



**Cornell College
Employee Health Care Plan**

February 1, 2010

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SUMMARY PLAN DESCRIPTION

This booklet contains a general description of benefits available under the Plan and is written to help participants understand them. The details of coverage are limited to the terms and conditions specified in this document which is intended to serve as both the Summary Plan Description and plan document. This document will now be referred to as the Plan. Participants may examine the Plan or obtain copies of it at any time. It is on file with Cornell College.

This Plan was established for the exclusive benefit of the employees of Cornell College with the intention it will continue indefinitely. However, Cornell College reserves the right to amend, modify or terminate this Plan at any time without prior notice to the Plan participants. Any amendment or modification will be in writing, effected through a written resolution signed by the Vice President of Business Affairs/Treasurer of Cornell College, and will be binding. If this Plan is terminated, participants may not receive benefits for claims incurred on or after the effective date of termination.

In addition, this Plan may not discriminate against any participant based on: health status; medical condition (including both physical and mental illnesses); claims experience; receipt of health care; medical history; genetic information; medical evidence of good health (including participation in certain dangerous recreational activities and conditions arising out of acts of domestic violence); and disability as mandated by the Health Insurance Portability and Accountability Act of 1996.

Based on the factors described above, this Plan may not require any individual (as a condition of enrollment or continued enrollment under this Plan) to pay a premium or contribution which is greater than the premium or contribution paid by a similarly situated individual enrolled in this Plan. Nothing in the preceding sentence will be construed: (a) to restrict the amount that may be charged for coverage under this Plan; or (b) to prevent this Plan from establishing premium discounts or rebates or modifying otherwise applicable cost-sharing amounts, copays or deductibles in return for adherence to programs of health promotion and disease prevention.

INTRODUCTION

This Plan is designed to cover a participant's various health care expenses. This is a self-funded Plan of benefits which provides coverage for the health care needs of each covered person up to the lifetime maximum as specified in the **Benefit Summary**.

It is important that each participant understands this Plan in order to use it effectively. Each participant is encouraged to take the time to read this booklet to gain a basic understanding of the benefits. The **Benefit Summary** which follows provides a brief review of the allowable benefits. The "**What Are Covered Expenses?**" section provides greater detail regarding the participant's benefits. Specially designated sections outline care not covered by this Plan.

If the participant has any questions about this Plan of benefits, he/she may contact First Administrators, Inc.

Correspondence can be mailed to:

First Administrators, Inc.
P.O. Box 9900
Sioux City, IA 51102

or

the participant may call:

Nationwide.....1-800-694-4106
Sioux City1-712-279-8805

PPO INTRODUCTION

This Plan features a preferred provider organization. The preferred provider organization utilizes a network of hospitals and physicians who have contracted to offer their services at a discounted rate. A directory of these providers can be furnished automatically to the employee, without charge. If a participant uses preferred providers, the Plan will pay a higher level of benefits.

The preferred provider network's goal is to contain spiraling health care costs through utilization management and to do this without sacrificing the comprehensive nature of the benefits provided. Participating physicians follow specific guidelines to eliminate unnecessary inpatient hospital stays by utilizing outpatient services when possible and applying the wise use of diagnostic testing when applicable.

Participants always have freedom of choice. The services of any covered provider may be used. However, if participants go to a physician or hospital affiliated with the preferred provider network, the out-of-pocket costs may be less. Please refer to the **Benefit Summary** for specific information.

Please see the identification card for the participating provider network. Participating physicians within the PPO area can be located at:

SelectFirst™: www.firstadministrators.com

PHCS: www.phcs.com

PROTECTED HEALTH INFORMATION

PLAN SPONSOR'S CERTIFICATION OF COMPLIANCE

The Company is the Plan Sponsor of this Plan, unless the participant has been notified, in writing, that another entity is the Plan Sponsor. The Plan, any business associate servicing this Plan, or the Benefit Services Administrator cannot disclose protected health information to the Plan Sponsor unless the Plan Sponsor agrees to abide by the provisions outlined in this section.

The Plan Sponsor of this Plan has provided certification they agree to abide by these provisions.

PURPOSE OF DISCLOSURE TO PLAN SPONSOR

The Plan, any business associate servicing the Plan, or the Benefit Services Administrator will disclose protected health information to the Plan Sponsor only to permit the Plan Sponsor to administer the Plan consistent with the requirements of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations (45 Code of Federal Regulations Parts 160-64). Any disclosure to and use by the Plan Sponsor of protected health information will be subject to and must be consistent with the provisions outlined in the "Restrictions on Plan Sponsor's Use and Disclosure of "Protected Health Information")" and "Adequate Separation Between the Plan Sponsor and the Plan" sections that follow.

Neither this Plan, the Benefit Services Administrator, nor any business associate servicing the participant's Plan will disclose protected health information to the Plan Sponsor unless the disclosures are explained in the Notice of Privacy Practices distributed to plan participants.

Neither the Plan, the Benefit Services Administrator, nor any business associate servicing this Plan will disclose protected health information to the Plan Sponsor for the purpose of employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

RESTRICTIONS ON PLAN SPONSOR'S USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

The Plan Sponsor:

- (a) will not use or further disclose protected health information, except as permitted or required by law;
- (b) will ensure that any agent, including any subcontractor, to whom it provides protected health information, agrees to the same restrictions and conditions that apply to the Plan Sponsor;
- (c) will not use or disclose protected health information for employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.
- (d) will report to the Plan, promptly upon the learning of, any use or disclosure of protected health information, that is inconsistent with the uses and disclosures stated in the provisions outlined in this section ("Protected Health Information");
- (e) will make protected health information available to Plan participants in accordance with 45 CFR § 164.524;
- (f) will make protected health information available for amendment, and will, on notice, amend protected health information in accordance with 45 CFR § 164.526;
- (g) will track disclosures it may make of protected health information so that it can provide the information required by the Plan to account for disclosures in accordance with 45 CFR § 164.528;
- (h) will make its internal practices, books, and records relating to its use and disclosure of protected health information available to this Plan, and to the U.S. Department of Health and Human Services and to determine compliance with 45 CFR Parts 160-64.
- (i) this Plan maintains a Notice of Privacy Practices, which provides a complete description of participants' rights under HIPAA's privacy rules. To obtain a copy of the Notice, or if the participant has questions about the privacy of his/her health information or wishes to file a

complaint under HIPAA, he/she should contact the Privacy Officer.

When protected health information is no longer needed for the plan administrative functions for which the disclosure was made, the Plan Sponsor will, if feasible, return or destroy all protected health information, in whatever form or medium received from the Plan, including all copies of any data or compilations derived from and/or revealing member identity. If it is not feasible to return or destroy all of the protected health information, the Plan Sponsor will limit the use or disclosure of protected health information it cannot feasibly return or destroy to those purposes that make the return or destruction of the information infeasible.

ADEQUATE SEPARATION BETWEEN THE PLAN SPONSOR AND THE PLAN

Certain individuals under the control of the Plan Sponsor may be given access to protected health information received from the Plan, a business associate servicing the group health plan, or the Benefit Services Administrator. This class of employees will be identified by the Plan Sponsor to the Plan and the Benefit Services Administrator from time to time as required under 45 Code of Federal Regulations §164.504. These individuals include all those who may receive protected health information relating to payment under, health care operations of, or other matters pertaining to the Plan in the ordinary course of business.

These individuals will have access to protected health information only to perform the plan administration functions that the Plan Sponsor provides for the Plan.

Individuals granted access to protected health information will be subject to disciplinary action

and sanctions, including loss of employment or termination of affiliation with the Plan Sponsor, for any use or disclosure of protected health information in violation of or noncompliance with the provisions outlined in this section ("Protected Health Information"). The Plan Sponsor will promptly report such violation or noncompliance to the Plan, and will cooperate with the Plan to correct the violation or noncompliance, to impose appropriate disciplinary action or sanctions on each employee causing the violation or noncompliance, and to mitigate any negative effect the violation or noncompliance may have on the member, the privacy of whose protected health information may have been compromised by the violation or noncompliance.

SECURITY OF ELECTRONIC PROTECTED HEALTH INFORMATION

Title II of the Health Insurance Portability and Accountability Act of 1996 and the security regulations issued thereunder (collectively "HIPAA") requires Group Health Plans to secure participants' private health information that it creates, receives, maintains, or transmits electronically. This Plan will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic health information, and will require its agents and contractors to do the same. Reporting of known security incidents to the Plan is part of those safeguards.

This Plan has established safeguards that are supported by reasonable and appropriate security measures to ensure that the Plan does not disclose, or permit one of its agents or contractors to disclose, Protected Health Information to the entity adopting this Plan.

**CORNELL COLLEGE
BENEFIT SUMMARY**

Administered by First Administrators, Inc.

Group #: 32800

Effective Date: February 1, 2010

All benefits are subject to the following deductibles, coinsurance percentages and maximums unless otherwise stated.

MEDICAL BENEFITS	PATIENT'S LIABILITY		GENERAL PLAN LIMITS	PAGE
	PPO PLAN	NON-PPO PLAN		
Medical Calendar Year Deductible: - Per Individual/CAL YR - Per Family/CAL YR	\$1,000 \$2,000	\$2,000 \$4,000	Fourth quarter carryover deductible applies. <i>The PPO and Non-PPO deductibles are mutually satisfying.</i>	31
PPO Office Services Copay** - Primary Care Physician - Specialist	\$20 per visit \$25 per visit	N/A N/A	The copay does not apply to the calendar year deductible or the out-of-pocket maximum.	31
** PPO physician office services are paid at 100% subject to the PPO Office Services Copay for the first \$500 of eligible expenses, per visit. Eligible expenses from a PPO physician's office in excess of \$500 are subject to the PPO deductible and cost sharing amounts up to the PPO out-of-pocket maximum. The Office Services Copay includes all services and/or treatment performed in the PPO physician's office except: CT, MRA, MRI, PET, nuclear medicine; ultrasound; cancer screening; colonoscopy; flexible sigmoidoscopy or barium test; immunizations; maternity; preventive care benefits; sleep studies and well baby/well child care benefits, which are considered at the deductible and cost-sharing levels specified in the Benefit Summary . Note: The Office Services Copay will apply to office visits performed in an outpatient or ambulatory facility if the PPO physician does not have a local office.				
PPO NOTES: 1. If a participant requires treatment for a medical emergency, and is unable to reach a PPO provider, eligible expenses from a non-PPO provider will be considered at the PPO benefit level, subject to the PPO copay. 2. When a covered participant resides outside the PPO area, or is traveling outside the PPO area for reasons other than medical care (e.g., business or vacation), and a non-PPO provider or facility (including an urgent care facility) is used, eligible expenses from the non-PPO provider will be considered at the PPO benefit level, subject to the PPO Office Services Copay. 2. Ancillary services provided by a non-PPO provider in a PPO facility will be considered at the PPO benefit level. 3. Interpretation of x-ray and laboratory results ordered by a PPO provider and provided by a non-PPO provider will be considered at the PPO benefit level. 4. Charges for interpretation of x-ray or laboratory services performed in an independent radiology or pathology facility and billed by the PPO physician ordering the services will be considered in the same manner as any other x-ray or laboratory service performed in a PPO provider's office. 5. Non-PPO Emergency room physician charges will be considered at the PPO benefit level when services are provided in a PPO facility. 6. Services and/or treatment provided by a non-PPO provider when there is no PPO provider available within the PPO area will be considered at the PPO benefit level. 7. If a PPO provider refers a participant to a non-PPO provider, the eligible expenses will be considered at the non-PPO benefit level. The eligible expense for all of the above situations, unless otherwise specified, is determined by the provider and type of service, not the benefit level, as explained under the <i>What Are Eligible Expenses?</i> section. The eligible expense is based on the PPO fee schedule or discount, the maximum allowable fee, or the actual amount charged.				
Utilization Review: The Utilization Review program includes Preadmission Certification and Case Management administered by First Administrators, Inc. Preadmission Certification: Failure to comply with the Hospital Preadmission Certification provision will result in a \$500 penalty applied to hospital-related inpatient charges. Precertification must take place prior to a planned admission or within 2 business days following an unplanned/urgent care (emergency) admission. The Preadmission Certification penalty is waived for maternity lengths of stay of less than 48 hours for normal vaginal delivery and 96 hours for a cesarean section. Penalties will not apply to out-of-pocket maximums. Case Management: Failure to comply with the Case Management provision will result in a \$500 annual penalty per episode applied to all related charges. Penalties will not apply to deductibles or out-of-pocket maximums.				

This is only a summary of benefits. Refer to the following pages in this booklet for more information about the benefits.

BENEFIT SUMMARY (Cont.)

Note: When the PPO column below references a percentage, employees must first satisfy the annual deductible before the plan will pay the indicated percentage, unless an exception is noted. When the PPO column indicates a dollar amount, this is the copayment employees pay and this service is not subject to the annual deductible. Copayments do not apply to the annual deductible and out-of-pocket maximums.

MEDICAL BENEFITS	PPO PAYS	NON-PPO PAYS	GENERAL PLAN LIMITS	PAGE
Allergy - Office	80% **	60% 60%	Includes testing, injections and serum. **PPO Office services are subject to the PPO Office Services Copay provision.	39
Ambulance	80%	80%	Limited to local air or ground.	39
Ambulatory/Outpatient Surgery Facility	80%	60%		35
Anesthesia - Office	80% **	60% 60%	Includes CRNA benefits. **PPO Office services are subject to the PPO Office Services Copay provision.	35
Birthing Center	80%	60%		37
Cancer Screening (Routine and Diagnostic)	100%	60%	PPO Deductible and copay waived. Includes mammograms, pap smears and prostate screening. See also <i>Colonoscopy</i> and <i>Flexible Sigmoidoscopy or Barium Test</i> .	--
Cardiac Rehabilitation - Office	80% **	60% 60%	Limited to phase I (inpatient) and phase II (outpatient) treatment only; phase III treatment (diet, exercise, healthy lifestyle programs) is excluded. Services and/or treatment must be medically necessary and recommended or ordered by a physician. **PPO Office services are subject to the PPO Office Services Copay provision.	39
Chiropractic (Manual/Mechanical Manipulation of Spinal Column)	**	60%	Limited to 20 visits/CAL YR. All services combined, including any related x-rays or labs done in connection with chiropractic services. **PPO Office services are subject to the PPO Office Services Copay provision.	39
Colonoscopy (Routine and Diagnostic)	80%	60%	Deductible waived. Baseline age 50 and older, then each 10 years; under age 50, benefit will be considered for "family history of".	-
Contraceptive Management - Office	80% **	60% 60%	Includes injectable contraceptives (e.g., Depo-Provera), implantable contraceptives (e.g., Norplant) and contraceptive devices (e.g., IUD). PPO Office services are subject to the PPO Office Services Copay provision.	39
Dental Services Covered Under Medical - Office	80% **	60% 60%	Includes services provided within 72 hours of accidental injury; surgical removal of impacted teeth. Includes treatment of TMJ. **PPO Office services are subject to the PPO Office Services Copay provision.	38
Diabetic Self-Management Education Programs/Outpatient - Office	80% **	60% 60%	Limited to \$500/CAL YR; \$1,500 lifetime. **PPO Office services are subject to the PPO Office Services Copay provision.	39
Durable Medical Equipment	80%	80%	Rental not to exceed the purchase price.	39
Elective Sterilization	80%	60%		39
Emergency Room Services	\$100	60%	Includes facility and physician charges. Copay does not apply to deductible and out-of-pocket maximums. Copay is waived if the participant is admitted to the hospital.	-

This is only a summary of benefits. Refer to the following pages in this booklet for more information about the benefits.

BENEFIT SUMMARY (Cont.)

Note: When the PPO column below references a percentage, employees must first satisfy the annual deductible before the plan will pay the indicated percentage, unless an exception is noted. When the PPO column indicates a dollar amount, this is the copayment employees pay and this service is not subject to the annual deductible. Copayments do not apply to the annual deductible and out-of-pocket maximums.

MEDICAL BENEFITS	PPO PAYS	NON-PPO PAYS	GENERAL PLAN LIMITS	PAGE
Flexible Sigmoidoscopy or Barium Test (Routine and Diagnostic)	80%	60%	Deductible waived. Baseline age 50 and older, then each 5 years.	-
Hemodialysis (Kidney Disease Treatment)	80%	60%		39
Home Health Care	80%	60%	Limited to 100 visits/CAL YR.	34
Home Infusion	80%	60%		39
Hospice Care			Limited to 180 days/lifetime. Includes respite care. Excludes bereavement counseling. Room and board is limited to the facility's semi-private room rate.	36
- Inpatient	80%	60%		
- Outpatient	80%	60%		
- Respite Care	80%	60%	Limited to 15 days inpatient/lifetime and 15 days outpatient/lifetime. Must be used in increments of not more than 5 days at a time.	
Hospital	80%	60%	Limited to the semi-private room rate for the level of care the patient is receiving. Excludes take-home drugs.	33
Human Papillomavirus (HPV) Vaccine	100%	100%	Deductible PPO Office Services Copay waived.	-
Immunizations	100%	No Coverage	Deductible and PPO office services copay waived. Up to age 7. Over age 7 – see <i>Preventive Care</i> .	42
Infertility	80%	60%	Limited to \$15,000/lifetime per participant for all related services and supplies including prescription drugs. Infertility Benefits do not apply to the out-of-pocket maximum.	38
- Office	**	60%	**PPO Office services are subject to the PPO Office Services Copay provision.	
Maternity			Payable for employees and covered spouses only. Deductible and copay waived.	37
- Physician	100%	60%		
- Hospital	80%	60%		
- Postpartum Home Visit	100%	100%	Deductible waived. One postpartum home visit when a mother and her baby are voluntarily discharged within 48 hours of normal labor and delivery or within 96 hours of cesarean birth.	
- Inpatient Newborn Care	80%	60%	Deductible waived for initial hospitalization. Considered separately from mother's charges. Includes nursery room and board, physician visits and circumcision.	
Mental Health/ Chemical Dependency				33
- Inpatient	80%	60%		
- Outpatient	80%	60%		
Office	**	60%	**PPO Office services are subject to the PPO Office Services Co-pay provision.	
Morbid Obesity	80%	60%	Prior approval required. Nutritional education and surgical procedure. Must be at least 18 years of age and an appropriate surgical candidate.	39
- Office	**	60%	**PPO Office services are subject to the PPO Office Services Copay provision.	

This is only a summary of benefits. Refer to the following pages in this booklet for more information about the benefits.

BENEFIT SUMMARY (Cont.)

Note: When the PPO column below references a percentage, employees must first satisfy the annual deductible before the plan will pay the indicated percentage, unless an exception is noted. When the PPO column indicates a dollar amount, this is the copayment employees pay and this service is not subject to the annual deductible. Copayments do not apply to the annual deductible and out-of-pocket maximums.

MEDICAL BENEFITS	PPO PAYS	NON-PPO PAYS	GENERAL PLAN LIMITS	PAGE
Nursing Facility	80%	60%	Limited to 100 days/CAL YR. Limited to the nursing facility's semi-private room rate for the level of care the patient is receiving.	34
Outpatient Diagnostic X-ray and Laboratory	80%	60%	Deductible waived for PPO Providers except for CT, MRA, MRI, PET, nuclear medicine, ultrasound and radiation.	37
- Independent Laboratory or X-ray Facility	80%	60%		
- Office	**	60%	**PPO Office services are subject to the PPO Office Services Copay provision.	
Physician Services				33
- Inpatient	80%	60%	Limited to one visit/day per specialty unless additional visits are medically necessary.	
- Outpatient Hospital	80%	60%		
- Office	**	60%	**PPO Office services are subject to the PPO Office Services Copay provision.	
- Specialist	**	60%	**PPO Office services are subject to the PPO Office Services Copay provision.	
Preadmission Testing	80%	60%	Includes Consultations.	37
- Office	**	60%	**PPO Office services are subject to the PPO Office Services Copay provision.	
Prescription Drugs	80%*	80%*	Includes only those allowable drugs and medications that are not payable under the prescription drug card such as insulin pump and insulin pump supplies. *PPO deductible and out-of-pocket maximums apply.	39
Preventive Care	100%	No Coverage	Age 2 and older. Calendar year deductible and PPO Office Services Copay are waived. Each participant limited to \$300/CAL YR. Newborn to age 2 – see <i>Well-Baby/Well-Child Care</i> . Includes the following routine services: -physical examinations -mammograms** -pap smears** -x-rays and labs -prostate screening** -cancer screening** -hearing exams -immunizations (including flu shots)** -services for screening of “family history of” conditions **Charges for pap smears/mammograms/ prostate exams/immunizations/cancer screening in excess of the \$300 preventive benefits maximum will be paid subject to the applicable benefits as stated in this Benefit Summary. Note: Human Papillomavirus (HPV) Vaccine will be paid under the Human Papillomavirus (HPV) Vaccine Benefit. Deductible and PPO Office Services Copay are waived. Subject to the \$300/CAL YR preventive benefits limitation.	38
- Shingles and Hepatitis Vaccine	100%	100%		
Private Duty Nursing	80%	60%		40
Radiation Therapy and Chemotherapy	80%	60%		40
- Office	**	60%	**PPO Office services are subject to the PPO Office Services Copay provision.	
Second Surgical Opinion (voluntary)	**	60%	**PPO Office services are subject to the PPO Office Services Copay provision.	35

This is only a summary of benefits. Refer to the following pages in this booklet for more information about the benefits.

BENEFIT SUMMARY (Cont.)

Note: When the PPO column below references a percentage, employees must first satisfy the annual deductible before the plan will pay the indicated percentage, unless an exception is noted. When the PPO column indicates a dollar amount, this is the copayment employees pay and this service is not subject to the annual deductible. Copayments do not apply to the annual deductible and out-of-pocket maximums.

MEDICAL BENEFITS	PPO PAYS	NON-PPO PAYS	GENERAL PLAN LIMITS	PAGE
Surgical Benefits - Inpatient - Outpatient - Office - Assistant Surgeon	80% 80% ** 80%	60% 60% 60% 60%	**PPO Office services are subject to the PPO Office Services Copay provision. Limited to 20% of the eligible expense for the surgical procedure performed.	35
Therapy - Office - Occupational Therapy - Physical Therapy - Respiratory Therapy - Speech Therapy	** 80% 80% 80% 80%	60% 60% 60% 60%	**PPO Office services are subject to the PPO Office Services Copay provision. Excludes occupational therapy supplies.	40
Transplants - Transportation	80% 80%	60% 60%	Prior approval required. Includes heart, heart/lung, lung, liver, pancreas, kidney, kidney/pancreas, bone marrow, small bowel, stem cell and cornea. Limited to \$10,000/transplant.	36
Vision Exams	**	60%	**PPO Eyewear exams are subject to the PPO Office Services Copay provision. Limited to one exam per year.	40
Urgent Care Facility	**	60%	**PPO Urgent Care services are subject to the PPO Office Services Copay provision.	-
Well-Baby/Well-Child Care	100%	No Coverage	Limited to \$600/CAL YR up to age 2. Includes routine exams and routine labs/x-rays. Deductible and PPO Office Service Copay waived. Additional immunization benefit available – see <i>Immunizations</i> .	-
Wigs	80%	60%	Initial purchase of a wig due to hair loss after a cancer diagnosis.	40
MEDICAL BENEFITS	PPO PLAN	NON-PPO PLAN	GENERAL PLAN LIMITS	PAGE
PATIENT'S LIABILITY				
Out-of-Pocket Calendar Year Maximums: - Per Individual/CAL YR - Per Family/CAL YR	 \$2,000 \$4,000	 \$4,000 \$8,000	Includes Calendar Year Deductibles and cost-sharing amounts. Excludes fourth quarter carryover deductible, hospital preadmission certification penalty, infertility benefits, retail and mail order prescription drug program copays, emergency room copays, urgent care facility copays and PPO Office Services Copays. <i>PPO and Non-PPO out-of-pocket maximums are mutually satisfying.</i>	32
MEDICAL PLAN'S MAXIMUM LIABILITY				
Lifetime Medical Maximum Benefits	\$2,000,000			32

This is only a summary of benefits. Refer to the following pages in this booklet for more information about the benefits.

COVERAGE AND ELIGIBILITY

EMPLOYEE ELIGIBILITY

An employee is eligible for medical and prescription drug coverage if he/she is a full-time employee who is regularly scheduled to work 1,000 or more hours each year. If the employee ceases to work, or is no longer regularly scheduled to work 1,000 or more hours a year, he/she ceases to be a covered employee under this Plan. Faculty members are eligible for health care coverage if hired to teach four or more courses on a continuing basis. Seasonal or temporary employees are not eligible for coverage under this Plan.

Phased Retirement Program

The Phased Retirement Program will allow Faculty to continue benefits for up to three years. Faculty could drop down to a three course teaching load or the equivalent combination of administrative and teaching duties to qualify under this program and continue benefits.

EMPLOYEE ENROLLMENT AND EFFECTIVE DATE

This Plan is effective on the first day of the month on or after employment from the date the employee becomes eligible (i.e., the waiting period) providing he/she enrolls for coverage within 31 days following the completion of the waiting period.

If the employee is eligible for coverage, but not actively at work on the day his/her coverage is scheduled to begin because of any reason other than his/her own medical condition or disability, this Plan will become effective the day the employee returns to active work. This actively-at-work provision will not delay the effective date of coverage if the sole reason the employee is not working is because the day is not a regularly scheduled workday.

If the employee does not apply to become a covered employee by completing an enrollment form or application within the 31-day period following the waiting period, he/she will not be eligible for coverage under this Plan except during an open enrollment or special enrollment period.

A covered employee who elects to become a covered dependent under this Plan may do so and he/she will be deemed to have completed his/her

pre-existing condition exclusion period to the extent that it was satisfied under this Plan as a covered employee on the date of the transfer of coverage.

EMPLOYEE TERMINATION OF COVERAGE

Coverage will end on the earliest of the following dates:

- (a) the last day of the month in which the covered employee's active employment with Cornell College is terminated;
- (b) the last day of the month the covered employee ceases to be in a class of employees eligible for coverage;
- (c) the end of the period for which the employee has made contributions if he/she fails to make the next required contribution;
- (d) the date this Plan is terminated with respect to Cornell College, and there is no successor plan;
- (e) the last day of the month of layoff;
- (f) the end of the 12th month of sabbatical or military leave;
- (g) the date the covered employee receives the lifetime maximum benefit, as specified by this Plan; or
- (h) the last day of the month the covered employee voluntarily elects to be terminated from this Plan, subject to the pre-tax premium rules as outlined under **Pre-Tax Premium Program**.

If the covered employee ceases active employment due to authorized leave of absence (excluding FMLA, sabbatical or military leave), participation may be continued pursuant to rules adopted by Cornell College and applied on a uniform basis to all covered employees similarly situated but in no event longer than three months.

If the covered faculty employee ceases active employment due to authorized leave of absence (excluding FMLA, sabbatical or military leave), participation may be continued pursuant to rules adopted by Cornell College and applied on a uniform basis to all covered faculty employees similarly situated but in no event longer than 12 months.

If the employee ceases employment and is rehired within 31 days of terminating employment, his/her pretax premium election and corresponding coverage level in effect at the time of termination of employment will be automatically reinstated.

No new eligibility waiting period or pre-existing condition waiting period limitation will apply.

If the covered employee wishes to cancel coverage, he/she must notify the College within 31 days prior to the desired date of cancellation. Cancellation will be subject to the pre-tax premium rules as outlined under **Pre-Tax Premium Program**.

Unless otherwise specified under this Plan, when coverage terminates, benefits will not be provided for any healthcare services after the termination date even though these services are furnished as a result of an injury or illness that occurred prior to termination of coverage.

DEPENDENT ELIGIBILITY

A covered employee may choose to cover his/her dependents (as defined) under this Plan.

A covered employee's unmarried dependent children may be covered until they reach the age of 19. They may be covered until the age of 25 if they are unmarried, full-time students enrolled in an accredited school.

Dependent children include natural children, adopted children (as defined), stepchildren and children for whom the employee has legal guardianship. Refer to the definition of "Dependent" for more information.

If both parents are covered under this Plan as employees, a child can be covered as a dependent of only one parent. No one covered under this Plan as an employee can also be covered as a dependent.

Domestic Partners

Coverage is provided for domestic partners. An employee and his/her partner must sign a Declaration of Domestic Partnership (available from the Human Resources Department) in order to be eligible for domestic partner benefits. This document is solely for the purpose of determining eligibility for domestic partnership benefits. Each domestic partner must be an individual age 19 or older and mentally competent to consent to a contract. The domestic partners are not related by blood enough to bar marriage in the state of their legal residence. A domestic partner is not considered to be a spouse of the employee. Neither partner is legally married to, nor the domestic partner of, any other person.

If the employee and his/her domestic partner no longer meet the criteria listed on the above

mentioned form, the employee must notify the Human Resources Department in writing as required by the provisions outlined in the Declaration of Domestic Partnership. Coverage will terminate on the last day of the month that the partnership ends. Failure to request coverage termination for an ineligible domestic partner in a timely manner will require the employee to repay any subsidy paid by the College for the partner's coverage once he/she was deemed ineligible. The employee's partner will not be offered the option of COBRA continuation coverage. The employee may not file another domestic partnership declaration after filing a notification of partnership termination for at least 90 days. Please contact the Human Resources Department for assistance in completing the appropriate form.

Adopted Child

The term "dependent" found in this Plan shall include any unmarried child meeting the dependent eligibility requirements of this Plan who, prior to age 18, has been placed for adoption or who has been adopted by the participant.

Such a child shall be eligible for coverage as of the date of placement for adoption, or as of the date of actual adoption, whichever occurs first.

Coverage under this Plan for the adopted child shall be the same coverage which is available to all other dependent children under this Plan except that all pre-existing condition exclusions or additional waiting periods will be waived for such a child provided the child is enrolled within the time periods specified under the section entitled **Dependent Enrollment and Effective Date**.

QMCSO Provision

This Plan will provide benefits to the child(ren) of a participant if a Qualified Medical Child Support Order (QMCSO) is issued regardless of whether the child(ren) resides with the participant. If a QMCSO is issued, then the child(ren) shall become alternate recipient(s) of the benefits under this Plan, subject to the same limitations, restrictions, provisions and procedures as any other participant. A properly completed National Medical Support Notice (NMSN) will be treated as a QMCSO and will have the same force and effect.

Procedural QMCSO Requirements

Within a reasonable period of time following receipt of a medical child support order, the Plan Administrator will notify the participant and each child specified in the order whether the order is or is

not a Qualified Medical Child Support Order. A QMCSO is an order which creates or recognizes the right of an alternate recipient (participant's child who is recognized under the order as having a right to be enrolled under this Plan) or assigns to the alternate recipient the right to receive benefits. To be considered a Qualified Medical Child Support Order, the medical child support order must contain the following information:

- the name and last known mailing address of the participant and the name and address of each child to be covered by this Plan;
- a reasonable description of the type of coverage to be provided by this Plan to each named child, or the manner in which the type of coverage is to be determined; and
- the period to which such order applies.

If the order **is** determined to be a Qualified Order, each named child will be covered by this Plan in the same manner as any other dependent child is covered by this Plan.

Coverage for a child under a QMCSO will begin on the latest of the following dates:

- (a) if the employee already has coverage in force, the child will be covered;
- (b) as of the date specified in the order or, if no date is specified in the Order, the date the QMCSO is received;
- (c) if the employee is within the waiting period as specified under the section entitled **Employee Enrollment and Effective Date**, the child's coverage will become effective the same date the employee's coverage is effective; or
- (d) if the employee is otherwise eligible but previously waived coverage, the employee's and the child's coverage will become effective as of the date specified in (a) above.

Each named child will be considered a participant under this Plan but may designate another person, such as a custodial parent or legal guardian, to receive copies of explanations of benefits, checks and other material which would otherwise be sent directly to the named child.

If it is determined that the order **is not** a Qualified Order, each named child may appeal that decision by submitting a written letter of appeal to the Plan Administrator. The Plan Administrator shall review the appeal and reply in writing within 30 days of receipt of the appeal.

This Plan will not provide any type or form of benefit, or any option, not otherwise provided under this Plan and all other dependent eligibility, effective date and termination provisions will apply.

Michelle's Law: Coverage of Dependent Students on Medically Necessary Leave of Absence

In the case of an eligible dependent child, this Plan shall not terminate coverage due to a medically necessary leave of absence from, or any other change in enrollment at, a post-secondary education institution that commences while such dependent child is suffering from a serious illness or injury that causes such dependent child to lose student status for purposes of coverage under this Plan, before the earlier of:

- up to one year after the beginning of the leave of absence; or
- the date coverage would otherwise terminate under the Plan.

For the student to qualify for this extension, the plan must receive written certification from his/her treating physician stating that the student is suffering from a serious illness or injury and that the leave of absence is medically necessary.

A student will qualify for a medically necessary leave of absence from a post-secondary educational institution if the leave of absence:

1. begins while the child is suffering from a serious illness or injury;
2. is certified by a physician as being medically necessary; and
3. causes the child to lose student status for purposes of coverage under the plan.

If the dependent child's treating physician does not provide written documentation that the child is suffering from a serious illness or injury and that the leave of absence is medically necessary, this Plan will not provide continued coverage.

DEPENDENT ENROLLMENT AND EFFECTIVE DATE

Generally, coverage for dependents will become effective on the same day the employee's coverage begins. Any new dependent can become a covered dependent as of one of the following applicable dates:

- (a) the eligibility date for which written application is made and delivered to the Plan Administrator, if made on or before the date the individual becomes a dependent;
- (b) the eligibility date for which such written application is received when the application is made and delivered to the Plan Administrator within 31 days after the individual becomes a dependent; or
- (c) the eligibility date determined under the terms of an applicable special enrollment period. In some cases, such as marriage, birth, adoption, and placement for adoption, there may be special circumstances that will allow a dependent to enroll for coverage after the initial enrollment period. For further details on these circumstances, see the section on **Special Enrollment Periods**.

A covered dependent who becomes eligible as an employee under this Plan will be considered to have satisfied his/her waiting period and his/her pre-existing condition exclusion period on the date he/she becomes so eligible if, on that date, he/she has fully satisfied the waiting period and pre-existing condition exclusion period.

If the employee is absent from active work because of any reason other than his/her own medical condition or disability when coverage for his/her dependents would otherwise take effect, coverage for the dependents will become effective only upon the employee's return to active work. This actively-at-work provision will not delay the effective date of the coverage if the sole reason the employee is not working is because the day is not a regularly scheduled workday.

DEPENDENT TERMINATION OF COVERAGE

Coverage will end on the earliest of the following dates:

- (a) the last day of the month in which the employee's coverage terminates for any reason other than having received the maximum lifetime benefit;

- (b) the last day of the month in which the dependent ceases to be a covered dependent as defined by this Plan;
- (c) the last day of the month 90 days following graduation from high school or college (undergraduate or graduate programs);
- (d) in the event of a legal separation or divorce, coverage for the employee's spouse will cease at the end of the month in which the event occurred;
- (e) the last day of the month this Plan is amended to terminate dependent coverage of a class of employees of which the employee is a member;
- (f) the end of the period for which the employee has made contributions for a dependent's coverage if the next required contribution is not made;
- (g) the date this Plan is terminated with respect to the College and there is no successor plan;
- (h) the date the covered dependent receives the maximum lifetime benefit, as specified by this Plan;
- (i) the last day of the month the covered dependent voluntarily elects to be terminated from this Plan, subject to the pre-tax premium rules as outlined under **Pre-Tax Premium Program**; or
- (j) the first day of the next regular term if a dependent is a full-time student during one term with plans to return to school for the next term, but fails to do so.

If the covered dependent student is unable to attend school full-time because of sickness or accidental injury, coverage will continue until the first day of the next regular term.

If the covered dependent wishes to cancel coverage, he/she must notify the College within 31 days prior to the desired date of cancellation. Cancellation will be subject to the pre-tax premium rules as outlined under **Pre-Tax Premium Program**.

In the event a dependent again meets the requirements of a dependent as defined under the Plan (i.e., regains full-time student status), coverage will be effective on the date he/she becomes eligible provided application is made within 31 days of the event.

Unless otherwise specified under this Plan, when coverage terminates, benefits will not be provided

for any healthcare services after the termination date even though these services are furnished as a result of an injury that occurred prior to termination of coverage.

SPECIAL ENROLLMENT PERIODS

Special Enrollment rights are provided both to current employees who were eligible but declined enrollment in the Plan when first offered because they were covered under another plan and to individuals acquiring a dependent. These special enrollment rights permit these individuals to enroll without having to wait until the Plan's next regular enrollment period. If an individual requests enrollment while the individual is entitled to special enrollment, the individual is a special enrollee, even if the request for enrollment coincides with a late enrollment opportunity.

Pre-existing condition exclusion periods for special enrollees may not exceed 12 months.

Individuals Losing Other Coverage

This Plan will permit a current employee or dependent who is eligible, but not enrolled, to enroll for coverage under the terms of this Plan if **each** of the following conditions is met:

- (a) the current employee or dependent was covered under another group health plan or had other health insurance coverage at the time coverage under this Plan was offered;
- (b) the current employee stated in writing at the time this Plan was offered that the reason for declining enrollment was due to the current employee having coverage under another group health plan or due to the employee having other health insurance coverage, but only if this Plan required such a written statement at that time and provided the current employee or dependent with notice of the requirement (and consequences of the requirement) at that time;
- (c) the current employee or dependent lost other coverage pursuant to one of the following events:
 - the current employee or dependent was under COBRA and the COBRA coverage was exhausted;
 - the current employee or dependent was not under COBRA and the other coverage was terminated as a result of loss of eligibility (including as a result of legal separation, divorce, loss of dependent

status, death, termination of employment, or reduction in the number of hours worked);

- the current employee or dependent moved out of an HMO service area with no other option available;
 - the current employee or dependent met or exceeded a lifetime limit on all benefits (the event for reaching the lifetime limit is the earliest date that a claim is denied);
 - the plan is no longer offering benefits to a class of similarly situated individuals,
 - the benefit package option is no longer being offered and no substitute is available; or
 - the employer contributions were terminated; and
- (d) under the terms of this Plan, the current employee requests enrollment into this Plan not later than 31 days after an event, as described in (c) above.

For an eligible current employee or dependent who has met **each** of the conditions specified above, this Plan will be effective on the first of the month coincident with or next following the date the other coverage was lost.

This Plan will also permit a current employee or dependent who is eligible, but not enrolled, to enroll for coverage under the terms of this Plan if the current employee or dependent lost eligibility under Medicaid or Children's Health Insurance Program (CHIP).

The current employee must request enrollment into this Plan not later than 60 days after the event, as described above.

For an eligible current employee or dependent who has met the conditions specified above, this Plan will be effective no later than the first day of the first calendar month as long as the written request for enrollment is made within the required days from loss of coverage.

Dependent Beneficiaries

This Plan will provide for a dependent special enrollment period during which the person may be enrolled under this Plan as a dependent of the current employee (and, if not otherwise enrolled, the current employee, spouse and any otherwise eligible dependent may be enrolled at the same time):

- (a) the current employee has coverage under this Plan (or the current employee has met any waiting period applicable to becoming covered under this Plan and is eligible to be enrolled under this Plan, but failed to enroll during a previous enrollment period); and
- (b) a person becomes a dependent of the current employee through marriage, birth, adoption or placement for adoption.

In the case of the birth or adoption of a child, the spouse and/or other eligible dependents of the current employee may also be enrolled as a dependent if the spouse and/or other dependents are otherwise eligible for coverage.

The dependent special enrollment period will be a period of 31 days beginning on the date of marriage, birth, adoption or placement for adoption.

If a current employee requests enrollment for a dependent during the dependent special enrollment period, the coverage for the dependent will become effective:

- (a) in the case of marriage, either the date of marriage or the first of the month coincident with or next following the date of the marriage;
- (b) in the case of a dependent's birth, as of the date of birth; or
- (c) in the case of a dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.

If the covered current employee has family coverage, newborns are automatically covered under this Plan from the moment of birth. An enrollment form or application will not be required.

This Plan will provide for a dependent special enrollment period during which the person may be enrolled under this Plan as a dependent of the current employee (and, if not otherwise enrolled, the current employee, spouse and/or other eligible dependents may be enrolled at the same time) if:

- the current employee or dependent becomes eligible for a new premium assistance subsidy plan under Medicaid or Children's Health Insurance Program (CHIP).

This dependent special enrollment period will be a period of 60 days beginning on the date of eligibility. [Flexible spending plans and high deductible health plans are not eligible for this special enrollment period.]

If a current employee requests enrollment for a dependent during the dependent special enrollment period, the coverage for the dependent will become effective as of the first day of the month after the request for enrollment is received.

DEPENDENT CHILDREN WITH DISABILITIES

Coverage of an unmarried dependent child shall not cease because of attainment of the termination age specified in this Plan, while the employee's coverage is in force and the child otherwise qualifies as a dependent, if the child:

- (a) is incapable of self-sustaining employment by reason of a handicapping mental or physical disability; and
- (b) became so disabled prior to attainment of the termination age specified in this Plan.

The employee must submit to Cornell College, within 31 days of such dependent's attainment of the termination age, written proof of the disability as described and continue to pay premiums, if any, for the dependent's coverage. The coverage of any such dependent will be subject to all other termination provisions of this Plan.

Cornell College, upon receipt of proof of the disability, shall have the right and opportunity to have a physician it designates examine any such dependent when and as often as Cornell College may reasonably require. Cornell College will not require the dependent to be examined more than once each year after such disability has continued on an uninterrupted basis for at least two years following the date the initial written proof of disability was received.

All rights under the provisions of this section shall automatically and immediately cease on the earliest of the following dates:

- (a) the date the dependent's disability as described no longer exists;
- (b) the date the dependent fails to submit to any required medical examination;
- (c) the date the employee fails to submit any required proof of the uninterrupted existence of the dependent's disability; or
- (d) the date the dependent otherwise ceases to qualify as a dependent except for the attainment of the maximum age as specified by this Plan.

OPEN ENROLLMENT PERIOD

Cornell College will offer an annual enrollment period during which an employee may elect to participate in the Plan. Any otherwise eligible employee who has previously waived coverage may elect to participate in the Plan, provided he/she applies during this enrollment period. All new participants added during the enrollment periods are subject to a 12-month pre-existing condition exclusion period. The enrollment period will be held annually with a January 1 effective date.

FAMILY AND MEDICAL LEAVE ACT OF 1993

This Section only applies to employers required to comply with the Federal Family and Medical Leave Act.

ENTITLEMENT TO LEAVE

This Act requires an employer which employs 50 or more employees (within a 75-mile radius) to allow an employee who has been employed for 12 months or more and accumulated hours of service in excess of 1,250 hours from the date of employment or the end of the last qualified leave, to take a total of 12 weeks of leave during any 12-month period, as defined by the employer, for:

- (a) the birth of a son or daughter of the employee and in order to care for such son or daughter;
- (b) placement of a son or daughter with the employee for adoption or foster care;
- (c) care for a spouse, son, daughter or parent of the employee, if such spouse, son, daughter, or parent has a serious health condition; or
- (d) a serious health condition which makes the employee unable to perform the functions of the position of such employee; or
- (e) a qualifying exigency arising out of the fact that the spouse, son, daughter, or parent of the employee is on active duty (or has been notified of an impending call or order to active duty) in the Armed Forces in support of a contingency operation.

EXPIRATION OF ENTITLEMENT

The entitlement to leave under subparagraphs (a) and (b) of Entitlement of Leave for a birth or placement of a son or daughter shall expire at the end of the 12-month period beginning on the date of such birth or placement.

SERVICEMEMBER FAMILY LEAVE

An eligible employee who is the spouse, son, daughter, parent or next of kin of a covered servicemember shall be entitled to a total of 26 workweeks of leave during a single 12-month period to care for the servicemember. The leave described in this paragraph shall only be available during a single 12-month period.

COMBINED TOTAL LEAVE

During the single 12-month period as described in Servicemember Family Leave, an eligible employee shall be entitled to a combined total of 26 workweeks of leave under Entitlement to Leave and Servicemember Family Leave. Nothing in this paragraph shall be construed to limit the availability of leave under Entitlement to Leave during any other 12-month period.

Any employee taking a leave shall be entitled to continue to use his/her benefits during the duration of the leave if he/she participates in a "group health plan" as defined in §5000(b)(1) of the Internal Revenue Code of 1986. The employer must continue the benefits at the level and under the conditions of coverage that would have been provided if the employee had remained employed. If the employee who is responsible for payment misses a premium payment during the leave of absence, the employer may terminate coverage provided that the employee has been given notification of termination and a grace period as defined by the FMLA. If the benefits are terminated during the leave, the employee is entitled to be fully reinstated upon returning to work. If the employee for any reason fails to return from the leave, the employer may recover from the employee the premium or portion of the premium that the employer paid, provided the employee fails to return to work for any reason other than the recurrence of the health condition or circumstances beyond the control of the employee.

Leave taken under the Act does not constitute a "qualifying event" so as to trigger COBRA rights. However, a qualifying event triggering COBRA coverage may occur when it becomes known that the employee is not returning to work. Therefore, if an employee does not return at the end of 12 weeks Family and Medical Leave, the COBRA qualifying event occurs at that time.

This is only a summary of the Family and Medical Leave Act of 1993. Please contact Cornell College for more information.

THE UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994

The Plan Sponsor shall fully comply with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). If any part of this Plan is found to be in conflict with this Act, the conflicting provision shall be null and void. All other benefits and exclusions of the Plan will remain effective to the extent there is no conflict with this Act.

USERRA provides for, among other employment rights and benefits, continuation of health care coverage to a covered employee and covered dependents, during a period of active service or training with any of the Uniformed Services. The Plan provides that a covered employee may elect to continue such coverages in effect at the time the employee is called to active service. The maximum period of coverage for the employee and the covered employee's dependents under such an election shall be the lesser of:

- the 24-month period beginning on the date on which the covered employee's absence begins; or
- the period beginning on the date on which the covered employee's absence begins and ending on the day after the date on which the covered employee fails to apply for or return to a position of employment as follows:
 - for service of less than 31 days, no later than the beginning of the first full regularly scheduled work period on the first full calendar day following the completion of the period of service and the expiration of eight hours after a period allowing for the safe transportation from the place of service to the covered employee's residence or as soon as reasonably possible after such 8-hour period;
 - for service of more than 30 days but less than 181 days, no later than 14 days after the completion of the period of service or as soon as reasonably possible after such period;
 - for service of more than 180 days, no later than 90 days after the completion of the period of service; or
 - for a covered employee who is hospitalized or convalescing from an illness or injury

incurred in or aggravated during the performance of service in the Uniformed Services, at the end of the period that is necessary for the covered employee to recover from such illness or injury. Such period of recovery may not exceed two years.

A covered employee who elects to continue health plan coverage under the Plan during a period of active service in the Uniformed Services may be required to pay not more than 102% of the full premium under the plan associated with such coverage for the employer's other employees, except that in the case of a covered employee who performs service in the Uniformed Services for less than 31 days, such covered employee may not be required to pay more than the employee share, if any, for such coverage. Continuation coverage cannot be discontinued merely because activated military personnel receive health coverage as active duty members of the Uniformed Services, and their family members are eligible to receive coverage under the Department of Defense's managed health care program, TRICARE.

In the case of a covered employee whose coverage under a health plan was terminated by reason of services in the Uniformed Services, the pre-existing exclusion and waiting period may not be imposed in connection with the reinstatement of such coverage upon reemployment under this Act. This applies to the covered employee who is reemployed and any dependent whose coverage is reinstated. The waiver of the pre-existing exclusion shall not apply to illness or injury which occurred or was aggravated during performance of service in the Uniformed Services.

"Uniformed Services" shall include full time and reserve components of the United States Army, Navy, Air Force, Marines, Coast Guard, Army National Guard, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or emergency.

If the covered employee is called to a period of active service in the Uniformed Service, he/she should check with the Plan Administrator for a more complete explanation of rights and obligations under USERRA.

COVERAGE CONTINUATION UNDER FEDERAL LAW - COBRA

The following information about the participant's right to continue his/her health care coverage in the Plan is important. Please read it very carefully.

COBRA continuation coverage is a temporary extension of group health coverage under the Plan under certain circumstances when coverage would otherwise end. The right to COBRA coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA coverage can become available to the participant when he/she would otherwise lose group health coverage under the Plan. It can also become available to the participant's spouse and dependent children, if they are covered under the Plan, when they would otherwise lose their group health coverage under the Plan. The following paragraphs generally explain COBRA coverage, when it may become available to the participant and his/her family, and what the participant needs to do to protect the right to receive it.

COBRA (and the description of COBRA coverage contained in this Plan) applies only to the benefits offered under the Plan and not to any other benefits offered under the Plan or by Cornell College (such as life insurance, disability, or accidental death or dismemberment benefits). The Plan provides no greater COBRA rights than what COBRA requires. Nothing in this Plan is intended to expand the participant's rights beyond COBRA's requirements.

For additional information about rights and obligations under the Plan and under federal law, the participant should contact Cornell College, which is the Plan Administrator.

WHAT IS COBRA COVERAGE?

COBRA coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a “qualifying event.” Specific qualifying events are listed below in the section entitled “Who is Entitled to Elect COBRA?”

After a qualifying event occurs and any required notice of that event is properly provided to the Plan Administrator, COBRA coverage must be offered to each person losing Plan coverage who is a “qualified beneficiary.” The participant, his/her spouse, and dependent children could become qualified beneficiaries and would be entitled to elect COBRA if coverage under the Plan is lost because of the qualifying event. (Certain newborns, newly adopted children, and alternate recipients under QMCSO’s may also be qualified beneficiaries. This is discussed in more detail in separate paragraphs below.)

COBRA coverage is the same coverage that the Plan gives to other participants or beneficiaries under the Plan who are not receiving COBRA coverage. Each qualified beneficiary who elects COBRA will have the same rights under the Plan as other participants or beneficiaries covered under the component or components of the Plan elected by the qualified beneficiary, including open enrollment and special enrollment rights. Under the Plan, qualified beneficiaries who elect COBRA must pay for COBRA coverage.

Additional information about the Plan is available in other portions of this Plan.

WHO IS ENTITLED TO ELECT COBRA?

The employee will be entitled to elect COBRA if he/she loses his/her group health coverage under the Plan because his/her hours of employment are reduced; or his/her employment ends for any reason other than his/her gross misconduct.

As the spouse of an employee, the spouse will be entitled to elect COBRA if he/she loses his/her group health coverage under the Plan because any of the following qualifying events happens:

- the employee dies;
- the employee’s hours of employment are reduced;
- the employee’s employment ends for any reason other than his or her gross misconduct;

- the employee becomes entitled to Medicare benefits prior to his/her qualifying event; or
- the spouse becomes divorced or legally separated from the employee.

As the dependent child of an employee, the dependent child will be entitled to elect COBRA if he/she loses his/her group health coverage under the Plan because any of the following qualifying events happens:

- the parent-employee dies;
- the parent-employee’s hours of employment are reduced;
- the parent-employee’s employment ends for any reason other than his or her gross misconduct;
- the parent-employee becomes entitled to Medicare benefits;
- the parents become divorced or legally separated; or
- the dependent stops being eligible for coverage under the Plan as a “dependent child.”

If an employee takes FMLA leave and does not return to work at the end of the leave, the employee (and the employee’s spouse and dependent children, if any) will be entitled to elect COBRA if (1) they were covered under the Plan on the day before the FMLA leave began (or became covered during the FMLA leave); and (2) they will lose Plan coverage because of the employee’s failure to return to work at the end of the leave. (This means that some individuals may be entitled to elect COBRA at the end of an FMLA leave even if they were not covered under the Plan during the leave.) COBRA coverage elected in these circumstances will begin on the last day of the FMLA leave, with the same 18-month maximum coverage period (subject to extension or early termination) generally applicable to the COBRA qualifying events of termination of employment and reduction of hours. (See the section below entitled “Length of COBRA Coverage.”)

WHEN IS COBRA COVERAGE AVAILABLE?

When the qualifying event is the end of employment, reduction of hours of employment, or death of the employee, the Plan will offer COBRA coverage to qualified beneficiaries. The

participant need not notify the Plan Administrator of any of these three qualifying events.

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), a COBRA election will be available only if the participant notifies the Benefit Services Administrator in writing within 60 days after the later of (1) the date of the qualifying event; and (2) the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the qualifying event.

The written notice must include the plan name or group name, the employee's name, the employee's Social Security Number, the dependent's name and a description of the event.

If these procedures are not followed or if the written notice is not provided to the Plan Administrator during the 60-day notice period, **THE PARTICIPANT WILL LOSE HIS/HER RIGHT TO ELECT COBRA.**

ELECTING COBRA COVERAGE

To elect COBRA, the participant must complete the Election Form that is part of the Plan's COBRA election notice and submit it to the Benefit Services Administrator. An election notice will be provided to qualified beneficiaries at the time of a qualifying event. The participant may also obtain a copy of the Election Form from the Benefit Services Administrator. Under federal law, the participant must have 60 days after the date the qualified beneficiary plan coverage terminates, or, if later, 60 days after the date of the COBRA election notice provided to him/her at the time of his/her qualifying event to decide whether he/she wants to elect COBRA under the Plan.

Mail the completed Election Form to:

First Administrators, Inc.
COBRA Department
PO Box 8150
Rapid City, SD 57709-8150

The Election Form must be completed in writing and mailed to the individual and address specified above. The following are not acceptable as COBRA elections and will not preserve COBRA rights: oral communications regarding COBRA coverage, including in-person or telephone statements about an individual's COBRA coverage; and electronic communications, including email and faxed communications.

The election must be postmarked no later than 60 days after the date of the COBRA election notice provided at the time of the qualifying event. **IF THE PARTICIPANT DOES NOT SUBMIT A COMPLETED ELECTION FORM BY THIS DUE DATE, HE/SHE WILL LOSE HIS OR HER RIGHT TO ELECT COBRA.**

If the participant rejects COBRA before the due date, he/she may change his/her mind as long as he/she furnishes a completed Election Form before the due date. The Plan will only provide continuation coverage beginning on the date the waiver of coverage is revoked.

The participant does not have to send any payment with his/her Election Form when he/she elects COBRA. Important additional information about payment for COBRA coverage is included below.

Each qualified beneficiary will have an independent right to elect COBRA. For example, the employee's spouse may elect COBRA even if the employee does not. COBRA may be elected for only one, several, or for all dependent children who are qualified beneficiaries. Covered employees and spouses (if the spouse is a qualified beneficiary) may elect COBRA on behalf of all of the qualified beneficiaries, and parents may elect COBRA on behalf of their children. Any qualified beneficiary for whom COBRA is not elected within the 60-day election period specified in the Plan's COBRA election notice **WILL LOSE HIS OR HER RIGHT TO ELECT COBRA COVERAGE.**

When the participant completes the Election Form, he/she must notify the Benefit Services Administrator if any qualified beneficiary has become entitled to Medicare and, if so, the date of Medicare entitlement. If the participant becomes entitled to Medicare (or first learns that he/she is entitled to Medicare) after submitting the Election Form, immediately notify the Benefit Services Administrator of the date of the Medicare entitlement at the address specified above for delivery of the Election Form.

Qualified beneficiaries who are entitled to elect COBRA may do so even if they have other group health plan coverage or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, as discussed in more detail below, a qualified beneficiary's COBRA coverage will terminate automatically if, after electing COBRA, he or she becomes entitled to Medicare benefits or becomes covered under other group health plan coverage (but only after any applicable

pre-existing condition exclusions of that other plan have been exhausted or satisfied). See the section below entitled "Termination of COBRA Coverage Before the End of the Maximum Coverage Period."

SPECIAL CONSIDERATIONS IN DECIDING WHETHER TO ELECT COBRA

In considering whether to elect COBRA, the participant should take into account that a failure to elect COBRA will affect his/her future rights under federal law. First, he/she can lose the right to avoid having pre-existing condition exclusions applied to the participant by other group health plans if he/she has a 63-day gap in health coverage, and election of COBRA may help avoid such a gap. Second, the participant will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if he/she elects COBRA coverage and does not exhaust COBRA coverage for the maximum time available. Finally, the participant should take into account that he/she has special enrollment rights under federal law. The participant has the right to request special enrollment in another group health plan for which he/she is otherwise eligible (such as a plan sponsored by the spouse's employer) within 30 days after the participant's group health coverage under the Plan ends because of one of the qualifying events listed above. The participant will also have the same special enrollment right at the end of COBRA coverage if he/she gets COBRA coverage for the maximum time available.

LENGTH OF COBRA COVERAGE

COBRA coverage is a temporary continuation of coverage. The COBRA coverage periods described below are maximum coverage periods. COBRA coverage can end before the end of the maximum coverage period for several reasons, which are described in the section below entitled "Termination of COBRA Coverage Before the End of the Maximum Coverage Period."

When Plan coverage is lost due to the death of the employee, the covered employee's divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA coverage can last for up to a total of 36 months.

When Plan coverage is lost due to the end of employment or reduction of the employee's hours of employment, and the employee became entitled

to Medicare benefits less than 18 months before the qualifying event, COBRA coverage for qualified beneficiaries (other than the employee) who lose coverage as a result of the qualifying event can last until up to 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare eight months before the date on which his employment terminates, COBRA coverage under the Plan's Medical and Dental components for his spouse and children who lost coverage as a result of his termination can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). This COBRA coverage period is available only if the covered employee becomes entitled to Medicare within 18 months BEFORE the termination or reduction of hours.

Otherwise, when Plan coverage is lost due to the end of employment or reduction of the employee's hours of employment, COBRA coverage generally can last for only up to a total of 18 months.

EXTENSION OF MAXIMUM COVERAGE PERIOD

If the qualifying event that resulted in the participant's COBRA election was the covered employee's termination of employment or reduction of hours, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. The participant must notify the Benefit Services Administrator of a disability or a second qualifying event in order to extend the period of COBRA coverage. Failure to provide notice of a disability or second qualifying event will eliminate the right to extend the period of COBRA coverage. Along with the notice of a disability, the qualified beneficiary must also supply a copy of the Social Security Administration disability determination.

If a qualified beneficiary is determined by the Social Security Administration to be disabled and the participant notifies the Benefit Services Administrator in a timely fashion, all of the qualified beneficiaries in the family may be entitled to receive up to an additional 11 months of COBRA coverage, for a total maximum of 29 months. This extension is available only for qualified beneficiaries who are receiving COBRA coverage because of a qualifying event that was the covered employee's termination of employment or reduction of hours. The qualified beneficiary must be determined disabled at any time during the first 60 days of COBRA coverage.

Each qualified beneficiary will be entitled to the disability extension if one of them qualifies.

The disability extension is available only if the participant notifies the Benefit Services Administrator in writing of the Social Security Administration's determination of disability within 60 days after the latest of:

- the date of the Social Security Administration's disability determination;
- the date of the covered employee's termination of employment or reduction of hours; or
- the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the covered employee's termination of employment or reduction of hours.

The written notice must include the plan name or group name, the employee's name, the employee's Social Security Number, the dependent's name and a description of the event.

The participant must also provide this notice within 18 months after the covered employee's termination of employment or reduction of hours in order to be entitled to a disability extension.

If these procedures are not followed or if the written notice is not provided to the Benefit Services Administrator during the 60-day notice period and within 18 months after the covered employee's termination of employment or reduction of hours, **THEN THERE WILL BE NO DISABILITY EXTENSION OF COBRA COVERAGE.**

An extension of coverage will be available to spouses and dependent children who are receiving COBRA coverage if a second qualifying event occurs during the 18 months (or, in the case of a disability extension, the 29 months) following the covered employee's termination of employment or reduction of hours. The maximum amount of COBRA coverage available when a second qualifying event occurs is 36 months. Such second qualifying events may include the death of a covered employee, divorce or legal separation from the covered employee, or a dependent child's ceasing to be eligible for coverage as a dependent under the Plan. These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the Plan if the first qualifying event had not occurred. (This extension

is not available under the Plan when a covered employee becomes entitled to Medicare.)

This extension due to a second qualifying event is available only if the participant notifies the Benefit Services Administrator in writing of the second qualifying event within 60 days after the later of (1) the date of the second qualifying event; and (2) the date on which the qualified beneficiary would lose coverage under the terms of the Plan as a result of the second qualifying event (if it had occurred while the qualified beneficiary was still covered under the Plan).

If these procedures are not followed or if the written notice is not provided to the Benefit Services Administrator during the 60-day notice period, **THERE WILL BE NO EXTENSION OF COBRA COVERAGE DUE TO A SECOND QUALIFYING EVENT.**

In addition to the regular COBRA termination events specified later in this section, the disability extension period will end the first of the month beginning more than 30 days following recovery.

Example: If disability ends June 10, coverage will continue through the month of July (7/31).

TERMINATION OF COBRA COVERAGE BEFORE THE END OF THE MAXIMUM COVERAGE PERIOD

COBRA coverage will automatically terminate before the end of the maximum period if:

- any required premium is not paid in full on time;
- a qualified beneficiary becomes covered, after electing COBRA, under another group health plan (but only after any pre-existing condition exclusions of that other plan for a pre-existing condition of the qualified beneficiary have been exhausted or satisfied);
- a qualified beneficiary becomes entitled to Medicare benefits after electing COBRA;
- the employer ceases to provide any group health plan for its employees; or
- during a disability extension period, the disabled qualified beneficiary is determined by the Social Security Administration to be no longer disabled. For more information about the disability extension period, see the section above

entitled “Extension of Maximum Coverage Period.”

COBRA coverage may also be terminated for any reason the Plan would terminate coverage of a participant or beneficiary not receiving COBRA coverage (such as fraud).

The participant must notify the Benefit Services Administrator in writing within 30 days if, after electing COBRA, a qualified beneficiary becomes entitled to Medicare or becomes covered under other group health plan coverage (but only after any pre-existing condition exclusions of that other plan for a pre-existing condition of the qualified beneficiary have been exhausted or satisfied).

COBRA coverage will terminate (retroactively if applicable) as of the date of Medicare entitlement or as of the beginning date of the other group health coverage (after exhaustion or satisfaction of any pre-existing condition exclusions for a pre-existing condition of the qualified beneficiary). The Plan Administrator will require repayment to the Plan of all benefits paid after the termination date, regardless of whether or when the participant provides notice to the Benefit Services Administrator of Medicare entitlement or other group health plan coverage.

If a disabled qualified beneficiary is determined by the Social Security Administration to no longer be disabled, the participant must notify the Benefit Services Administrator of that fact within 30 days after the Social Security Administration’s determination.

If the Social Security Administration’s determination that the qualified beneficiary is no longer disabled occurs during a disability extension period, COBRA coverage for all qualified beneficiaries will terminate (retroactively if applicable) as of the first day of the month that is more than 30 days after the Social Security Administration’s determination that the qualified beneficiary is no longer disabled. Cornell College will require repayment to the Plan of all benefits paid after the termination date, regardless of whether or when the participant provides notice to the Benefit Services Administrator that the disabled qualified beneficiary is no longer disabled. (For more information about the disability extension period, see the section above entitled “Extension of Maximum Coverage Period).

COST OF COBRA COVERAGE

Each qualified beneficiary is required to pay the entire cost of COBRA coverage. The amount a qualified beneficiary may be required to pay may

not exceed 102% (or, in the case of an extension of COBRA coverage due to a disability, 150%) of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving COBRA coverage. The amount of the COBRA premiums may change from time to time during the period of COBRA coverage and will most likely increase over time. The participant will be notified of COBRA premium changes.

TEMPORARY PREMIUM REDUCTION

The federal stimulus package, which was enacted as the American Recovery and Reinvestment Act of 2009 (ARRA) and extended by the Fiscal Year 2010 Department of Defense Appropriations Act (2010 DOD Act) temporarily reduces the premium for COBRA coverage for eligible individuals. COBRA (the Consolidated Omnibus Budget Reconciliation Act of 1985) allows certain people to extend employer-provided group health coverage, if they would otherwise lose the coverage due to certain qualifying events.

In accordance with ARRA and related extension(s), individuals who are eligible for and who elect COBRA coverage due to their own or a family member’s involuntary termination from employment may qualify for a reduced premium. This premium reduction is generally available for continuation coverage under the Federal COBRA provisions, as well as for group health insurance coverage under state continuation coverage laws.

Special rules apply for HIPAA’s pre-existing condition rules during this extended election period. The period beginning on the date of the qualifying event and ending on the beginning of the period of coverage is disregarded for purposes of the 63-day break in creditable coverage rules of HIPAA.

If an individual was offered Federal COBRA continuation coverage as a result of an involuntary termination of employment that occurred at any time during the eligible time period and he or she declined COBRA coverage at that time or elected COBRA and later discontinued it, he or she may have another opportunity to elect COBRA coverage and qualify for a reduced premium.

For questions regarding the participant’s rights and obligations as well as time periods applicable to this Legislation please contact the Plan Administrator.

Payment for COBRA Coverage

All COBRA premiums must be paid by check or money order.

The participant's first payment and all monthly payments for COBRA coverage must be made payable to Cornell College and mailed to:

First Administrators, Inc.
COBRA Department
PO Box 8150
Rapid City, SD 87709-8150

The payment is considered to have been made on the date that it is postmarked. The participant will not be considered to have made any payment by mailing a check if his/her check is returned due to insufficient funds or otherwise.

If the participant elects COBRA, he/she does not have to send any payment with the Election Form. However, he/she must make his/her first payment for COBRA coverage not later than 45 days after the date of election. (This is the date the Election Form is postmarked, if mailed, or the date the Election Form is received by the individual at the address specified for delivery of the Election Form, if hand-delivered). See the section above entitled "Electing COBRA Coverage."

The first payment must cover the cost of COBRA coverage from the time coverage under the Plan would have otherwise terminated up through the end of the month before the month in which the participant makes his/her first payment. For example, Sue's employment terminated on September 30, and she loses coverage on September 30. Sue elects COBRA on November 15. Her initial premium payment equals the premiums for October and November and is due on or before December 30, the 45th day after the date of her COBRA election. The participant is responsible for making sure that the amount of his/her first payment is correct. He/she may contact the Benefit Services Administrator to confirm the correct amount of the first payment.

Claims for reimbursement will not be processed and paid until the participant has elected COBRA and made the first payment for it.

If the participant does not make the first payment for COBRA coverage in full within 45 days after the date of his/her election, he/she will lose all COBRA rights under the plan.

After the participant makes his/her first payment for COBRA coverage, he/she will be required to make monthly payments for each subsequent month of COBRA coverage. The amount due for

each month for each qualified beneficiary will be disclosed in the election notice provided at the time of the qualifying event. Under the Plan, each of these monthly payments for COBRA coverage is due on the first day of the month for that month's COBRA coverage. If the participant makes a monthly payment on or before the first day of the month to which it applies, his/her COBRA coverage under the Plan will continue for that month without any break. The Benefit Services Administrator will not send periodic notices of payments due for these coverage periods (that is, we will not send a bill for the COBRA coverage – it is the participant's responsibility to pay his/her COBRA premiums on time).

Although monthly payments are due on the first day of each month of COBRA coverage, the participant will be given a grace period of 30 days after the first day of the month to make each monthly payment. COBRA coverage will be provided for each month as long as payment for that month is made before the end of the grace period for that payment. However, if the participant pays a monthly payment later than the first day of the month to which it applies, but before the end of the grace period for the month, his/her coverage under the Plan will be suspended as of the first day of the month and then retroactively reinstated (going back to the first day of the month) when the monthly payment is received. This means that any claim submitted for benefits while coverage is suspended may be denied and may have to be resubmitted once coverage is reinstated.

If the participant fails to make a monthly payment before the end of the grace period for that month, **HE OR SHE WILL LOSE ALL RIGHTS TO COBRA COVERAGE UNDER THE PLAN.**

MORE INFORMATION ABOUT INDIVIDUALS WHO MAY BE QUALIFIED BENEFICIARIES

A child born to, adopted by, or placed for adoption with a covered employee during a period of COBRA coverage is considered to be a qualified beneficiary provided that, if the covered employee is a qualified beneficiary, the covered employee has elected COBRA coverage for himself or herself. The child's COBRA coverage begins when the child is enrolled in the Plan, whether through special enrollment or open enrollment, and it lasts for as long as COBRA coverage lasts for other family members of the employee. To be enrolled in the Plan, the child must satisfy the

otherwise applicable Plan eligibility requirements (for example, regarding age).

A child of the covered employee who is receiving benefits under the Plan pursuant to a Qualified Medical Child Support Order (QMCSO) received by Cornell College during the covered employee's period of employment with Cornell College is entitled to the same rights to elect COBRA as an eligible dependent child of the covered employee.

ASSISTANCE WITH QUESTIONS

Questions concerning the Plan or the participant's COBRA rights should be addressed to the contact or contacts identified below. For more information about rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

KEEP THE PLAN INFORMED OF ADDRESS CHANGES

In order to protect the participant's family's rights, he/she should keep the Plan Administrator informed of any changes in the addresses of family members. The participant should also keep a copy, for his/her records, of any notices sent to the Benefit Services Administrator or the Plan Administrator.

PLAN CONTACT INFORMATION

The participant may obtain information about the Plan and COBRA coverage on request from:

Cornell College
600 First Street West
Mount Vernon, IA 52314-1098

-or-

First Administrators, Inc.
COBRA Department
PO Box 8150
Rapid City, SD 57709-8150
(Toll Free) 1-800-658-3073

The contact information for the Plan may change from time to time. The most recent information will be included in the Plan's most recent Summary Plan Description (if the participant is not sure whether this is the Plan's most recent Summary Plan Description, he/she may request the most recent one from the Benefit Services Administrator or the Plan Administrator).

INDIVIDUAL HEALTH COVERAGE PROVISION

If the state in which a qualified beneficiary resides does not offer adequate alternative mechanisms for providing access to health benefits for individuals, Federal law requires insurance companies that sell individual health insurance policies in the state where a qualified beneficiary resides to offer a beneficiary, whose continuation coverage is exhausted, the opportunity to purchase an individual health insurance policy from the insurer. The offer of individual health coverage need not be made if the participant is covered under another group health plan, Medicare or Medicaid, or by any other policy of health insurance.

Please contact the Plan Administrator, or the employer, if interested in individual health coverage through this provision.

CREDITABLE COVERAGE PROVISION

Qualifying periods of time during which a participant had “Creditable Coverage” will be applied toward the satisfaction of the participant’s pre-existing condition exclusion period. Prior carriers or employers will provide certification regarding a participant’s prior coverage. In addition, the participant may request a certificate of Creditable Coverage under this Plan at any time from the Benefit Services Administrator or the College, up to 24 months after the participant’s coverage ceases. This certification will be used to determine what portion of the participant’s pre-existing condition exclusion period, if any, must still be satisfied.

Written requests for Certificates must include:

- the full name of the individual for whom the Certificate is requested;
- the last date that the individual was covered under the plan;
- the name of the participant that enrolled the individual in the plan;
- a telephone number to reach the individual for whom the Certificate is requested, in the event of any difficulties;
- the name of the person making the request and evidence of that person’s authority to request and receive the Certificate on behalf of the individual;
- the address to which the Certificate should be mailed; and
- the requestor’s signature.

After receiving a request that meets these requirements, the Plan will act in a reasonable and prompt fashion to provide the Certificate.

Prior coverage does not qualify under this provision if there is a break in coverage of 63 consecutive days or more. Waiting periods are not considered periods without coverage nor are they counted as Creditable Coverage. Refer to the **Definitions** section for a definition of “Creditable Coverage.”

As required by the Trade Act of 2002, the days between the date an individual loses group health coverage and the first day of the second COBRA election period are not taken into account in determining whether a significant break in coverage has occurred.

PRE-EXISTING CONDITION EXCLUSION PERIOD

This Plan includes an exclusion period for new participants with pre-existing (not otherwise excludable) medical conditions. A pre-existing medical condition is an injury or illness which was present prior to the participant’s date of enrollment (see definition) for which any medical advice, diagnosis, care or treatment (including having a prescription for legend drugs, whether or not the drugs are taken) was provided or recommended by a physician prior to the participant’s date of enrollment. Genetic information is not treated as a pre-existing condition in the absence of a diagnosis of a condition related to the genetic information.

This provision will also be in effect if there is a change in the participant’s coverage which the participant elected to make and which increased this Plan’s liability.

The pre-existing condition exclusion period works as follows:

If a participant has a pre-existing, allowable medical condition (physical or mental) within the 6-month period prior to his/her date of enrollment for medical coverage (this 6-month period is called the look-back period), that allowable condition will not be covered by this Plan until 12 months following the participant’s date of enrollment.

The 12-month pre-existing condition exclusion period will be reduced by the length of the aggregate period of any creditable prior coverage.

This Plan will apply the standard method of counting Creditable Coverage. The standard method of counting Creditable Coverage determines an individual’s Creditable Coverage without reference to specific benefits provided during the individual’s prior coverage periods.

Charges incurred during the 12-month pre-existing condition exclusion period will be reviewed by the Benefit Services Administrator and allowable conditions which appear to be pre-existing will be investigated.

Benefits will be available for all covered services with the exception of the allowable condition(s) specifically identified as being pre-existing.

The pre-existing condition exclusion period never applies to pregnancy, regardless of whether the woman had previous coverage. In addition, a pre-existing condition exclusion period will not be applied to a newborn, an adopted child who is

under age 18 at the time of the adoption, or a child placed for adoption who is under age 18 at the time of placement for adoption, if the child becomes covered under a group health plan or other Creditable Coverage within 31 days of the birth, adoption, or placement for adoption. This exception does not apply, however, after the child has a break in coverage of 63 or more consecutive days.

All pre-existing condition exclusion periods (and accompanying 6-month look-back periods) for *special enrollees* begin on the participant's or dependent's effective date. Pre-existing condition exclusion periods (and accompanying 6-month look-back periods) for *new hires* will begin on the date the participant enters a class eligible for coverage.

PRE-TAX PREMIUM PROGRAM

The pre-tax premium program allows an employee to purchase this Plan with pre-tax dollars. Under the pre-tax premium program, the money that an employee would normally have deducted on an after-tax basis would instead be deducted on a pre-tax basis through salary redirection. The advantage of the pre-tax premium program is that the employee pays no FICA (Social Security) taxes or Federal income taxes on the pre-tax premium contributions he/she makes. Furthermore, the premium is also exempt from state income taxes in most states. This means a higher take-home pay for the employee than if he/she purchased this Plan with after-tax dollars.

Note: Because the premium contributions the employee makes to this Plan are not taxed as wages for Social Security purposes, the employee's ultimate Social Security benefits might be somewhat less than they could have been. This depends on many things, including the employee's earnings history, whether he/she is above or below the Social Security "wage base,"

and what happens to the Social Security laws between now and when he/she retires.

The pre-tax premium program is available to the employee if he/she meets the eligibility requirements under this Plan. The employee's premium will automatically be deducted from his/her paycheck on a pre-tax basis. If the employee wishes to pay his/her premiums on an after-tax basis he/she must notify Human Resources. The employee's enrollment regarding the tax status of premiums will continue in effect until the employee changes it. The employee can make this change only during the period prior to the start of each premium-only plan year as designated by the Plan Administrator or if he/she experiences a change in status, as defined by the Internal Revenue Service.

The employee's choices are in effect for the entire premium-only plan year.

The employee may only reduce coverage under special circumstances, such as changes in (family status or termination of coverage prior to the start of each premium-only plan year as designated by the Plan Administrator unless he/she experiences a qualifying status change.

Examples of qualifying status changes include changes in:

- legal marital status;
- number of dependents;
- employment for the employee or dependent;
- open enrollment offered by the spouse's employer;
- number of hours worked; or
- eligibility of a dependent.

The mid-year change must be consistent with the change in status to the extent that it is necessary or appropriate as a result of the change.

Remember, the employee's eligibility to apply for coverage after initial enrollment is limited to the special enrollment provisions as stated under **Special Enrollment Periods**.

BENEFIT MANAGEMENT PROVISIONS

To ensure that cost-effective services are provided, SelectFirstTM places responsibility for benefit management with physicians, as they control health care utilization. When benefit management procedures are not followed, the result will be a reduction in payment to contracting providers for which the patient is not liable.

PRIOR APPROVAL

Prior approval is required prior to the participant receiving certain services, supplies, or procedures. The participant or the health care provider must request Prior Approval from the Benefit Services Administrator.

Prior approval does not guarantee benefits under this Plan. The approved services will be subject to all applicable limitations and exclusions of this Plan, including the participant's eligibility to receive benefits. If prior approval is denied, the participant will receive written notice in which the reason(s) for denial will be listed. The notice will be mailed to the most current address we have on record for the participant and his or her health care provider.

Please refer to the **Benefit Summary** for services requiring prior approval.

UTILIZATION REVIEW

Each hospital stay, planned or unplanned, requires preadmission certification. Preadmission certification includes physician review, continued stay review, and discharge planning.

Planned inpatient stays must be reported to the utilization review unit prior to admission. Unplanned/Urgent Care (emergency) admissions must be reported **within two business days** following the date of admission.

Observation exceeding 23 hours will be considered an inpatient admission and must be reviewed. Each hospital, rehabilitation or nursing facility stay, planned or unplanned, requires Utilization Review.

A request for precertification will be accepted from anyone familiar with the patient, but ultimate responsibility remains the patient's. In most cases certification is given during the initial conversation. If, for some reason, an inpatient stay does not meet the criteria, the nurse

reviewer will consult with a physician reviewer and respond to the appropriate parties.

Utilization Review is not required for hospital admissions for childbirth if the length of stay for the mother and newborn child does not exceed 48 hours following a normal vaginal delivery, or 96 hours following a cesarean section. Utilization Review is required for maternity stays that exceed 48 hours for a vaginal delivery or 96 hours for cesarean delivery.

The utilization review company, available 24 hours per day, can be reached at:

Nationwide1-800-782-9955

Important Note: If the participant disagrees with a reduction in or denial of benefits, please see the Claim Review Procedure sections for information on how to file an appeal. These sections also outline the time frames in which the Plan must respond to the claim and/or appeal.

Pre-admission certification

Pre-admission certification is required prior to the participant receiving certain services. The participant or the health care provider must request pre-admission certification from the Utilization Review Company.

Certain factors may alter or impact whether the participant receives approval. These factors include benefit limitations, continued Plan participation, and the date he or she receives services.

SelectFirstTM and Non-SelectFirstTM Providers

All scheduled inpatient admissions must be reviewed by the Utilization Review Company before hospitalization occurs. It is the SelectFirstTM provider's responsibility to obtain this pre-admission certification for all scheduled hospitalizations.

If a participant obtains services from a non-SelectFirstTM provider, it is the responsibility of the patient to obtain Utilization Review prior to the hospital admission. **The participant** will be responsible for any penalty for failure to obtain Utilization Review.

When the participant receives care from a SelectFirstTM Care provider, the provider will handle the pre-admission certification for the participant. If a penalty for failure to comply is involved, the participant is not responsible. However, if the participant seeks care from a non-SelectFirstTM provider, he or she is

responsible for compliance with the Utilization Review Provisions as described in the following sections, and any penalties (See *Penalty for Non-Compliance*) incurred will be the participant's responsibility.

Please refer to the **Benefit Summary** for services requiring pre-admission certification.

PHYSICIAN REVIEW

Our nurse reviewers certify the majority of inpatient stays, but if the participant's condition or treatment plan does not satisfy certain criteria, consultation begins with a physician reviewer. The selection of a physician reviewer depends on the patient's diagnosis and the procedures that have been or will be involved in the course of treatment. The physician selected will represent a medical specialty which is directly related to the patient's condition.

The attending physicians' name(s) will be shared with the physician reviewer after a decision is made. Then the attending physician is encouraged to talk with the physician reviewer about any questions or concerns regarding the decision.

In the event of a denial or reduction of benefits, the participant or his/her authorized representative; the attending physician and the hospital are notified immediately.

CONTINUED STAY REVIEW

The Utilization Review staff does not assign lengths of stay when an inpatient stay is certified. Each admission is closely monitored to verify that services being provided remain medically necessary. This review begins on the second day of a hospital stay. Physician reviewers are consulted whenever services being provided or requested do not meet medical necessity standards.

DISCHARGE PLANNING

Discharge planning begins the day of admission. The purpose of this provision is to ensure maximum coordination among the family, health care provider and Utilization Review staff in the event discharge to alternative care is warranted. Every effort is made throughout each stay to

maintain patient care in the most cost-effective setting while not sacrificing the quality of care.

PENALTY FOR NON-COMPLIANCE

If the participant fails to comply with any part of the preadmission certification provision, this Plan will apply a separate \$500 penalty to the inpatient hospital-related charges. This \$500 penalty will not apply to the out-of-pocket maximums.

This penalty will be waived for maternity stays with a duration of 48 hours for a normal vaginal delivery, or 96 hours for a cesarean section. Penalties may be applied to maternity stays which exceed these guidelines if not precertified.

Any amount not payable as a result of this reduction shall not be covered under any other benefit provision of this Plan.

CONCURRENT CARE

If ongoing treatment benefits are reduced or terminated before the end of such treatment, the participant will be notified sufficiently in advance to give ample time to appeal the decision before the reduction or termination goes into effect.

CASE MANAGEMENT

Case management is a program designed to assist the participant with a potentially long-term, high-cost or catastrophic illness and/or injury. The objective is to offer alternatives to traditional care settings. Health care benefits are tailored to meet medical needs while promoting quality and cost-effective outcomes. Case management administration is performed on a case-by-case basis. Benefits may include supplies or services which are not normally a covered benefit under this Plan. Case management's goal is to return people to productive lives after a catastrophic illness or injury whenever possible.

Examples of the types of conditions requiring an evaluation are AIDS, brain tumors, cancer, gastrointestinal conditions, head and spinal cord injuries, severe burns and/or strokes.

If the participant fails to comply with any part of the case management requirements, this Plan will apply a separate \$500 annual penalty. This \$500 penalty will not apply to the annual deductible or the out-of-pocket maximums.

HOW PPO'S WORK

PAYMENT METHODS

PPO Providers

All PPO providers are contracted to accept payment arrangements and as a result, receive direct payment from the health plan. These payment arrangements may result in savings for both the member and their health plan as the provider agrees to accept this reimbursement as full payment with the exception of any applicable deductible, coinsurance, or copayment the member may have.

When services and/or treatment are performed by a non-SelectFirstTM licensed practitioner under the direct supervision of a SelectFirstTM provider, charges for the non-SelectFirstTM provider will be payable at the SelectFirstTM reimbursement level.

Non-PPO Providers

When services and/or treatment are received from a non-PPO provider the participant will be responsible for the difference between the billed amount and the paid amount. Depending upon how benefits are assigned, payment may be issued to the provider or the participant. Please reference the PPO Notes section of the **Benefit Summary** for exceptions.

HOW THE MEDICAL PLAN WORKS

DESCRIPTION OF MEDICAL BENEFITS

Individual Deductible

Each participant, unless otherwise specified, will be responsible for the individual calendar year deductible amount specified in the **Benefit Summary** before any medical benefits will be paid by this Plan. The amount of individual deductible is determined by the type of provider from whom the participant receives treatment (PPO or non-PPO) and whether the treatment was incurred in or out of the PPO area. See the **Benefit Summary** for individual deductible amounts.

Family Deductible

If the employee elects to take family coverage, the total deductible the employee and his/her covered dependents have to pay in a calendar year will never be more than the family deductible amount specified in the **Benefit Summary**; each participant's responsibility will be limited to the individual deductible amount specified in the **Benefit Summary**. The family deductible is the same regardless of the number of the employee's dependents. Like the individual deductible, the amount of family deductible is determined by the type of provider from whom the participant receives treatment (PPO or non-PPO) and whether the treatment was incurred in or out of the PPO area. See the **Benefit Summary** for family deductible amounts.

PPO Office Services Copay

In most cases, each separate visit to a PPO physician's office will require a PPO office services copay (see **PPO Office Services Copay** in the **Benefit Summary** for exceptions). This copay does not apply to the calendar year deductible or to the out-of-pocket maximum described below.

This copay does not apply to office services performed by a non-PPO physician or to office services incurred outside the PPO area, except as otherwise specified in **PPO Notes** found in the **Benefit Summary**.

Deductible Carryover

Eligible expenses incurred during October, November and December which were applied toward that year's deductible will also be applied toward the next year's deductible.

Common Accident Deductible

If two or more family members are injured in the same accident, only one deductible will be applied to all of the related charges.

Cost-sharing

Once the participant has paid the calendar year deductible, this Plan will pay the cost-sharing percentages of the covered medical expenses outlined in the **Benefit Summary**.

Out-of-Pocket Maximum

There are limits on how much the employee will have to pay per individual, or per family, in allowable medical expenses per calendar year. The **Benefit Summary** specifies what the out-of-pocket maximum includes and what it excludes. The out-of-pocket maximum never includes ineligible charges. Once the out-of-pocket maximum has been met, this Plan pays 100% of the allowable expenses, excluding copays.

Lifetime Maximum

All allowable medical expenses under this Plan are limited to an overall lifetime maximum benefit for each participant as specified in the **Benefit Summary**. This lifetime maximum applies across all plans or options sponsored by the employer for all eligible expenses.

The lifetime maximum benefits paid under any predecessor plan(s), this Plan, and any subsequent plan(s) will be as specified in the **Benefit Summary**.

Once a participant has met the lifetime maximum, he/she will be terminated under the Plan and any subsequent changes to benefit levels (including changes to the lifetime maximum) will not affect the termination status of the participant. Future Plan open or special enrollment events will not affect the termination status of a participant that was previously terminated for achieving the lifetime maximum.

In addition, this Plan may contain other calendar year or lifetime benefit maximums. These maximums are included in the overall medical lifetime maximum benefit.

WHAT ARE COVERED EXPENSES?

Covered services must be medically necessary. The Benefit Services Administrator determines what is medically necessary; however, if necessary, the Plan Administrator makes the final determination whether a service is medically necessary, and that decision is final and conclusive. This Plan may include benefits not normally considered medically necessary. These are specifically included as benefits on the following pages.

The fact that a physician or dentist may have prescribed, ordered, recommended, or approved the provision of certain services or supplies does not necessarily mean such services or supplies are medically necessary or make the service a covered expense.

Following is an explanation of the eligible expenses under this Plan. If services (and/or treatment) are received from a PPO provider, expenses are subject to the PPO's pricing agreement. However, failure to present the Plan's Benefit ID card at the time services are rendered may result in services being considered at the non-PPO level of benefits and limited to the lesser of the actual amount charged or the maximum allowable fee. If services (and/or treatment) are received from a non-PPO physician, surgery expenses and anesthesia are subject to the lesser of the actual amount charged or the maximum allowable fee.

HOSPITAL BENEFITS

Hospital benefits include the daily room and board charge for each day of confinement, up to the semi-private room rate for the level of care the patient is receiving. If the hospital does not have semi-private rooms, benefits will be paid at the lowest private room rate. Charges for special care units (e.g., isolation or intensive care rooms and operating rooms) are covered provided the level of care was prescribed by a physician and deemed to be medically necessary.

Hospital confinements must be a result of an injury or illness. This will not apply when charges are incurred in connection with services for a newborn child. If the child is a "well-baby," but the mother remains necessarily confined to the hospital, an additional inpatient day shall also be available for the newborn.

Payment will be made for hospital miscellaneous charges such as oxygen tents and surgical supplies during a period of confinement for which room and board benefits are payable.

Personal convenience items, including, but not limited to, televisions, telephones and admission kits are not payable expenses under this Plan.

Hospital Weekend Admissions

Except for emergencies, admissions to the hospital on a weekend are usually not necessary. Hospital benefits will not be payable under this Plan for Friday, Saturday or Sunday admissions unless the confinement is:

- medically necessary as determined under this Plan;
- for a medical emergency;
- for maternity; or
- for a next-day surgical procedure.

PHYSICIAN SERVICES

Outpatient Services

Outpatient services by a physician for treatment of an injury or illness are covered benefits of this Plan. Please refer to the **Benefit Summary** for specific limitations.

In-Hospital Services

In-hospital services by a physician for treatment of an injury or illness are covered benefits of this Plan. Only one visit per day per specialty will be considered an eligible expense, unless additional visits are deemed to be medically necessary.

This benefit also includes consultations by other physicians, if medically necessary and recommended by the attending physician. The consulting physician must be conferring in a medical specialty different than the specialty of the attending physician or any other consulting physician.

MENTAL HEALTH AND CHEMICAL DEPENDENCY BENEFITS

This Plan provides benefits for the following mental health and chemical dependency related services. Benefits are subject to the limits shown on the **Benefit Summary**.

Some items **not** covered under Mental Health/Chemical Dependency care are:

- residential treatment;
- certain developmental and learning disorders;
- certain disorders of early childhood, such as academic underachievement disorder;
- communication disorders, such as stuttering and stammering;
- impulse control disorders, such as pathological gambling;
- nicotine dependence;
- sensitivity, shyness and social withdrawal disorder; and
- sexual identification or gender disorders.

Hospital Inpatient Benefits

Benefits include daily room and board charges up to the hospital's semi-private room rate. Unless otherwise excluded, this Plan will provide benefits for hospital miscellaneous charges such as therapy and supplies incurred during the time room and board benefits are payable.

Chemical Dependency Facility Benefits

A chemical dependency facility provides treatment for addictive disorders. This benefit will pay for the daily room and board charges subject to the limits of this Plan. Unless otherwise excluded, this Plan will provide benefits for miscellaneous charges such as therapy and supplies incurred during the time room and board benefits are payable. Confinement in a chemical dependency facility must be recommended by and under the supervision of a physician.

NURSING FACILITY BENEFITS

Benefits are provided for a nursing facility if the care is medically necessary to treat an injury or illness and is prescribed by a physician. Nursing facility benefits for each participant are limited as specified in the **Benefit Summary**. Services

must be medically necessary and care cannot be of a custodial nature.

Nursing facilities are used by those who require rehabilitation or additional time to recover from an injury or illness but do not need the acute care provided in a hospital.

Payable charges for services include room and board (including general nursing care), special treatment rooms, x-ray and laboratory examinations, physical, occupational or speech therapy, oxygen and other gas therapy and any other services customarily provided by a nursing facility. Room and board charges will be limited to the semi-private room rate for the level of care the patient is receiving in the nursing facility.

Nursing facility benefits do not include services in connection with a mental health or chemical dependency disorder.

HOME HEALTH CARE BENEFITS

Home health care benefits consist of the following medically necessary services for the treatment of an injury or illness when prescribed by a physician:

- part-time nursing care provided in the participant's home by a registered nurse (RN), a licensed practical nurse (LPN), or a licensed public health nurse (LPHN);
- physical, occupational or speech therapy provided in the participant's home;
- physical, occupational or speech therapy, or the use of medical appliances or equipment, provided on an outpatient basis by a home health agency, a hospital, or other facility under an arrangement with a home health care agency;
- home health aide;
- medical supplies, drugs and medications prescribed by a physician; and
- laboratory services by or on behalf of a hospital.

Home health care benefits for each participant are limited as specified in the **Benefit Summary**.

Home health care benefits will not include any services performed by a member of the participant's immediate family or a person ordinarily residing in the participant's home. Home health care benefits do not include meals, personal convenience items or housekeeping

services. No home health care services are payable for the treatment of a mental health or chemical dependency disorder.

Review and approval by the Benefit Services Administrator is recommended prior to commencement of home health care.

SURGICAL BENEFITS

Surgical benefits include professional fees for performing a covered surgical procedure to treat an injury or illness. Services may be provided on an inpatient or outpatient basis at a hospital, in an ambulatory surgery center or in a physician's office. Surgical benefits include:

- surgical, operative and cutting procedures, and major endoscopic procedures;
- treatment of fractures or dislocations or suturing of wounds;
- cutting procedures for the treatment of oral diseases or extraction of impacted teeth;
- medically necessary surgical assistance by a physician. Benefits are not provided if the assistant is an intern, resident, or member of the hospital staff or is compensated by the hospital. The surgical procedure and medical condition of the participant must require the services of a surgical assistant. Benefits are limited to 20% of the eligible expense for the surgical procedure performed; and
- administration of anesthesia in connection with a surgical procedure if the anesthetic is administered by a physician or certified registered nurse anesthetist (CRNA) other than the operating or assistant surgeon, the physician is not employed or compensated by the institution in which the surgery is performed and the physician bills for the administration of the anesthetics.

Compensation for usual pre-operative and post-operative care is included in the payment for surgical services.

Benefits for multiple surgical procedures will be considered at 100% of the eligible expense for the primary procedure and 50% of the eligible expense for any secondary procedures.

Benefits for two like surgical procedures (i.e., bilateral procedures) will be considered at 150% of the eligible expense for the procedure.

This Plan is in compliance with the Women's Health and Cancer Rights Act of 1998 and, for individuals who choose breast reconstruction surgery, the Plan will allow benefits for reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and treatment of physical complications of all stages of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the patient.

AMBULATORY/OUTPATIENT SURGERY FACILITY BENEFITS

This benefit includes coverage for the facility charges of an "ambulatory surgery center." An ambulatory surgery center is any public or private establishment with an organized medical staff of physicians, with permanent facilities that are equipped and operated primarily for the purpose of performing outpatient surgical procedures, with continuous physician services and registered professional nursing services whenever a patient is in the facility, and which does not provide services or other accommodations for patients to stay overnight.

VOLUNTARY SECOND/THIRD SURGICAL OPINION PROVISION

The voluntary second/third surgical opinion program's goal is to provide sufficient information before a participant decides to have elective surgery. This information may be valuable and help the participant decide whether to use an alternative treatment for his/her medical condition.

This Plan suggests participants obtain a second opinion for the following surgeries:

Surgery List

-
- | | |
|-----------------------|--------------------|
| • Back Surgery | • Hysterectomy |
| • Breast Surgery | • Knee Surgery |
| • Bunion Surgery | • Nasal Surgery |
| • Cataract Surgery | • Prostate Surgery |
| • Foot Surgery | • Tonsillectomy, |
| • Gallbladder Surgery | Adenoidectomy |
| • Hemorrhoid Surgery | • Varicose Vein |
| • Hernia Repair | Surgery |
| • Hip Surgery | • Wrist Surgery |

Whenever possible, the specialist providing the second (or third) opinion should use the same test results as used by the first physician.

Duplicate laboratory tests or x-rays taken are not usually medically necessary. Copies of the original test results should be provided to the specialist when the participant has the second (or third) opinion.

The final decision on whether or not to have surgery is the participant's. While the intent is not to limit access to medical care, this Plan wants each participant to be informed and comfortable with his/her decision to have surgery.

HOSPICE CARE BENEFITS

Hospice services are those which help terminally ill participants and their families continue life with minimal disruption of normal activities.

The decisions relating to patient care are shared by an interdisciplinary hospice care team. The team is responsible for assuring continuity of care and providing professional management of all services. The attending physician is considered a member of this team. The attending physician updates, reviews, and approves the care plan as often as appropriate to meet the changing needs of the hospice patient and his/her family. The physician remains the primary provider of medical care.

Services reimbursed by this Plan for hospice care must be necessary for the palliation or management of the terminal illness and related conditions. Services covered must be consistent with the plan of care of the hospice care team. All services must be prescribed by and under the supervision of the attending physician and approval from the Benefit Services Administrator should be obtained prior to commencement of hospice care.

The following types of hospice expenses are covered by this Plan:

- room and board in a hospice facility, hospital (up to the hospital's semi-private room rate for the level of care the patient is receiving) or nursing facility (up to the nursing facility's semi-private room rate for the level of care the patient is receiving);
- part-time or intermittent nursing care by a registered nurse (RN) or licensed practical nurse (LPN);
- other necessary services such as medical supplies, medicines, drugs, physician's services and the rental or purchase of durable medical equipment;

- psychological and dietary counseling;
- physical and occupational therapy;
- part-time or intermittent home health aide services consisting mainly of caring for the individual;
- assessment of the individual's social, emotional and medical needs, and the home and family situation; and
- respite care which is furnished during a period of time when the participant's family or usual caretaker cannot, or will not, attend to the participant's needs.

Some items **not** covered under hospice care are:

- bereavement counseling;
- funeral arrangement;
- services of volunteers;
- pastoral counseling;
- financial or legal counseling which includes estate planning or the drafting of a will;
- homemaker or caretaker services which are not solely related to care of the participant, including sitter or companion services for either the participant who is ill or other members of the family;
- transportation; and
- housecleaning and maintenance of the house.

TRANSPLANT BENEFITS

Benefits are payable for participant charges of transplant services.

Benefits include:

- organ and/or tissue procurement which consists of removing, preserving and transporting the donated organ and/or tissue;
- air and ground ambulance service. Each participant is limited to the maximum specified in the **Benefit Summary**; and
- private nursing care by a registered nurse (RN) and/or a licensed practical nurse (LPN).

If a covered transplant procedure is not performed as scheduled due to the intended recipient's medical condition or death, benefits

will be paid for charges incurred for procurement and transportation as described above.

When both the recipient and donor are covered by this Plan, services will be covered for each patient with eligible expenses. If only the recipient is covered by this Plan, benefits for both the recipient and donor will be provided, unless benefits for the donor are available under any other form of health care coverage. If the donor is covered under this Plan but the recipient is not covered, expenses will be covered if donor charges are not covered by the recipient's coverage.

Some items **not** covered under transplant benefits are:

- lodging and meals;
- any charges incurred by the donor of an organ or tissue unless otherwise specified by this Plan;
- any charges incurred for the transportation of the living donor for an organ or tissue transplant;
- any services or supplies related to transplants involving mechanical organs;
- expenses associated with the purchase of any organ; and
- expenses in connection with surgery or treatment classified by the Centers for Medicare and Medicaid Services (formerly known as Health Care Financing Administration) of the United States Department of Health and Human Services as "experimental", "investigational" or as not "reasonable" or "necessary".

Refer to the **Benefit Summary** for specific limitations.

OUTPATIENT DIAGNOSTIC X-RAY AND LABORATORY BENEFITS

Benefits are payable for outpatient diagnostic x-ray or laboratory services which are provided or recommended by a physician. The services may be performed in the physician's office, the outpatient department of a hospital or in a free-standing diagnostic lab or x-ray center.

Please refer to the **Preventive Care Benefits, Cancer Screening, Colonoscopy, Flexible Sigmoidoscopy or Barium Test and Well-Baby/Well-Child Care** sections of the **Benefit Summary** for additional information.

HOSPITAL PREADMISSION TESTING BENEFITS

To avoid unnecessary time confined in the hospital, it is recommended that diagnostic x-ray and laboratory procedures are performed on an outpatient basis prior to the hospital admission. All services must be recommended by a physician.

The services may be performed in the physician's office, the outpatient department of a hospital or in a free-standing diagnostic lab and x-ray center.

MATERNITY BENEFITS

Expenses incurred by a female employee or spouse who is a participant of this Plan, as the result of pregnancy will be covered in the same manner as services for any other illness. Benefits will be paid according to the Plan provision for the type of expense incurred, i.e., hospital expenses under the hospital expense benefit, obstetrical delivery under the surgical expense benefit, etc.

This Plan is in compliance with The Newborns' and Mothers' Health Protection Act of 1996. This act specifies that if plans provide maternity benefits for mothers and newborns, those benefits must include a minimum 48-hour hospital confinement following a vaginal delivery or a minimum 96-hour hospital confinement following a cesarean delivery. Earlier discharges are permitted if the attending physician and the mother agree to an earlier discharge. Penalties cannot be applied if inpatient maternity stays that are within these time frames are not precertified. However, penalties may be applied to maternity stays that exceed these timeframes, if not precertified.

Inpatient Newborn Benefits

Expenses incurred for care of a newborn will be considered separate from the mother's maternity expenses and subject to all plan provisions (e.g., out-of-pocket maximums) on the same basis as any other medical claim. Benefits include nursery room and board, physician visits and circumcision.

BIRTHING CENTER BENEFITS

Birthing centers provide care for pregnant women through the services of a nurse midwife. A nurse midwife provides obstetric services with an obstetrician on 24-hour medical back-up in case of complications. The mother and baby are

usually discharged from the center within 10-12 hours after birth with home follow-up visits provided. Services may vary from center to center.

Covered services include the room and board charges and eligible expenses for any necessary services and supplies while confined. Benefits are limited to expenses incurred while confined for a period of time not to exceed 24 hours. Expenses incurred beyond the initial 24-hour period may be eligible expenses under other benefits of this Plan.

INFERTILITY BENEFITS

Services or supplies related to the diagnosis or treatment of female or male infertility will be covered but limited to a lifetime maximum payment as specified in the **Benefit Summary**. Cost-sharing percentages applied to infertility services will not be used to satisfy the out-of-pocket expenses, nor will infertility services ever be paid in full.

Benefits are not available for the collection or purchase of donor semen (sperm) or oocytes (eggs); services of a surrogate parent; freezing of sperm, oocytes, or embryos; or the reversal of sterilization.

DENTAL SERVICES COVERED UNDER MEDICAL BENEFITS

The following services, including those services billed by a dentist, are covered under the medical portion of this Plan:

- jaw and natural teeth repair if due to, and incurred within, 72 hours after an accidental injury unless due to self-inflicted injury or domestic violence (excludes treatment for injuries associated with the act of mastication). Treatment must be completed within one year of the date of the injury;
- the correction of congenital abnormalities of the jaw;
- reduction of fractures of the facial bones;
- excision of lesions;
- incision of accessory sinus, mouth, salivary glands, or ducts;
- plastic reconstruction or repair of the mouth or lips to correct defects due to an accidental injury;
- surgical removal of impacted teeth;

- inpatient surgical removal of impacted teeth if hospitalization is required because of a hazardous medical condition (e.g., hemophilia); and
- treatment of temporomandibular joint syndrome(TMJ).

PREVENTIVE CARE BENEFITS

This Plan has been designed to encourage each participant to promote good health by providing benefits for certain preventive care.

Services for screening of "family history of" conditions will be considered preventive care. Medical documentation will be required. Prior authorization is recommended.

Routine x-ray and laboratory services will be considered routine preventive care. This includes routine pap smears and mammograms.

Please refer to the Preventive Care, Well-Baby/Well-Child Care, Cancer Screening, Colonoscopy, Flexible Sigmoidoscopy or Barium Test or Immunizations section(s) of the **Benefit Summary** for a complete list of eligible expenses and the limitations applicable to each benefit.

Provided below is a list of other medical services covered by this Plan:

OTHER COVERED MEDICAL CARE

- (1) elective, induced **abortion**;
- (2) **allergy** tests and allergy injections and serum;
- (3) **alternative benefits** when medically necessary and cost effective;
- (4) professional air or ground **ambulance** service to the nearest, local adequate hospital or nursing facility for medically necessary treatment of an injury or illness;
- (5) treatment or services for **behavioral disorders** (i.e., attention deficit disorder) or developmental delays. Behavioral modification is covered by this Plan;
- (6) **biofeedback** for medical diagnoses if medically necessary and performed by a qualified practitioner;
- (7) **blood** derivatives, components, and their administration and the cost of blood in the case of a hemophiliac;
- (8) phase I and phase II of **cardiac rehabilitation**; manual, mechanical manipulation of the spinal column (**chiropractic benefits**);
- (9) **charges for injectable contraceptives** (e.g., Depo-Provera), implantable contraceptives (e.g., Norplant), contraceptive devices (e.g., IUD, diaphragm, cervical cap), and surgical removal of contraceptive devices and implantable contraceptives;
- (10) **cosmetic services** and/or supplies, for surgery to correct a condition resulting from an accident or to correct a congenital condition of a dependent child covered by this Plan. Breast reconstruction surgery following a mastectomy is not considered cosmetic surgery under this Plan;
- (11) treatment or service provided by an outpatient **diabetic self-management program**. Benefits are payable, provided:
 - a. the program is conducted by health care professionals, including but not limited to:
 - physicians;
 - registered nurses;
 - registered pharmacists; and

-such health care professional knows about the diabetic disease process and the treatment of diabetes;

This does not include programs designed for the primary purpose of weight reduction. Please refer to the **Benefit Summary** for specific limitations;

- (12) **drugs** (including birth control pills and insulin) and medications obtainable only with a physician's written prescription and dispensed only by a licensed pharmacist, which are listed in the *U.S. Pharmacopeia* and approved by the United States Food and Drug Administration and not provided through the Prescription Drug card program;
- (13) purchase or rental up to the purchase price of **durable medical** and mechanical equipment which is medically necessary for the treatment of the patient, such as insulin pump and supplies, wheelchairs, hospital beds, and respirators;
- (14) **elective sterilizations**, such as tubal ligations and vasectomies;
- (15) the initial pair of contacts or **eyeglasses** following cataract surgery;
- (16) surcharges and/or taxes for reimbursement of uncompensated care costs or other taxes imposed by a **governmental body** are eligible expenses under this Plan;
- (17) **hemodialysis** (kidney disease treatment);
- (18) **home infusion**;
- (19) treatment of **morbid obesity**, including gastroplasty, gastric stapling, gastric bypass, panniculectomy and abdominoplasty;
- (20) **oxygen** and equipment for its administration;
- (21) **pre-admission testing**;
- (22) **physical therapy** provided by a licensed physical therapist;
- (23) **private duty nursing** services of a registered nurse (RN) in or out of a hospital or a licensed practical nurse (LPN) in a hospital. Private duty nursing services are covered only to the extent that they are medically necessary and prescribed by a physician. Payment is not made for services which are custodial;

Provided below is a list of other medical services covered by this Plan:

- (24) physician's professional services** provided in a hospital's outpatient or emergency room facility, the physician's office, or the participant's home;
- (25) prosthetic appliances** used to aid in the function of or to replace a limb or an eye if the appliance is the original appliance or a replacement required by pathological changes or normal growth;
- (26) radiation therapy** and chemotherapy;
- (27) routine vision exams** (including eyewear exams) are eligible as a benefit as specified in the **Benefit Summary**;
- (28) medically necessary supplies**, including, but not limited to, casts, splints, surgical stockings and braces;

- (29) speech, occupational and inhalation/respiratory therapy** (limited to a medical condition) under the supervision of a physician. Occupational therapy supplies are not a covered benefit of this Plan; and
- (30) wigs.** Initial purchase of a wig due to hair loss after a cancer diagnosis.

Certain medical services are not covered under this Plan. No claims will be paid for:

MEDICAL EXCLUSIONS

- (1) **acupuncture** or acupressure therapy;
- (2) **anesthesia** that is local or topical when billed separately from related surgical or medical procedures;
- (3) cost of **blood** except in the case of a hemophiliac;
- (4) phase III **cardiac rehabilitation**;
- (5) treatment of **complications** resulting from services provided for any injury or illness not otherwise covered; except as otherwise provided for in this Plan;
- (6) charges for services in connection with one or more **corns, calluses or toenails**, unless the charges are for the partial or complete removal of nail roots or reasonably necessary in the treatment of a metabolic or peripheral vascular disease;
- (7) **cosmetic services** and/or supplies. Breast reconstruction surgery following a mastectomy is not considered cosmetic surgery under this Plan;
- (8) any **court ordered rehabilitative treatment**, service or supply;
- (9) any charges for **custodial care**, domiciliary care, or rest cures. Additionally, expenses incurred for accommodations (including room and board and other institutional services) and nursing services for a participant because of age or a mental or physical condition primarily to assist the participant in daily living activities will be considered custodial care. The fact that the participant is also receiving medical services that are merely maintenance care that cannot reasonably be expected to substantially improve a medical condition will not prevent this limitation from applying. See **Case Management** for additional information;
- (10) charges for a **dependent** for any medical expense for which he/she is entitled to benefits as an employee or former employee of Cornell College;
- (11) any **dental work** or treatment or dental x-rays unless due to an accidental injury which occurred to sound natural teeth or to the jaw;
- (12) PPO **discount amounts**, "cash discounts", over-the-counter (OTC) items, and sales tax. Surcharges and/or taxes for reimbursement of uncompensated care costs or other taxes imposed by a governmental body are eligible expenses under this Plan;
- (13) any charges which **exceed a benefit maximum**;
- (14) the portion of a charge for services and supplies in **excess of the maximum allowable fee** and/or the PPO fee schedule;
- (15) expenses in connection with surgery or treatment classified by the Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services as "**experimental**", "investigational" or as not "reasonable" or "necessary";
- (16) charges incurred to determine the need for or fitting of **eyeglasses** or contact lenses, visual analysis or testing of visual acuity, biomicroscopy, field charting, aniseikonic investigation, orthoptic training, visual training, servicing of visual corrective devices, or consultations related to such services. This Plan does not pay for eyeglasses, contact lenses, or any similar devices to assist with one's vision unless otherwise specified as covered under this Plan;
- (17) services provided by a **family member**, whether relationship is by blood or marriage, or by any person who regularly resides in the participant's home;
- (18) charges for services in connection with weak, strained or **flat feet**, any instability or imbalance of the foot, or any metatarsalgia unless the charges are for an open cutting operation;
- (19) any confinement, treatment, service, or supply in or by a **government owned** or operated facility, or where care is provided at government expense, i.e., a VA facility, unless there is a legal obligation for the participant to pay for such treatment or service in the absence of coverage. If the injury or illness is non-service related, this Plan will be liable for benefits for covered services;

Certain medical services are not covered under this Plan. No claims will be paid for:

- (20) **hearing aids**, examinations, or the fitting and/or repair of such hearing appliances except as specified in the **Benefit Summary**;
- (21) **hospital admissions** which are primarily for diagnostic evaluations, physical therapy, or occupational therapy, unless medically necessary;
- (22) **hypnotherapy**;
- (23) charges incurred while engaging in an **illegal occupation**, commission of or attempted commission of an assault or a felonious act;
- (24) **immunizations**, except as specified in the **Benefit Summary**;
- (25) charges for the treatment of **impotency**;
- (26) **LASIK surgery**;
- (27) charges for any **maintenance-type therapy** not reasonably expected to improve the patient's condition;
- (28) **marital or family counseling**;
- (29) **maternity charges for dependent children** except for complications;
- (30) **nonprescription medicines**, vitamins, nutrients, and food supplements, even if prescribed or administered by a physician;
- (31) charges for which the participant would **not be responsible** in the absence of this Plan;
- (32) charges incurred while the participant is **not eligible** for coverage;
- (33) any confinement, treatment, service, or supply if not recommended and approved by a physician and deemed to be **not medically necessary** for the condition of the participant, or any surgery or other type of medical treatment performed on an elective, non-medically necessary basis unless otherwise specified as covered by this Plan;
- (34) **nutritional consultations**, instruction, services or supplies for educational, vocational or training purposes, unless otherwise specified by this Plan;
- (35) any injury sustained or illness contracted while **on duty** with any military, naval, or air force of any country or international organization or the result of an act of declared or undeclared war (including resistance to armed aggression) occurring while a participant under this Plan;
- (36) **orthotic foot devices** such as arch supports and in-shoe supports, orthopedic shoes, elastic supports or exams to prescribe or fit such foot devices, supports, or shoes;
- (37) costs of drugs, procedures, services, supplies or treatment rendered or received in person, by mail or otherwise **outside the United States** if the purpose of such travel or communication is to obtain or receive such service, supply or treatment;
- (38) charges for occupational injury or sickness that occurs while working for **pay or profit**, including self-employment;
- (39) **personal convenience items**, including, but not limited to, air conditioners or dehumidifiers, which can be used in the absence of an injury or illness;
- (40) routine **physical examinations** or screening procedures, physicals performed for travel, employment, insurance, school, or other similar reasons, except as specified in the **Benefit Summary**;
- (41) **pre-existing conditions** as defined by this Plan;
- (42) **radial keratotomy** surgery if done for the purpose of correcting refractive errors;
- (43) **reversal of elective sterilizations** or infertility treatment as a result of elective sterilization;
- (44) charges due to insurrection or voluntary participation in a **riot**;
- (45) expenses applied toward **satisfaction of the deductibles** or cost-sharing expenses of this Plan;
- (46) services and supplies for recreational or educational therapy or forms of non-medical **self-help or self-cure**, except as specified in the **Benefit Summary**;
- (47) **sex transformation** counseling or surgery, or treatment related to a sexual dysfunction or a gender identification problem;
- (48) nicotine transdermal systems, and any other nicotine-containing smoking deterrent or **smoking cessation product**, whether or not they require a physician's prescription;

Certain medical services are not covered under this Plan. No claims will be paid for:

- (49)** cost of **travel or lodging** related to getting medical treatment, or travel, even if recommended by a physician, unless specified as a covered benefit of this Plan;
- (50)** any services or supplies provided for **weight reduction**, unless otherwise specified by this Plan;

- (51)** **wigs**, unless hair loss is the result of a cancer diagnosis; and
- (52)** hospital and professional services to which the participant is entitled **without charge** or to which the participant is entitled by any governmental program, except state Medicaid programs.

PRESCRIPTION CARD SERVICE BENEFITS

Prescription drug benefits are administered through a program called Caremark. Under Federal Law, prescription drugs are those obtainable only with a physician's prescription and dispensed by a licensed pharmacist.

Prescription drugs can be purchased from any participating pharmacy. Copays required at the time of purchase are as listed in the **Benefit Summary**. Generic drugs are mandatory unless the physician requests "Dispense as Written", i.e., the physician specifically requests a brand-name drug. If the participant specifically requests a brand name drug when a generic is available, he/she will be responsible for the cost difference between the brand drug and the generic drug in addition to the copay. Participants are limited to a 34-day supply per copay.

Please refer to the **Benefit Summary** for specific limitations.

MAIL ORDER PRESCRIPTION DRUG BENEFITS

This Plan includes a mail order drug benefit for the purchase of maintenance drugs. Maintenance drugs are those medications which a physician has prescribed to treat an ongoing condition such as high blood pressure, diabetes or heart condition.

The mail order drug program is administered by Caremark and helps participants save money by providing as much as a 90-day supply for one copay. Generic drugs are mandatory unless the doctor requests dispense as written. The participant will be responsible for the cost difference between the brand name drug and the generic drug in addition to the copay.

To take advantage of this optional benefit, the participant should request a kit from Cornell College's Human Resources Department or the Benefit Services Administrator.

Please refer to the **Benefit Summary** for specific limitations.

Important Note: If the participant disagrees with a reduction in or denial of benefits, see the Claim Determination and Claim Review Procedure sections for information on how to file an appeal. These sections also outline the

time frames in which the Plan must respond to your claim and/or appeal.

Restrictions relating to "Pre-Existing Conditions" and "Coordination of Benefits will not apply to this prescription drug benefit."

PRIOR AUTHORIZATION

Certain drugs are covered by the drug card or mail order program only with prior authorization. The prior authorization process allows the Plan to verify that the drug is part of a specific treatment plan and is medically necessary.

Failure to obtain prior authorization may delay the filling of a prescription.

In order to prior authorize a prescription, the physician should provide the Benefit Services Administrator with the written documentation of the reason the drug should be covered and the length of time the drug should be covered.

If the prescription is authorized, the participant will be able to fill his/her prescription at any participating pharmacy, including mail order.

If prior authorization is not received for a drug, the participant may be responsible for the entire billed charge to the pharmacy.

Certain drugs are limited by drug-specific quantity limitations per month, benefit period or lifetime as specified by the Plan and based on medical necessity.

Certain drugs meeting medical necessity requirements will not be authorized under the drug card or mail order program but may be covered under the medical benefit plan subject to deductible and cost-sharing.

OTHER FACTS ABOUT THE HEALTH PLAN

COORDINATION OF BENEFITS

Coordination of benefits (COB) refers to a process that is utilized when the participant has other insurance or coverage that provides the same or similar benefits as this Plan. The benefits payable under this Plan, when combined with the benefits paid under other coverage, will not be more than 100% of either this Plan's payment arrangement amount or the other carrier's payment arrangement amount.

Standard Coordination of Benefits

This Plan, utilizing its normal benefit calculation method, will determine the amount to be paid and then subtract the payment(s) made by plans determined to be primary. The sum of all payments will never exceed the actual charge.

When you receive services, you need to let us know that you have other coverage. Other coverage includes: group insurance; other group benefit plans (e.g., HMOs, PPOs, and self-insured programs); Medicare or other governmental benefits; and the medical benefits coverage in your automobile insurance (whether issued on a fault or no fault basis). To help us coordinate your benefits, you should:

- Inform your provider by giving him/her information about your other coverage at the time you receive services. Your provider will pass the information on to us when the claim is filed.
- Indicate that you have other coverage when you fill out a claim form by completing the appropriate boxes on the form. You will receive a letter from us if we need any additional information.

It is important that you provide us with the requested information concerning your other coverage. If you do not give us the necessary information, your claims will be denied.

The following guidelines will be used to determine which plan will be primary:

- If one plan has a COB provision and the other does not, the plan without a COB clause will be primary.
- The medical benefits of your auto coverage will pay before this plan if the auto coverage does not contain a coordination of benefits

provision that specifies it is secondary or excess to health insurance or health benefit plans.

- If both plans have a COB clause, the plan covering you as an employee will be primary over the plan covering you as a dependent.
- If you are the main person covered under both plans (you are not a dependent under either plan), the plan that has provided coverage the longest will be primary.
- The plan covering you as an active participant will pay before the plan covering you as an inactive participant. Participants in retiree plans, COBRA or other similar continuation coverage are considered inactive participants.
- For a dependent child, the primary plan is the plan of the parent whose birthday (excluding year of birth) occurs earlier in the calendar year. For example, if the father's birthday is June 1 and the mother's birthday is May 1, the mother's plan would be primary for the children.
- If both parents have the same birth month and day, the plan which has been in effect longest would be primary.
- When the parents of a dependent child are divorced or separated and the parent with custody has not remarried, that parent's plan is primary for the child. The plan of the parent without custody pays second. When the parent with custody has remarried, that parent's plan is primary, the stepparent's plan is secondary and the plan of the parent without custody will be coverage of last resort. If there is a court decree which stipulates which parent has financial responsibility for the medical bills for the dependent child, the benefits of that parent's plan will be determined before the benefits of any other plans which cover the child as a dependent.
- If none of the guidelines listed above apply, the plan which has covered you or your dependent the longest will be primary.

Special Rules for SelectFirst™ Providers

If this Plan is the secondary payer, and the provider is a SelectFirst™ participating provider, the billed charges will be subject to the SelectFirst™ fee schedule or discount. This Plan's payments as secondary payer, combined

with the primary payer's payment, will never exceed the allowable payment according to the SelectFirst™ fee schedule or discount arrangement.

MEDICARE AS SECONDARY PAYER

Since 1980, Congress has passed legislation making Medicare the secondary payer and group health plans the primary payer in a variety of situations. These laws apply only if the participant has both Medicare and Cornell College's health coverage under this Plan and Cornell College has the minimum required number of employees as described in the following paragraphs.

Working Aged

This provision applies only to group health plans of employers with at least 20 employees for each working day for at least 20 calendar weeks in the current or preceding year. Under this provision, Medicare is the secondary payer if the beneficiary is both of the following:

- age 65 or older; and
- a current employee or spouse of a current employee covered by an employer group health plan.

Working Disabled

This provision applies only to group health plans of employers that had at least 100 full-time, part-time, or leased employees on at least 50% of the regular business days during the preceding calendar year. Under this provision, Medicare is the secondary payer if the beneficiary is all of the following:

- under age 65;
- a recipient of Medicare disability benefits; and
- a current employee, or a spouse or dependent of a current employee, covered by an employer group health plan.

End-Stage Renal Disease (ESRD)

The ESRD requirements apply to group health plans of all employers, regardless of the number of employees. Under these provisions, Medicare is the secondary payer during the first 30 months of Medicare coverage if both of the following are true:

- the beneficiary has Medicare coverage as an ESRD patient; and

- the beneficiary is covered by an employer group health plan.

If the beneficiary is already covered by Medicare due to age or disability and becomes eligible for Medicare ESRD coverage, Medicare generally is the secondary payer during the first 30 months of ESRD eligibility. However, if the group health plan is secondary to Medicare (based on other Medicare secondary payer requirements) at the time the beneficiary becomes covered for ESRD, the group plan remains secondary to Medicare.

The above provisions are a general summary of the laws, which may change from time to time. For more information, contact Cornell College or the Social Security Administration.

MEDICARE AS PRIMARY PAYER

When the foregoing subsection "Medicare as Secondary Payer" does not apply, benefits otherwise payable under this Plan for allowable expenses shall be reduced so that the sum of benefits payable under this Plan and Medicare shall not exceed the total of such allowable expense. Benefits shall be payable under this Plan after Medicare benefits have been paid whether or not such participant is disabled and not in an active employment status and under or over age 65, other than as specified for an ESRD beneficiary in the foregoing subsection.

Benefits shall be considered payable by Medicare for purposes of this section when the participant is eligible for Medicare benefits:

Benefits could be reduced if the participant:

- has not enrolled or applied for benefits under Medicare;
- has failed to take any action required by Medicare to qualify for benefits; or
- received benefits payable by Medicare if services were received in a facility to which Medicare would have paid.

In the event a participant enters into a private contract with a Physician in accordance with Medicare private contracting arrangements, this Plan shall not coordinate benefits or assume a primary payer position on any such participant.

RELEASE OF INFORMATION

The Benefit Services Administrator may, without notice to or consent of the covered person, release to or obtain from any insurance company or other organization or person any information

regarding coverage, expenses, and benefits which the Benefit Services Administrator, at its sole discretion, considers necessary to apply the provisions of this Plan.

RIGHT OF RECOVERY

Whenever benefits have been paid in excess of the minimum amount necessary to satisfy the intent of the Coordination of Benefits provision, the Plan Administrator will have the right to recover those payments to the extent of the excess amount from any one or more of the following as the Plan Administrator determines:

- any persons to whom such payments were made; or
- any insurance companies or any other organizations.

The Plan Administrator will also have the right to cause the payment of any amounts it determines to be warranted to satisfy the intent of the **Coordination of Benefits** provision of this Plan to any organizations making payments under other plans which should have been made under this Plan.

THIRD PARTY REIMBURSEMENT

If benefits have been paid or are payable under this Plan for services received by a participant, and it is later established that the charges for these services were not paid or are not payable by the participant or that the participant was otherwise reimbursed or may be reimbursed, except by insurers of policies of health insurance issued to the participant as an individual, this Plan will be entitled to a refund of the amount of the benefits paid which are in excess of the benefits that would have been payable based on the actual charges incurred and paid.

SUBROGATION

Payment Condition

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 a participant, Plan beneficiary, and/or their dependants, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this section as “participant(s)”) or a third party, where another party 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”).

A participant, 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 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 Participant agrees the Plan shall have an equitable lien on any funds received by the participant 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 participant agrees to include the Plan’s name as a co-payee on any and all settlement drafts.

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

Subrogation

As a condition to participating in and receiving benefits under this Plan, the participant 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 participant is entitled, regardless of how classified or characterized.

If a participant receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the Plan to any claim, which any participant 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.

The Plan may in its own name or in the name of the participant, 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.

If the participant fails to file a claim or pursue damages against:

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

the participant authorizes the Plan to pursue, sue, compromise and/or settle any such claims in the participant's and/or the Plan's name and agrees to fully cooperate with the Plan in the prosecution of any such claims. The participant 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

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 participant 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 participant recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved.

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.

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 participant, 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.

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 participant.

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

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:

- the responsible party, its insurer, or any other source on behalf of that party;
- any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
- any policy of insurance from any insurance company or guarantor of a third party;
- worker's compensation or other liability insurance company; or
- 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 participant, and funds held in trust over which the Plan has an equitable lien exist separately from the property and estate of the participant, such

that the death of the participant, or filing of bankruptcy by the participant, 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 participant 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.

Obligations

It is the participant's obligation at all times, both prior to and after payment of medical benefits by the Plan:

- 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;
- 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;
- to take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights;
- to do nothing to prejudice the Plan's rights of subrogation and reimbursement;
- to promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received; and
- to not settle or release, without the prior consent of the Plan, any claim to the extent that the Plan Beneficiary may have against any responsible party or Coverage.

If the participant 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 participant will be responsible for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the participant.

The Plan's rights to reimbursement and/or subrogation are in no way dependent upon the participant's' cooperation or adherence to these terms.

Offset

Failure by the participant 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 participant may be withheld until the participant satisfies his or her obligation.

Minor Status

In the event the participant 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.

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

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.

WORKERS' COMPENSATION

This Plan is not meant to be a substitute for workers' compensation. Any benefits paid by this Plan which are determined to be the liability of any workers' compensation plan of benefits will be refunded to this Plan by the participant and/or his/her heirs or estate. Any participant hereby agrees to reimburse this Plan for any payments so made under this Plan out of any monies

recovered from any workers' compensation plan as the result of judgment, settlement or otherwise, and the participant does agree to take such action, to furnish such information and assistance, and to execute and deliver all necessary instruments as the Plan Administrator may require to facilitate the enforcement of this Plan's rights and not to prejudice those rights. Any portion of any settlement that is agreed upon which is for future expenses will also be recoverable under this Plan, as those expenses occur.

OVERPAYMENT OF CLAIMS

Each participant hereby authorizes the deduction of any excess benefit received or benefits which should not have been paid from any present or future compensation payments.

CONFORMITY WITH LAW

To the extent not pre-empted by ERISA, this Plan shall be governed by the laws of the state of Iowa. If any provision of this Plan is contrary to any law to which it is subject, or if a law relevant to this Plan is not specifically addressed within the contents of pertinent documents, such provision will be amended to satisfy the law's minimum requirement.

CLAIMS FILING AND APPEALS

ASSIGNMENT OF BENEFITS

In PPO Area

Because of a contractual agreement with SelectFirstTM, benefits will be automatically assigned to participating providers. This Plan will not honor assignment of benefits received for any non-participating physicians or facilities. These benefits will be sent directly to the participant. Providers who do not participate in this network will not have benefits directly assigned to them. It is the participant's responsibility to make full payment to a non-participating provider.

Out-of-Area

This Plan accepts all assignments of benefits to make direct payments to providers of benefits, including, but not limited to, physicians, hospitals, and nursing facilities.

In General

Unless applicable law otherwise requires, no amount payable at any time will be subject in any manner to alienation by anticipation, sale, transfer, assignment, bankruptcy, pledge, attachment, charge or encumbrance of any kind and any attempt to alienate, sell, transfer, assign, pledge, attach, charge or otherwise encumber any amount, whether presently or at a later date payable, will be void. This Plan will not be liable for, or subject to, the debts or liabilities of any person entitled to any amount payable under this Plan. If by reason of the bankruptcy or other event happening at any such time such amount would not be enjoyed by them, then the Plan Administrator in its sole discretion, may terminate its interest in any such amount and will hold or apply it to or for the benefit of the participant, their spouse, children or other dependents, or any of them, in such manner as the Plan Administrator may deem proper.

FILING OF CLAIMS

Claims must be received within 12 months of the day charges are incurred to be eligible for benefits, except as provided in the PPO contract.

Whenever the participant obtains healthcare services he/she should present the healthcare identification card. Instructions for billing by the

provider of care or the member are included on the member identification card. Physicians, hospitals and clinics may file claims for the participant; however, the participant is ultimately responsible for the filing of claims.

A paper healthcare claim will be considered filed on the date it is received by the Benefit Services Administrator. For a claim reprinted or identified as non-PPO by a PPO vendor, the claim will be considered filed on the date it is received from the PPO network. Electronic claims are considered received the day subsequent to the transmission of the claim by the provider. There are specific fields that are required for each type of claim to constitute a "clean claim". This criteria is available, upon request, from the Benefit Services Administrator.

For claims not filed by the provider of service, the following steps should be taken to ensure that claims are filed correctly. Claim forms may be obtained from either the Benefit Services Administrator or Cornell College.

- (1) Claims must be received within 12 months of the day charges are incurred, except as provided in the PPO contract.
- (2) Complete the personal section of the claim form. Be sure to indicate any other group, franchise or association-sponsored plan he/she has in addition to this Plan.
- (3) Sign the assignment of benefits portion of the claim form. Unless assigned benefit payments will be directed to the participant. Either have the provider complete the appropriate section or the participant should attach the original itemized bill to the claim form. This bill should identify the patient, the date, the nature of treatment or service and the amount charged. Canceled checks or cash receipts do not contain the information needed to process a claim.
- (4) Sign and date the form in the authorization section.
- (5) Use a separate claim form for each member of the family and retain a copy for his/her files.
- (6) For hospital admissions, present the ID card to the admitting clerk.

All claims should be mailed to:
First Administrators, Inc.
Claims Department
P.O. Box 9900
Sioux City, Iowa 51102

CLAIM DETERMINATION

This section describes the procedures the Plan will follow in making a determination on a claim for benefits. A claim is any request for a Plan benefit made by a participant or a representative of a participant that complies with the Plan's reasonable procedure for making benefit claims.

Upon receipt of a claim, the Plan must respond to the participant within the time frames stated below. These time frames are the maximum number of calendar days in which a determination must be made and communicated to the participant.

Urgent Care Claims

An urgent care claim is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the participant or the participant's ability to regain maximum function or, in the opinion of a physician with knowledge of the participant's medical condition, would subject the participant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

The participant's physician may determine if the claim is an urgent care claim. Otherwise, an individual acting on behalf of the Plan, applying the judgment of a prudent layperson that possesses an average knowledge of health and medicine, may make the determination.

A response to an urgent care claim will be provided within 72 hours of the receipt of the claim by the Plan. If a participant fails to provide sufficient information, the Plan will notify the participant within 24 hours of receiving the claim of the specific information necessary to complete the claim. The participant will then have 48 hours to provide the additional information and, once received, a decision will be communicated within 48 hours. Without complete information, the claim will be denied.

Urgent care claims include, but are not limited to, requests for precertification. Please see the Utilization Review section for further information.

Pre-Service Claims

A pre-service claim is any claim for a benefit under this Plan, with respect to which the terms of the Plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

If the participant fails to follow the Plan's procedures for filing a pre-service claim, the Plan will notify the participant of the failure and the proper procedures to be followed within five days of such failure. Otherwise, a response to a pre-service claim will be provided within 15 days of the receipt of the claim by the Plan. This period may be extended one time by the Plan for up to 15 days if an extension is necessary due to matters beyond control of the Plan. The participant will be notified of the extension prior to the expiration of the initial 15-day period, the circumstances requiring the extension and the date by which a decision is expected. If the extension is necessary due to the failure of the participant to provide sufficient information, the Plan will notify the participant of the specific information necessary to complete the claim. The participant will then have 45 days to provide the additional information and, once received, a decision will be communicated within 15 days. Without complete information, the claim will be denied. If the Plan does not provide a notice of extension within 15 days, the participant has the right to begin an appeal as outlined in the **Claim Review Procedure** section.

Pre-service claims include, but are not limited to, requests for precertification. Please see the **Utilization Review** section for further information.

Concurrent Care Claims

Concurrent Care is an ongoing course of treatment (inpatient or outpatient) to be provided over a period of time or number of treatments which has been approved by the Plan. If ongoing treatment benefits are reduced or terminated by the Plan before the end of the period for which such treatment was approved, the participant will be notified sufficiently in advance to allow the participant to appeal the adverse determination and obtain a decision on the appeal before the reduction or termination goes into effect.

If a participant requests an extension of a course of treatment that is an urgent care claim as defined above, the Plan will notify the participant of its determination within 24 hours of the Plan's receipt of the request.

If the participant requests an extension of a course of treatment that is not an urgent care claim, the request will be considered a new claim and will be subject to the time frames and procedures that are appropriate to the type of claim (i.e., pre-service or post-service). Please refer to the appropriate section for timelines and procedures specific to these types of claims.

Post-Service Claims

A post-service claim is any claim for a benefit that is not a pre-service claim. Post-service claims are claims for services already received by the participant.

The Plan will respond to a post-service claim within 30 days of receipt of the claim by the Plan. This period may be extended one time by the Plan for up to 15 days if an extension is necessary due to matters beyond control of the Plan. The participant will be notified of the extension prior to the expiration of the initial 30-day period and will be given the date by which a decision is expected. If the Plan does not provide a notice of extension within 30 days, the participant has the right to begin an appeal as outlined in the **Claim Review Procedure** section.

If a participant fails to provide sufficient information, the participant will be notified within 30 days of the Plan's receipt of the claim of the specific information necessary to complete the claim. The participant will then have 45 days from receipt of the notice to provide the additional information and, once received, a decision will be communicated within 15 days. Without complete information, the claim will be denied.

NOTIFICATION OF DECISION

If a claim has been wholly or partially denied, written notification will be provided by the Plan which will describe:

- (a) the specific reason(s) for the denial;
- (b) reference to the specific Plan provision(s) on which the denial is based;
- (c) a description of any additional material or information necessary for the participant to perfect the claim and an explanation of why such material or information is necessary;
- (d) an explanation of this Plan's claim review procedure, including a statement of the participant's right to bring civil action under

ERISA Section 502(a) following an adverse benefit determination;

- (e) a copy of any internal rule, guideline, protocol or other similar criterion relied upon in denying the claim or, in lieu thereof, a statement that such information is available free of charge upon request;
- (f) an explanation of the scientific or clinical judgment relied upon in denying the claim based on medical necessity, experimental treatment or similar exclusion or limit, applying the terms of the Plan to the participant's medical circumstances or, in lieu thereof, a statement that such information is available free of charge upon request; and
- (g) for urgent care claims, a description of the expedited appeal process.

For urgent care claims, this information may be provided to the participant orally, provided that written notification is furnished within three days of the oral notification.

CLAIM REVIEW PROCEDURE

Claim Inquiry

If a claim has been wholly or partially denied and the participant does not agree with the reduction, or if the participant has a complaint regarding a claim, he/she may make an inquiry by calling the number listed on the Notification of Decision.

Filing an Appeal

In case of an adverse benefit determination, the participant has the right to a full and fair review. An adverse benefit determination is a denial, reduction or termination of a benefit.

With the exception of urgent care claims, the request to review a claim must be in writing and must be submitted to the address on the Notification of Decision. This request must be submitted within 180 days following the receipt of the adverse benefit determination. For information on appealing an adverse benefit determination of an urgent care claim, see the **Urgent Care Claims** section below.

The participant may submit written comments, documents, or other information in support of the appeal. The participant will be provided, upon request and free of charge, reasonable access to and copies of all relevant records used in making the decision. The review will take into account all information regarding the denied or reduced

claim whether or not presented or available at the initial determination.

The review will be conducted by someone other than the original decision maker(s) and without regard to the original decision. If a decision requires medical judgment, an appropriate medical expert who was not previously involved in the case will be consulted. If the decision on appeal is adverse, the participant may request in writing the identity of the medical expert who was consulted.

Urgent Care Claims

For appeals involving urgent care claims, the participant may request either orally or in writing an expedited appeal. For an expedited appeal, information, including the decision, will be communicated by telephone, facsimile, or other similarly prompt method.

Notification of the decision on appeal will be provided within 72 hours of the Plan's receipt of the appeal request.

Pre-Service Claims

For appeals involving pre-service claims, notification of the decision will be provided within 30 days of the Plan's receipt of the appeal request.

Concurrent Care Claims

If a participant appeals an adverse benefit determination of a claim involving an ongoing course of treatment, the decision on appeal will be made according to the time frames and procedures that are appropriate to the type of claim (i.e., urgent care, pre-service or post-service). Please refer to the appropriate section for timeliness and procedures specific to these types of claims.

Post-Service Claims

For appeals involving post-service claims, notification of the decision will be provided within 60 days of the Plan's receipt of the appeal request.

NOTIFICATION OF DECISION ON APPEAL

If the decision on appeal is adverse, written notification will be provided by the Plan that will describe:

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

- (b) reference to the specific Plan provision(s) on which determination is based;
- (c) a statement that the participant is entitled to receive, upon request and at no cost, reasonable access to and copies of all documents, records and other information relevant to the participant's claim for benefits;
- (d) a statement describing any voluntary appeal procedures offered by the Plan and the participant's right to obtain information about such procedures, as well as the right to bring civil action as described in ERISA Section 502(a);
- (e) a copy of any internal rule, guideline, protocol or other similar criterion if relied upon in making the adverse determination or, in lieu thereof, a statement that such information is available free of charge upon request; and
- (f) an explanation of the scientific or clinical judgment relied upon in making the adverse determination, based on medical necessity, experimental treatment or similar exclusion or limit, applying the terms of the Plan to the participant's medical circumstances or, in lieu thereof, a statement that such information is available free of charge upon request.

AUTHORIZED REPRESENTATIVE

The participant may authorize another person to represent him/her and with whom he/she wants the Benefit Services Administrator to communicate regarding specific claims or an appeal. This authorization must be in writing, signed and dated by the participant, and include all the information required in the Authorized Representative form. This form is available from Cornell College. In a medically urgent situation, the treating health care practitioner may act as a participant's authorized representative without completion of the Authorized Representative form. An assignment of benefits, release of information, or other similar form that the participant may sign at the request of a health care provider does not make a provider an authorized representative. The participant can revoke the authorized representative at any time, and the participant can authorize only one person as his/her representative at a time.

DEFINITIONS

"**ACCIDENTAL INJURY**" means an injury, independent of disease or bodily infirmity of any other cause, which happens by chance.

"**ACTIVE DUTY**" means full-time duty in the active military service of the United States. Such term includes full-time training duty, annual training duty, and attendance, while in the active military service, at a school designated as a service school by law or by the Secretary of the military department concerned. Such term does not include full-time National Guard duty.

"**ACTIVELY AT WORK ON A FULL-TIME BASIS**" means an employee must work for his/her employer at his/her usual place of work or such other place or places as required by his/her employer in the course of such work for the full number of hours and full rate of pay, as set by the employment practices of this employer.

"**ADOPTED CHILD(REN)**" means any child legally placed in an employee's home by an adoption agency who meets the eligibility requirements of this Plan, whether or not the adoption is final. Placement is defined as the assumption and retention of a legal obligation for total or partial support of a child in anticipation of adoption of such child.

"**ADVERSE BENEFIT DETERMINATION**" means a denial, reduction, or termination of a benefit.

"**ALLOWABLE EXPENSES**" means the portion of an eligible expense actually payable by this Plan after taking into account copay, deductible, and cost-sharing amounts, any applicable benefit maximum or maximums, and any other limitation or exclusion provided for under this Plan. This calculation is based on the payment method utilized by this Plan.

"**ALTERNATE RECIPIENT**" means any child of a participant who is recognized under a Qualified Medical Child Support Order (QMCSO) as having a right to enrollment in this Plan with respect to such participant.

"**AMBULATORY/OUTPATIENT SURGERY FACILITY**" provides surgical services on an outpatient basis for patients who do not need to occupy an inpatient, acute care hospital bed.

"**AMENDMENT**" means a formal document that changes a provision of this Plan, duly signed by the authorized person or persons as designated by the College.

"**APPLIANCE**" means a device used to replace missing parts or restore function, such as a denture, splint or obturator.

"**BENEFITS**" mean those medically necessary services and supplies that qualify for payment under this Plan.

"**BENEFIT PERIOD**" means the same as Calendar Year. It begins on the day coverage goes into effect and starts over each January 1.

"**BENEFIT SERVICES ADMINISTRATOR**" means First Administrators, Inc., an Iowa corporation.

"**BENEFITS**" means those medically necessary services and supplies that qualify for payment under this Plan.

"**BIRTHING CENTER**" provides obstetrical care and related services on an outpatient basis.

"**BOARD**" means the Board of Directors of the College.

"**BRAND NAME PRESCRIPTION DRUG**" means the pharmaceutical products manufactured and sold under the name assigned by the developer/manufacturer.

"**BUSINESS ASSOCIATE**" means a person or organization that performs a function or activity on behalf of a covered entity, but is not part of the covered entity's workforce. A business associate can also be a covered entity in its own right. (Also see Part II, 45 Code of Federal Regulations Part 160.103).

"**CALENDAR YEAR**" means the 12-month period commencing January 1 and ending the next following December 31.

"**CHEMICAL DEPENDENCY**" means any condition resulting from dependency on or abuse of a psychoactive substance as described in the *Diagnostic and Statistical Manual of Mental Disorders, Third Edition - Revised*, (DSM-III-R), published by the American Psychiatric Association or subsequent revisions to DSM-III-R.

"**CHEMICAL DEPENDENCY FACILITY**" is a licensed, free-standing and approved by this Plan to provide treatment for chemical dependency conditions.

"**CHILD(REN)**" means unmarried child(ren) of a covered employee, under age 19, including natural children, adopted children (as defined), stepchildren and children for whom the employee has legal guardianship.

"CLAIM" means any request for a Plan benefit made by a participant or a representative of a participant that complies with the Plan's reasonable procedure for making benefit claims.

"COLLEGE" means Cornell College, an Iowa college which elects in writing to adopt this Plan.

"COMMON ACCIDENT DEDUCTIBLE" means a single deductible amount the participant is responsible for when two or more of the participant's family members receive covered services for injuries suffered in the same accident.

"COMMUNITY MENTAL HEALTH CENTER" or "MENTAL HEALTH CLINIC" means a facility established for the purpose of providing consultation, diagnosis, and treatment in connection with a mental health disorder and approved as such by a state department or agency having authority over such facilities.

"CONTINGENCY OPERATION" means designated by the Secretary of Defense as an operation in which members of the armed forces are or may become involved in military actions, operations, or hostilities against an enemy of the United States or against an opposing military force.

"COPAY" means the predetermined amount paid by the participant on a per item or per service basis.

"COSMETIC SERVICES" means treatment or surgical procedures intended to improve physical appearance, but which do not treat illness, restore, or materially improve a deficiency in normal physiological function. Cosmetic services performed to alleviate psychological distress are not covered by the Plan.

"COST-SHARING" means the percentage(s) of eligible expenses allocable to the participant and the employer after any applicable copays, calendar year deductibles, or non-compliance penalties have been applied.

"COVERED DENTAL EXPENSES" means expenses incurred which are medically necessary that are not specifically excluded from coverage elsewhere in this Plan.

"COVERED DEPENDENT" means a spouse or a dependent child who has satisfied the definition of dependent and the eligibility requirements specified under **Dependent Eligibility**.

"COVERED EMPLOYEE" means any employee who is eligible for benefits as specified under **Employee Eligibility**.

"COVERED EXPENSES" means those expenses covered by this Plan, including the hospital, surgical, and medical care expenses described in this booklet. However, expenses are not covered if they are expressly excluded, are not medically necessary, are experimental or investigational in nature, or if they exceed the maximum amount considered by this Plan. See also the definitions of eligible expenses and allowable expenses.

"COVERED SERVICEMEMBER" means a member of the Armed Forces, including a member of the National Guard or Reserves, who is undergoing medical treatment, recuperation, or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list, for a serious injury or illness. Also included is a veteran who is undergoing medical treatment, recuperation, or therapy, for a serious injury or illness and who was a member of the Armed Forces (including a member of the National Guard or Reserves) at any time during the period of 5 years preceding the date on which the veteran undergoes that medical treatment, recuperation, or therapy.

"CREDITABLE COVERAGE" means coverage under a group health plan (including a governmental or church plan), health insurance coverage (either group or individual insurance, including COBRA continuation coverage, or short-term "bridge" policy), Medicare, Medicaid, military-sponsored health care, a program of the Indian Health Service, a state health benefit risk pool, the Federal Employees Health Benefits Plan (FEHBP), a public health plan as defined in subsequent Centers for Medicare and Medicaid Services regulations, State Children's Health Insurance Program (S-Chip), public health plans provided by a foreign country or a political subdivision and any health benefit plan under Peace Corps Act 5(e).

"Creditable Coverage" does **not** include accident or disability income, liability, workers' compensation, automobile medical insurance, health coverage for limited benefits, such as limited scope dental or vision benefits or long-term care plans, or plans under which health benefits are secondary or incidental.

"CUSTODIAL CARE" means help with daily living activities. This type of care does not require the continuing attention and assistance of licensed medical or trained paramedical personnel. Some examples of custodial care are assistance in walking and getting in and out of bed; aid in bathing, dressing, feeding and other

forms of assistance with normal bodily functions, preparation of special diets; and supervision of medication which usually can be self-administered. Custodial Care is not a benefit under this Plan.

"DEDUCTIBLE" means the amount for covered services the participant pays before this Plan begins paying benefits.

"DENTIST" means a duly licensed Doctor of Dental Surgery (DDS) or Doctor of Dental Medicine (DMD) practicing within the scope of the dental profession and any other physician furnishing any dental services which such physician is licensed to perform.

"DEPENDENT" means any one or more of the following:

- (a) the spouse of an employee;
- (b) unmarried children of an employee under the age of 19, including natural children, adopted children (as defined), stepchildren and children for whom the employee has legal guardianship;
- (c) unmarried children of an employee including natural children, adopted children (as defined), stepchildren and children for whom the employee has legal guardianship who have attained age 19 but who have not attained age 25 and who are full-time students enrolled in an accredited educational institution; and
- (d) unmarried children of an employee including natural children, adopted children (as defined), stepchildren and children for whom the employee has legal guardianship who are incapable of self-sustaining employment due to mental or physical disability, provided such disability commenced prior to attainment of the termination age specified in this Plan and such children were covered prior to attainment of such age and continuously thereafter under this Plan or a predecessor plan.

A spouse age 65 or older of an active employee who makes a written election to be covered by Medicare instead of this Plan may not, by law, be considered a dependent under this Plan.

"DISABLED" means the temporary inability of a covered employee to perform each and every regular duty pertaining to his/her occupation or employment for compensation or profit, or the temporary inability of a covered dependent to

engage in the normal activities of a person in good health of like age and sex.

"DOMESTIC PARTNER" means an individual age 19 or older who lives with the employee of the same sex and who is not a relative of the employee by any degree of kinship. A domestic partner is not considered to be a spouse of the employee.

"DOMICILIARY CARE" means inpatient institutional care provided to the participant not because it is medically necessary, but because care in the home setting is not available, is unsuitable, or members of the patient's family are unwilling to provide care. Institutionalization because of abandonment constitutes domiciliary care. Domiciliary care is not a benefit under this Plan. Some examples of domiciliary care for which benefits are not payable:

- home care is not available, such as where institutionalization is primarily because parents work or where a hospital stay is extended beyond what is medically necessary because the patient lives alone;
- home care is not suitable, such as where a child is institutionalized because a parent(s) is an alcoholic who is not responsible enough to care for the child or because someone in the home has a contagious disease; or
- the family is unwilling to care for a person in the home, such as where a family does not want to handle a child who is difficult to manage.

"DURABLE MEDICAL EQUIPMENT" means medical equipment not otherwise excluded which is designed for repeated use, is primarily and customarily used to serve a medical purpose, and is not useful to a person in the absence of an injury or illness. For the purpose of determining whether a piece of equipment constitutes durable medical equipment for coverage under this Plan. First Administrator's, Inc. may consult the equipment list compiled from time to time for use in the administration of the Medicare program. Examples of durable medical equipment include, but are not limited to, wheelchairs, hospital beds, and respirators. Air conditioners, humidifiers, dehumidifiers, air purifiers, and other similar convenience items are not considered durable medical equipment.

"EFFECTIVE DATE" means the first day that benefits under this Plan would be in effect, after satisfaction of the waiting period, if applicable,

and any other provisions or limitations contained herein.

"ELECTIVE SURGICAL PROCEDURE" means a non-emergency surgery that can be scheduled at any time without risking the patient's life or risking serious impairment to the patient's bodily functions.

"ELIGIBLE EXPENSE" means the portion of a covered expense which is considered for payment under this Plan. If the course or manner of treatment of a condition is expressly excluded by this Plan, not medically necessary, is experimental, investigational, or not included because of any reason described in the Plan, then the expense for the treatment is not eligible. See the definition of allowable expense for a description of how; this Plan computes the portion of an eligible expense which it will pay..

"EMERGENCY" means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson, possessing an average knowledge of health and medicine, could reasonably expect absence of immediate medical attention to result in one of the following:

- placing the health of the individual or, with respect to a pregnant woman, the health of the woman and her unborn child, in serious jeopardy;
- serious impairment to bodily function; or
- serious dysfunction of any bodily organ or part.

"EMPLOYEE" means any individual who is employed by the College.

"ENROLLMENT DATE" or **"DATE OF ENROLLMENT"** means the first day of a participant's waiting period under this Plan (typically, the date the employee's employment begins). The enrollment date for anyone who enrolls during a special enrollment period is the first day of coverage under this Plan.

"ERISA" means the Employee Retirement Income Security Act of 1974, a Federal law protecting a participant's rights under this Plan.

"EXPERIMENTAL OR INVESTIGATIONAL SERVICES OR SUPPLIES" means that one or more of the following is true:

- (a) the device, drug or medicine 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 device, drug or medicine is furnished;

- (b) the drug, device, medical treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment or procedure was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if Federal law requires such review and approval, and furthermore, that the treating facility's Institutional Review Board is reviewing such drug, device, treatment or procedure as being experimental or investigational;
- (c) reliable evidence shows that the treatment, procedure, device, drug or medicine is the subject of ongoing phase I, II or III clinical trials or is under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis; and/or
- (d) reliable evidence shows that the consensus of opinion among experts regarding the treatment, procedure, device, drug or medicine 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 the standard means of treatment or diagnosis.

Reliable evidence means 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 treatment, procedure, device, drug or medicine; or the written informed consent used by the treating facility or by another facility studying substantially the same treatment, procedure, device, drug or medicine.

In addition, no reimbursement is available for payments of any: (1) treatments, services or supplies that are educational or provided primarily for research; or (2) treatments, procedures, devices, drugs or medicines or other expense relating to transplants of nonhuman organs.

Refer to the **Transplant Benefits** section for information on transplant benefits.

"FEE SCHEDULE" means a contractually specified amount payable for a physician's services within the PPO area.

"FULL-TIME STUDENT" means a covered dependent who meets the age requirements of this Plan and is enrolled in a full-time (as defined by the institution they are attending) course of study in an accredited institution of higher learning.

"GENERIC PRESCRIPTION DRUGS" means the pharmaceutical products manufactured and sold under their common chemical or non-proprietary name. The generic equivalent of a brand name drug must meet the same standards for safety, purity, strength, and effectiveness as the brand name drug. Both have the identical chemical composition and therapeutic effect.

"HIPAA" means the Health Insurance Portability and Accountability Act, a Federal law that allows persons to qualify immediately for comparable health insurance coverage when they change their employment relationships. Title II, Subtitle F, of HIPAA gives Health and Human Services (HHS) the authority to mandate the use of standards for the electronic exchange of health care data; to specify what medical and administrative code sets should be used within those standards; to require the use of national identification systems for health care patients, providers, payers (or plans) and employers (or sponsors); and to specify the types of measures required to protect the security and privacy of personally identifiable health care information. (Also known as the Kennedy-Kassebaum Bill, the Kassebaum-Kennedy Bill, K2, or Public Law 104-191).

"HOME HEALTH AGENCY" is a Medicare approved association or organization which provides skilled nursing care in the participant's home.

"HOME HEALTH SERVICES" are health care services performed in the participant's home by a home health agency.

"HOSPICE" provides care (usually in the home) for patients who are terminally ill and have a life expectancy of six months or less. The Hospice must be accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), be Medicare approved, and/or be licensed by the state in which it operates.

"HOSPITAL" is an institution that primarily provides diagnostic and therapeutic services for surgical and medical diagnosis, treatment and care of injured or ill persons. The facility must be licensed as a hospital under applicable laws.

"HOSPITAL CONFINEMENT" means being registered for a minimum of 23 hours as a bed

patient in a hospital, nursing facility or chemical dependency facility upon the recommendation of a physician or as a patient in a hospital because of a surgical operation or receiving emergency care in a hospital for an injury within 48 hours after the injury is received.

"ILLNESS" means any bodily disorder, bodily injury, disease, or mental health condition including pregnancy and complications of pregnancy.

"IMMEDIATE FAMILY" means a participant's legal spouse, parents, children, grandparents and siblings (brothers and/or sisters). This includes such persons whether related by blood or marriage (in-laws).

"IMMUNIZATION" is an injection with a specific antigen to promote antibody formation to make a person immune to a disease or less susceptible to a contagious disease.

"INFERTILITY" means the inability or diminished ability to produce offspring.

"INJURY" means a physical condition which is the result of an accident caused by an external force with respect to that participant, and which results in loss covered by this Plan; or a condition caused as the result of an incident which is precipitated by an act of unusual circumstances likely to result in unexpected consequences; the condition must be an instantaneous one, rather than one which continues, progresses or develops.

"INPATIENT" means being confined in a hospital or a nursing facility as a resident patient and subject to at least one day's room and board charges by the hospital, nursing facility or chemical dependency facility.

"INTENSIVE CARE UNIT" means a unit exclusively reserved for critically and seriously ill or injured patients requiring constant audiovisual observation as prescribed by the attending physician which provides room and board, specialized registered nurse (RN) and other nursing care, and special equipment or supplies immediately available on a stand-by basis segregated from the rest of the hospital's facilities.

"LEGEND DRUGS" mean those drugs classified within any of the five categories for drugs that come under the jurisdiction of the most recent Controlled Substance Act and which may only be dispensed by a licensed pharmacist upon the written prescription of a physician. Compounded

medications of which at least one ingredient is classified as noted above shall be included.

"LICENSED PRACTICAL NURSE" means an individual who has received specialized nursing training and practical nursing experience and who is licensed to perform nursing services by the state in which he/she performs such services, other than one who ordinarily resides in the participant's home or who is a member of the participant's immediate family.

"LICENSED PUBLIC HEALTH NURSE" means a professional nurse who has the right to use the title registered nurse (RN), other than one who ordinarily resides in the patient's home or who is a member of the patient's immediate family, and who has extended their study in the public health field.

"LIFETIME" means the period of time a person is actually a participant under this Plan, commencing with the original effective date, and is not intended to imply or suggest benefits beyond an individual's termination date or this Plan's termination date as herein specified.

"LOCAL AIR AND GROUND AMBULANCE" means medically necessary transportation to an appropriate inpatient or outpatient facility in the surrounding area where the ambulance transportation originated. To determine if the ambulance transportation is covered, this Plan considers if no other method of transportation is appropriate, that the services necessary to treat the injury or illness are not available in the hospital, nursing facility or chemical dependency facility in which the participant is an inpatient or outpatient and the point of destination is the nearest one with adequate and appropriate methods of care.

"MAINTENANCE DRUG" means the prescription drugs and medications which are prescribed to treat a chronic medical condition, such as hypertension, diabetes, and certain heart conditions. "Maintenance drug" includes diabetic supplies such as hypodermic syringes, needles, and blood-sugar testing supplies.

"MAXIMUM ALLOWABLE FEE" means an amount established, using various methodologies, for covered services and supplies. The settlement amount is based on the lesser of the covered charge for a service or supply or the maximum allowable fee.

Information regarding the calculation and determination of the maximum allowable fee is available to you. Upon receiving your request for

such information, First Administrators, Inc. or your group health plan sponsor will provide the following:

- the frequency of the determination of the maximum allowable fee;
- a general description of the methodology used to determine the maximum allowable fee, including geographic locations; and
- the percentile that determines the maximum benefit that we will pay for any procedure, if the maximum allowable fee is determined by taking a sample of fees submitted on actual claims and then determining the benefit by selecting a percentile of those fees.

"MAXIMUM LIFETIME BENEFIT" means the highest dollar amount of allowable expenses that could be paid to or on behalf of any participant during the participant's lifetime, subject to the terms of this Plan.

"MEDICALLY NECESSARY" means that a procedure, service or supply is all of the following:

- appropriate and necessary for the diagnosis and treatment of an injury or illness;
- consistent with professionally recognized standards of health care determined within the state in which the participant resides and given at the right time and in the right setting;
- not more costly than alternative services that would be effective for diagnosis and treatment of the participant's condition; and
- enables the participant to make reasonable progress in treatment.

"MEDICARE" is the Federal government's health insurance program established under Title XVIII of the Social Security Act for people age 65 and older and people of any age entitled to monthly disability benefits under the Social Security or Railroad Retirement Program. It is also available for those with chronic renal disease who require hemodialysis or kidney transplant.

"MENTAL HEALTH DISORDER" means any disorder classified in the *Diagnostic and Statistical Manual of Mental Disorders, Third Edition-Revised* (DSM-III-R), or subsequent revisions to DSM-III-R, and includes behavioral or psychological conditions not attributable to a mental disorder that are the focus of professional attention or treatment, but only to the extent services for such conditions are otherwise considered to be benefits under this Plan.

"MORBID OBESITY" means a participant is at least 18 years of age and an appropriate surgical candidate under the following requirements to receive benefits:

- the participant has a Body Mass Index of at least 40, or greater than 35 in conjunction with a severe coexisting condition, such as cardiopulmonary complications or severe diabetes;
- the participant failed to achieve and sustain weight loss with supervised dietary and conservative treatment over time; and
- in the treating physician's judgment, the participant is motivated to follow the necessary post-operative plan of care and is an acceptable operative risk.

"NEXT OF KIN" means the nearest blood relative of an individual.

"NON-PPO MEMBER" or "NON-PPO PROVIDER" means any health care provider who is not a contracting member of a preferred provider organization utilized by this Plan.

"NOTIFICATION OF DECISION" means delivery or furnishing of information by the Plan to an individual regarding decision of the claim for benefits. Information is considered delivered or furnished as of the date it is mailed by or verbally provided by the Plan.

"NURSING FACILITY" provides continuous skilled nursing services as ordered and certified by the attending physician. A registered nurse (RN) must supervise services and supplies on a 24-hour basis. A nursing facility must also be licensed under the laws of the state in which it operates.

"OUT-OF-POCKET MAXIMUM" is a specified amount that the participant must pay for covered services, out of his/her pocket, in a calendar year. The out-of-pocket maximum is satisfied as indicated on the **Benefit Summary**. Once the out-of-pocket maximum has been met, this Plan pays 100% of the allowable expenses, excluding copays.

"OUTPATIENT" means a participant who receives treatment at a hospital, clinic or dispensary or other medical care facility but is not confined to continuous 24-hour inpatient care.

"PALLIATIVE" means affording temporary relief, but not a cure.

"PARTICIPANT" means any covered employee and any covered dependent.

"PHYSICIAN" means a provider of medical services legally licensed to practice medicine and surgery or any other legally licensed practitioner of the healing arts rendering, within the scope of the individual's license, services which are covered under this program and for which benefits are required to be provided by law when rendered by such a practitioner. In no event will the term "physician" include a resident physician, intern, or other individual in training, or a member of the participant's family.

"PLAN" means this Cornell College Employee Health Care Plan, as set forth herein, and as from time to time amended, which is administered by First Administrators, Inc., the Benefit Services Administrator.

"PLAN ADMINISTRATOR" means the person or persons appointed to administer this Plan, if any, otherwise, the College.

"PLAN SPONSOR" means an entity that sponsors a health plan. This can be an employer, a union or some other entity. (Also see Part II, 45 Code of Federal Regulations Part 164.501).

"PLAN YEAR" means the 12 consecutive month period commencing January 1 and ending on the next following December 31.

"POST-SERVICE CLAIM" means any claim for benefits under the Plan that is not a pre-service claim. Post-service claims are claims for services already received by the participant.

"PPO AREA" means the area encompassing the contracted PPO providers.

"PPO MEMBER" or "PPO PROVIDER" means a contracted health care provider who is a member of a preferred provider organization featured by this Plan.

"PREADMISSION TEST" means any diagnostic test or study required as part of a hospital's admission policy or which is necessary for a scheduled surgical procedure, and which is performed prior to a hospital confinement.

"PRE-EXISTING CONDITION" means any limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the effective date of coverage, whether or not any medical advice, diagnosis, care or treatment was recommended or received before that day.

"PREFERRED PROVIDER ORGANIZATION" or "PPO" means an organization composed of a group of health care providers who have

contracted to offer their services at a discounted rate in accordance with the formal agreement between the College and the preferred provider organization.

"PRESCRIPTION DRUG" means covered legend drugs, medicines or medications prescribed by a physician and dispensed by a licensed pharmacist necessary to treat an injury or illness.

"PRE-SERVICE CLAIM" means any claim for a benefit under this Plan with respect to which the terms of the Plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

"PRIVATE DUTY NURSING" means continuous bedside nursing service, rendered by one nurse to one patient, either in a hospital, nursing facility, hospice facility or the patient's home, as opposed to general duty nursing, which renders services to a number of patients in an inpatient setting.

"PROCUREMENT COSTS" means those charges for services associated with the procurement of a human organ for transplant, including, but not limited to, surgical removal of an organ from a living donor, pathology and radiology services and services necessary to preserve the viability of the organ to be transplanted.

"PROSTHESIS" or "PROSTHETIC APPLIANCE" means a device used as an artificial substitute to replace a limb or an eye, used to improve, aid or augment the performance of a natural function. In no event will the term "prosthesis" include devices such as eyeglasses, hearing aids, orthopedic shoes, arch supports, orthotic devices, trusses, or examinations for the prescription or fitting thereof.

"PROTECTED HEALTH INFORMATION (PHI)" means individually identifiable health information (any health information that can be tied back to an individual). (See Part II, 45 Code of Federal Regulations Part 164.501).

"PSYCHOLOGIST" means a person who holds a Ph.D. in clinical psychology, is recognized by the American Board of Examiners in Professional Psychology and who is licensed in and performs such services in accordance with the laws of the state in which such services are provided.

"QUALIFIED BENEFICIARY" means a participant who qualifies for continuation of coverage under the provisions of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, as then constituted or later amended.

"QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)" means a judgment, decree or order (including judicially approved settlement agreements having the effect of an order) which provides for child support with respect to a child of a participant under this Plan or provides health benefit coverage to such a child, and qualifies with the requirements set forth in this Plan. The QMCSO must be a judgment or decree issued by a court of competent jurisdiction or a state agency that administers child support enforcement programs.

"REGISTERED NURSE" means a professional nurse who has the right to use the title registered nurse (RN), other than one who ordinarily resides in the patient's home or who is a member of the patient's immediate family.

"REINSURER" means the insurance company providing the excess risk insurance maintained by the College.

"RESIDENTIAL TREATMENT FACILITY" means a 24-hour inpatient facility established for the purpose of mental health and/or chemical dependency treatment and approved as such by a state department or agency having authority over such programs.

"ROOM AND BOARD" means all charges commonly made by a hospital for room and meals and for all general services and activities essential to the care of registered bed patients.

"SECOND SURGICAL OPINION" means a consultation with another physician which the Plan may allow to determine the appropriateness of a surgical procedure as the preferred course of treatment as recommended by the attending physician.

"SPECIAL CARE UNIT" means a section, ward, or wing within the hospital which is separated from other hospital facilities and:

- (a) is operated exclusively for the purpose of providing professional care and treatment for critical injuries or illnesses;
- (b) has special supplies and equipment necessary for such care and treatment available on a standby basis for immediate use; and
- (c) provides room and board and constant observation and care by a registered nurse (RN) and other specially trained hospital .

"SPECIALIST" means all physicians except for Obstetricians/Gynecologists, Pediatrics, Family Practice, General Medicine, Physician's Assistants, Geriatrics, Osteopaths, Optometrists, Ophthalmologists and Chiropractors.

"SPOUSE" means a person to whom a covered employee is legally married, as determined and defined by the laws of the state of the covered employee's residence.

"STEPCHILD" means any unmarried biological or adopted child of the spouse of an employee who has not reached the age of 19, and any unmarried biological or adopted child of the spouse of an employee who has not yet reached the age of 25 and is a full-time student in an accredited school.

"SURGICAL PROCEDURE" means cutting, suturing, treatment of burns, correction of fractures, reduction of dislocations, manipulation of joints under general anesthesia, electro-cauterization, tapping (paracentesis), application of plaster casts, administration of pneumothorax, endoscopy, the injection of sclerosing solutions, and obstetrical procedures.

"TERMINALLY ILL" means having a life expectancy of six months or less due to an illness from which the participant is not expected to recover. This is usually a chronic illness or condition for which there is no known cure.

"TOTAL DISABILITY" means:

- (a) In the case the covered employee, due to illness or injury, the employee is wholly and continuously prevented from performing the material duties of his/her regular occupation including any occupation for which the employee is reasonably qualified by reason of education, training or experience;
- (b) In the case of a covered dependent, due to illness or injury, he or she is wholly and continuously prevented from engaging in substantially all of the material activities of a person of the same gender and age who is in good health.

"URGENT CARE CLAIM" means any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the participant or the participant's ability to regain maximum function or, in the opinion of a physician with knowledge of the participant's medical condition, would subject the participant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

"VISIT" means each attendance to the covered participant by a physician or medical practitioner (i.e., consultation or treatment).

"WAITING PERIOD" means the period that must pass before coverage for an employee or dependent who is otherwise eligible to enroll under the terms of the Plan can become effective.

"WELL-BABY CARE" or "WELL-CHILD CARE" means pediatric preventive services appropriate to the age of a child as defined by current Recommendations for Preventive Pediatric Health Care of the American Academy of Pediatrics. Pediatric preventive services shall include, at minimum, a history and complete physical examination as well as developmental assessment, anticipatory guidance, immunizations, and laboratory services including, but not limited to, screening for lead exposure as well as blood levels.

Group plans which provided coverage for pediatric vaccines as of May 1, 1993, may not reduce or eliminate this coverage. Failure to comply will result in an excise tax penalty equal to the penalty for plans that fail to provide COBRA coverage.

STATEMENT OF RIGHTS

Participants of this Plan are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). These rights are provided to you below, as required by federal law and regulation.

ERISA provides that all Plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office, all plan documents, including insurance contracts and copies of all documents such as annual reports (Form 5500) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration (EBSA).

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, bargaining agreements, copies of the latest annual report (Form 5500) and updated Plan Descriptions. The Plan Administrator may make reasonable charges 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 financial report.

Continue Group Health Plan Coverage

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

You may qualify for reduction or elimination of exclusionary periods of coverage for pre-existing conditions under this Plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you

may be subject to a pre-existing condition exclusion for 12 months after your enrollment date in your coverage.

Prudent Actions By Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes obligations upon the people who are responsible for the operation of the employee benefit Plan. These persons are referred to as "fiduciaries" in the law. Fiduciaries must act solely in the interest of their Plan duties. Fiduciaries who violate ERISA may be removed and required to make good any losses they have caused this Plan

The employer, of a Plan participant, may not fire or discriminate against that participant to prevent him or her from obtaining or exercising his or her rights under ERISA.

Enforce Your Rights

If a participant is denied a benefit, in full or in part, he or she has a right to know why this was done, to obtain the 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 administrator. If you have a claim for benefits which is denied or ignored, in full or in part, a participant may file suit in a state or Federal court. In addition, if a participant disagrees with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, he/she may file suit in Federal court. If Plan fiduciaries are misusing this Plan's money, or if a participant is discriminated against for asserting his or her rights, a participant has the right to file a suit in a Federal court or request assistance from the U.S. Department of Labor. If the participant is successful in, the lawsuit the court may require the other party to pay the participant's legal costs, including attorney's fees. If the participant is unsuccessful, the court may require the participant to pay these costs and fees, for example, if it finds the claim was frivolous.

Assistance with your Questions

If the participant has any questions about this Plan, the participant should contact the Plan Administrator. If the participant has any questions about this statement or about his/her rights under ERISA, or if the participant needs assistance in obtaining documents from the Plan Administrator, the participant should contact the nearest office of the Employee Benefits Security

Administration, U.S. Department of Labor, listed in the telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. The participant may also obtain certain publications about his or her rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

INFORMATION REQUIREMENTS OF ERISA

Named Fiduciary/ Plan Sponsor:	Cornell College 600 First Street Southwest Mount Vernon, IA 52314-1098
Employer Identification #:	42-0680335
Plan Name:	Cornell College Employee Health Care Plan
Plan Number:	501
First Administrators, Inc. Group Number:	32800
Plan Year Ends:	December 31
Participants:	Eligible employees and their covered dependents.
Plan Administrator and Agent for Legal Process of Plan:	Cornell College 600 First Street Southwest Mount Vernon, IA 52314-1098
Plan Costs:	The Plan Sponsor and the employees pay the costs of this Plan.
Type of Plan:	Group Health Plan
Type of Administration:	Contract Administration
Third Party Administrator:	First Administrators, Inc. P.O. Box 8150 Rapid City, South Dakota 57709-8150
Authority to Amend Plan:	Vice President of Business Affairs/Treasurer
Administration and Plan Administrator Authority:	<p>The Plan is administered through the local offices of the Plan Administrator to which the participant is associated. The Plan Administrator has retained the services of an Independent Benefit Services Administrator experienced in claims processing.</p> <p>The Plan is a legal entity. Legal notices may be filed with, and legal process served upon the Benefit Services Administrator and Plan Administrator.</p> <p>The Plan Administrator has the full and final authority to decide all questions or controversies of whatever character arising in any manner between any parties or persons in connection with the Plan or the interpretation thereof, including the construction of the language of the Summary Plan Description, and any writing, decision, benefit eligibility and determination, instrument or accounts in connection with same and with the operation of this Plan or otherwise, which shall be binding upon all persons dealing with this Plan or claiming any benefits thereunder, except to the extent that the Plan Administrator may subsequently determine, in their sole discretion, that their original decision was in error or to the extent such decision may be determined to be arbitrary or capricious by a court or arbitrator having jurisdiction over such matters.</p>

If the employer is unable to fund this Plan, the participant may be financially responsible for any incurred and unpaid claims. The Benefit Services Administrator assumes no financial liability.

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