of an adverse benefit determination on appeal?** The Claims Administrator will provide the claimant with a written or electronic notification of any adverse benefit decision. The notification will state, in a manner calculated to be understood by the claimant:

(a) The specific reason(s) for the adverse determination;

(b) Reference to the specific Plan provisions on which the determination is based;

(c) Information sufficient to identify the health claim involved (if applicable) (including the date of service, the health care provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning);

(d) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant’s claim for benefits (whether information is relevant to a claim for benefits shall be determined pursuant to the applicable regulations);

(e) A description of the Plan’s review procedures (including both the available internal appeals and external appeals process) and time limits;

(f) A statement regarding the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established to assist individuals with the internal claims and appeals and external review process;

(g) A description of the Plans review procedures and time limits (including a statement of the claimant’s rights to bring a civil suit under Section 502(a) of ERISA following an adverse benefit determination on review); and

In the case of a claim involving a group health or disability benefit:

- If an Internal Rule was relied upon in making the adverse benefit determination, the notification will contain the Internal Rule, or a statement that such an Internal Rule was relied upon, and that a copy of the Internal Rule will be provided free of charge to the claimant upon request.
If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion, the notification will contain either an explanation of the scientific or clinical judgment (applying the terms of the Plan to the claimant’s medical circumstances), or a statement that such an explanation will be provided free of charge upon request.

6.6 Do I have the right to pursue an external review of my claim? The Patient Protection and Affordable Care Act of 2010 ("PPACA") allows claimants to file an external appeal of a medical benefit claim following a final adverse benefit determination by the Plan, if the claim involves a medical judgment by the Plan or a rescission of coverage. External appeals are conducted by an independent review organization consisting of health professionals who have no connection to the Plan, the claimant’s health care provider, or the health care facility involved in the claimant’s care. A claimant will be notified about how to pursue an external appeal in the final adverse determination notification made by the Plan. An external review is only available following a final adverse determination by the Plan.

It is intended that these benefit claim procedures will comply with the benefit claim procedure requirements for non-grandfathered plans under the PPACA and its implementing regulations, and should be interpreted and applied to the full extent possible in a manner that is consistent with that intention. If it becomes necessary, prompt modification to these benefit claims procedures will be made to help ensure full compliance with the benefit claims procedure requirements of PPACA. If you have a question regarding the claims appeal process, please contact the applicable claims administrator or the Office of Human Resources.

VII. ERISA RIGHTS

As a Participant in the Plan you are entitled to certain rights and protections under ERISA. ERISA provides that all Plan Participants shall be entitled to:

Receive Information About Your Plan and Benefits

This includes the ability to:

- Examine, without charge, at the Plan Administrator’s office and at other specified locations, such as worksites, all documents governing the Plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, and copies of the latest annual
report (Form 5500 Series) and updated SPD. The Plan administrator may make a reasonable charge for the copies.

- Receive a summary of the Plan’s annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report.

**Continue Group Health Plan Coverage**

You may have a right to continue health care coverage for yourself, your spouse or your dependents if there is a loss of Group Health Benefit and/or vision coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this SPD and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

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

**Prudent Actions by Plan Fiduciaries**

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

**Enforce Your Rights**

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

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

**Assistance with Your Questions**

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

**VIII. QUALIFIED MEDICAL CHILD SUPPORT ORDERS**

The Plan provides Group Health Benefits in accordance with the applicable requirements of any "qualified medical child support order" as required under ERISA. In general, the term "qualified medical child support order" means a "medical child support order" which requires the Plan to provide a child of a participant with health coverage under the Plan where the child would not otherwise be covered, for instance, as a result of a parent's divorce.

Group health plans and health insurers may not deny eligibility to enroll, renew or continue coverage in a plan, in order to avoid providing the above-described coverage provided by the law. Further, the law prohibits (i) penalizing or otherwise reducing or limiting the reimbursement of an attending provider for the required care; or (ii) providing any incentive (monetary or otherwise) to induce the attending provider to provide care that would be inconsistent with the law.

The above-described coverage required by the law may only be subject to the annual deductibles and coinsurance provisions that apply to similarly benefits. Contact the Plan Administrator if you have questions.
IX. NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

Under this Federal law, sometimes referred to as the "NMHPA," certain requirements are imposed on group health plans that provide maternity or newborn infant coverage. This includes the fact that the group health plans and health insurance issuers (such as insurance companies and HMOs) may not restrict benefits for any hospital 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, the NMHPA 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, as applicable.

X. WOMEN'S HEALTH AND CANCER RIGHTS ACT

Under this Federal law, group health plans that provide medical and surgical benefits for mastectomies must provide coverage in connection with the mastectomy, in the manner determined by the attending physician and the patient, for: (i) reconstruction of the breast on which the mastectomy was performed; (ii) surgery and reconstruction of the other breast to produce a symmetrical appearance; and (iii) prostheses and treatment of physical complications at all stages of mastectomy, including lymphedema.

Group health plans and health insurers may not deny eligibility to enroll, renew or continue group health plan coverage to avoid providing coverage for breast reconstruction or mastectomy complications. Further, the law prohibits: (i) penalizing or otherwise reducing or limiting the reimbursement of an attending provider for the required care; or (ii) providing any incentive (monetary or otherwise) to induce the attending provider to provide care that would be inconsistent with the law.

The above-described coverage required by the law may only be subject to the annual deductibles and coinsurance provisions that apply to similar benefits.
APPENDIX A

AFFILIATED EMPLOYERS PARTICIPATING IN THE PLAN

There are no Affiliated Employers currently participating in the Plan.
APPENDIX B

BENEFITS & CONTRIBUTIONS

Set forth below is a description of the benefits and contribution requirements for Eligible Retirees under the Plan.

I. GROUP HEALTH BENEFITS

Each Eligible Retiree may elect coverage under the Medical Insurance Plan and Dental Insurance Plan, in accordance with Appendices C and D respectively. Eligible Retirees are generally required to pay the entire cost of the coverage elected.\(^1\)

The actual dollar amount of the required premiums for the coverage elected each Plan Year will be communicated to Participants during the annual Open Enrollment Period before the Plan Year begins. In addition, Plan changes may require contribution rate changes during the Plan Year which will be communicated to Participants periodically. These communications are hereby incorporated by reference and made a part of this Plan.

II. VISION BENEFITS

Eligible Retirees may elect Vision Benefits, in accordance with Appendix E. Eligible Retirees are generally required to pay the entire cost of the coverage elected.

\(^1\) In some instances, for some “grandparented” Eligible Retirees, the cost of coverage selected may be shared between the College and the Eligible Retiree. The list of “grandparented” Eligible Retirees is maintained in the College’s Office of Human Resources. For those Eligible Retirees not currently paying 100% of the cost of coverage, such costs are expected to increase by the regular annual premium increase plus 6% each year, but in no event will increase greater than 25% per year. Failure to pay the required premiums in a timely manner will result in termination of coverage. Also, the College has on occasion offered special retirement incentive programs which may include some employer-paid premiums. Retirees in these programs have written agreements with the College regarding these benefits; other retirees are not eligible.
APPENDIX C

MEDICAL INSURANCE PLAN

INTRODUCTION

The College sponsors this self-funded ERISA welfare plan which provides medical insurance benefits for all Eligible Employees, Eligible Retirees and their Dependents enrolled for coverage. Stop loss reinsurance has been purchased to protect the Plan Sponsor from unpredictable claims experience.

Please note that this Appendix C describes the medical insurance benefits available to both Eligible Employees and Eligible Retirees. In general, Eligible Retirees who have not yet attained age 65 receive the same benefits and coverage as active employees. Eligible Retirees who have attained age 65 and are eligible for Medicare and eligible disabled participants who are no longer working but are eligible for Medicare as a result of their disability receive benefits pursuant to the Medicare Carve-Out provisions in this Appendix C. The following pages describe Plan provisions that specifically pertain to Eligible Retirees:

Eligibility p. C-3

Eligible Retiree Definition p. C-34

Surviving Spouse of a Retiree p. C-41

Medicare p. C-41

Medicare Carve-Out p. C-42

Medicare / Medicare Carve-Out Chart p. C-43

Each covered person is entitled to the benefits outlined in this Appendix. To obtain benefits from the Plan, the Participant must submit a diagnostic bill to:

Comprehensive Benefits Administrator, Inc. dba CBABlue
P.O. Box 2365
South Burlington, VT 05407-2365
Customer Service & Pre-Certification: (888) 222-9206
https://lin04.cbabluevt.com/middleburyindex.htm

This claim submission is required for reimbursement to the Participant or direct payment to the service provider by the Middlebury College Health and Welfare Benefits Plan (“Plan”).
A clerical error will neither invalidate the Participant’s coverage if otherwise validly in force, nor continue coverage otherwise validly terminated.

Comprehensive Benefits Administrator, Inc. dba CBABlue, an independent licensee of the Blue Cross and Blue Shield Association, provides administrative claims payment services only and does not assume any underwriting financial risk or obligation with respect to claims liability. To the extent CBABlue assumes any liability, it is only as may be required by the Contract Administrative Services Agreement between the College and CBABlue, or as required by law.

PLAN ENROLLMENT

Eligibility: Only Eligible Retirees, as defined in Section 2.2, are eligible for coverage under this Plan. Notwithstanding the foregoing, a former employee who otherwise satisfies the requirements to be an Eligible Retiree under the terms of the Plan, is not eligible for the medical coverage provided under this Plan if the retiree resides outside of the United States.

Plan Enrollment: Eligible Retirees may continue participation in the Plan upon retirement from the Employer. Effective January 1, 2014, an Eligible Retiree also may elect to enroll in the retiree benefits offered under the Plan even if the Eligible Retiree did not enroll in such benefits immediately following retirement. However, in order to enroll at a later date, an Eligible Retiree must provide the College with acceptable evidence of other medical coverage during the period following retirement from employment with the College to the date of enrollment (e.g., proof of coverage through a spouse’s employer or Marketplace coverage), unless federal law requires otherwise. If you are enrolling in the Plan following the loss of such other medical coverage, you must request enrollment within 30 days of the coverage loss.

Annual Open Enrollment Period: There will be an annual Open Enrollment Period prior to the beginning of each Plan Year. The effective date of coverage will be January 1.

Dependent Coverage

Eligibility: The Dependent(s) of an Eligible Employee or Eligible Retiree, as defined in this Appendix, will become eligible for coverage on the date of the Eligible Employee’s or Eligible Retiree’s eligibility for coverage and/or on the date which the Eligible Employee or Eligible Retiree acquires the Dependent.

If an Eligible Employee or Eligible Retiree and Spouse are both eligible for coverage under the Plan, only one will be eligible to enroll Dependent(s). Also, a Participant cannot be covered as an Eligible Employee or Eligible Retiree and at the same time as a Dependent.
**Plan Enrollment:** To obtain coverage, a Dependent(s) must be enrolled within thirty (30) days of the Dependent’s eligibility date. A Dependent will be enrolled in the Plan when the Eligible Employee or Eligible Retiree has completed and signed a benefit enrollment form or notice of change form and it is delivered to the Plan Sponsor. Dependents who are not enrolled within thirty (30) days following the eligibility date will only be eligible to enroll during the annual Open Enrollment Period described below or under the “Transfer of Coverage” section as described herein.

If an Eligible Employee or Eligible Retiree acquires a new Dependent as a result of marriage, birth, adoption, or placement for adoption, then the Dependent(s) may be enrolled in the Plan, provided enrollment occurs within thirty (30) days of one of the above life events. If the new Dependent is acquired as a result of marriage, birth, adoption, or placement for adoption, and the Eligible Employee or Eligible Retiree has not previously enrolled in the Plan, the Eligible Employee or Eligible Retiree may enroll in the Plan at this time, provided the enrollment occurs within thirty (30) days of one of the above life events. Coverage will begin on the first day of the month following the month in which the new Dependent was acquired. In the case of a birth, coverage begins on the day of birth; in the case of adoption, coverage begins on the day custody is awarded.

If an Eligible Employee is required to provide benefits for his Dependent(s) under the direction of a court order and the Eligible Employee is not enrolled in the Plan, the Eligible Employee may enroll himself and his Dependent(s) provided enrollment occurs within thirty (30) days of issuance of the court order. The Plan’s Open Enrollment provision will not apply. The effective date of coverage will be the date of the court order. However, if the Eligible Employee has not yet satisfied the Plan’s waiting period, coverage will become effective after satisfaction of such waiting period.

If a Dependent who is enrolled as a full-time student in an accredited secondary school or college (including graduate school) takes a leave of absence from full-time student status due to an illness or injury, he or she will continue to be covered under the Plan as an eligible Dependent for a period of up to twelve (12) months from the date of the leave of absence, provided the medical necessity of the leave of absence has been certified by the Dependent’s attending physician and written documentation of the illness or injury and medical necessity of the leave of absence has been provided to the College. In no event will a Dependent be covered beyond the age at which coverage of a Dependent who is enrolled as a full-time student terminates under the Plan.

**Annual Open Enrollment Period:** There will be an annual Open Enrollment Period prior to the beginning of each Plan Year. The effective date of coverage will be January 1.

**TRANSFER OF COVERAGE**

Eligible Employees who lose medical coverage being provided by their Spouse may enroll for coverage under this Plan provided such Eligible Employee enrolls in the Plan, within 30 days of
the loss of other coverage, and provides evidence that they were covered and that coverage has been terminated.

All eligible Spouses and Dependents of Middlebury College Eligible Employees who were enrolled in other group medical coverage, who lose their group medical coverage may enroll for coverage under the Plan provided such Spouse and/or Dependents enroll in the Plan within thirty (30) days of the Spouse’s termination of employment or loss of insurance and provides evidence that they were covered and that coverage has been terminated.
SCHEDULE OF BENEFITS

**Employee Deductible:**
- Individual: $300 per calendar year
- Two Person: $600 per calendar year
- Family (True Family Aggregate): $900 per calendar year

**Employee Coinsurance:**
- Individual: 20%
- Two Person: 20%
- Family: 20%

**Plan Coinsurance:**
- Individual: 80%
- Two Person: 80%
- Family: 80%

**Employee Out-of-Pocket Maximum:**
- Individual: $1,100 per calendar year
- Two Person: $2,200 per calendar year
- Family (True Family Aggregate): $3,300 per calendar year

**Physician’s Office Visits:**
- Employee Pays: 20% (deductible waived)
- Plan Pays: 80% (deductible waived)

**Recommended Preventive Services:**
- Employee Pays: 0% (deductible waived)
- Plan Pays: 100%

**Physical Therapy:**
- Employee Pays
- Plan Pays: Deductible; then 20%; 80% after deductible

**Chiropractic Care:**
- Employee Pays
- Plan Pays: Deductible; then 20%; 80% after deductible

**Therapeutic Massage:**
- Employee Pays
- Plan Pays: Deductible; then 20%; 80% after deductible

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1 See page C-39 of this Appendix for a description of the Plan services that are considered Recommended Preventive Services.

2 Treatment Plan and/or Proof of Medical Necessity may be required.
<table>
<thead>
<tr>
<th>Service</th>
<th>Employee Pays</th>
<th>Plan Pays</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Diagnostic, X-ray &amp; Labs</strong></td>
<td>Deductible; then 20%</td>
<td>80% after deductible</td>
</tr>
<tr>
<td>(except for services related to a physician’s office visit or well care as defined in the Plan Details section):</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Employee Pays</td>
<td>Plan Pays</td>
</tr>
<tr>
<td><strong>Infertility Treatment</strong></td>
<td>Deductible; then 20% (any surgical corrective procedure must be medically necessary)</td>
<td>80% after deductible; maximum prescription drug benefit of $2,000 annually; maximum medical benefit of $15,000 per lifetime</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Routine Vision Examinations:</strong>&lt;sup&gt;3&lt;/sup&gt;</td>
<td>Deductible; then 20% to a maximum of 1 exam every 2 calendar years</td>
<td>80% after deductible to a maximum of 1 exam every 2 calendar years</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Hearing Exams/Aids:</strong></td>
<td>Deductible; then 20% to a maximum of $2,500 per lifetime</td>
<td>80% after deductible to a maximum of $2,500 per lifetime</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<sup>3</sup> If you are enrolled in the Vision Benefits Plan described in Section 4.1(h) of the Plan (or other vision coverage not obtained through the Employer (“Other Vision Coverage”)), the Vision Benefits Plan or Other Vision Coverage will be the primary coverage for eligible vision expenses. Accordingly, individuals who are covered under the Vision Benefits Plan or Other Vision Coverage should submit claims for routine vision examinations under the Vision Benefits Plan or Other Vision Coverage first. The Medical Plan will only cover expenses incurred for eligible routine medical examinations to the extent such expenses have first been submitted under the Vision Benefits Plan or Other Vision Coverage and are determined to not be a covered expense under such plan.
Emergency Room Services:  
Employee Pays 20%  
Plan Pays 80%

Non-emergency use of ER:  
Employee Pays $25 penalty per occurrence; then deductible and 20%  
Plan Pays 80% after deductible and $25 penalty

Inpatient Pre-Admission Certification Penalty:  
Employee Pays None

Inpatient Mental Health/Substance Abuse:  
Employee Pays Deductible; then 20%  
Plan Pays 80% after deductible

Outpatient Mental Health:  
Employee Pays 20% (deductible waived)  
Plan Pays 80% (deductible waived)

Outpatient Substance Abuse:  
Employee Pays 20% (deductible waived)  
Plan Pays 80% (deductible waived)

Convalescent/Rehabilitation Hospital/Extended Care Facility:  
Employee Pays Deductible; then 20% to a maximum of 120 days per lifetime  
Plan Pays 80% after deductible to a maximum of 120 days per lifetime

Deductible waived provided services are diagnosed as a medical emergency and emergency services begin within 72 hours of an accidental injury or within 12 hours of the first symptoms of an illness.
### Prescription Drug Plan (Retail – 30 day supply):

**Employee Pays (copayment)**

- $10 generic
- $25 preferred brand
- $40 non-preferred brand

**Out-of-Pocket Maximum:**

- $500 Individual
- $1,000 Two Person
- $1,500 Family

**Plan Pays**

100% after copayment for
generic, preferred brand; and
non-preferred brand and
100% after out-of-pocket
maximum

### Prescription Drug Plan (Mail Order – 90 day supply):

**Employee Pays (copayment)**

- $20 generic
- $50 preferred brand
- $80 non-preferred brand

**Out-of-Pocket Maximum:**

- $500 Individual
- $1,000 Two Person
- $1,500 Family

**Plan Pays**

100% after copayment for
generic, preferred brand; and
non-preferred brand and
100% after out-of-pocket
maximum

### Individual Annual Maximum For Essential Health Benefits

**Plan Pays**

No Limit

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Note: See item 21 in the Section titled Medical Covered Expenses (p. C-18) for information regarding contraceptive coverage that is paid at 100% by the Plan.
NOTE:

1. This Plan is participating with Blue Cross Blue Shield of Vermont preferred provider network as well as the BlueCard Program. The preferred providers will bill the Contract Administrator directly and write off charges that exceed their contractual allowances.

2. All covered charges billed by non-participating providers will be subject to a maximum allowable benefit.

3. See the “Plan Details” and “Medical Covered Expenses” sections for additional information.

4. The retail and mail order calendar year prescription out-of-pocket maximum is a combined maximum for both retail and mail order prescriptions.

TERMINATION OF BENEFITS

An Eligible Employee’s, Eligible Retiree’s and/or a Dependent’s coverage under the Plan will terminate:

1. on the date the Plan terminates; or

2. on the last day of the month in which an Eligible Employee or Eligible Retiree withdraws from the Plan; or

3. on the last day of the calendar month in which an Eligible Employee is terminated, unless continuation of coverage, as provided herein, is elected; or

4. on the date a Dependent withdraws from the Plan or a Dependent ceases to meet the definition of a Dependent as defined herein or Dependent coverage is discontinued under the Plan for any reason, unless continuation of coverage, as provided herein, is elected; or

5. on the date an Eligible Employee or Dependent enters the military, naval, or air force of any country or international organization on a full-time, active duty basis other than scheduled drills or other training not exceeding one (1) month in any calendar year (see Military Leave section below); or

6. on the last date of the period for which contribution has been made if the Eligible Employee or Eligible Retiree fails to make any required contribution; or

7. the first day following the failure of an Eligible Employee to return from an Approved Leave of Absence.
MILITARY LEAVE

The Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA") provides special continuation coverage to covered Eligible Employees who otherwise lose health insurance coverage under the Plan because they leave employment to serve in the uniformed services. Under USERRA, affected covered Eligible Employees and their Dependents must be offered the right to continue coverage for up to eighteen (18) months. Your Employer may charge 102% of the applicable premium, provided the length of the military leave is longer than thirty (30) days. However, on the date that the Eligible Employee completes his active duty and returns to employment, the Eligible Employee and his eligible Dependents will be re-enrolled in the Plan and coverage will be provided immediately. However, any limitations on the Eligible Employee’s or Dependent’s coverage which were in affect before the active military duty leave will continue to apply.

SICK LEAVE CONVERSION AT RETIREMENT

Retirees eligible for retiree medical insurance are eligible for the retirement conversion of Sick Leave Reserve ("SLR"), if applicable.

At retirement accumulated SLR hours will convert to insured days (weekends and the holidays listed in the Employee Handbook will not count) at a conversion rate of 7.75 hours per day. For each insured day your Employer will pay 100% of the premium to continue the medical benefits for the enrolled Eligible Employee and enrolled eligible Dependents, until the end of the month in which the last SLR day is used. If an Eligible Employee or Dependent is over sixty-five (65), your Employer will pay the cost of the retiree medical for the number of insured days. At the end of the insured days the Eligible Employee and their Dependents will be eligible to continue the retiree medical insurance at their own expense.

Example: If the number of SLR days was thirty (30) and the Eligible Employee retires on 7/1/08, the converted sick leave would run out on 8/12/08. Therefore, the insurance would continue until 8/30/08.

Retiring part-time employees have the option of converting combined time off ("CTO") hours to insurance days at a conversion rate of 7.75 hours per day.

Faculty (who do not have CTO or SLR days) will be given a week of insurance continuation for each academic year in which a full course load was carried. (The Vice President for Academic Affairs and the Director of Human Resources will resolve any conflicts).

There is no cash conversion of SLR. Conversion of SLR to insurance days is only available as outlined in the sections on Sick Leave Conversion at Retirement and Sick Leave Survivor’s Conversion.
SURVIVOR’S BENEFIT

Employees enrolled for the Middlebury College medical insurance have a survivor’s benefit. If an Eligible Employee dies while in an Active Status, then the enrolled survivors will be given survivor’s benefits for medical insurance. Medical benefits will be continued:

1. For sixty (60) days following the date of death with all premiums paid by your Employer.

2. Following those sixty (60) days, accumulated Sick Leave Reserve will be converted to insured days (weekends and holidays listed in the Employee Handbook will not count). For each insured day the Plan Administrator will pay 100% of the premium to continue the medical insurance coverage.

3. If survivors pay on a monthly basis 75% of the full internal premium, for the balance of one year following the sixty (60) days and Sick Leave Reserve.

4. If survivors pay on a monthly basis 100% of the full internal premium, until eligibility ends. For surviving children the eligibility will be the same as in the active plan. For surviving Spouses, eligibility will end when the person becomes eligible for another plan or becomes eligible for Medicare. However, a surviving Spouse’s eligibility will not end at Medicare eligibility if the Eligible Employee could have qualified as a retiree at the time of death. In such instance, the surviving Spouse will be given sixty (60) days to enroll for Medicare Parts A and B, and will be transferred from the “active” coverage under the Plan to the “retiree” coverage.

<table>
<thead>
<tr>
<th>Timeframe</th>
<th>% of full internal premium paid by Middlebury College</th>
<th>% of full internal premium paid by survivor</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st 60 days following death of Eligible Employee, then</td>
<td>100</td>
<td>0</td>
</tr>
<tr>
<td>Sick Leave Conversion to Insurance days, then</td>
<td>100</td>
<td>0</td>
</tr>
<tr>
<td>Balance of one year from date of death of Eligible Employee, then</td>
<td>25</td>
<td>75</td>
</tr>
<tr>
<td>From end of 1st year to end of eligibility</td>
<td>0</td>
<td>100</td>
</tr>
</tbody>
</table>

PLAN DETAILS

Preferred Provider Network Program: The Plan includes access to Blue Cross Blue Shield of Vermont’s preferred provider network and the BlueCard Program in order to obtain discounts from participating providers for covered medical care. The Plan identification card identifies the selected preferred provider network and a current list of the participating providers is available through the CBABlue link on the Middlebury College website. Use of the network is
voluntary and the benefits of utilizing participating providers include provider fee discounts, direct billing to the Plan for covered services, and network provider write-offs of any charges in excess of the discounted fee schedule.

**Inaccessible In-Network Provider:** Should a covered participant request services from a non-network provider because no in-network provider exists for that area of specialty within a fifty (50) mile radius of the covered person’s place of residence, then benefits for covered services may be considered for payment at the in-network benefit level. In order for the Plan to approve reimbursement at the in-network benefit level, the Contract Administrator’s Utilization Review Department must review and make an authorization determination for the requested medical services. To request this exception, members must contact the Utilization Review Department by calling 888-222-9206 or sending a letter to CBA Blue, P.O. Box 2365 South Burlington, VT 05407-2365. All requests must include at least the following information: patient name and ID number, diagnosis, requested service and explanation of medical necessity, distance from home to the nearest in-network provider able to provide the requested service, provider’s name, and the request to have services paid at the in-network benefit level because there is no available in-network provider. This provision is effective as of November 1, 2011.

**The BlueCard Program:** When you receive health care services through BlueCard outside the geographic area covered by Blue Cross Blue Shield of Vermont’s preferred provider network, claims processing is coordinated with the out-of-area Blue Cross Blue Shield plans through the BlueCard Program. The amount you pay for covered services is calculated on the lower of:

- The actual billed charges for your covered service; or
- The negotiated price that the local Blue Cross Blue Shield Plan (“Host Blue”) passes on to us.

Often, this “negotiated price” will consist of a simple discount which reflects the actual price paid by the Host Blue. However, sometimes it is an estimated discount that factors into the actual price expected settlements, withholds, any other contingent payment arrangements and non-claims transactions with your health care provider or with a specified group of providers. The negotiated price may also be billed charges reduced to reflect an average expected savings with your health care provider or with a specified group of providers. The price that reflects average savings may result in greater variation (more or less) from the actual price paid than will the estimated price.

The negotiated price may also be prospectively adjusted to correct for over- or underestimation of past prices. However, the amount you pay is considered a final price. Statutes in a small number of states may require the Host Blue to use a basis for calculating member liability for covered services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or to add a surcharge. Should any state statutes mandate member liability calculation methods that differ from the usual BlueCard method noted above in paragraph one of this section or require a surcharge, the Contract Administrator would then calculate your liability for any covered health care services in accordance with the applicable state statute in effect at the time you received your care.
Medical Deductible Carry-Over Provision: If, after September 30th of any year, a covered person incurs services for which any or all of the medical deductible amount must be paid, then that portion of the medical deductible paid by the covered person after September 30th will be deemed to have been paid toward the next year’s medical deductible as well.

Inpatient Pre-Admission Certification Penalty: The Plan requires that all non-emergency hospital admissions be pre-certified and authorized by the Contract Administrator. This does not include hospital stays in connection with childbirth for the mother or newborn child which are forty-eight (48) hours or less for vaginal deliveries, or ninety-six (96) hours or less for cesarean section deliveries. When a doctor recommends that the Participant be admitted to a hospital, it is the Participant’s responsibility to notify the Plan and to obtain pre-certification and authorization of the hospital admission, by calling the Customer Service number on your ID card. It is the Participant’s responsibility to be sure that in the event of an emergency admission, the Contract Administrator is notified within forty-eight (48) hours or on the next workday following the emergency admission. If the Contract Administrator is closed due to a weekend or holiday, the emergency admission must be reported on the next workday.

In order for the Plan to approve the inpatient stay, the attending physician must certify to the Contract Administrator that, in the physician’s professional opinion, the stay is necessary for the condition. The Plan reserves the right to request an independent medical opinion by a physician of the Plan’s choice.

Should the Contract Administrator determine that the hospital admission is not necessary for the condition, the Participant, the physician, and the hospital will be notified so that discharge procedures may begin. Should the covered person not be discharged within seventy-two (72) hours of the notification and there is no new medical evidence to support confinement, the covered person will be responsible for hospital cost incurred after the seventy-two (72) hours have elapsed.

PRESCRIPTION DRUG BENEFITS

Retail Prescription Drug Plan: The Plan includes a prescription drug program. Prescriptions filled at participating pharmacies are limited to a maximum thirty (30) day supply (only one thirty-day supply may be filled at a time; no refill will be allowed before the expiration of thirty days). Individual prescriptions are subject to the copayments listed below. The balance of the covered prescription expense will be paid at 100% to a maximum out-of-pocket of $500 per individual/$1,000 per 2-person/$1,500 per family.

<table>
<thead>
<tr>
<th>Copayment</th>
<th>Preferred Brand Copayment</th>
<th>Non-Preferred Brand</th>
</tr>
</thead>
<tbody>
<tr>
<td>$10</td>
<td>$25</td>
<td>$40</td>
</tr>
</tbody>
</table>

A list of participating pharmacies can be obtained by visiting:

https://lin04.cabbluevt.com/middleburyindex.htm
Prescriptions purchased at non-participating pharmacies will not be covered expenses, unless purchased outside the United States.

**Step Therapy Program:** In order for the Plan to manage the quickly rising prescription drug costs, RESTAT has instituted a Step Therapy Program to ensure that covered persons are receiving appropriate, yet cost-effective drug therapies. If a covered person is taking certain drugs, such as Proton Pump Inhibitors-PPI and Non-sedating Antihistamines it will be necessary for the physician, pharmacist and RESTAT to work together to ensure that the prescription is covered under the prescription benefit. Please visit RESTAT’s website at [www.restat.com](http://www.restat.com) for the most current version of the Step Therapy guidelines.

**Mail Order Maintenance Prescription Drug Program:** Maintenance drugs to treat chronic illnesses should be purchased through the mail order program. These illnesses include: diabetes, epilepsy, anemia, constipation, arthritis, high blood pressure, tuberculosis, various gastric disease, emphysema, menopause, mental and nervous disorders, thyroid disease, adrenal disease, ulcers, and any other condition that requires continuous medication. Mail order prescriptions are limited to a maximum ninety (90) day supply. Mail order prescriptions are subject to the copayments listed below. The balance of the covered expense will be paid at 100% to a maximum out-of-pocket of $500 per individual/$1,000 per 2-person/$1,500 per family.

<table>
<thead>
<tr>
<th>Generic Copayment</th>
<th>Preferred Brand Copayment</th>
<th>Non-Preferred Brand Copayment</th>
</tr>
</thead>
<tbody>
<tr>
<td>$20</td>
<td>$50</td>
<td>$80</td>
</tr>
</tbody>
</table>

The calendar year prescription out-of-pocket maximum is a combined maximum for both retail and mail order prescriptions.

When filling a prescription, the doctor or the covered person may request the brand name drug over the generic. The covered person will pay the brand name copayment.

**Split Incentive Program:** New England Mail Order Pharmacy’s (“NEMOP”) Split Incentive Program offers a way to reduce the price and copayments for prescription medications. Since expensive drugs are often available in many strengths, and the difference in cost between the strengths is often insignificant, savings occur when tablets equal to twice the dose are dispensed and one-half of the tablet is taken. Patients get the correct dose of medication, while overall cost of prescriptions are reduced. NEMOP provides tablet splitters and instructions when the covered person fills their first prescription. The Split Incentive Program cannot be used for every prescription. Some tablets should not be broken, some medicines only come in capsule form and others may not be available in the dosage needed to participate. NEMOP pharmacists will automatically use the Split Incentive Program when appropriate. Mail order prescriptions are subject to the copayments listed below and are limited to one (1) copayment per ninety (90) day supply.
MEDICAL COVERED EXPENSES

Expenses incurred for the following medical, health care services, and supplies will be considered a covered expense, provided the expenses are (i) medically necessary to treat an illness or injury, (ii) prescribed by an attending physician, and (iii) are incurred during a period that coverage was in effect in accordance with the applicable provisions of the Plan. Payment of such expenses will be subject to all applicable deductible, coinsurance limits, the maximum individual limit, and all other limitations described herein.

1. Inpatient hospital charges for room and board, operating room, x-rays, physical therapy, radiation therapy, chemotherapy, prescription drugs, anesthesia, laboratory expenses, intensive care unit, and other necessary services and supplies during any one (1) period of hospital confinement, as shown below. Should the facility have no semi-private rooms or less expensive accommodations available, or the patient’s condition requires the Participant or the Dependent to be isolated for their own health or the health of others, the private room rate will be allowed.

**Room and Board:**

<table>
<thead>
<tr>
<th>semi-private room allowance</th>
<th>semi-private room rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>private room allowance</td>
<td>semi-private room rate</td>
</tr>
<tr>
<td>intensive care allowance</td>
<td>actual charge (not to exceed MAB allowance)</td>
</tr>
</tbody>
</table>

2. Outpatient hospital or Ambulatory Surgical Center charges provided on an outpatient basis for surgery, but only for those charges incurred on the same day surgery is performed.

3. Charges for inpatient physician visits while the Participant or their Dependents are hospital confined as a result of an illness or an accidental injury. No benefits will be paid for more than one (1) visit per day by any one (1) physician or for the treatment received in connection with, on, or after the date of an operation for which a surgical expense benefit is payable under the Plan if such treatment is given by the physician who performed the operation.

4. Charges of a professional anesthesiologist, radiologist, or pathologist.

5. Charges for pre-admission testing, exams, x-ray and laboratory examinations on an outpatient basis made within fourteen (14) days of scheduled hospital admission and related to a condition previously diagnosed.
6. Charges for the transportation of a covered person in a ground or air ambulance that is regularly used for professional ambulance service, to and from the nearest hospital that can provide the necessary care.

7. **Emergency Room Services:** Emergency room charges for treatment of an illness or an accidental injury. Charges for emergency room services are covered expenses provided treatment is sought within twelve (12) hours of the first symptoms of illness. Charges may include facility fees, physician fees, x-rays, laboratory tests, and other necessary services and supplies, unless otherwise specified herein. Benefits will be payable at 80% provided services are diagnosed as a medical emergency and emergency services begin within seventy-two (72) hours of such accidental injury or treatment is rendered within twelve (12) hours of the first symptoms of an illness for a medical emergency.

**Non-Emergency Use of the Emergency Room:** Non-emergency use of an emergency room, as determined by the Contract Administrator, will not result in a rejection of the claim. However, a penalty of $25 per occurrence for a non-emergency use of an emergency room will be applied.

**Patient Protection Act Requirements:** Emergency Room Services provided under the Plan shall be provided in accordance with implementing regulations under Section 2719A of the Public Health Service Act. Pursuant to these requirements, the Plan will provide emergency room services: (a) without the need for any prior authorized determination (even if the emergency services are provided on an out-of-network basis); (b) without regard to whether the health care provider furnishing the emergency services is a participating network provider with respect to the services; (c) if the emergency services are provided out of network, without imposing any administrative requirements or limitation on coverage that is more restrictive than the requirements or limitations that apply to emergency services received from in-network providers; (d) if the emergency services are provided out-of-network, by imposing the same coinsurance rate as applies to in-network benefits (provided, however, that the Plan may require the participant to pay such additional amounts based on the difference between the in-network and out-of-network charge for the service as permitted by implementing regulations under Section 2719A of the Public Health Service Act); and (e) without regard to any other term or condition of the coverage other than the exclusion or coordination of benefits and an affiliation or waiting period as permitted under applicable federal law.

8. Diagnostic x-rays and laboratory charges for expenses incurred as a result of an illness or injury.

9. Charges for routine vision examinations. Benefits are subject to the calendar year deductible and coinsurance provisions. Maximum of one exam per covered person every two calendar years.

10. Charges for treatment by a qualified physiotherapist, occupational therapist, or speech therapist, except for the treatment of a learning disability as diagnosed by a physician.
11. Charges for physical therapy.

12. Charges for therapeutic massage as a replacement for physical therapy will be covered when prescribed by a doctor in the same manner as physical therapy provided treatment is for a medical condition.

13. Charges for dental services rendered by a physician, dentist, or oral surgeon for the treatment of a fractured jaw and dislocations of the jaw, and for cutting procedures in the oral cavity other than for the care of teeth and gums and for extractions, including treatment of cysts or tumors, or injury to sound natural teeth incurred as a result of an accident.

14. Charges for medically necessary private duty nursing care rendered on an outpatient basis by a registered nurse (RN) or, if none is available as certified by the attending physician for services of a licensed practical nurse (LPN), but only for nursing duties and excluding custodial care.

15. Charges for x-ray, laboratory, and radium expenses excluding dental x-rays, unless rendered for the treatment for a fractured jaw, cysts, tumors, or injury to sound natural teeth as a result of an accident will be considered covered expenses.

16. **Physician’s Office Visits:** Charges for physician’s office visits by a licensed physician when the Participant or his Dependent(s) incur expenses as a result of an illness or accidental injury are covered expenses. Benefits are payable at 80%. The calendar year deductible will be waived. The provision applies to any additional services provided at the time of the visit. If there are services provided in the physician’s office, but there is not an office visit charge, the services will still be payable at 80%. Any services or tests performed outside of the physician’s office are subject to the calendar year deductible and coinsurance provisions.

17. Charges for physician’s home and office visits when the Participant or his Dependent incur expenses as a result of an illness or accidental injury.

18. Charges for services of a surgeon and an assistant surgeon if two (2) or more procedures are performed during the course of a single operation through the same incision or in the same operative field involving multiple incisions, the maximum eligible expense for all procedures combined shall be limited to the amount payable for the procedure having the greater benefit plus fifty (50%) of the amount payable for the procedure(s) having the lesser benefit. Benefits are payable for the professional services of a legally qualified physician in rendering technical assistance to the operating surgeon when required in connection with a surgical procedure performed on an inpatient basis (benefits will not exceed twenty-five (25%) of the reasonable and customary allowance for the procedure performed). However, no benefits are payable for surgical assistance rendered in a hospital where it is routinely available as a service provided by a hospital intern, resident, or house officer.

19. If a Recommended Preventive Service is provided in connection with a physician’s office visit, and the Recommended Preventive Service is billed separately, the Plan’s
normal cost-sharing provisions for the office visit will apply with respect to the office visit charge. If a Recommended Preventive Service is provided in connection with a physician’s office visit and the Recommended Preventive Service is not billed separately, the Plan may impose the normal cost-sharing charge for the office visit, provided the primary purpose of the office visit is not the delivery of a Recommended Preventive Service (if the primary purpose of the visit is the delivery of a Recommended Preventive Service such cost-sharing charges shall not be applicable). The requirements of this paragraph are subject to any changes made pursuant to final regulations issued under Section 2713 of the Public Health Service Act.

20. **Prescription Drugs:** Charges for medically necessary dressings and medicines, fluoride and child, adult and prenatal vitamins for which a physician’s prescription is required and dispensed by a licensed pharmacy. Supplements prescribed by a naturopathic provider are not covered expenses. For prescription drugs to be covered expenses, in-network providers must be used, unless the providers are outside of the United States.

21. All prescribed Food and Drug Administration (FDA) approved contraceptive methods for women, and patient education and counseling for all women with reproductive capacity are covered at 100% at the in-network benefit level or when received from a participating pharmacy. All prescribed brand oral contraceptives will be covered at 100% when received from a participating pharmacy only if medically necessary or a generic equivalent is not available.

22. Charges for diabetic supplies such as: insulin, accu strips, lancets, and syringes necessary for the administration of prescription drugs and professional instructions, not including printed material for their use. Insulin dispensers and blood testing machines with a letter of medical necessity.

23. Charges for artificial limbs or eyes, casts, splints, surgical dressings, trusses, crutches, braces (except dental), orthotics or prescribed corrective appliances inside shoes, oxygen and the rental of equipment for its use, rental of a wheelchair or hospital type bed and the rental of durable medical equipment which has no personal use in the absence of the condition for which it was prescribed (rental charges will not exceed the retail purchase price of such equipment), rental of an iron lung or other mechanical equipment required for treatment of respiratory paralysis, or radium or radioactive isotopes for diagnosis or therapy. If the purchase of any medical equipment is more cost effective than renting such equipment at the discretion of the Contract Administrator, the Plan will cover the purchase price. The Plan will also cover repair costs to the rented or purchased equipment.

24. Charges for elective abortions or for routine and reverse sterilizations.

25. Charges for x-rays, radium or radioactive isotopes for diagnosis or therapy; blood or blood plasma; and anesthesia and fluids needed for surgery.
26. Charges for maternity care including prenatal, delivery, postpartum care, and services performed by a Certified Nurse Midwife, as well as charges arising from complications that may occur during maternity and delivery. Comprehensive lactation support and counseling by a trained provider during pregnancy and/or in the post-partum period and costs for renting breastfeeding equipment are payable at 100% of the in-network benefit level.

27. Charges for treatment in a Convalescent or Rehabilitation Hospital/Extended Care Facility/Skilled Nursing Facility if within fourteen (14) days of discharge from a Hospital period of confinement, for a medically necessary illness or injury, a covered person is, pursuant to a written certification by a supervising Physician, requested to be confined in a Convalescent or Rehabilitation Hospital/Extended Care Facility/Skilled Nursing Facility. Confinement in the Convalescent or Rehabilitation Hospital/Extended Care Facility/Skilled Nursing Facility must be for the same or related condition which necessitated the Hospital confinement, up to a maximum of one hundred twenty (120) days of confinement per lifetime.

28. Newborn care charges are a covered expense for an Employee’s newborn dependents. Charges for care of newborn children to include hospital charges for nursery room and board and miscellaneous expenses, charges by a pediatrician for attendance at a cesarean section, physician examination for a newborn while hospital confined and circumcision.

29. **Chiropractic Care:** Charges for home, office, and nursing home visits as well as examinations, x-rays, consultations, spinal manipulations, electrical stimulation, and interpretation are covered expenses, unless such charges are for maintenance care purposes. Any care associated with any visceral condition arising from problems or dysfunctions of the abdominal or thoracic organs is not a covered expense.

30. Organ transplant benefits to include charges for organ transplants and peripheral stem cell transplants for the treatment of cancer are considered a covered expense when the transplant procedure is not considered experimental/investigative and the covered person is considered an eligible recipient. Donor charges are considered a covered expense provided the charges are not covered under any insurance policy the donor may hold. Donor charges are limited to:

   a. evaluating the organ or tissue;
   
   b. removing the organ or tissue from the donor; and

   c. transporting the organ or tissue from within the United States and Canada to the transplant site.

31. Hospice care charges, as defined herein. Benefits include counseling and support services, for a maximum duration of six (6) months of care.

32. **Recommended Preventive Services:** As defined in this Appendix (See page C-39). Covered expenses can include routine physical examinations, well-female care,
medically necessary well child care up to age thirteen (13), examinations (including breast and pelvic), immunizations, consultations, laboratory tests, pap smears (including laboratory fees), x-rays, mammograms, and EKG’s. Recommended Preventive Services are payable at 100%, including sterilizations for women when rendered by an in-network provider. The calendar year deductible will be waived.

33. **Mental Health Care and Substance Abuse:** Charges resulting from inpatient mental health care and alcohol and/or drug addiction in a hospital, public, or licensed mental hospital, or drug/alcohol abuse treatment facility, or outpatient mental health services provided by a board certified physician, a licensed psychologist, clinical or certified social worker, pastoral counselor or certified alcohol counselor (CAC) will be considered covered expenses.

34. **Home Health Care:** Charges for the following services or supplies furnished to the employee and their dependents at home:

   a. Part-time intermittent nursing care by or under the supervision of a registered professional nurse (RN); and/or visits by persons who have completed a home health aide training course under the supervision of registered nurse for the purpose of giving personal care to the patient.

   b. Physician’s home and office visits, physical therapy, occupational therapy, and speech therapy.

   c. Medical supplies, laboratory services, drugs, and equipment prescribed by a physician to the extent such items would have been covered if you or your dependent had been hospitalized.

   d. **Exclusions and Limitations:** In no event will home health care expenses include charges for loss resulting from services solely for custodial care, transportation services, any period during which the Participant or Dependent are not under the continuing care of a physician, injury, or sickness arising out of or in the course of employment, declared or undeclared war or act of war.

35. Any taxes and/or surcharges applied to a covered expense are considered eligible expenses when the tax or surcharge is mandated by state or federal government until such time that ERISA preemption is clearly established by law prohibiting the applicable tax and/or surcharge.

36. Any of the following services in connection with a mastectomy:

   a. all stages of reconstruction of the breast on which the mastectomy is performed;

   b. surgery and reconstruction of the other breast to produce a symmetrical appearance; and

   c. protheses and treatment of physical complications of the mastectomy, including lymphedema.
The Women’s Health and Cancer Rights Act of 1998 requires the Plan Sponsor to notify a covered Participant or Dependent under this Plan of their rights related to benefits provided through the Plan in connection with a mastectomy. A covered Participant or Dependent under this Plan has rights for coverage to be provided in a manner determined in consultation with the attending physician for the above referenced services.

37. Charges for mastectomy bras are a covered expense to a maximum of two (2) bras per covered person per calendar year.

38. Charges for a wig or hairpiece are a covered expense if the covered person has been diagnosed with cancer, and the treatment for the condition has caused hair loss. Benefits will not exceed one (1) wig per covered person every five (5) calendar years.

39. Charges for a medically prescribed weight loss program in life threatening situations. The program must be prescribed by a physician and for a covered person who is at least fifty (50) pounds or more overweight.

40. Charges for an initial pair of lenses necessitated by a surgical procedure, limited to one (1) pair of lenses per surgery. Charges for eye examinations to prescribe or fit corrective lenses, or the actual cost of corrective lenses are not covered expenses.

41. Charges for hearing tests, hearing aids and repair subject to a maximum of $2,500 per covered person per lifetime.

42. Charges for diagnosis, treatment and surgery by a licensed Podiatrist.

43. Charges for dietary supplements and nutritional formulas limited to formulas for PKU, maple syrup disease, histinidemea and homoceprinuria.

44. Charges for medically necessary (i) male impotence medications, including Viagra, and (ii) female libido enhancement drugs.

45. Charges for acupuncture.

46. Charges for immunizations to travel abroad.

47. Charges for immunizations such as tetanus, diphtheria, Gardasil, and shingles vaccine, provided they are medically necessary or recommended by a physician as preventive care.

48. Charges for prescribed smoking deterrents to a maximum of two (2) cycles per calendar year.
49. Charges for the treatment of temporomandibular joint syndrome (TMJ), including a splint or other prescribed appliance will be covered, up to a lifetime maximum of $5,000.

50. **Autism Disorders:** Charges for services to diagnose and treat autism spectrum disorders for a child beginning at 18 months of age and continuing until the child reaches age 6 or enters first grade, whichever comes first. This may include, but is not limited to a physician, a psychologist, or a covered provider who is an autism services provider. This coverage includes:

a. Assessments, evaluations (including neuropsychological evaluations), genetic testing, and/or other tests to determine if a covered person has an autism spectrum disorder.

b. Habilitative and rehabilitative care. This is care to develop, maintain, and restore, to the maximum extent practicable, the functioning of the covered person. This care includes, but is not limited to, applied behavior analysis that is supervised by a board certified behavior analyst.

c. Psychiatric and psychological care that is furnished by a covered provider such as a physician who is a psychiatrist or a psychologist.

d. Therapeutic care that is furnished by a covered provider. This may include, but is not limited to, a speech, occupational or physical therapist, or a licensed independent clinical social worker. When physical therapy is furnished as part of the treatment of an autism spectrum disorder, the visit limit will not apply to these services.

e. Covered drugs and supplies that are furnished by a covered pharmacy.

No benefits are provided for services that are furnished by school personnel under an individual education program or services that are furnished or that are required by law to be furnished by a school or in a school-based setting.

The coverage for autism spectrum disorder described in this section is intended to be consistent with the autism spectrum disorder coverage required for insured plans under Vermont State Law. Unless the context indicates otherwise, terms used in this section shall have the same meaning as provided for in the Vermont autism statute.

51. **Infertility Treatment:** Charges for infertility treatment services are covered, as described below.

a. Infertility means the inability to conceive after regular sexual relations without contraception. To be eligible for infertility benefits, the covered person and her spouse/partner:

   i. must have at least a 2-year history of unexplained infertility; or
ii. the infertility must be associated with at least one of the following: endometriosis; DES exposure; blocked or surgically removed fallopian tubes that are not the result of voluntary sterilization; abnormal male factors contributing to the infertility; or

iii. have been unable to sustain a successful pregnancy.

b. Infertility treatment benefits will not be provided under the Plan unless the covered person has been unable to obtain successful pregnancy through any less costly infertility treatments covered by the Plan.

c. Infertility treatment or procedures must to be performed at facilities that conform to the American Society of Reproductive Medicine and the Society of Reproductive Endocrinology and Infertility Guidelines.

d. The following medically necessary surgical corrective procedures are covered and require pre-approval:

i. Artificial Insemination with donor sperm (AI)
ii. Intrauterine Insemination (IUI)
iii. Oocyte stimulation and retrieval
iv. Assisted Hatching
v. In Vitro Fertilization (IVF), including donor oocyte fertilization, up to four (4) cycles (the procedure must be done in accordance with American Society for Reproductive Medicine (ASRM) guidelines for number of embryos transferred)
vi. Intracytoplasmic sperm injection (ICSI)

vii. Pharmaceuticals associated with a covered service
viii. Preimplantation genetic diagnosis (PGD) for single cell disorders
ix. Oocyte and sperm storage

e. The following procedures are not covered by the Plan:

i. GIFT (Gamete Intrafallopian Transfer)
ii. ZIFT (Zygote Intrafallopian Transfer)

f. The lifetime maximum benefit under the Plan for infertility treatments is $15,000.

g. The maximum annual prescription drug benefit under the Plan for infertility treatments is $2,000.

52. Charges for Approved Clinical Trials.
GENERAL MEDICAL EXCLUSIONS AND LIMITATIONS

1. Expenses for confinement, treatment, services, or supplies except to the extent herein provided which are:
   
   (a) not furnished or ordered by a recognized provider and not medically necessary to diagnose or treat a sickness or injury;
   
   (b) experimental or investigational in nature.

2. Expenses for services for disease or injury sustained as a result of war, declared or undeclared. For all purposes of this Plan, terrorism is considered an act of war.

3. Expenses for services for disease or injury sustained as a result of participation in a riot or civil disobedience, or while committing or attempting to commit an assault or a felony.

4. Expenses incurred in connection with any accidental bodily injury or illness arising out of or in the course of any employment, regardless of whether the employment is for profit or compensation. This exclusion applies to all covered individuals, including but not limited to, self employed individuals who choose not to provide themselves with insurance coverages such as, but not limited to, workers’ compensation and occupational disease, regardless of whether such coverage or coverages are required by law.

5. Expenses incurred while on full-time active duty in armed forces of any country, combination of countries, or international authority.

6. Expenses for supplies, equipment, hair prosthesis for cosmetic use, improper use, loss or other non-medically necessary reasons.

7. Expenses for dental services, except to the extent herein provided.

8. Expenses for vision therapy or orthoptics, except following surgery to the muscles controlling the eye or in treatment of strabismus.

9. Expenses incurred for or in connection with any corrective treatment or surgery to correct a refractive error (i.e. such as hyperopia, myopia, astigmatism, or radial keratotomy, etc.).

10. Expenses for eyeglasses or contact lenses, whether or not all or any portion of the expenses related to prescribing, fitting, or correcting lenses, except as specified herein.

11. Expenses for treatment, services, supplies, and facilities provided by or in a hospital owned or operated by any government or agency thereof where such care is provided at government expense under a plan or program established pursuant to the laws or regulations of any government or under a plan or program under which any government
participates other than as an employer. The term “any government” includes the federal, veteran, state, provincial, municipal, local government, or any political subdivision thereof, of the United States or any other country. The Plan will not exclude benefits for a covered person who receives billable medical care at any of the above facilities.

12. Expenses for treatment, services, or supplies provided by the employee, spouse, parent, son, daughter, brother, or sister of a covered person or by a member of the covered person’s household.

13. Expenses for which there is no legal obligation to pay or for which no charges would be made if the person had no medical or dental coverage.

14. Expenses for services for which the covered person recovers the cost by legal action or settlement.

15. Expenses for transsexual surgery or related procedures.

16. Expenses for cosmetic or reconstructive surgery except for expenses:

   (a) incurred within two (2) years after an accident, to repair or alleviate the damage from that accident; or

   (b) incurred for reconstructive surgery following a mastectomy or for surgery and reconstruction of the other breast to produce symmetrical appearance; or

   (c) incurred as a result of a birth defect.

17. Expenses solely for custodial care, which is care designed essentially to help a person in the activities of daily living and which does not require the continuous attention of trained medical or paramedical personnel.

18. Expenses for routine foot care by a Podiatrist, to include treatment of corns, callouses, clavi, dystrophic nails, excrescences, helomas, hyperkeratosis, onychausix, onychocryptosis, and tylomas, bunions (except capsular or bone surgery), flat feet, fallen arches, weak feet, or chronic foot strain, except where a systemic condition has resulted in severe circulatory impairment or desensitization in the feet as these conditions make it hazardous for the cutting of nails, corns, etc., to be performed by a nonprofessional person.

19. Expenses for telephone, radio, television, and beautification services or for the preparation of reports, evaluations and forms, phone consultations, or for missed appointments or for time spent traveling or in connection therewith that may be incurred by the physician or dentist or other health care professional in the course of rendering services.
20. Routine or elective expenses except as set forth herein. [i.e. shoe inserts, ankle pads, printed material, arch supports, elastic stockings, over the counter fluoride, over the counter prenatal, child and adult vitamins, nutritional or dietary counseling, food supplements, and any “over the counter drug” which can be purchased with or without a prescription or when no injury or illness is involved].

21. Expenses for breast reduction surgery unless the covered person is within their normal weight range as determined by industry standards, has a chronic back problem, and a minimum of 500 grams of tissue per breast is being removed.

22. Expenses incurred prior to the covered person’s effective date of coverage or following the termination date of coverage.

23. Expenses in excess of the maximum allowed benefit in the locality where it is rendered or in excess of the lifetime maximum benefit stated herein.

24. Expenses for biofeedback training or equipment.

25. Expenses for massage therapy not medically necessary.


27. Expenses for surrogacy.

28. Expenses for genetic screening and genetic screening procedures, except in women over thirty-five (35) and where a family history of genetically-linked disorders is present.

29. Expenses for equipment which has personal use in the absence of the condition for which is prescribed including, but not limited to, air conditioners, air purifiers, dehumidifiers, humidifiers, waterbeds and exercise equipment.

30. Expenses for learning disorders; educational, academic N.I.Q. testing.

31. Expenses for supplies, equipment, hair prosthesis for cosmetic use, improper use, loss or other non-medically necessary reasons.

32. Expenses for chiropractic care associated with any visceral condition arising from problems or dysfunctions of the abdominal or thoracic organs, and any chiropractic expenses related to maintenance care.

33. Expenses for marital counseling.

**PATIENT PROTECTIONS**

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The Plan generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in the Plan’s network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact CBA Blue at the address below.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from the Plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact CBA Blue at the address below.

Comprehensive Benefits Administrator, Inc. dba CBABlue
P.O. Box 2365
South Burlington, VT 05407-2365
(888) 222-9206

CLAIM FILING PROCEDURES

Written notice of the Eligible Employee’s, Eligible Retiree’s or the Dependent’s claim (proof of claim) must be received by the Contract Administrator within twelve (12) months after the occurrence or commencement of any loss covered by the Plan. Failure to furnish written proof of claim within the time required will invalidate the claim. It is the Participant’s responsibility to inform his provider(s) of this claim submission time limit.

Filing a Prescription Drug Claim

In-Network: Normally, a Participant uses the prescription drug card, and benefits are received at the time of purchase. However, if a Participant pays full retail price rather than using a prescription drug card at an in-network pharmacy, reimbursement can be obtained by sending the claim to:

Restat Patient Reimbursement
P.O. Box 758
West Bend, WI 53095-0758

Out-of-Network: Prescription drugs from out-of-network providers are not covered except when purchased outside the United States. Claims for out-of-country prescription drugs should be sent to CBABlue at the address below.

Filing a Medical Claim
To obtain benefits under this Plan, a diagnostic bill must be submitted that provides sufficient information, including the Participant’s name, claimant’s name, claimant’s address, and Plan number to allow the Contract Administrator to properly adjudicate each claim. The Contract Administrator may require additional forms and information to assist them in this process.

**Mail all medical claims and out-of-country pharmacy claims to:**

Comprehensive Benefits Administrator, Inc. dba CBABlue  
P.O. Box 2365  
South Burlington, VT 05407-2365  
(888) 222-9206

**Plan Administration:**

**Plan Administrator and Designated Decision Maker**

The Plan is administered by the Plan Administrator in accordance with the provisions of the Employee Retirement Income Security Act of 1974, as amended (“ERISA”). An individual or entity may be appointed by the Plan Sponsor to be Plan Administrator and serve at the convenience of the Plan Sponsor. If the Plan Administrator resigns, dies, is otherwise unable to perform, is dissolved, or is removed from the position, the Plan Sponsor shall appoint a new Plan Administrator as soon as reasonably possible.

Notwithstanding any provisions of this Plan Document and Summary Plan Description to the contrary, the Plan Sponsor has the authority to, and hereby does, allocate certain fiduciary responsibility to ELAP Services, LLC (the “Designated Decision Maker” or “DDM”). The fiduciary responsibility allocated to the DDM is limited to discretionary authority and ultimate decision-making authority with respect to any final appeals of denied claims, which shall be referred to the DDM by the Plan Administrator (the “Referred Appeals”). The DDM shall have no authority, responsibility or liability other than with respect to the Referred Appeals.

The Plan Administrator shall establish the policies, practices and procedures of the Plan. The Plan Administrator and the Designated Decision Maker shall administer this Plan in accordance with its terms. It is the express intent of this Plan that the Plan Administrator and the Designated Decision Maker 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 provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits (including the determination of what services, supplies, care and treatments are experimental), to decide disputes which may arise relative to a covered person’s rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator and/or the Designated Decision Maker as to the facts related to any claim for benefits and the meaning and intent of any provision of the Plan, or its application to any claim, shall receive the maximum deference provided by law and will be final and binding on all interested parties. Benefits under this Plan will be paid only if the Plan Administrator or the Designated Decision Maker decides, in its discretion, that the covered person is entitled to them.
Duties of the Plan Administrator

The duties of the Plan Administrator include the following:

1. To administer the Plan in accordance with its terms;
2. To determine all questions of eligibility, status and coverage under the Plan;
3. To interpret the Plan, including the authority to construe possible ambiguities, inconsistencies, omissions and disputed terms;
4. To make factual findings;
5. To decide disputes which may arise relative to a covered person’s rights;
6. To prescribe procedures for filing a claim for benefits, to review claim denials and appeals relating to them and to uphold or reserve such denials;
7. To keep and maintain the Plan documents and all other records pertaining to the Plan;
8. To appoint and supervise a third party administrator to pay claims;
9. To perform all necessary reporting as required by ERISA;
10. To establish and communicate procedures to determine whether a medical child support order or national medical support notice is a QMCSO;
11. To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate; and
12. To perform each and every function necessary for or related to the Plan’s administration.

Duties of the Designated Decision Maker

The Designated Decision Maker shall have the following duties with respect to the Referred Appeals:

1. To administer the Plan in accordance with its terms;
2. To determine all questions of eligibility, status and coverage under the Plan;
3. To interpret the Plan, including the authority to construe possible ambiguities, inconsistencies, omissions, and disputed terms;
4. To make factual findings;
5. To decide disputes which may arise relative to a covered person’s rights;
6. To review Referred Appeals and to uphold or reverse any denials; and
7. To keep and maintain records pertaining to the Referred Appeals.

The duties of the DDM shall be limited to those set forth above.

SUBROGATION, REIMBURSEMENT & THIRD PARTY RECOVERY PROVISION

Payment Condition

1. The Plan, in its sole discretion, may elect to conditionally advance payment of benefits in those situations where an injury, sickness, disease or disability is caused in whole or in part by, or results from the acts or omissions of Plan Participants, and/or their dependents, beneficiaries, estate, heirs, guardian, personal representative, or
assigns (collectively referred to hereinafter in this section as “Plan Participant(s)”)
or a third party, where any party besides the Plan may be responsible for expenses arising from an incident, and/or other funds are available, including but not limited to no-fault, uninsured motorist, underinsured motorist, medical payment provisions, third party assets, third party insurance, and/or grantor(s) of a third party (collectively “Coverage”).

2. Plan Participant(s), his or her attorney, and/or legal guardian of a minor or incapacitated individual agrees that acceptance of the Plan’s conditional payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain one hundred percent (100%) of the Plan’s conditional payment of benefits or the full extent of payment from any one or combination of first and third party sources in trust, without disruption except for reimbursement to the Plan or the Plan’s assignee. By accepting benefits the Plan Participant(s) agrees the Plan shall have an equitable lien on any funds received by the Plan Participant(s) and/or their attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The Plan Participant(s) agrees to include the Plan’s name as a co-payee on any and all settlement drafts.

3. In the event a Plan Participant(s) settles, recovers, or is reimbursed by any Coverage, the Plan Participant(s) agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the Plan Participant(s). If the Plan Participant(s) fails to reimburse the Plan out of any judgment or settlement received, the Plan Participant(s) will be responsible for any and all expenses (fees and costs) associated with the Plan’s attempt to recover such money.

4. If there is more than one party responsible for charges paid by the Plan, or may be responsible for charges paid by the Plan, the Plan will not be required to select a particular party from whom reimbursement is due. Furthermore, unallocated settlement funds meant to compensate multiple injured parties of which the Plan Participant(s) is/are only one or a few, that unallocated settlement fund is considered designated as an “identifiable” fund from which the plan may seek reimbursement.

Subrogation

1. As a condition to participating in and receiving benefits under this Plan, the Plan Participant(s) agrees to assign to the Plan the right to subrogate and pursue any and all claims, causes of action or rights that may arise against any person, corporation and/or entity and to any Coverage to which the Plan Participant(s) is entitled, regardless of how classified or characterized, at the Plan’s discretion.

2. If a Plan Participant(s) receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the Plan to any claim, which any Plan Participant(s) may have against any Coverage and/or party causing the sickness or injury to the extent of such conditional payment by the Plan plus reasonable costs of collection.
3. The Plan may, at its discretion, in its own name or in the name of the Plan Participant(s) commence a proceeding or pursue a claim against any party or Coverage for the recovery of all damages to the full extent of the value of any such benefits or conditional payments advanced by the Plan.

4. If the Plan Participant(s) fails to file a claim or pursue damages against:

a) the responsible party, its insurer, or any other source on behalf of that party;
b) any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
c) any policy of insurance from any insurance company or guarantor of a third party;
d) worker’s compensation or other liability insurance company; or
e) any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage; the Plan Participant(s) authorizes the Plan to pursue, sue, compromise and/or settle any such claims in the Plan Participant(s)’ and/or the Plan’s name and agrees to fully cooperate with the Plan in the prosecution of any such claims. The Plan Participant(s) assigns all rights to the Plan or its assignee to pursue a claim and the recovery of all expenses from any and all sources listed above.

**Right of Reimbursement**

1. The Plan shall be entitled to recover 100% of the benefits paid, without deduction for attorneys’ fees and costs or application of the common fund doctrine, make whole doctrine, or any other similar legal theory, without regard to whether the Plan Participant(s) is fully compensated by his/her recovery from all sources. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any State prohibiting assignment of rights which interferes with or compromises in any way the Plan’s equitable lien and right to reimbursement. The obligation to reimburse the Plan in full exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses. If the Plan Participant(s)’ recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved.

2. No court costs, experts’ fees, attorneys’ fees, filing fees, or other costs or expenses of litigation may be deducted from the Plan’s recovery without the prior, expressed written consent of the Plan.

3. The Plan’s right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of the Plan Participant(s), whether under the doctrines of causation, comparative fault or contributory negligence, or other similar doctrine in law. Accordingly, any lien reduction statutes, which attempt to apply such laws and reduce a subrogating Plan’s recovery will not be applicable to the Plan and will not reduce the Plan’s reimbursement rights.
4. These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgment of these rights is required by the Plan and signed by the Plan Participant(s).

5. This provision shall not limit any other remedies of the Plan provided by law. These rights of subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable sickness, injury, disease or disability.

**Excess Insurance**

1. If at the time of injury, sickness, disease or disability there is available, or potentially available any Coverage (including but not limited to Coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of Coverage, except as otherwise provided for under the Plan’s Coordination of Benefits section. The Plan’s benefits shall be excess to:

   a) the responsible party, its insurer, or any other source on behalf of that party;
   b) any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
   c) any policy of insurance from any insurance company or guarantor of a third party;
   d) worker’s compensation or other liability insurance company; or
   e) any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

**Separation of Funds**

Benefits paid by the Plan, funds recovered by the Plan Participant(s), and funds held in trust over which the Plan has an equitable lien exist separately from the property and estate of the Plan Participant(s), such that the death of the Plan Participant(s), or filing of bankruptcy by the Plan Participant(s), will not affect the Plan’s equitable lien, the funds over which the Plan has a lien, or the Plan’s right to subrogation and reimbursement.

**Wrongful Death**

In the event that the Plan Participant(s) dies as a result of his or her injuries and a wrongful death or survivor claim is asserted against a third party or any Coverage, the Plan’s subrogation and reimbursement rights shall still apply, and the entity pursuing said claim shall honor and enforce these Plan rights and terms by which benefits are paid on behalf of the Plan Participant(s) and all others that benefit from such payment.

**Obligations**

1. It is the Plan Participant(s)’ obligation at all times, both prior to and after payment of medical benefits by the Plan:
a) to cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the Plan’s rights;
b) to provide the Plan with pertinent information regarding the sickness, disease, disability, or injury, including accident reports, settlement information and any other requested additional information;
c) to take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights;
d) to do nothing to prejudice the Plan’s rights of subrogation and reimbursement;
e) to promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received; and
f) to not settle or release, without the prior consent of the Plan, any claim to the extent that the Plan Participant may have against any responsible party or Coverage.

2. If the Plan Participant(s) and/or his or her attorney fails to reimburse the Plan for all benefits paid or to be paid, as a result of said injury or condition, out of any proceeds, judgment or settlement received, the Plan Participant(s) will be responsible for any and all expenses (whether fees or costs) associated with the Plan’s attempt to recover such money from the Plan Participant(s).

3. The Plan’s rights to reimbursement and/or subrogation are in no way dependent upon the Plan Participant(s)’ cooperation or adherence to these terms.

Offset

Failure by the Plan Participant(s) and/or his or her attorney to comply with any of these requirements may, at the Plan’s discretion, result in a forfeiture of payment by the Plan of medical benefits and any funds or payments due under this Plan on behalf of the Plan Participant(s) may be withheld until the Plan Participant(s) satisfies his or her obligation.

Minor Status

1. In the event the Plan Participant(s) is a minor as that term is defined by applicable law, the minor’s parents or court-appointed guardian shall cooperate in any and all actions by the Plan to seek and obtain requisite court approval to bind the minor and his or her estate insofar as these subrogation and reimbursement provisions are concerned.

2. If the minor’s parents or court-appointed guardian fail to take such action, the Plan shall have no obligation to advance payment of medical benefits on behalf of the minor. Any court costs or legal fees associated with obtaining such approval shall be paid by the minor’s parents or court-appointed guardian.
Language Interpretation

1. The Plan Administrator retains sole, full and final discretionary authority to construe and interpret the language of this provision, to determine all questions of fact and law arising under this provision, and to administer the Plan’s subrogation and reimbursement rights. The Plan Administrator may amend the Plan at any time without notice.

Severability

In the event that any section of this provision is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining sections of this provision and Plan. The section shall be fully severable. The Plan shall be construed and enforced as if such invalid or illegal sections had never been inserted in the Plan.

DEFINITIONS

The following words and phrases are included here for explanatory purposes only. This list is not intended to include all terms used herein. Any word or phrase not specifically defined below will have its usual and customary meaning. The inclusion of any word or phrase below is not intended to imply that coverage is provided under the Plan with respect to any such condition, service, facility, or person.

**Accident:** An unforeseen or unexplained sudden injury occurring by chance without intent or volition.

**Adverse Benefit Determination:** Any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Participant’s beneficiary’s eligibility to participate in the Plan, and including, with respect to group health plans, a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate. A rescission of coverage also shall be considered an adverse benefit determination.

**Aggregate:** The combined total of all family members.

**Ambulatory Surgical Center:** A facility which is not physically attached to a health care facility, which provides surgical treatment to patients not requiring hospitalization, and does not include the offices of private physicians or dentists whether in an individual or group practice.

**Approved Clinical Trial:** The Plan covers expenses for Approved Clinical Trials in accordance with the requirements of Section 2709 of the Public Health Service Act ("PHSA"), subject to the otherwise applicable limitations and under the Plan, to the extent permitted under Section 2709 of the PHSA. Pursuant to Section 2709 of the PHSA, the Plan may not: (1) deny a
qualified individual participation in an approved clinical trial with respect to the treatment of cancer or another life-threatening disease or condition; (2) deny (or limit or impose additional conditions on) the coverage of routine patient costs for items and services furnished in connection with participation in the trial; and (3) discriminate against the individual on the basis of the individual’s participation in the trial. A qualified individual is generally a participant or beneficiary who is eligible to participate in an approved clinical trial according to the trial protocol with respect to the treatment of cancer or another life-threatening disease or condition and either (a) the referring health care professional is a participating provider and has concluded that the individual’s participation in such trial would be appropriate; or (b) the participant or beneficiary provides medical and scientific information establishing that the individual’s participation in such trial would be appropriate.

An Approved Clinical Trial will be covered regardless of whether it is otherwise considered to be Experimental/Investigative under the terms of the Plan.

**Birthing Center:** A public or private facility, other than private offices or clinics of physicians, which meets the free standing birthing center requirements of the State Department of Health in the state where the covered person receives the services.

The birthing center must provide: a facility which has been established, equipped, and operated for the purpose of providing prenatal care, delivery, immediate postpartum care and care of a child born at the center; supervision of at least one (1) specialist in obstetrics and gynecology; a physician or certified nurse midwife at all births and immediate postpartum period; extended staff privileges to physicians who practice obstetrics and gynecology in a area hospital; at least two (2) beds or two (2) birthing rooms; full-time nursing services directed by an R.N. or certified nurse midwife; arrangements for diagnostic x-ray and lab services; and the capacity to administer local anesthetic or to perform minor surgery.

In addition, the facility must only accept patients with low risk pregnancies, have a written agreement with a hospital for emergency transfers and maintain medical records on each patient and child.

**Coinsurance:** Coinsurance percentages represent the portions of covered expenses paid by the covered person and by the Plan after satisfaction of any applicable deductible. These percentages apply only to covered expenses which do not exceed the reasonable and customary charges. The covered person is responsible for all non-covered expenses and any amount which exceeds the reasonable and customary charge for covered expenses.

**Co-pay or Copayment:** Co-pay means a fixed dollar amount, which you must pay for covered services. You must pay the co-pay directly to the provider.

**Contract Administrator:** Third party claims administrator, hired by the Plan Sponsor to handle the day-to-day administration of the Plan, including:

1. reviewing and processing claims for proper benefit payments and providing explanation of benefits to covered Participant and/or providers;
2. remitting benefit payments for covered expenses under the Plan to covered Eligible Participant and/or providers;

3. reviewing all claims appeals.

**Contributory Coverage:** Plan benefits for which a Participant enrolls and agrees to make any required contributions toward the cost of coverage.

**Convalescent Hospital/Extended Care Facility/Skilled Nursing Facility:** An institution which is licensed pursuant to state and/or local laws and is operated primarily for the purpose of providing treatment for individuals convalescing from injury or illness, including that part or unit of a hospital which is similarly constituted and operated, and:

1. has organized facilities for medical treatment and provides for twenty-four (24) hour nursing service under the full-time supervision of a physician or a registered nurse. Full-time supervision means a physician or a registered nurse is regularly on the premises at least forty (40) hours per week;

2. maintains daily clinical records concerning each patient and has a written agreement or arrangement with a physician to provide services and emergency care for its patients;

3. provides appropriate methods for dispensing and administering drugs and medicines;

4. has transfer agreements with one (1) or more hospitals, a utilization review procedures in effect, and operational policies developed with the advice of and reviewed by a professional group including at least one (1) physician. A convalescent hospital/extended care facility will not include any institution which is a rest home for the aged, or a place for the treatment of mental disease, drug addiction or alcoholism, or a nursing home.

5. qualifies as an “extended care facility” under the health insurance provided by Title XVIII of the Social Security Act, at the time.

**Covered Person:** A covered Eligible Employee, covered Eligible Retiree or a covered Dependent as determined under the applicable Plan provision.

**Creditable Coverage:** Coverage with a previous carrier that is credited toward the preexisting condition limitation provision of this Plan. Creditable Coverage includes Medicare, Medicaid, state health benefits risk pool coverage, group health plans, etc. Waiting periods are not considered breaks in coverage. Days in a waiting period are not creditable coverage.

**Custodial Care:** Care which is designed essentially to help a person in the activities of daily living and which does not require the continuous attention of trained medical or paramedical
personnel. Custodial care includes services that could be performed by a relative or friend with minimal instruction or supervision.

**Custodial Parent:** The parent awarded custody by court decree. If there is no court decree, the custodial parent is the one with whom the child resides for more than half the year.

**Day of Confinement:** Any period of twenty-four (24) hours or any part thereof for which a full charge for room and board is made by a Hospital.

**Deductible:** The amount of covered expenses the covered Participant must pay during each calendar year before the Plan will consider expenses for reimbursement. The individual deductible applies separately to each covered person. The family deductible is the maximum deductible applied to each family. When the family deductible is satisfied, no further deductible will be applied for any covered family member during the remainder of that calendar year.

**Dental Services:** Procedures involving the teeth, gums, or supporting structures.

**Dentist:** A duly licensed doctor of dentistry and a dental professional or practitioner who is duly licensed under appropriate state licensing authorities, provided a benefit is claimed for services which are within the scope of such person’s license and for which a reimbursement under the Plan would be made had such services been performed by a doctor of dentistry, and under applicable state laws, such professional or practitioner must be treated under the Plan in the same manner as if such services were provided by a doctor of dentistry.

**Dependent:**

1. the lawful Spouse (including same-sex spouse) of an Eligible Employee or Eligible Retiree; or
2. the child of an Eligible Employee or Eligible Retiree who has not attained his or her twenty sixth (26th) birthday; or
3. an Eligible Employee’s or Eligible Retiree’s Same-Sex Spouse, Domestic Partner or Civil Union Partner, as defined by your Employer’s Office of Human Resources.

The term “child,” as used above, includes an Eligible Employee’s or Eligible Retiree’s natural child, a legally adopted child (including a child in the custody of the Eligible Employee or Eligible Retiree under an interim court order of adoption, whether or not a final adoption order is ever issued), a stepchild (including the child of a same-sex spouse, domestic partner or civil union partner), a foster child, or a child for whom legal guardianship (as evidenced by a court order) has been granted, but excludes a child who is eligible for Employee coverage under this Plan.

The mentally or physically handicapped child of an Eligible Employee or Eligible Retiree who is incapable of earning his or her own living and who is age 26 or older (“Disabled Adult
Child”) may be enrolled in the medical benefits under the Plan during the initial eligibility period of the Eligible Employee or Retiree, upon the occurrence of a qualifying change in family status (as defined by the Plan), or during open enrollment, provided that (a) the child is a Disabled Adult Child at the time that the Eligible Employee or Retiree initially enrolls in the medical benefits under the Plan, and (b) the child was a Disabled Adult Child prior to attaining age 26. A Disabled Adult Child will continue to be considered a Dependent while such child remains disabled, subject to all of the terms of the Plan, provided the Eligible Employee or Retiree submits proof of the child’s disability (as described above) at the time of enrollment and at such further times as the Plan Administrator or its designee may request. If the Eligible Employee’s or Retiree’s child is not considered a Disabled Adult Child at the time that the Eligible Employee initially enrolls in the medical benefits under the Plan, such child may not be later enrolled in the medical benefits under the Plan, even if the child is considered a Disabled Adult Child at a later date.

Additionally, should an Eligible Employee or Eligible Retiree have a child covered under the Plan who reaches age 26 and if such child is then mentally or physically handicapped and incapable of earning his own living, the Plan will continue to consider such child as a Dependent beyond such age, while such child remains in such condition, subject to all of the terms of the Plan, provided the Eligible Employee or Eligible Retiree has, within thirty (30) days of the date on which the child attained such age, submitted proof of the child’s incapacity, as described above.

The Plan Sponsor will have the right to require satisfactory proof of continuance of such mental or physical incapacity and the right to examine such child at any time after receiving proof of the child’s incapacity. Upon failure to submit such required proof or to permit such an examination when requested by the Plan Sponsor, or when the child ceases to be so incapacitated, coverage with respect to the child will cease. This continuation of coverage will be subject to all the provisions of the “Termination of Benefits” section of this Plan except as modified herein.

**Dependent Coverage:** Plan benefits extended to the Dependent(s) of a covered Eligible Employee or Eligible Retiree.

**Effective Date:** The date the Plan becomes liable to provide coverage under the terms of the Plan.

**Eligibility Date:** The date an Eligible Employee, Eligible Retiree and/or their Dependent(s) become eligible to enroll in the Plan, as set forth in Article II of this SPD.

**Eligible Employees:** As defined in Section 2.1.

**Eligible Retirees:** As defined in Section 2.2. Eligible Retired Employees may remain in the active medical plan until obtaining age sixty-five (65). However, for Plan purposes they will be considered a retiree upon the date of retirement. They will begin being billed for retiree premiums at this time or at the end of the Sick Leave Reserve Conversion period.
**Employee Coverage:** Group medical benefits provided under the Plan on behalf of a covered Eligible Employee.

**Essential Health Benefits:** Essential Health Benefits are generally defined as those benefits that are described in Section 1302(b) of the Patient Protection and Affordable Care Act and implementing regulations. Essential health benefits include the following general categories and the items and services covered within the categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

**Expense:** A charge a covered person is legally obligated to pay. An expense is deemed to be incurred on the date the service or supply is furnished.

**Experimental/Investigative:** A drug, device, medical treatment or procedure is experimental or investigative:

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 procedures 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

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 will 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, device, medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure.

**Health Care Professional:** A physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with State law.
Home Health Care Agency: A licensed and state approved home health care facility possessing a valid certificate of approval issued in accordance with Title XVIII of the Social Security Act and licensed and approved by the appropriate state authorities which specializes in providing health care and therapeutic services to a person in such person’s home.

Home Health Care Plan: A program for care and treatment of a covered person established and approved, in writing, by such covered person’s attending physician, together with such physician’s certification that the proper treatment of the injury or sickness would require confinement as a resident inpatient in a hospital or confinement in a skilled nursing facility as defined in Title XVIII of the Social Security Act, at the time, in the absence of services and supplies provided as part of the home health care plan.

Hospice: An agency that provides counseling and incidental medical services for a terminally ill individual who has been diagnosed by a physician as having a life expectancy of six (6) months or less. Room and board may be provided. The agency must meet all of the following tests: (i) approved under any required state or governmental Certificate of Need; (ii) provides twenty-four (24) hour a day, seven (7) day a week service; (iii) it is under the full-time supervision of at least one (1) duly qualified physician; (iv) has a nurse coordinator who is a registered graduate nurse with at least four (4) years of full-time clinical experience. Two (2) of these years must involve caring for terminally ill patients; (v) has a social service coordinator who is licensed in the area in which it is located; (vi) the main purpose of the agency is to provide hospice services; (vii) has a full-time administrator; (viii) maintains written records of services given to each patient; (ix) its employees are bonded; (x) it provides malpractice and malplacement insurance; (xi) is established and operated in accordance with any applicable state laws.

Hospital: A duly licensed, if required, and legally-constituted and operated institution which is primarily engaged in providing diagnostic services, therapeutic services for diagnosis, care and treatment of sick or injured persons on an inpatient and/or outpatient basis, and which provides such care and treatment: (i) under the supervision of one (1) or more physicians, (ii) with twenty-four (24) hour nursing service under the supervision of one (1) or more physicians licensed to practice medicine; and (iii) which has organized facilities for laboratory and diagnostic work and major surgery. The term “Hospital” will not include, other than incidentally, an institution which is primarily a rest home, a nursing home, a convalescent home, a rehabilitation center, an extended care facility, a place (primarily) for the treatment of tuberculosis, mental, emotional, drug or alcoholic disorders, or a home for the aged. Services rendered in the infirmary or clinic of a college, university, or private boarding school will be eligible expenses. In such instances, if a covered person is confined in a school facility that does not meet the definition of a hospital because it has no operating room, benefits may be paid, provided the charges for such confinement do not exceed the reasonable and customary charges for the disability involved.

Hospital Confinement: Being registered as a bed-patient in a hospital upon the recommendation of a physician, or as a result of a surgical operation, or by reason of receiving emergency medical care.
**Illness:** Sickness or disease which results in expenses for medical care, services, and supplies covered by the Plan. Such expense must be incurred while the covered person, whose illness is the basis of the claim, is covered under the Plan. Medical expenses incurred by a covered person because of pregnancy will be covered to the same extent as any other illness.

**Injury:** Accidental bodily harm resulting from an accident.

**Inpatient Basis:** Hospital confinement including one (1) or more days of confinement for which a room and board charge is made by a hospital.

**Intensive Care Unit:** An accommodation in or part of a hospital, other than a post-operative recovery room, which, in addition to providing room and board:

1. is established by the hospital for the purpose of providing formal intensive care;

2. is exclusively reserved for critically ill patients requiring constant audio/visual observation prescribed by a physician and performed by a physician or by a specifically trained registered nurse; and

3. provides all necessary lifesaving equipment, drugs, and supplies in the immediate vicinity on a standby basis.

**Maximum Allowable Benefit (MAB):** An amount a provider is allowed for a particular service. If an out-of-network provider charges more than the maximum allowable benefit, the Plan will not cover more than the maximum allowable benefit and the Participant is responsible for the difference.

**Medical Emergency:** The sudden, unexpected onset of a medical condition with severe symptoms requiring urgent and immediate medical attention. Such conditions are considered hazardous to the patient’s life, health, or physical well-being. Criteria used in determining the existence of a “medical emergency” condition and whether benefits will be paid are as follows:

1. the condition must be of such nature that failure to receive immediate care of treatment could reasonably result in deterioration to the point of placing the patient’s life in jeopardy and/or cause serious impairment to bodily function;

2. a chronic condition for which symptoms have existed over a period of time would not qualify as a medical emergency. However, if symptoms become acute enough to require emergency medical assistance, it might, at that point, qualify; and

3. care must be received within twenty-four (24) hours of onset for the condition to qualify as a medical emergency. The non availability of a private physician or the fact that the physician may refer an eligible employee or dependent to the emergency room does not, in itself, constitute a “medical emergency.”
Medical Intervention: Any medical treatment, service procedure, facility, equipment, drug, device, or supply.

Medically Necessary: Health care services, supplies, or treatment will be considered medically necessary if:

1. there is a sickness or injury which requires treatment; or
2. the confinement, service, or supply used to treat the sickness or injury is:
   - required;
   - generally professionally accepted as usual, customary, and effective means of treating the sickness or injury in the United States; and
   - approved by regulatory authorities such as the Food & Drug Administration; and
3. diagnostic x-rays and laboratory tests when they are performed due to definite symptoms of sickness or injury, or they reveal the need for treatment.

Mental Hospital: An institution (other than a hospital as defined) which specializes in the diagnosis and treatment of mental illness or functional nervous disorders and which is operated pursuant to law and meets all of the following requirements:

1. is licensed to give medical treatment and is operated under the supervision of a physician;
2. offers nursing services by registered graduate nurses (RN) or licensed practical nurses (LPN) and provides, on the premises, all the necessary facilities for medical treatment;
3. is not, other than incidentally, a place of rest or a place for the aged, drug addicts, or alcoholics; or a place for convalescent, custodial, or educational care.

Mental Illness: Neuroses, psychoneuroses, psychoses, and other mental and emotional disorders falling within any of the diagnostic categories in the mental disorders section of the international classification of diseases.

Newborn Care Charges: Charges for care of newborn children as more specifically defined herein.

Out-of-Pocket Maximum: Under the terms of this Plan, the maximum amount any individual covered under the Plan would be required to pay toward the reasonable and customary (R&C) allowance on all covered expenses during a calendar year. The out-of-pocket maximum will be determined by adding the deductible and employee share of coinsurance amounts as set forth by this Plan.

Outpatient Basis: Any hospital expenses incurred for which no room and board charge is made.
Outpatient Mental Health Treatment Facility: A comprehensive, health service organization, a licensed or accredited hospital, or community mental health center or other mental health clinic or day care center which furnished mental health services with the approval of the appropriate governmental authority, any public or private facility or portion thereof providing services especially for the diagnosis, evaluation, service or treatment of mental illness or emotional disorder.

Period of Confinement: Any period of Hospital confinement as a result of the same or related conditions separated by less than six (6) months will be considered the same period of confinement.

Physician: A duly licensed doctor of medicine, a medical professional, or a practitioner who is duly licensed under appropriate state licensing authorities, provided: (i) a benefit is claimed for services which are within the scope of such person’s license and for which a reimbursement under the Plan would be made had such services been performed by a doctor of medicine, and (ii) under applicable state laws, such professional or practitioner must be treated under the Plan in the same manner as if such services were provided by a medical doctor. This shall include a chiropractor, Christian Science practitioner, dentist, optometrist, Physician (including psychiatrist), Doctor of Osteopathy (D.O.), podiatrist, psychologist, massage therapist, naturopath or acupuncturist.

Plan Anniversary Date: The date occurring in each calendar year which is an anniversary of the effective date of the Plan.

Plan Sponsor: Middlebury College

Recommended Preventive Services: In accordance with Section 2713 of the Public Health Service Act, and implementing regulations thereunder, the following services are considered Recommended Preventive Services: (a) evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force (Task Force) with respect to the individual involved (excluding those recommendations regarding breast cancer screening, mammography, and prevention issued on or around November of 2009); (b) immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved (for this purpose, a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention is considered in effect after it has been adopted by the Director of the Centers for Disease Control and Prevention, and a recommendation is considered to be for routine use if it is listed on the Immunization Schedules of the Centers for Disease Control and Prevention); (c) with respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (“HRSA”); and (d) with respect to women, evidence-informed preventive care and screening provided for in comprehensive guidelines supported by HRSA (not otherwise recommended by the recommendations of the Task Force). Effective for the Plan Year beginning January 1, 2013, those standards developed by HRSA on August 1, 2011 regarding women’s preventive services, including preventive
services with regard to contraceptive methods and counseling, shall be considered Recommended Preventive Services.

The Plan may use reasonable medical management techniques to determine the frequency, method, treatment or setting for a Recommended Preventive Service.

A current listing of the Recommended Preventive Services can be obtained at the following website maintained by the United States Department of Health and Human Services: http://www.healthcare.gov/law/regulations/prevention/index.html.

In accordance with implementing regulations, the Plan is not required to provide Recommended Preventive Services for services provided by out-of-network providers, and to the extent such services are covered out-of-network, the Plan may impose the otherwise applicable cost-sharing requirements.

**Rehabilitation Hospital:** A facility which meets all requirements of a hospital (as defined herein) other than the “surgical facilities” requirements and, in addition, meets the following criteria:

1. it must be accredited by the Joint Commission of Accreditation of Hospitals and be approved for Federal Medicare Benefits as a qualified hospital;

2. it must maintain transfer agreements with acute care facilities to handle surgical and/or medical emergencies; and

3. it must maintain a utilization review committee.

**Rehabilitative Care:** Necessary inpatient medical care (as prescribed by a physician) rendered in a rehabilitation hospital (as defined herein) excluding custodial care or occupational training.

**Residential Treatment Facility:** A child care institution that provides residential care and treatment for emotionally disturbed children and adolescents. The facility must be accredited as a residential treatment facility by the Council on Accreditation of Hospitals or the American Association of Psychiatric Services for Children.

**Substance Abuse:** Any use of alcohol or drugs which produces a state of psychological and/or physical dependence.

**Substance Abuse Treatment Facility:**

1. A public or private facility providing services especially for detoxification or rehabilitation of substance abusers and which is licensed to provide such services;

2. A comprehensive health service organization, community mental health clinic or day care center which furnishes mental health services with the approval of the
appropriate governmental authority, any public or private facility or portion thereof providing services especially for the rehabilitation of substance abusers and which is licensed to provide such services.

Surviving Spouse of a Retiree: In the event of the death of a retiree, the Eligible Retiree’s Spouse can elect to continue his/her coverage and will be billed accordingly.

Termination Date: See “Termination of Benefits” section for details.

Totally Disabled: A covered person who, because of disease or injury, is unable to engage in any gainful occupation for profit or compensation for which the employee qualifies by reason of education, activities of a person of the same sex or age.

Waiting Period: The period of time between an Eligible Employee’s date of employment and their effective date of coverage.

MEDICARE PROVISIONS

General Medicare Benefit Information: Most employees who are eligible for Medicare Part A benefits can receive such benefits at no cost because they or their Spouse paid Medicare taxes while working. Ineligible employees age sixty-five (65) and over, who are required to pay for Medicare Part A coverage, may purchase Medicare Part A by making application and paying the full cost. Participation in Medicare Part B and, effective January 1, 2006, Medicare Part D, is available to all employees age sixty-five (65) and over who make application and pay the full cost of the coverage.

Active Employees: All active Eligible Employees and their Dependents, age sixty-five (65) and over, who are eligible for coverage under the Plan, will be provided with coverage under this Plan on the same basis as available to covered Eligible Employees under the age of sixty-five (65). Due to the Eligible Employee’s current employment status, the Plan will be the primary payer of benefits and Medicare, if the Eligible Employee is participating, will be the secondary payer of benefits.

Each Participant over the age of sixty-five (65) has the right to reject the Employer-provided group health plan and elect to have Medicare as their only coverage. Should the Participant elect this option, Medicare will become the Participant’s only health insurance coverage and will be the primary payer of benefits.

For an Eligible Employee or Dependent, if Medicare eligibility is due solely to end-stage renal disease (“ESRD”), the Plan will be primary only during the first thirty (30) months of Medicare coverage. Thereafter, Medicare will be primary payer of benefits and the Plan will be secondary.

This provision will comply with the Social Security Act as amended from time to time.
MEDICARE CARVEOUT PLAN PROVISIONS

Medicare Carve-Out: Your Employer offers Eligible Retirees, Dependents and survivors a Medicare Carve Out Plan. Carve Out generally offers protection for medical expenses not paid by Medicare. Medicare Carve Out applies to all Eligible Retirees age sixty-five (65) or older, as well as Participants who are no longer actively employed due to disability (during the time they remain on the Plan). Medicare Carve Out is designed to provide protection against high medical bills. Carve out complements Medicare by providing payment for expenses not paid by Medicare. Payment is determined by the design of the medical insurance coverage.

Retired Employees: Eligible Retired Employees who are enrolled in the Plan upon obtaining age sixty-five (65) either as an Eligible Retiree or as an Eligible Employee are automatically eligible to continue in the Plan provided they have met the definition of Eligible Retiree and their legal residence is in the United States. Due to the fact such Eligible Retired Employees are no longer in active employment, Medicare will be the primary payer of benefits and Plan benefits will be integrated on a carve-out basis. The administration for retiree medical coverage under the Plan will be the same as for active Eligible Employees, regarding status changes and life style changes. Should a retiree opt out of the medical insurance plan and wish to re-enroll, they will only be allowed to re-enroll if required by Federal law.

Medicare Coordination: This Plan will coordinate its benefits with those received by primary Medicare so that the total amount payable by Medicare and this Plan will be no more than 100 percent of the expenses incurred that are covered by this Plan. Any Participant or Dependent who is eligible to enroll in Medicare must enroll in both Parts A and B of Medicare as soon as eligibility commences. If either the Participant or Dependent does not enroll in Parts A and B of Medicare as soon as eligibility for such coverage commences, such Participant or Dependent shall not be eligible for the benefits available under this Plan. However, this section will not apply if your Employer is obligated by law to have this Plan pay its benefits before Medicare covers the health care services provided to the Participant or Dependent.

Please note: Coordination between the Plan and Medicare Part D is different than coordination between the Plan and Medicare Parts A and B. Since the benefits provided to Eligible Retired Employees under the Plan include prescription drug benefits, if you are eligible for Medicare Part D and choose to enroll for Medicare Part D coverage, your benefits generally will not increase, but you will have an increase in cost due to the cost of your Medicare Part D premiums. As a result, there may not be any advantage to you enrolling for Medicare Part D coverage. However, if you choose to enroll in Medicare Part D, this Plan will pay secondary to Medicare Part D coverage. Please consider this carefully before deciding whether or not to enroll and pay for Medicare Part D coverage.
<table>
<thead>
<tr>
<th><strong>IN-HOSPITAL EXPENSES:</strong></th>
<th>MEDICARE PART A is a Hospital Insurance Plan which provides payment for hospital inpatient services, such as semi-private room and board, normal hospital services, post-hospital care in a skilled nursing facility and post-hospital care in the home.</th>
<th>CARVE OUT will pay the difference between what the Medical Insurance Plan would have paid and what Medicare Part A actually paid for covered expenses.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DOCTORS AND OTHER MEDICAL EXPENSES:</strong></td>
<td>MEDICARE PART B is the Medical Insurance Plan which provides payment for reasonable charges for physician’s services, home health care services, diagnostic services and medical services and supplies.</td>
<td>CARVE OUT will pay the difference between what the Medical Insurance Plan would have paid, and what Medicare Part B actually paid for covered expenses.</td>
</tr>
<tr>
<td><strong>NURSING CHARGES:</strong></td>
<td>MEDICARE makes no payment for nursing charges.</td>
<td>After satisfaction of the plan deductible, CARVE OUT will pay for these charges up to the limits of the Medical Insurance Plan.</td>
</tr>
<tr>
<td><strong>OUT-PATIENT DRUGS:</strong></td>
<td>MEDICARE PARTS A and B make no payment for out-patient drugs.</td>
<td>CARVE OUT pays expenses for out-patient drugs on the same basis as for Active Eligible Employees.</td>
</tr>
<tr>
<td></td>
<td>MEDICARE PART D provides coverage for out-patient prescription drugs for enrolled participants. Participants are required to pay the applicable premium.</td>
<td>Given this out-patient drug coverage, participants will generally experience no advantage</td>
</tr>
<tr>
<td>MEDICAL EXPENSES WHILE RESIDING OR TRAVELING OUTSIDE THE UNITED STATES:</td>
<td>MEDICARE generally makes no payment for medical expenses incurred while residing or traveling outside the United States.</td>
<td>CARVE OUT has no limit on medical expenses incurred while traveling outside the United States except for the maximum benefit of the Medical Insurance Plan. Retirees who legally reside outside of the United States and who are not eligible for Medicare due to their legal residence are not eligible for the medical benefits offered under the Plan.</td>
</tr>
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APPENDIX D

DENTAL INSURANCE PLAN

INTRODUCTION

The College sponsors this self-funded ERISA welfare plan which provides dental benefits for all Eligible Employees, Eligible Retirees and their Dependents enrolled for coverage.

Please note that this Appendix D describes the dental insurance benefits available to both Eligible Employees and Eligible Retirees. The following pages describe Plan provisions that specifically pertain to Eligible Retirees:

- Eligibility p. D-2
- Eligible Retiree Definition p. D-16
- Surviving Spouse of a Retiree p. D-18

Each covered person is entitled to the benefits outlined in this Appendix. To obtain benefits from the Plan, you must submit a diagnostic bill from the provider to:

Comprehensive Benefits Administrator, Inc. dba CBABlue
PO Box 9350
South Burlington, VT 05407-9350
(888) 222-9206

This claim submission is required for reimbursement to the Participant or direct payment to the service provider by the Middlebury College Health and Welfare Benefits Plan (“Plan”).

A clerical error will neither invalidate the Participant’s coverage if otherwise validly in force, nor continue coverage otherwise validly terminated.

In the event you receive dental services from a dentist who participates in the CBABlue Program, you may receive certain “in-network” discounts. Please contact CBABlue or Human Resources for additional information.

PLAN ENROLLMENT

Unless otherwise noted, coverage becomes effective the first of the month after (or coincident with) the employee’s or dependent’s entering eligible status.
Employee Coverage

Eligibility: Only Eligible Employees, as defined in Section 2.1, are eligible for coverage under this Plan.

Plan Enrollment: An Eligible Employee must enroll for coverage within thirty (30) days of his eligibility date. The Eligible Employee will be enrolled when a benefit enrollment form is completed, signed, and delivered to your Employer within the time limit. Eligible Employees who are not enrolled within thirty (30) days following the eligibility date will only be eligible to enroll under the “Transfer of Coverage” provision as described herein or during the annual Open Enrollment Period.

Annual Open Enrollment Period: There will be an annual Open Enrollment Period prior to the beginning of each Plan Year. The effective date of coverage will be January 1.

If an Eligible Employee enrolls during the annual Open Enrollment Period, then the Eligible Employee will be considered a Late Entrant and will be subject to the late entrant provisions as stated on the Schedule of Benefits. (The “late entrant” provisions will apply unless there is a simultaneous Transfer of Coverage.)

Disability Leave: Employment for the purpose of the Plan will be deemed to be continued by your Employer following the date of the disability leave of the Eligible Employee until employment is terminated by the Employer or the Eligible Employee.

General Leave of Absence: Employment for the purpose of the Plan will be deemed to be continued by your Employer following the date of an approved leave of absence for a period of one (1) year, or until employment is terminated by the Employer or the Eligible Employee.

Layoff: Employment for the purpose of the Plan will be deemed to be continued by your Employer following the date of the Eligible Employee’s layoff until employment is terminated by the Employer or the Eligible Employee.

Retiree Coverage

Eligibility: Only Eligible Retirees, as defined in Section 2.2, who legally reside in the United States are eligible for coverage under this Plan.

Plan Enrollment: Eligible Retirees may continue participation in the Plan upon retirement from your Employer. In the event an Eligible Retiree does not continue participation immediately after retirement, he or she will not be allowed to re-enroll in the Plan (even if there is a change in the facts that caused the Eligible Retiree to cease participation in the Plan), unless federal law requires otherwise.

Annual Open Enrollment Period: There will be an annual Open Enrollment Period prior to the beginning of each Plan Year. The effective date of coverage will be January 1.
Dependent Coverage

Eligibility: The Dependent(s) of an Eligible Employee or Eligible Retiree, as defined in this Appendix, will become eligible for coverage on the date of the Eligible Employee's or Eligible Retiree’s eligibility for coverage and/or on the date which the Eligible Employee or Eligible Retiree acquires the Dependent.

If an Eligible Employee or Eligible Retiree and Spouse are both eligible for coverage under the Plan, only one will be eligible to enroll Dependents. Also, a Participant cannot be covered as an Eligible Employee or Eligible Retiree and at the same time as a Dependent.

Plan Enrollment: To obtain coverage, a Dependent(s) must be enrolled within thirty (30) days of the Dependent’s eligibility date. A Dependent will be enrolled in the Plan when the Eligible Employee or Eligible Retiree has completed and signed a benefit enrollment form or notice of change form and it is delivered to the Plan Sponsor. Dependents who are not enrolled within thirty (30) days following the eligibility date will only be eligible to enroll under the “Transfer of Coverage” provision as described herein or during the annual Open Enrollment Period.

If an Eligible Employee or Eligible Retiree acquires a new Dependent as a result of marriage, birth, adoption, or placement for adoption then the Dependent(s) may be enrolled in the Plan, provided enrollment occurs within thirty (30) days of one of the above life events. If the new Dependent is acquired as a result of marriage, birth, adoption, or placement for adoption, and the Eligible Employee or Eligible Retiree has not previously enrolled in the Plan, the Eligible Employee or Eligible Retiree may enroll in the Plan at this time, provided the enrollment occurs within thirty (30) days of one of the above life events. Coverage will begin on the first day of the month following the month in which the new Dependent was acquired. In the case of a birth, coverage begins on the day of birth; in the case of adoption, coverage begins on the day custody is awarded.

If an Eligible Employee is required to provide benefits for his Dependent(s) under the direction of a court order and the Eligible Employee is not enrolled in the Plan, the Eligible Employee may enroll himself and his Dependent(s) provided enrollment occurs within thirty (30) days of issuance of the court order. The Plan’s open enrollment provision will not apply. The effective date of coverage will be the date of the court order. However, if the Eligible Employee has not yet satisfied the Plan’s waiting period, coverage will become effective after satisfaction of such waiting period.

If a Dependent has continued coverage due to student status, withdraws from classes, then re-enrolls for classes, coverage begins on the date the Dependent resumes classes.

Annual Open Enrollment Period: There will be an annual Open Enrollment Period prior to the beginning of each Plan Year. The effective date of coverage will be January 1.
If a Dependent enrolls during the Open Enrollment period the Dependent will be considered a Late Entrant and will be subject to the late entrant provisions as stated on the Schedule of Benefits. (The “late entrant” provisions will apply unless there is a simultaneous Transfer of Coverage.)

TRANSFER OF COVERAGE

All Eligible Employees, Spouses and Dependents who were enrolled in other group dental coverage, who lose their group dental coverage may enroll for coverage under the Plan provided they enroll in the Plan within thirty (30) days of the loss of insurance and provide evidence that they were covered and that coverage has been terminated.

The Late Entrant provisions will not apply if there is a Transfer of Coverage.

SCHEDULE OF DENTAL BENEFITS

<table>
<thead>
<tr>
<th>Class</th>
<th>Description</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Class 1</td>
<td>Diagnostic/Preventive Care</td>
<td>100%</td>
</tr>
<tr>
<td>Class 2</td>
<td>Basic Care</td>
<td>80%</td>
</tr>
<tr>
<td>Class 3</td>
<td>Major Care</td>
<td>80%</td>
</tr>
<tr>
<td>Class 4</td>
<td>Orthodontic Care</td>
<td>80%</td>
</tr>
</tbody>
</table>

Individual Calendar Year Deductible: $25 (applies to classes 2, 3 & 4)

Individual Calendar Year Maximum: $2,000 (classes 1, 2, & 3)

Individual Lifetime Maximum: $2,000 (class 4 only)

This Plan is participating with the Dental Blue® and Dental GRID preferred provider dental networks. These preferred providers will bill the Contract Administrator directly and write off charges that exceed their contractual allowances.

Note:

1. Please see the “Covered Dental Expenses” section for further details.
2. If two (2) or more alternate procedures, services, or courses of treatment may satisfactorily correct a dental condition, the least expensive procedure will be considered for reimbursement. Such determination will be made by the Contract Administrator based upon professionally endorsed standards of dental care.

3. No payment will be made for expenses incurred as a result of Class 3 services during the first twelve (12) months following the Eligible Employee’s, Eligible Dependent’s, or Eligible Retiree’s actual date of enrollment for Late Entrants.

4. No payment will be made for expenses incurred as a result of Class 4 services during the first twenty-four (24) months following the Eligible Employee’s, Eligible Dependent’s, or Eligible Retiree’s actual date of enrollment for Late Entrants.

5. Individuals added during the annual Open Enrollment Period who do not also qualify under the Transfer of Coverage provisions will be considered Late Entrants in the Plan.

6. This Plan is participating with the Dental Blue® preferred provider dental network. These preferred providers will bill the Contract Administrator directly and write off charges that exceed their contractual allowances.

7. All covered charges billed by non-participating providers will be subject to a maximum allowable benefit.

**TERMINATION OF BENEFITS**

An Eligible Employee’s, Eligible Retiree’s and/or a Dependent’s coverage under the Plan will terminate:

1. on the date the Plan terminates; or

2. on the last day of the month in which an Eligible Employee or Eligible Retiree withdraws from the Plan; or

3. on the last day of the calendar month in which an Eligible Employee is terminated, unless continuation of coverage, as provided herein, is elected; or

4. on the date a Dependent withdraws from the Plan or a Dependent ceases to meet the definition of a Dependent as defined herein or Dependent coverage is discontinued under the Plan for any reason, unless continuation of coverage, as provided herein, is elected; or

5. on the date an Eligible Employee or Dependent enters the military, naval, or air force of any country or international organization on a full-time, active duty basis.
other than scheduled drills or other training not exceeding one (1) month in any calendar year (see Military Leave section below); or

6. on the last date of the period for which contribution has been made if the Eligible Employee or Eligible Retiree fails to make any required contribution; or

7. the first day following the failure of an Eligible Employee to return from an Approved Leave of Absence.

MILITARY LEAVE

The Uniformed Services Employment and Reemployment Rights Act of 1994 (“USERRA”) provides special continuation coverage to Eligible Employees who otherwise lose health insurance coverage under the Plan because they leave employment to serve in the uniformed services. Under USERRA, affected Eligible Employees and their Dependents must be offered the right to continue coverage for up to eighteen (18) months. Your Employer may charge 102% of the applicable premium, provided the length of the military leave is longer than thirty (30) days. However, on the date that the Eligible Employee completes his active duty and returns to employment, the Eligible Employee and his eligible Dependents will be re-enrolled in the Plan and coverage will be provided immediately. However, any limitations on the Eligible Employee’s or Dependent’s coverage which were in affect before the active military duty leave will continue to apply.

SICK LEAVE CONVERSION BENEFIT

Retirees eligible for retiree dental insurance are eligible for the retirement conversion of Sick Leave Reserve (“SLR”).

At retirement accumulated SLR hours will convert to an insured day (weekends and the holidays listed in the Employee Handbook will not count) at a conversion rate of 7.75 hours per day. For each insured day your Employer will pay 100% of the premium to continue the dental benefits for the enrolled Eligible Employee and enrolled eligible Dependents, until the end of the month in which the last insurance day is used. If an Eligible Employee or Dependent is over sixty-five (65), your Employer will pay the cost of the retiree dental for the number of insured days. At the end of the insured days the Eligible Employee and their Dependents will be eligible to continue the retiree dental insurance at their own expense.

Example: If the number of SLR days was thirty (30) and the Eligible Employee retires on 7/1/08, the converted sick leave would run out on 8/12/08. Therefore, the insurance would continue until 8/30/08.

Retiring part-time employees have the option of converting combined time off (“CTO”) hours to insurance days at a conversion rate of 7.75 hours per day.
Faculty (who do not have CTO or Sick Leave Reserve days) will be given a week of insurance continuation for each academic year in which a full course load was carried. (The Vice President for Academic Affairs and the Director of Human Resources will resolve any conflicts.)

There is no cash conversion of SLR. Conversion of SLR to insurance days is only available as outlined in the sections on Sick Leave Conversion and Sick Leave Survivor’s Conversion.

**SURVIVOR’S BENEFIT**

Employees enrolled in the Middlebury College dental insurance plan have a survivor’s benefit. If an Eligible Employee dies while in an Active Status, then the enrolled Dependents will be given survivor’s benefits for dental insurance. These benefits will be continued:

1. For sixty (60) days following the date of death with all premiums paid by your Employer.

2. Following those sixty (60) days, accumulated SLR will be converted to insured days (weekends and holidays listed in the Employee Handbook will not count.) For each insured day the Plan Administrator will pay 100% of the premium to continue the dental insurance.

3. If survivors pay on a monthly basis 75% of the full internal premium for the balance of one year following the sixty (60) days and SLR.

4. If survivors pay on a monthly basis 100% of the full internal premium, until eligibility ends. For surviving children the eligibility will be the same as in the active plan. For surviving Spouses, eligibility will end when the person becomes eligible for another plan or becomes eligible for Medicare.

<table>
<thead>
<tr>
<th>Timeframe</th>
<th>% of full internal premium paid by Middlebury College</th>
<th>% of full internal premium paid by survivor</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st 60 days following death of Eligible Employee, then</td>
<td>100</td>
<td>0</td>
</tr>
<tr>
<td>Sick Leave Conversion to Insurance days, then</td>
<td>100</td>
<td>0</td>
</tr>
<tr>
<td>Balance of one year from date of death of Eligible Employee, then</td>
<td>25</td>
<td>75</td>
</tr>
<tr>
<td>From end of 1st year to end of eligibility</td>
<td>0</td>
<td>100</td>
</tr>
</tbody>
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INCREASES/DECREASES IN COVERAGE

**Increases:** Any amendment to the Plan providing an increase in the amount of the Participant’s and Dependent's coverage will become effective as of the date of such amendment, provided that the Eligible Employee is in Active Service on that date and the Eligible Retiree and Eligible Employee's Dependent(s), meet the definition of Eligible Retiree and Dependent, respectively, on that date.

**Decreases:** Any amendment to the Plan providing a decrease in the amount of the Participant’s and Dependent's coverage will become effective on the effective date of such amendment.

PLAN DETAILS

**Pre-Determination of Dental Benefits**

Pre-determination of benefits means a review by the Contract Administrator of a dentist's description of planned treatment and expected charges including those for diagnostic x-rays.

It is recommended that a treatment plan be submitted to the Contract Administrator before a course of treatment begins for any course of treatment which can reasonably be expected to involve extensive dental work in excess of $300. Pre-determination of benefits does not guarantee payment.

All pre-determinations should be mailed to:

Comprehensive Benefits Administrator, Inc. dba CBABlue  
PO Box 9350  
South Burlington, VT 05407-9350  
(888) 222-9206

EXTENDED BENEFITS

Dental procedures, other than dentures or bridges, will be considered a covered dental service if such procedures relate to a particular multiple-appointment dental procedure which had commenced before coverage ceased, but only to the extent that such procedures are performed within thirty-one (31) days after termination of coverage.

Orthodontic services will be considered as covered dental services if, on or before the date of termination, payment of orthodontic benefits have commenced. However, benefits will be continued for no longer than the ninety (90) days immediately following the date of termination.

If a final impression for a denture has been taken, then charges for the construction and/or insertion of such denture or bridge will be considered as a covered dental charge only to the
extent that such construction or insertion procedures are performed within thirty-one (31) days after termination of coverage.

**COVERED DENTAL EXPENSES**

Covered dental expense means the maximum allowable benefit charge made by a dentist for the performance of a dental service covered by the dental portion of the Plan, provided such a service is performed by or under the direction of a licensed dentist for necessary care of the teeth.

The total amount payable for covered dental expenses incurred by the Participant and each covered Dependent (s) in any one (1) calendar year for dental services will in no event exceed the maximums shown in the Schedule of Benefits.

**CLASS 1: Diagnostic and Preventive Care**

Oral Examinations (not more than two (2) exams in a calendar year) includes routine and periodic exams
Cleanings (not more than two (2) cleanings in a calendar year)  
Topical Application of Sealants (only for Dependent children under age nineteen (19), not more than one (1) treatment per permanent posterior tooth in any three (3) year period)  
Topical Application of Fluoride (only for Dependent children under age nineteen (19), not more than one (1) treatment per calendar year)

**CLASS 2: Basic Care**

Palliative emergency treatment and emergency oral examinations  
Amalgam, composite, plastic or acrylic filling and bonding  
Extractions, including wisdom teeth (including soft tissue, partial and completely bony) and alveolectomy at the time of tooth extraction  
Oral Surgery  
General Anesthesia administered in connection with a covered Dental Service only if administered by an individual licensed to administer general anesthesia  
Endodontics (root canal therapy)  
Recementing of crowns, inlays and/or bridges  
Denture adjustments and relining and/or rebasing  
Apicoectomy  
Hemisection  
Injection of antibiotic drugs  
Consultations with Dentist for case presentation when diagnostic procedures have been performed by a general dentist  
Periodontics as follows:  
  - Occlusal equilibration, when no restoration is involved  
  - Gingivectomy and gingivoplasty  
  - Gingival curettage  
  - Scaling and root planing
Osseous surgery (osteoplasty and ostectomy), including flap entry and closure
Surgical periodontic examination
Mucogingivoplasty surgery
Management of acute periodontal infection and oral lesions

X-rays
- Bitewings (two (2) sets per calendar year)

Space Maintainers (effective as of January 1, 2007)
CLASS 3: Major Care

Dentures, full and partial, and fixed bridges. Removable bridges (unilateral)-one piece casting, chrome cobalt alloy clasp attachment (all types) per unit including pontics
Inlays, onlays, gold fillings, crowns (including precision attachment for dentures) provided, however, that gold or crown restorations are covered only when the tooth cannot be restored with a filling material or if the tooth is an abutment to a covered partial denture or fixed bridge
Crowns which are acrylic, acrylic with gold, acrylic with non-precious metal, porcelain with gold, porcelain with non-precious metal, gold or non-precious metal
Fixed bridgework (including inlays and crowns to form abutments) to replace one (1) or more natural teeth extracted while covered under these benefits
A denture or a fixed bridge involving replacement of a tooth or teeth missing since birth
Partial or full removable dentures to replace one (1) or more natural teeth extracted while covered under these benefits
Replacement of or addition of teeth to an existing removable denture (full or partial) or fixed bridgework as follows:
  replacement or addition of teeth is made necessary by the extraction of natural teeth which occurred while covered under this Plan
  replacement is necessary to correct temporomandibular joint disturbances caused by the existing denture or bridgework when the prosthesis cannot be economically modified to correct the condition
  replacement is necessary when an immediate temporary denture was inserted shortly following extraction of teeth and cannot be economically modified to the final shape required
  the existing denture or bridgework was installed at least five (5) years prior to this replacement and the existing denture or bridgework cannot be made serviceable
  replacement is necessary as a result of an injury occurring while covered
Pontics (artificial teeth) which are cast gold, cast non-precious metal, porcelain fused to gold, porcelain fused to non-precious metal, plastic processed to gold, plastic processed to non-precious metal
Dental Implants

CLASS 4: Orthodontic Care

Installation of orthodontic appliances and all orthodontic treatments and conditions resulting from the malocclusion through correction of abnormally positioned teeth
Diagnostic services, including examination, study models, radiographs and all other diagnostic aids used to determine orthodontic needs
Appliances for tooth guidance, limited to one (1) appliance per covered person
Appliances to control harmful habits limited to one (1) application per covered person
Retention appliances limited to one (1) appliance per covered person
GENERAL DENTAL EXCLUSIONS AND LIMITATIONS

Following is a list of services/supplies that will not be paid by the Plan:

1. Any expenses incurred in connection with any accidental bodily injury or illness arising out of or in the course of any employment, regardless of whether the employment is for profit or compensation. This exclusion applies to all covered individuals, including but not limited to, self-employed individuals who choose not to provide themselves with insurance coverages such as, but not limited to, workers’ compensation and occupational disease, regardless of whether such coverage or coverages are required by law.

2. Any expenses for services for which a charge is not usually made, for a charge that would not be made if the individual had no dental coverage, or for services rendered by a person to his/her own family members.

3. Any expenses for services for cosmetic purposes unless made necessary by an accident occurring while covered (facings on molar crown or pontics are always considered cosmetic).

4. Any expenses for confinement in a hospital.

5. Any expenses which the Participant or their family members are not legally required to pay.

6. Any expenses in excess of what is the maximum allowable benefit, as determined by the Plan.

7. Any expenses for unnecessary care or treatment, including personalization of characterization of teeth or dentures.

8. Any expenses for replacement of a lost or stolen appliances or procedures for the purpose of splinting, or to alter vertical dimension or restore occlusion.

9. Any expenses for education or training in and supplies used for dietary or nutritional counseling, oral hygiene or dental plaque control.

10. Any service or supply which is not furnished by a dentist, except a service performed by a dental hygienist working under the supervision of a dentist and x-rays ordered by a dentist.

11. Any expenses for completion of claim forms or for failure to keep a scheduled dentist appointment.

12. Any expenses for appliances or restorations, other than full dentures, whose primary purpose is to alter vertical dimension, stabilize periodontally involved teeth or restore occlusion, or to splint or replace teeth structure lost as a result of abrasion or attrition.
13. Any expenses for an appliance, or modification of one, if an impression was made before the individual was covered; a crown, bridge or gold restoration for which the tooth was prepared before the individual was covered; root canal therapy if pulp chamber was opened before coverage began.

14. Any expenses for treatments or procedures which are experimental whether for diagnosis or treatment of any sickness or injury as determined by the American Dental Association or the appropriate dental specialty society or that do not meet common dental standards.

15. Any expenses for services that are deemed to be medical services.

16. Any expenses for prescription drugs or medications, except as provided herein.

17. Any expenses for over-the-counter home fluoride treatments (i.e. omni gel).

18. Any expenses for services which have not been completed.

19. Any expenses for a crown, gold restoration, denture, fixed bridge or addition of teeth to pre-existing bridge, if the work involves a replacement or modification to an existing appliance installed less than five (5) years before. For this purpose inlays, onlays and crowns on the same tooth are limited to once every five (5) years.

20. Any expenses for a crown made completely of porcelain.

21. Any expenses for orthodontic treatment for which an impression was made or an appliance installed before the covered person was enrolled in the Plan.

22. Any expenses for separate charges for adjustments to dentures within six (6) months of initial installation.

23. Any expenses for a denture or fixed bridge involving replacement of teeth missing before the individual was covered, unless it also replaces a tooth that is extracted while covered, and the tooth was not an abutment for a denture or fixed bridge installed during the preceding five (5) years.

24. Incurred charges for a service or supply on the date the service is provided except:

   a. Expenses for fixed bridgework, crowns, inlays or restorations on the first date of preparations of the tooth or teeth involved, provided the covered person remains continuously covered during the course of treatment.

   b. Expenses for full or partial dentures on the date the final impression is taken, provided the covered person remains continuously covered during the course of treatment.

   c. Expenses for relining or rebasing of an existing partial or complete denture on
the first day of preparation of the reline or rebase of such denture, provided
the covered person remains continuously covered during the course of
treatment.

d. Expenses or charges for endodontic service on the date the specific root canal
procedure commenced, provided the covered person remains continuously
covered during the course of treatment.

e. Expenses or charges for orthodontic services on the date the initial active
appliance was installed.

25. Any expenses for the diagnosis or treatment of temporomandibular joint (TMJ)
dysfunction.

26. Any expenses for services furnished by or for the U.S. Government, or any other
government unless payment is legally required, or to the extent provided under any
government program or law under which the individual is, or could be covered.

27. Any expenses for services not included under the “Covered Dental Expenses” section.

28. Any expenses applied toward satisfaction of a deductible under the “Covered Dental
Expenses” section.

CLAIM FILING PROCEDURES

Written notice of the Participant’s or their Dependent's claim (proof of claim) must be received
by the Contract Administrator as soon as is reasonably possible but within twelve (12) months
after the occurrence or commencement of any loss covered by the Plan. Failure to furnish
written proof of claim within the time required will invalidate the claim. It is the Participant’s
responsibility to inform his or her provider(s) of this claim submission time limit.

Filing a Dental Claim:

To obtain benefits under this Plan, a diagnostic bill must be submitted that provides sufficient
information, including the Participant’s name, claimant's name, claimant's address and Plan number to
allow the Contract Administrator to properly adjudicate each claim. The Contract Administrator may
require additional forms and information to assist them in this process.

Mail all dental claims to:

Comprehensive Benefits Administrator, Inc. dba CBABlue
P.O. Box 9350
South Burlington, VT 05407-9350
(888) 222-9206

D-14
SUBROGATION, REIMBURSEMENT & THIRD PARTY RECOVERY PROVISION

If the Participant, or anyone who receives benefits under this Plan becomes ill or is injured, and is entitled to receive money from any source, including but not limited to any party’s liability insurance and uninsured/underinsured motorist proceeds, then the benefits provided or to be provided by the Plan are secondary, not primary, and will be paid only if the individual fully cooperates with the terms and conditions of the Plan.

As a condition of receiving benefits under this Plan, the Participant or covered person agrees that acceptance of benefits is constructive notice of this provision in its entirety and agrees to reimburse the Plan 100% of benefits provided without reduction for attorney’s fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise. If the Participant or covered person retains an attorney, then the Participant or covered person agrees to only retain one who will not assert the Common Fund or Made Whole Doctrines. Reimbursement will be made immediately upon collection of any sum(s) recovered regardless of its legal, financial, or other sufficiency. If the injured person is a minor, any amount recovered by the minor, the minor trustee, guardian, parent, or other representative, will be subject to this provision regardless of state law and/or whether the minor’s representative has access or control of any recovery funds.

The Participant or covered person agrees to sign any documents requested by the Plan including, but not limited to, reimbursement and/or subrogation agreements as the Plan or its agent(s) may request. Also, the Participant or covered person agrees to furnish any other information as may be requested by the Plan or its agent(s). Failure or refusal to execute such agreements or furnish information does not preclude the Plan from exercising its right to subrogation or obtaining full reimbursement. Any settlement or recovery received will first be deemed for reimbursement of medical expenses paid by the Plan. Any excess after 100% reimbursement of the Plan may be divided up between the Participant or covered person and their attorney if applicable. The Participant or covered person agrees to take no action, which in any way prejudices the rights of the Plan.

If it becomes necessary for the Plan to enforce this provision by initiating any action against the Participant or covered person, then the Participant or covered person agrees to pay the Plan’s attorney’s fees and costs associated with the action regardless of the action’s outcome.

The Plan Sponsor has sole discretion to interpret the terms of this provision in its entirety and reserves the right to make changes as it deems necessary.

If the Participant or covered person takes no action to recover money from any source, then the Participant or covered person agrees to allow the Plan to initiate its own direct action for reimbursement.
DEFINITIONS

The following words and phrases are included here for explanatory purposes only. This list is not intended to include all terms used herein. Any word or phrase not specifically defined below will have its usual and customary meaning. The inclusion of any word or phrase below is not intended to imply that coverage is provided under the Plan.

**Accident:** An unforeseen or unexplained sudden injury occurring by chance without intent or volition.

**Coinsurance:** The percentage of charges for covered expenses that a covered person is required to pay under the Plan.

**Contract Administrator:** Third party claims administrator, hired by the Plan Sponsor to handle the day-to-day administration of the Plan, including:

1. Reviewing and processing claims for proper benefit payments and providing explanation of benefits to covered Participant and/or providers;
2. Remitting benefit payments for covered expenses under the Plan to covered Participants and/or providers;
3. Reviewing all claim appeals.

**Covered Person:** A covered Participant or a covered Dependent as determined under the applicable Plan provisions.

**Custodial Parent:** The parent awarded custody by court decree. If there is no court decree, the custodial parent is the one with whom the child resides for more than half the year.

**Deductible:** The amount of covered expenses the covered Participant must pay during each calendar year before the Plan will consider expenses for reimbursement. The individual deductible applies separately to each covered person. The family deductible is the maximum deductible applied to each family. When the family deductible is satisfied, no further deductible will be applied for any covered family member during the remainder of that calendar year.

**Dental Services:** Procedures involving the teeth, gums, or supporting structures.

**Dentist:** A duly licensed Doctor of Dentistry and a Dental professional or practitioner, who is duly licensed under appropriate state licensing authorities, provided: (i) a benefit is claimed for services which are within the scope of such person's license and for which a reimbursement under the Plan would be made had such services been performed by a Doctor of Dentistry, and (ii) under applicable state laws, such professional or practitioner must be treated under the Plan in the same manner as if such services were provided by a Doctor of Dentistry.
Dependent:

1. the lawful Spouse (including a same-sex spouse) of an Eligible Employee or Eligible Retiree; or

2. the child of an Eligible Employee or Eligible Retiree who has not attained his or her twenty-sixth (26th) birthday; or

3. an Eligible Employee’s or Eligible Retiree’s Domestic Partner or Civil Union Partner, as defined by your Employer’s Office of Human Resources.

The term “child,” as used above, includes an Eligible Employee’s or Eligible Retiree’s natural child, a legally adopted child (including a child in the custody of the Eligible Employee or Eligible Retiree under an interim court order of adoption, whether or not a final adoption order is ever issued), a stepchild (including the child of a same-sex spouse, domestic partner or civil union partner), a foster child, or a child for whom legal guardianship (as evidenced by a court order) has been granted, but excludes a child who is eligible for Employee coverage under this Plan.

Should an Eligible Employee or Eligible Retiree have a child covered under the Plan who reaches age 26 and if such child is then mentally or physically handicapped and incapable of earning his own living, the Plan will continue to consider such child as a Dependent beyond such age, while such child remains in such condition, subject to all of the terms of the Plan, provided the Eligible Employee or Eligible Retiree has, within thirty (30) days of the date on which the child attained such age, submitted proof of the child’s incapacity, as described above.

The Plan Sponsor will have the right to require satisfactory proof of continuance of such mental or physical incapacity and the right to examine such child at any time after receiving proof of the child’s incapacity. Upon failure to submit such required proof or to permit such an examination when requested by the Plan Sponsor, or when the child ceases to be so incapacitated, coverage with respect to the child will cease. This continuation of coverage will be subject to all the provisions of the “Termination of Benefits” section of this Plan except as modified herein.

Dependent Coverage: Group Plan benefits extended to the Dependent(s) of a covered Participant.

Effective Date: The date the Plan becomes liable to provide coverage under the terms of the Plan.

Eligibility Date: The date a Participant and/or his Dependent(s) become eligible to enroll in the Plan, as set forth in Article II of this SPD.

Eligible Employees: As defined in Section 2.1.
Eligible Retirees: As defined in Section 2.21. In order to be eligible, your legal residence must be the United States of America. They will begin being billed for retiree premiums at the time of retirement or at the end of the Sick Leave Reserve Conversion period, whichever is later.

Employee Coverage: Group dental benefits provided under the Plan on behalf of a covered Eligible Employee.

Expense: A charge a covered person is legally obligated to pay. An expense is deemed to be incurred on the date the service or supply is furnished.

Hospital: A duly licensed, if required, and legally constituted and operated institution which is primarily engaged in providing diagnostic services, therapeutic services for diagnosis, care, and treatment of sick or injured persons on an inpatient and/or outpatient basis and which provides such care and treatment: (i) under the supervision of one (1) or more physicians, (ii) with twenty-four (24) hour nursing service under the supervision of one (1) or more physicians licensed to practice medicine; and (iii) which has organized facilities for laboratory and diagnostic work and major surgery. The term "Hospital" will not include, other than incidentally, an institution which is primarily a rest home, a nursing home, a convalescent home, a rehabilitation center, an extended care facility, a place (primarily) for the treatment of tuberculosis, mental, emotional, drug or alcoholic disorders, or a home for the aged.

Services rendered in the infirmary or clinic of a college, university, or private boarding school will be eligible expenses. In such instances, if a covered person is confined in a school facility that does not meet the definition of a Hospital because it has no operating room, benefits may be paid, provided the charges for such confinement do not exceed the Maximum Allowable Benefit charges for the disability involved.

Illness: Sickness or disease which results in the incurrence, by a covered person, of expenses for dental care, services and supplies covered by the Plan. Such expense must be incurred while the covered person whose illness is the basis of claim is covered under the Plan. Pregnancy will be treated as any other illness.

Injury: Accidental bodily harm.

Inpatient Basis: Hospital confinement, including one (1) or more days of confinement for which a room and board charge is made by a Hospital.

Late Entrant: An individual who was not covered at the time he or she was originally eligible for coverage under the Plan, but who was later enrolled for coverage. Service restrictions apply (see “Schedule or Benefits,”) except where there is a “Transfer of Coverage”.

Maximum Allowable Benefit: An amount a provider is allowed for a particular service. If an out-of-network provider charges more than the maximum allowable benefit, the Plan will not cover more than the maximum allowable benefit and the person is responsible for the difference.
Maximum Calendar Year Benefits: The maximum benefit amount under this Plan for all covered dental expenses incurred by a covered person in one (1) calendar year. See amounts on the Schedule of Benefits.

Maximum Lifetime Benefits: The maximum benefit amount under this Plan for all covered dental expenses incurred by a covered person in a lifetime. See amounts on the Schedule of Benefits.

Non-Dependent/Dependent: A Participant covered under this Plan (non-dependent) who is also covered under another group dental insurance plan as a Dependent.

Outpatient Basis: Any hospital expenses incurred for which no room and board charge is made.

Physician: A duly licensed Doctor of Medicine, a medical professional, or a practitioner who is duly licensed under appropriate state licensing authorities, provided: (i) a benefit is claimed for services which are within the scope of such person's license and for which a reimbursement under the Plan would be made had such services been performed by a Doctor of Medicine, and (ii) under applicable state laws, such professional or practitioner must be treated under the Plan in the same manner as if such services were provided by a Medical Doctor.

Plan Anniversary Date: The date occurring in each calendar year which is an anniversary of the effective date of the Plan.

Plan Sponsor: Middlebury College

Prior Plan: The prior dental insurance plan offered by the Plan Sponsor.

Pronouns: Masculine pronouns used herein apply to both sexes.

Surviving Spouse of a Retiree: In the event of the death of an Eligible Retiree, the Eligible Retiree’s Spouse can elect to continue his/her coverage in the Plan and will be billed accordingly.

Termination Date: See “Termination of Benefits” section for details.

Totally Disabled: A covered person who, because of illness or injury, is unable to engage in any gainful occupation for profit or compensation for which the covered person qualifies by reason of education, training, or experience. In the case of a dependent, the term "occupation" will include the normal activities of a person of the same age or sex.

Transfer of Coverage: All Eligible Employees, Spouses and Dependents who were enrolled in other group dental coverage, who lose their group dental coverage may enroll for coverage under the Plan provided they enroll in the Plan within thirty (30) days of the loss of insurance and provide evidence that they were covered and that coverage has been terminated. The Late Entrant provisions will not apply if there is a Transfer of Coverage.
**Waiting Period:** The period of time between an Eligible Employee's date of employment and their effective date of coverage.

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**CBA Blue**

An Independent Licensee of the Blue Cross and Blue Shield Association

**Dental Blue® Network Program**

The Plan includes access to CBA Blue’s preferred dental provider network, Dental Blue®, in order to obtain discounts from participating providers for covered dental care. Use of the network is voluntary and the benefits of utilizing participating providers include provider fee discounts, direct billing to the Plan for covered services, and network provider write-offs of any charges in excess of the discounted fee schedule.

**Dental GRID Network Program**

The Plan includes access to the Dental GRID network which links participating Blue Cross and Blue Shield dental providers in several states into one overall national dental network with broad access to participating dentists. Use of the network is voluntary and the benefits of utilizing participating providers include provider fee discounts, direct billing to the Plan for covered services, and network provider write-offs of any charges in excess of the discounted fee schedule.
APPENDIX E

VISION BENEFITS PLAN
VISION SERVICE PLAN INSURANCE COMPANY  
3333 QUALITY DRIVE  
RANCHO CORDOVA, CALIFORNIA 95670  

GROUP VISION CARE POLICY

Group Name  
PRESIDENT AND FELLOWS OF MIDDLEBURY COLLEGE

Policy Number  
30022396

State of Delivery  
VERMONT

Effective Date  
JANUARY 1, 2014

Policy Term  
TWENTY-FOUR (24) MONTHS

Premium Due Date  
FIRST DAY OF MONTH

In consideration of the statements and agreements contained in the Group Application and in consideration of payment by the Group of the premiums as herein provided, VISION SERVICE PLAN INSURANCE COMPANY ("the Company") agrees to insure certain individuals under this Group Vision Care Policy ("Policy") the benefits provided herein, subject to the exceptions, limitations and exclusions hereinafter set forth. This Policy is delivered in and governed by the laws of the state of delivery and is subject to the terms and conditions recited on the subsequent pages hereof, which are a part of this Policy.

James M. McGrann, Secretary
GENERAL
This Schedule lists the vision care benefits to which Insureds of VISION SERVICE PLAN INSURANCE COMPANY ("the Company") are entitled, subject to any Copayments and other conditions, limitations and/or exclusions stated herein. Vision care services and vision care materials may be received from any licensed optometrist, ophthalmologist, or dispensing optician, whether Member Doctors or Non-Member Providers. This Schedule forms a part of the Policy or Evidence of Coverage to which it is attached.

Member Doctors are those doctors who have agreed to participate in VSP’s Choice Network.

When Plan Benefits are received from Member Doctors, benefits appearing in the first column below are applicable subject to any Copayments as stated below. When Plan Benefits are received from Non-Member Providers, the Insured is reimbursed for such benefits according to the schedule in the second column below less any applicable Copayments.

PLAN BENEFITS

<table>
<thead>
<tr>
<th>MEMBER DOCTOR BENEFIT</th>
<th>NON-MEMBER PROVIDER BENEFIT</th>
</tr>
</thead>
</table>

VISION CARE SERVICES

Eye Examination  Covered in Full*  Up to $ 45.00*

Complete initial vision analysis that includes an appropriate examination of visual functions, including the prescription of corrective eyewear where indicated.

*Less any applicable Copayment.
Subsequent regular eye examinations once every plan year beginning on January 1st.
## VISION CARE MATERIALS

<table>
<thead>
<tr>
<th></th>
<th>MEMBER DOCTOR BENEFIT</th>
<th>NON-MEMBER PROVIDER BENEFIT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lenses</td>
<td></td>
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</tr>
<tr>
<td>Single Vision</td>
<td>Covered in Full*</td>
<td>Up to $ 30.00*</td>
</tr>
<tr>
<td>Bifocal</td>
<td>Covered in Full*</td>
<td>Up to $ 50.00*</td>
</tr>
<tr>
<td>Trifocal</td>
<td>Covered in Full*</td>
<td>Up to $ 65.00*</td>
</tr>
<tr>
<td>Lenticular</td>
<td>Covered in Full*</td>
<td>Up to $ 100.00*</td>
</tr>
</tbody>
</table>

*Less any applicable Copayment

Available once every other plan year beginning on January 1st.

<table>
<thead>
<tr>
<th>Frames</th>
<th>Covered up to Plan Allowance*</th>
<th>Up to $ 70.00*</th>
</tr>
</thead>
</table>

*Less any applicable Copayment.

Available once every other plan year beginning on January 1st.

Lenses and frames include such professional services as are necessary, which shall include:

- Prescribing and ordering proper lenses;
- Assisting in the selection of frames;
- Verifying the accuracy of the finished lenses;
- Proper fitting and adjustment of frames;
- Subsequent adjustments to frames to maintain comfort and efficiency;
- Progress or follow-up work as necessary.
**CONTACT LENSES**

Contact lenses are available *once every other plan year* in lieu of all other lens and frame benefits available herein. When contact lenses are obtained, the Insured shall not be eligible for lenses and frames again for two plan years.

**NECESSARY**

Necessary Contact Lenses are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by Insured’s Member Doctor or Non-Member Provider. Prior review and approval by the Company are not required for Insured to be eligible for Necessary Contact Lenses.

<table>
<thead>
<tr>
<th>MEMBER DOCTOR BENEFIT</th>
<th>NON-MEMBER PROVIDER BENEFIT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professional Fees and Materials - Covered in Full*</td>
<td>Professional Fees and Materials - Up to $210.00*</td>
</tr>
</tbody>
</table>

**ELECTIVE**

<table>
<thead>
<tr>
<th>MEMBER DOCTOR BENEFIT</th>
<th>NON-MEMBER PROVIDER BENEFIT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Materials - Up to $130.00</td>
<td>Professional Fees and Materials - Up to $105.00</td>
</tr>
</tbody>
</table>

Elective Contact Lens fitting and evaluation** services are covered in full once every other plan year, after a maximum $60.00 Copayment.

*Less any applicable Copayment

**15% discount applies to Member Doctor’s usual and customary professional fees for contact lens evaluation and fitting.
COPAYMENT

The benefits described above are available to each Insured from any participating Member Doctor at no cost to the Insured, with the exception of any applicable Copayment as described below.

A Copayment amount of $10.00 shall be payable by the Insured to the Member Doctor at the time of the examination.

LOW VISION BENEFIT

The Low Vision benefit is available to Insureds who have severe visual problems that are not correctable with regular lenses.

<table>
<thead>
<tr>
<th>MEMBER DOCTOR BENEFIT</th>
<th>NON-MEMBER PROVIDER BENEFIT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supplementary Testing</td>
<td>Covered in Full</td>
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<tr>
<td></td>
<td>Up to $125.00*</td>
</tr>
</tbody>
</table>

Complete low vision analysis and diagnosis that includes a comprehensive examination of visual functions, including the prescription of corrective eyewear or vision aids where indicated.

Supplementary Care 75% of Cost 75% of Cost*

Subsequent low vision therapy.

Copayment

75% of the benefits payable by the Company and 25% payable by Insured.

Benefit Maximum

The maximum benefit available is $1,000.00 (excluding Copayment) every two years.

*NON-MEMBER BENEFIT

Low Vision benefits secured from a Non-Member Provider are subject to the same time limits and Copayment arrangements as described above for a Member Doctor. The Insured should pay the Non-Member Provider his/her full fee. The Insured will be reimbursed in accordance with an amount not to exceed what the Company would pay a Member Doctor in similar circumstances.

NOTE: There is no assurance that this amount will be within the 25% Copayment feature.
EXCLUSIONS AND LIMITATIONS OF BENEFITS

Some brands of spectacle frames may be unavailable for purchase as Plan Benefits, or may be subject to additional limitations. Covered Persons may obtain details regarding frame brand availability from their VSP Member Doctor or by calling VSP’s Customer Care Division at (800) 877-7195.

PATIENT OPTIONS

This Policy is designed to cover visual needs rather than cosmetic materials. When the Insured selects any of the following extras, the Policy will pay the basic cost of the allowed lenses or frames, and the Insured will pay the additional costs for the options.

- Optional cosmetic processes.
- Anti-reflective coating.
- Color coating.
- Mirror coating.
- Scratch coating.
- Blended lenses.
- Cosmetic lenses.
- Laminated lenses.
- Oversize lenses.
- Polycarbonate lenses.
- Photochromic lenses, tinted lenses except Pink #1 and Pink #2.
- Progressive multifocal lenses.
- UV (ultraviolet) protected lenses.
- A frame that costs more than the Plan allowance.
- Contact lenses (except as noted elsewhere herein).
- Certain limitations on low vision care.

NOT COVERED

There are no benefits for professional services or materials connected with:

- Orthoptics or vision training and any associated supplemental testing; plano lenses (less than a ± .50 diopter power); or two pair of glasses in lieu of bifocals;

- Replacement of lenses and frames furnished under this Policy that are lost or broken, except at the normal intervals when services are otherwise available;

- Medical or surgical treatment of the eyes;

- Any eye examination or any corrective eyewear required by an employer as a condition of employment;

- Corrective vision treatment of an experimental nature, such as, but not limited to, RK and PRK Surgery.

THE COMPANY MAY, AT ITS DISCRETION, WAIVE ANY OF THE POLICY LIMITATIONS IF, IN THE OPINION OF THE COMPANY’S OPTOMETRIC CONSULTANTS, IT IS NECESSARY FOR THE VISUAL WELFARE OF THE INSURED.
The Company shall be entitled to receive premiums for each month on behalf of each Enrollee and his/her Eligible Dependents, if any, in the amounts specified below.

$  5.61  per month for each eligible Enrollee without dependents.
$ 11.19  per month for each eligible Enrollee with one eligible dependent.
$ 18.04  per month for each eligible Enrollee with two or more eligible dependents.

NOTICE: The premium under this Policy is subject to change upon renewal (after the end of the initial Policy Term or any subsequent Policy Term), or upon change of the Schedule of Benefits or a material change in any other terms or conditions of the Policy.
GENERAL

This Rider lists additional vision care benefits to which Insureds of VISION SERVICE PLAN INSURANCE COMPANY are entitled, subject to any applicable Copayments and other conditions, limitations and/or exclusions stated herein or in the Schedule of Benefits with which it is associated. Plan Benefits under the Diabetic Eyecare Program are available to Insureds who have been diagnosed with type 1 or type 2 diabetes and specific ophthalmological conditions. This Rider forms a part of the POLICY or Evidence of Coverage to which it is attached.

ELIGIBILITY

The following are Covered Persons under this POLICY, pursuant to eligibility criteria established by Client:

- Enrollee.
- The legal spouse of Enrollee.
- The domestic partner of the same or opposite gender as Enrollee, pursuant to Group’s eligibility.
- The children of the domestic partner provided they depend upon the Enrollee for support and maintenance.
- Any child of an Enrollee, including any natural child from the date of birth, legally adopted child from the date of placement for adoption with the Enrollee, or other child for whom a court holds the Enrollee responsible.

Dependent children are covered up to age 26.

A dependent, unmarried child over the limiting age may continue to be eligible as a dependent if the child is incapable of self-sustaining employment because of mental or physical disability, and chiefly dependent upon Enrollee for support and maintenance.
PROGRAM DESCRIPTION

The Diabetic Eyecare Plus Program ("DEP Plus") is intended to be a supplement to Insureds group medical plan. Providers will first submit a claim to Insureds group medical insurance plan, and then to the Company. Any amounts not paid by the medical plan will be considered for payment by the Company. (This is referred to as "Coordination of Benefits" or "COB." Please refer to the Coordination of Benefits section of Covered Person’s Evidence of Coverage for additional information regarding COB.) If Insured does not have a group medical plan, providers will submit claims directly to the Company.

Examples of symptoms which may result in a Covered Person seeking services under DEP Plus may include, but are not limited to:

- blurry vision
- transient loss of vision
- trouble focusing
- “floating” spots

Examples of conditions which may require management under DEP Plus may include, but are not limited to:

- diabetic retinopathy
- diabetic macular edema
- rubeosis

REFERRALS

If Insured Member Doctor cannot provide Covered Services, the doctor will refer the Insured to another Member Doctor or to a physician whose offices provide the necessary services.

If the Insured requires services beyond the scope of DEP Plus, the Member Doctor will refer the Insured to a physician.

Referrals are intended to insure that Insured receive the appropriate level of care for their presenting condition. Insured do not require a referral from a Member Doctor in order to obtain Plan Benefits.
PLAN BENEFITS
MEMBER DOCTORS

COVERED SERVICES

Eye Examination: Covered in full after a Copayment of $20.00.

Special Ophthalmological Services: Covered in Full.

EXCLUSIONS AND LIMITATIONS OF BENEFITS

The Diabetic Eyecare Plus Program provides coverage for limited, vision-related medical services. A current list of these procedures will be made available to Insured upon request. The frequency at which these services may be provided is dependent upon the specific service and the diagnosis associated with such service.

NOT COVERED

1. Services and/or materials not specifically included in this Rider as Plan Benefits.
2. Frames, lenses, contact lenses or any other ophthalmic materials.
3. Orthoptics or vision training and any associated supplemental testing.
4. Surgery of any type, and any pre- or post-operative services.
5. Treatment for any pathological conditions.
6. An eye exam required as a condition of employment.
7. Insulin or any medications or supplies of any type.
8. Local, state and/or federal taxes, except where the Company is required by law to pay.

DIABETIC EYECARE PROGRAM DEFINITIONS

Diabetes A disease where the pancreas has a problem either making, or making and using, insulin.

Type 1 Diabetes A disease in which the pancreas stops making insulin.

Type 2 Diabetes A disease in which the pancreas either makes too little insulin or cannot properly use the insulin it makes to convert blood glucose to energy.

Diabetic Retinopathy A weakening in the small blood vessels at the back of the eye.

Rubeosis Abnormal blood vessel growth on the iris and the structures in the front of the eye.

Diabetic Macular Edema Swelling of the retina in diabetes mellitus due to leaking of fluid from blood vessels within the macula.
VI. ELIGIBILITY FOR COVERAGE

6.01 (b) **Eligible Dependents.** Add the Following:

(1a) The domestic partner of the same or opposite in gender as Enrollee, pursuant to the Group's eligibility rules which are applicable to the Group's general medical benefits, and

(2b) Any children of the domestic partner provided they depend upon the Enrollee for support and maintenance.
APPENDIX F

COORDINATION OF BENEFITS (COB)

Should a covered person be enrolled in this Plan while enrolled in any other plan providing similar benefits, Coordination of Benefits (COB) rules control whether benefits are payable under this Plan before those of the other plans. The benefits payable under this Plan will not be reduced where the COB rules provide that this Plan pays first. The benefits payable under this Plan may, however, be reduced where the COB rules provide that another plan pays first. In any case, the total of all benefits payable under all plans will not exceed 100% of the allowable expenses, and no plan will pay more than it would otherwise pay in the absence of the COB rules. There is no duplication of benefits or payment.

If a plan does not have its own COB rules, it will be primary to this Plan (that is, it will pay benefits before this Plan does).

Even if a plan does have its own COB rules, the first of this Plan’s following COB rules to apply will determine which of the plans is primary:

1. Non-Dependent/Dependent – Any plan under which the covered person is covered as an employee, member or subscriber (that is, other than as a dependent) will pay first. Any plan under which the covered person is covered as a dependent of the employee will pay second.

2. Dependent Child/Parents Not Separated or Divorced – If a dependent child is covered under the plans of both the child’s parents, and the parents are not separated or divorced (regardless of whether they were ever married), the plan of the parent whose birth date occurs earlier in the calendar year will pay first, and the plan of the parent whose birth date occurs later in the calendar year will pay second. If the birth dates of the parents are the same, the plan which has covered a parent for the longest period of time will pay benefits before the plan of the other parent.

3. Dependent Child/Separated or Divorced Parents – Where a dependent child is covered under the plans of both parents, the parents are separated or divorced from one another, and there is otherwise no court decree setting forth the responsibility for the child’s health care costs:

   a) the plan under which the child is covered as a dependent of the custodial parent will pay first;
   b) the plan under which the child is covered as a dependent of the custodial parent’s spouse will pay second; and
   c) the plan under which the child is covered as a dependent of the noncustodial parent will pay third.
4. Active/Inactive Employee – Any plan under which the covered person is covered as an active employee (or as that employee’s dependent) will pay first. Any plan under which the covered person is covered as a laid off or retired employee (or as that employee’s dependent) will pay second. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

5. Continuation Coverage – Any plan under which the covered person is covered as an employee (or as that employee’s dependent) will pay first. Any plan under which the covered person is covered under a right of continuation as provided under federal or state law (for example, under the Consolidated Omnibus Budget Reconciliation Act of 1985), will pay second. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

If none of the above rules determine the order of benefits, the plan which has covered the eligible person for the longest period of time will pay first; the plan which has covered the eligible person for the shortest period of time will pay last.

**Right to Receive and Release Needed Information:** The Plan may release or receive any information needed to enforce this provision. Any person claiming benefits under this Plan must furnish the Plan with any information requested by the Plan to enforce the COB provisions in accordance with the HIPAA Privacy Requirements.

**Right to Make Payments:** Should another plan provide benefits which should have been paid by this Plan, the Plan has the right to make payment to the other plan directly. That payment will satisfy the obligation of this Plan.

**Right to Recovery:** The Plan has the right to recover from the covered person any overpayment made if the Plan was not made aware of the other available benefits.

**Coordination with Other Liability:** This Plan will pay benefits secondary to the covered person’s personal automobile insurance (including, but not limited to, no-fault insurance and uninsured motorist coverage) or other liability insurance policies through which medical payments may be made for expenses resulting from or in connection with an accidental injury.

**Coordination with Prescription Claims:** There is no coordination of benefits with prescription drugs.