
PLAN DOCUMENT AND
SUMMARY PLAN DESCRIPTION
FOR

RANDOLPH COLLEGE HEALTH BENEFIT PLAN

If you have Medicare or will become eligible for Medicare in the next 12 months, a new Federal law gives you more choices about your prescription drug coverage, starting in 2006. Please see Medicare Eligible Participant Section for more information.

January 1, 2009

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INTRODUCTION

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Claim Provisions. Explains the rules for filing claims and the claim appeal process.

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

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

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

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

MEMBER RIGHTS AND RESPONSIBILITIES

Members' Rights

Members have the right to:

- Be provided with accurate information about the Group's services, benefits, their rights and responsibilities, and Participating Providers.
- Participate with their physician in decisions made regarding their health care.
- Have access to the Group and Southern Health's Customer Service Department.
- Discuss appropriate or Medically Necessary treatment options for medical conditions, regardless of the cost or benefit coverage.
- Be treated with respect and recognition of their dignity and need for privacy and confidentiality.
- Voice complaints and appeals about Your Group, Southern Health or the care provided by Participating Providers and to have a clear, documented method for addressing any complaints and appeals.
- To make recommendations regarding the Member Rights and Responsibility policy.

Members' Responsibilities to Providers

Members have the responsibility for cooperating with providers of health care services by:

- Providing information needed by health care professionals.
- Informing provider's office and facility staff of their Group coverage administered by Southern Health and notifying office and facility staff if their coverage ends.
- Following instructions and guidelines given by health care providers. Failure to comply with recommended treatment is an option for Members. However, when a Member fails to comply with the recommended treatment, the Group will have no further liability to pay for treatment for the particular condition until such time that the Member later decides to follow the prescribed treatment, assuming the prescribed treatment is a Covered Service. The Group will not be responsible for payment of services that may otherwise be Covered Services but that in the Group's discretion are the direct result of the Member's initial refusal to follow the recommended treatment.
- Cooperating with practitioners and providers of health care services by understanding their health problems and participating in the development of a mutually agreed upon treatment goal to the degree possible.

Members' Responsibilities to Know How and When to Seek Care

Members have the responsibility of knowing their health benefits, as well as any procedures required for seeking care, such as:

- Knowing whether they are seeking care from a Participating or non-participating provider. In most cases, benefits will vary according to the participation status of the provider delivering Covered Services.
- Verifying the current participation status of any provider for their specific benefit plan prior to receiving services.
- Always obtaining any required Preauthorizations as described in this Plan Document and Summary Plan Description. If they need to seek services from a non-participating provider, they will need to ensure that Southern Health, on behalf of the Group, has approved the services before receiving Covered Services.
- Understanding the terms and limitations of Preauthorizations for Covered Services and whether Preauthorizations are approved at the In-Network or Out-of-Network benefit level.
- Obtaining Preauthorization from Southern Health, on behalf of the Group, prior to continuation of care if they or a covered family member is receiving health care from a non-participating provider when they

enroll. They should consult with their treating physicians who will call Southern Health to obtain Preauthorizations.

- **Knowing the Preauthorization requirements that apply to both In- and Out-of-Network benefits and understanding the terms of their Preauthorization. Refer to “Preauthorization Exhibit” for a list of items that require Preauthorization.**
- Accessing Behavioral Health and Substance Abuse services as described in this Plan Document and Summary Plan Description.
- Members have the responsibility of promptly notifying the Group and Southern Health of any address or telephone number changes. If correspondence is not received because a Subscriber has failed to notify Southern Health of an address change, You or Your Dependent’s coverage could be terminated or not renewed in accordance with the terms and conditions of this contract without Your knowledge. You will be responsible for expenses You incur as a direct result of Your not notifying the Group of any address or telephone number change.
- Checking with their Group regarding Dependent eligibility and notifying the Group and Southern Health within thirty-one (31) days of any changes.
- Making sure all family members are aware of the correct procedures for obtaining the Group coverage described in this Description of Benefits and administered by Southern Health.

Failure to meet the responsibilities listed in this Plan Document may cause You to be financially responsible for services provided.

IMPORTANT NOTICE FOR MASTECTOMY PATIENTS

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

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

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

Preauthorization is required.

ELIGIBILITY, FUNDING, EFFECTIVE DATE AND TERMINATION PROVISIONS

A Plan Participant should contact the Plan Administrator to obtain additional information, free of charge, about Plan coverage of a specific benefit, particular drug, treatment, test or any other aspect of Plan benefits or requirements.

ELIGIBILITY

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

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

- (1) is a Full-Time, Active Employee of the Employer. An Employee is considered to be Full-Time if he or she normally works at least 1365 hours annually and is on the regular payroll of the Employer for that work.
- (2) is a Part-Time, Active Employee of the Employer. An Employee is considered to be Part-Time if he or she normally works at least 1365 hours annually and is on the regular payroll of the Employer for that work.
- (3) is a Retired Employee of the Employer who meets the eligibility requirements of the Employer.
- (4) is in a class eligible for coverage.

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

- (1) A covered Employee's Spouse and unmarried children from birth to the limiting age of 19 years. The Dependent children must be primarily dependent upon the covered Employee for support and maintenance. However, a Dependent child will continue to be covered after age 19, provided the child is a full-time student at an accredited school, primarily dependent upon the covered Employee for support and maintenance, is unmarried and under the limiting age of 25. When the child reaches either limiting age, coverage will end on the child's birthday. If the child does not maintain full-time status or graduates, coverage closes independent of limiting age.

Full-time student coverage continues between semester/quarters only if the student is enrolled as a full-time student in the next regular semester/quarter. If the student is not enrolled as a full-time student, coverage will be terminated retroactively to the last day of the attended school term.

The term "Spouse" shall mean the person recognized as the covered Employee's husband or wife under the laws of the state where the covered Employee lives. Domestic Partners, meeting the eligibility requirements of the Plan, are also considered eligible Dependents. The Plan Administrator may require documentation proving a legal marital relationship.

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

- shares your permanent address;
- has resided with you for no less than one year;
- is no less than 18 years of age;
- is financially interdependent with you and has proven such interdependence by providing documentation of at least two of the following arrangements: common ownership of real property or a common leasehold interest in such property; community ownership of a motor vehicle; a joint bank account or a joint credit account; designation as a beneficiary for life insurance or retirement benefits or under your partner's will; assignment of a durable power of attorney or health care power of attorney; or such other proof as is considered by the Employer to be sufficient to establish financial interdependency under the circumstance of your particular case;
- is not a blood relative any closer than would prohibit legal marriage; and
- has signed jointly with you, a notarized affidavit which can be made available to the Employer upon request.

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

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

You and your Domestic Partner must have registered as Domestic Partners, if you reside in a state that provides for such registration. The section entitled "Continuation of Coverage under COBRA" will not apply to your Domestic Partner and his or her Dependents.

The term "children" shall include natural children, adopted children or children placed with a covered Employee in anticipation of adoption. Step-children and children of Domestic Partners who reside in the Employee's household may also be included as long as a natural parent remains married to the Employee and also resides in the Employee's household.

If a covered Employee is the Legal Guardian of an unmarried child or children, these children may be enrolled in this Plan as covered Dependents.

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

Any child of a Plan Participant who is an alternate recipient under a qualified medical child support order shall be considered as having a right to Dependent coverage under this Plan.

A participant of this Plan may obtain, without charge, a copy of the procedures governing qualified medical child support order (QMCSO) determinations from the Plan Administrator.

In all cases, to qualify as an eligible Dependent under the Plan, the child must be dependent upon the covered Employee for over one-half of his support during the Plan Year. A special rule applies in the case of a child of divorced parents, legally separated parents or parents who lived apart at all times of the year or during the last six months of the calendar year. The child will be considered dependent upon the Employee for over one-half of his support if the child is in the custody of the Employee and/or the other parent for more than one-half of the year and the child is dependent upon one and/or both parents for more than one-half of his support for the year. The Plan Administrator may require documentation proving dependency, including birth certificates, tax records or initiation of legal proceedings severing parental rights.

- (2) A covered Dependent child who reaches the limiting age and is Totally Disabled, incapable of self-sustaining employment by reason of behavioral or physical handicap, primarily dependent upon the covered Employee for support and maintenance and unmarried. The Plan Administrator may require, at reasonable intervals during the two years following the Dependent's reaching the limiting age, subsequent proof of the child's Total Disability and dependency.

After such two-year period, the Plan Administrator may require subsequent proof not more than once each year. The Plan Administrator reserves the right to have such Dependent examined by a Physician of the Plan Administrator's choice, at the Plan's expense, to determine the existence of such incapacity.

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

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

If both mother and father are Employees, their children will be covered as Dependents of the mother or father, but not of both.

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

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

FUNDING

Cost of the Plan. Randolph College shares the cost of Employee and Dependent coverage under this Plan with the covered Employees. The enrollment application for coverage will include a payroll deduction authorization. This authorization must be filled out, signed and returned with the enrollment application.

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

PRE-EXISTING CONDITIONS

There are no pre-existing condition limitations.

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

ENROLLMENT

Enrollment Requirements. An Employee must enroll for coverage by filling out and signing an enrollment application along with the appropriate payroll deduction authorization. The covered Employee is required to enroll for Dependent coverage also.

Enrollment Requirements for Newborn Children.

A newborn child of a covered Employee who has Dependent coverage is not automatically enrolled in this Plan. Charges for covered nursery care will be applied toward the Plan of the newborn child. If the newborn child is required to be enrolled and is not enrolled in this Plan on a timely basis, as defined in the section "Timely Enrollment" following this section, there will be no payment from the Plan and the parents will be responsible for all costs.

Charges for covered routine Physician care will be applied toward the Plan of the newborn child. If the newborn child is required to be enrolled and is not enrolled in this Plan on a timely basis, there will be no payment from the Plan and the covered parent will be responsible for all costs.

If the child is required to be enrolled and is not enrolled within 31 days of birth, the enrollment will be considered a Late Enrollment.

TIMELY OR LATE ENROLLMENT

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

If two Employees (husband and wife) are covered under the Plan and the Employee who is covering the Dependent children terminates coverage, the Dependent coverage may be continued by the other covered Employee as long as coverage has been continuous.

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

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

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

SPECIAL ENROLLMENT RIGHTS

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

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

The Special Enrollment rules are described in more detail below. To request Special Enrollment or obtain more detailed information of these portability provisions, contact the Plan Administrator, Randolph College, 2500 Rivermont Avenue, Lynchburg, Virginia, 24503, (434) 947-8114.

SPECIAL ENROLLMENT PERIODS

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

- (1) Individuals losing other coverage creating a Special Enrollment right.** An Employee or Dependent who is eligible, but not enrolled in this Plan, may enroll if loss of eligibility for coverage is due to any of the following conditions:
 - (a)** The Employee or Dependent was covered under a group health plan or had health insurance coverage at the time coverage under this Plan was previously offered to the individual.
 - (b)** If required by the Plan Administrator, the Employee stated in writing at the time that coverage was offered that the other health coverage was the reason for declining enrollment.
 - (c)** The coverage of the Employee or Dependent who had lost the coverage was under COBRA and the COBRA coverage was exhausted, or was not under COBRA and either the coverage was terminated as a result of loss of eligibility for the coverage or because employer contributions towards the coverage were terminated. Coverage will begin no later than the first day of the first calendar month following the date the completed enrollment form is received.
 - (d)** The Employee or Dependent requests enrollment in this Plan not later than 31 days after the date of exhaustion of COBRA coverage or the termination of non-COBRA coverage due to loss of eligibility or termination of employer contributions, described above. Coverage will begin no later than the first day of the first calendar month following the date the completed enrollment form is received.
 - (e)** For purposes of these rules, a loss of eligibility occurs if:
 - (i)** The Employee or Dependent has a loss of eligibility on the earliest date a claim is denied that would meet or exceed a lifetime limit on all benefits.
 - (ii)** The Employee or Dependent has a loss of eligibility due to the plan no longer offering any benefits to a class of similarly situated individuals (i.e.: part-time employees).

- (iii) The Employee or Dependent has a loss of eligibility as a result of legal separation, divorce, cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan), death, termination of employment, or reduction in the number of hours of employment or contributions towards the coverage were terminated.
- (iv) The Employee or Dependent has a loss of eligibility when coverage is offered through an HMO, or other arrangement, in the individual market that does not provide benefits to individuals who no longer reside, live or work in a service area, (whether or not within the choice of the individual).
- (v) The Employee or Dependent has a loss of eligibility when coverage is offered through an HMO, or other arrangement, in the group market that does not provide benefits to individuals who no longer reside, live or work in a service area, (whether or not within the choice of the individual), and no other benefit package is available to the individual.

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

(2) Dependent beneficiaries. If:

- (a) The Employee is a participant under this Plan (or is eligible to be enrolled under this Plan but for a failure to enroll during a previous enrollment period), and
- (b) A person becomes a Dependent of the Employee through marriage, birth, adoption or placement for adoption,

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

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

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

- (a) in the case of marriage, the first day of the first month beginning after the date of the completed request for enrollment is received, or in the case of domestic partner relationship, on the date of registration of the domestic partner relationship; or
- (b) in the case of loss of coverage, the date of the loss of prior coverage if you complete and return the enrollment/change form in a timely manner and pay any required premiums for such new coverage;
- (c) in the case of a Dependent's birth, as of the date of birth; or
- (d) in the case of a Dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.

An Employee who is already enrolled in a benefit option may enroll in another benefit option under the Plan if their Dependent has a Special Enrollment right because the Dependent lost other health coverage.

ENROLLMENT OF DEPENDENT PURSUANT TO A QUALIFIED MEDICAL CHILD SUPPORT ORDER

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

EFFECTIVE DATE

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

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

Active Employee Requirement.

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

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

TERMINATION OF COVERAGE

When coverage under this Plan stops, Plan Participants will receive a certificate that will show the period of Creditable Coverage under this Plan. The Plan maintains written procedures that explain how to request this certificate. Please contact the Plan Administrator for a copy of these procedures and further details.

The Employer or Plan has the right to rescind any coverage of the Employee and/or Retiree and/or Dependents for cause, making a fraudulent claim or an intentional material misrepresentation in applying for or obtaining coverage, or obtaining benefits under the Plan. The Employer or Plan may either void coverage for the Employee and/or covered Retirees and/or covered Dependents for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage. The employer will refund all contributions paid for any coverage rescinded; however, claims paid will be offset from this amount. The employer reserves the right to collect additional monies if claims are paid in excess of the Employee's and/or Retiree's and/or Dependent's paid contributions.

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

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

- (4) The earliest date the Employee has a claim that is denied in whole or in part because the Employee has met or exceeded a lifetime limit on all benefits.
- (5) If an Employee commits fraud or makes a material misrepresentation in applying for or obtaining coverage, or obtaining benefits under the Plan, then the Employer or Plan may either void coverage for the employee and covered Dependents for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage.
- (6) If an Employee misuses the Plan identification card or allows persons other than the one specifically named on the ID card to attempt to obtain benefits, then coverage will be terminated for the Employee and covered Dependents upon thirty-one (31) days written notice from the Plan.
- (7) If a Network Provider, after Plan's reasonable efforts to provide this opportunity to the Employee, is unable to establish and maintain a satisfactory provider-patient relationship with an Employee, Plan may terminate the coverage of the employee and all other family members covered on that same policy. This can be done with thirty-one (31) days written notice to the Employee. Repeatedly seeking and receiving services that are not Medically Necessary as determined by the Plan and the provider in question shall also be considered the inability to establish and maintain a satisfactory provider-patient relationship.

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

For disability leave only: the date the Employer ends the continuance.

For leave of absence or layoff only: the date the Employer ends the continuance.

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

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

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

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

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

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

- (1) The maximum period of coverage of a person and the person's Dependents under such an election shall be the lesser of:
 - (a) The 24 month period beginning on the date on which the person's absence begins; or
 - (b) The day after the date on which the person was required to apply for or return to a position of employment and fails to do so.

- (2) A person who elects to continue health plan coverage must pay up to 102% of the full contribution under the Plan, except a person on active duty for 30 days or less cannot be required to pay more than the Employee's share, if any, for the coverage.
- (3) An exclusion or Waiting Period may not be imposed in connection with the reinstatement of coverage upon reemployment if one would not have been imposed had coverage not been terminated because of service. However, an exclusion or Waiting Period may be imposed for coverage of any Illness or Injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of uniformed service.

If the Employee wishes to elect this coverage or obtain more detailed information, contact the Plan Administrator Randolph College, 2500 Rivermont Avenue, Lynchburg, Virginia, 24503, (434) 947-8114. The Employee may also have continuation rights under USERRA. In general, the Employee must meet the same requirements for electing USERRA coverage as are required under COBRA continuation coverage requirements. Coverage elected under these circumstances is concurrent not cumulative. The Employee may elect USERRA continuation coverage for the Employee and their Dependents. Only the Employee has election rights. Dependents do not have any independent right to elect USERRA health plan continuation.

Surviving Spouse. If, as a retired faculty or staff member, you are participating in the College's medical insurance when you die, any of your Dependents who are then insured for such insurance may remain so insured as long as further payments of monthly premiums are continued. The insurance on any of those Dependents will remain in force until the earliest date below:

- the date of remarriage of the surviving spouse, if any;
- the date that the Dependent ceases to qualify as a Dependent for a reason other than lack of primary support by you.

The Dependent benefits payable after you die will be those in effect for your Dependents on the day prior to your death.

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

- (1) The date the Plan or Dependent coverage under the Plan is terminated.
- (2) The date that the Employee's coverage under the Plan terminates for any reason including death. (See the section entitled Continuation Coverage Rights under COBRA.)
- (3) The date a covered Spouse loses coverage due to loss of dependency status. (See the section entitled Continuation Coverage Rights under COBRA.)
- (4) On the first date that a Dependent child ceases to be a Dependent as defined by the Plan. (See the section entitled Continuation Coverage Rights under COBRA.)
- (5) The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due.
- (6) The earliest date the Dependent has a claim that is denied in whole or in part because it meets or exceeds a lifetime limit on all benefits.
- (7) If a Dependent commits fraud or makes a material misrepresentation in applying for or obtaining coverage, or obtaining benefits under the Plan, then the Employer or Plan may either void coverage for the Dependent for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage.
- (8) If a Dependent misuses the Plan identification card or allows persons other than the one specifically named on the ID card to attempt to obtain benefits, then coverage will be terminated for the Dependent upon thirty-one (31) days written notice from the Plan.

- (9) If a Network Provider, after Plan's reasonable efforts to provide this opportunity to the Dependent, is unable to establish and maintain a satisfactory provider-patient relationship with a Dependent, Plan may terminate the coverage of Dependent. This can be done with thirty-one (31) days written notice to the Dependent. Repeatedly seeking and receiving services that are not Medically Necessary as determined by the Plan and the provider in question shall also be considered the inability to establish and maintain a satisfactory provider-patient relationship.

OPEN ENROLLMENT

OPEN ENROLLMENT

Every December, the annual open enrollment period, Employees and their Dependents who are Late Enrollees will be able to enroll in the Plan.

Benefit choices for Late Enrollees made during the open enrollment period will become effective January 1.

Plan Participants will receive detailed information regarding open enrollment from their Employer.

NOTICE FOR MEDICARE ELIGIBLE PARTICIPANTS

Important Notice About Your Prescription Drug Coverage and Medicare

Please read this section carefully and keep this document where you can find it. This section has information about your current prescription drug coverage and new prescription drug coverage available January 1, 2006 for people with Medicare. It also tells you where to find more information to help you make decisions about your prescription drug coverage.

Starting January 1, 2006, new Medicare prescription drug coverage became available to everyone with Medicare. The Plan Administrator has determined that the prescription drug coverage offered under this Plan is, on average for all Covered Persons, expected to pay out as much as the standard Medicare prescription drug coverage will pay. Read this section carefully – it explains the options you have under the Medicare prescription drug coverage, and can help you decide whether or not you want to enroll in the Medicare prescription drug coverage.

Because your coverage under this Plan is on average at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay extra if you later decide to enroll in Medicare prescription drug coverage. People with Medicare are/were allowed to enroll in a Medicare prescription drug plan from November 15, 2005 through May 15, 2006 (“initial enrollment period”). For people that become eligible for Medicare Part D after February 1, 2006, the initial enrollment period is three months before the month in which the person first meets the Medicare eligibility requirements for Part D and ends 3 months after the month of first eligibility. However, because you have existing prescription drug coverage that, on average, is as good as Medicare coverage, you can choose to join a Medicare prescription drug plan later. Each year after the initial enrollment period, you will have the opportunity to enroll in a Medicare prescription drug plan between November 15th through December 31st.

If you decide to enroll in a Medicare prescription drug plan and drop your coverage under this Plan, be aware that you may not be able to get this coverage back. You should compare your coverage under this Plan, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. **In addition, your coverage under this Plan pays for other health expenses, in addition to prescription drugs, and if you choose to drop this Plan and enroll in Medicare prescription drug coverage, you will also lose all of those health benefits under this Plan as well as your current prescription drug benefits.**

You should also know that if you drop or lose your coverage with the Plan and do not enroll in Medicare prescription drug coverage after your coverage under this Plan ends, you may pay more to enroll in Medicare prescription drug coverage later. If after May 15, 2006, you go 63 days or longer without prescription drug coverage that is at least as good as Medicare’s prescription drug coverage; your monthly premium will go up at least 1% per month for every month after May 15, 2006 that you did not have that coverage. For example, if you go nineteen months without coverage, your premium will always be at least 19% higher than what most other people pay. You will have to pay this higher premium as long as you have Medicare coverage. In addition, you may have to wait until next November to enroll.

You may receive this notice at other times in the future such as before the next period you can enroll in Medicare prescription drug coverage, and if this coverage changes. You also may request a copy. Contact the Plan Administrator for further information.

More detailed information about the Medicare plans that offer prescription drug coverage is available in the “Medicare & You” handbook published by the Centers for Medicare and Medicaid Services (“CMS”), the federal agency responsible for the Medicare program. You can get more information about the Medicare prescription drug plans from these places:

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

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information about this extra help is available from the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this document. If you enroll in one of the plans approved by Medicare which offer prescription drug coverage after May 15, 2006, you may need to give a copy of this section when you join to show that you are not required to pay a higher premium amount.

SCHEDULE OF BENEFITS

Verification of Eligibility: (800) 627-4872

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

MEDICAL BENEFITS

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

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

Southern Health Services, Inc.
Town Center One, 1000 Research Park Blvd.
Charlottesville, VA 22911
(800) 627-4872
www.southernhealth.com

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

The Plan is a Participating Provider Organization (PPO) plan.

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

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

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

- If a Covered Person has no choice of Network Providers in the specialty that the Covered Person is seeking within the PPO service area and with prior approval from the Claims Administrator's Medical Director. Preauthorization is required.
- If a Covered Person is out of the PPO service area and has a Medical Emergency requiring immediate care.
- If a Covered Person is referred to a Non-Network Provider by an In-Network Provider and with prior approval from the Claims Administrator.

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

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

Deductibles/Copayments payable by Plan Participants

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

**RANDOLPH COLLEGE
SCHEDULE OF BENEFITS**
Administered by Southern Health Services, Inc.

OUTPATIENT SERVICES	In-Network PLAN PAYS	Out-of-Network PLAN PAYS
Child Preventive Services Exams, including well child care Immunizations Screening Tests, including hearing and eye chart screenings	100% AC 100% AC 100% AC	100% BC 100% BC 100% BC
Adult Preventive Services Exams, including well woman Immunizations Screening Tests, including mammograms, Pap Smear, PSA test, colonoscopy, HIV, routine blood and urine screenings	100% AC 100% AC 100% AC	100% BC 100% BC 100% BC
Physician Home/Office Visit (includes allergy testing/treatment) Primary Care Visit Specialist Visit including OB-GYN physician	80% AC ₁ 80% AC ₁	80% BC ₁ 80% BC ₁
Allergy Serum & Allergy Injections Primary Care Visit Specialist Visit In-Network, if the office visit Copayment is greater than the amount of the serum & injection, then the Member will only be charged the amount of the serum & injection.	80% AC ₁ 80% AC ₁	80% BC ₁ 80% BC ₁
Lab Services (other than preventive)	80% AC ₁	80% BC ₁
Mammogram (other than preventive)	80% AC ₁	80% BC ₁
Diagnostic Services (other than specialty diagnostics) Including, but not limited to, x-ray examinations, EKGs, EEGs, bone scans and ultrasounds.	80% AC ₁	80% BC ₁
Specialty Diagnostic Services Including, but not limited to, MRA, MRI, CAT Scan, PET Scan, and Sleep Studies – for a complete list and to preauthorize services, contact the Claims Administrator.	80% AC ₁	80% BC ₁
Outpatient Facility/Outpatient Surgery	80% AC ₁	80% BC ₁
Spinal Manipulations/Chiropractic Services Maximum of 20 outpatient visits per Benefit Year	80% AC ₁	80% BC ₁
Urgent Care Center When Medically Necessary, as determined by the Claims Administrator	80% AC ₁	80% BC ₁
MATERNITY SERVICES		
	In-Network PLAN PAYS	Out-of-Network PLAN PAYS
Prenatal Care & Postpartum Home or Office Visit (after initial office visit for diagnosis of Pregnancy)	80% AC ₁	80% BC ₁
Maternity Ultrasounds	80% AC ₁	80% BC ₁
Inpatient Hospital Services Total per admission Inpatient PCP/OB-GYN services	80% AC ₁ 80% AC ₁	80% BC ₁ 80% BC ₁
EMERGENCY CARE		
	In-Network PLAN PAYS	Out-of-Network PLAN PAYS
Emergency Room Services Total per admission	80% AC ₁	
Ambulance Transportation Non-emergency transportation must be Preauthorized by Southern Health.	80% AC ₁	80% BC ₁

BEHAVIORAL HEALTH AND SUBSTANCE ABUSE SERVICES	In-Network PLAN PAYS	Out-of-Network PLAN PAYS
Inpatient – Maximum 45 days per Benefit Year ² (Up to 10 Behavioral Health/Substance Abuse days per Benefit Year may be converted to Partial Days on a basis of 1 inpatient day to 1.5 Partial Days.) Per admission	80% AC ₁	80% BC ₁
Outpatient – Maximum 20 visits per Benefit Year ² Visits 1-20 (In-Network the Member will pay the lesser of the Copayment or 50% AC.) The Member's payment responsibility for inpatient or outpatient treatment of Biologically-Base Behavioral Illness will be the same as the payment responsibility expected at that place of service for physical illness. Any Benefit Maximum, Lifetime Maximum and out-of-pocket maximum normally associated with that service or place of service will also apply.	50% AC ₁	50% BC ₁

INPATIENT HOSPITAL SERVICES	In-Network PLAN PAYS	Out-of-Network PLAN PAYS
Total per admission	80% AC ₁	80% BC ₁

ABORTION includes elective and non-elective procedures	In-Network PLAN PAYS	Out-of-Network PLAN PAYS
Inpatient Facility, including professional services	80% AC ₁	80% BC ₁
Outpatient Surgical Facility, including professional services	80% AC ₁	80% BC ₁
Physician's Office	80% AC ₁	80% BC ₁

FAMILY PLANNING SERVICES	In-Network PLAN PAYS	Out-of-Network PLAN PAYS
Office Visits, Tests and Counseling	80% AC ₁	80% BC ₁
Surgical Sterilization Procedure for vasectomy/tubal ligation (excludes reversals)	80% AC ₁	80% BC ₁

OTHER BENEFITS	In-Network PLAN PAYS	Out-of-Network PLAN PAYS
Bariatric Surgery Physician Office Visit	80% AC ₁	Not covered
Inpatient Admission, including professional services	80% AC ₁	Not covered
Outpatient Facility, including professional services	80% AC ₁	Not covered
Cardiac Rehabilitation Therapy Maximum 40 outpatient visits per condition.	80% AC ₁	80% BC ₁
Durable Medical Equipment (DME) & Medical Supplies	80% AC ₁	80% BC ₁
Home Health Care Services Maximum 120 visit per Benefit Year	80% AC ₁	80% BC ₁
Hospice Care	80% AC ₁	80% BC ₁
Infertility Treatment (does not include coverage for In-Vitro, GIFT, ZIFT or artificial insemination) Inpatient Admission, including professional services	80% AC ₁	80% BC ₁
Outpatient Facility, including professional services	80% AC ₁	80% BC ₁
Non-Implanted Prosthetic Devices ²	50% AC ₁	50% BC ₁
Occupational, Speech and Physical Therapy Inpatient – 40 days combined Benefit Year maximum Total per admission, including professional services	80% AC ₁	80% BC ₁
Outpatient – 40 visits combined Benefit Year maximum Per visit, including professional services	80% AC ₁	80% BC ₁
Skilled Nursing Facility Maximum 120 inpatient days per Benefit Year	80% AC ₁	80% BC ₁

Therapeutic Injectable Medications When shipped directly to a Member from a third party vendor	80% AC ₁	80% BC ₁
Wisdom Tooth Extraction (bony impacted only) Initial Provider's Office Visit Surgical Procedure performed in provider's office Surgical Procedure performed in outpatient facility and each professional provider	80% AC ₁ 80% AC ₁ 80% AC ₁	80% BC ₁ 80% BC ₁ 80% BC ₁
Transplant Services Per admission to facility Outpatient services will be the same as the payment responsibility expected at that place of service for any physical illness.	80% AC ₁	80% BC ₁

PRESCRIPTION DRUG BENEFIT ₂	YOU PAY
For up to a 31 day supply Preferred Generic* Preferred Brand* Non-Preferred Brand and Generic*	\$10 \$20 \$45
For up to 90 day supply through mail-order program Preferred Generic Preferred Brand Non-Preferred Brand and Generic	\$20 \$40 \$90

DEDUCTIBLES AND MAXIMUMS	In-Network	Out-of-Network
Benefit Year Out-of-Pocket Maximum Individual Family Deductibles and Copayments do not apply to the Out-of-Pocket Maximum.		\$1,500 \$3,000
Lifetime Maximum Benefit Per Member Bariatric Surgery Organ Transplant Services, including ABMT Covered Donor Screening Services	\$5,000,000 \$10,000 Unlimited	Not covered \$10,000 \$10,000
Benefit Year Deductible Individual Family Preventative Care Services do not apply to the Deductible.		\$300 \$600

Benefit Payable is calculated after subtracting from the AC any applicable Deductible, Copayment, Coinsurance or Penalty owed by the Member. All Benefit Maximums are combined for In-Network and Out-of-Network unless otherwise Specified.

Benefits and Benefit Year: Benefits listed in this Schedule of Benefits are for Covered Services only. The Benefit Year is the Calendar year.

AC – Allowable Charge

BC – Billed Charge

₁ After Deductible

₂ Visit limit applies after the Deductible has been met

*** For Retail Maintenance Drugs, the Member pays 3 Copayments for 3 Prescribing Units.**

MEDICAL BENEFITS

Medical Benefits apply when Covered Charges are incurred by a Covered Person for care of an Injury or Sickness and while the person is covered for these benefits under the Plan. Certain services may require Preauthorization from the Claims Administrator. Please refer to the Preauthorization Exhibit for a listing of these services.

DEDUCTIBLE

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

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

COPAYMENT

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

BENEFIT PAYMENT

Each Benefit Year, benefits will be paid for the Covered Charges of a Covered Person that are in excess of the Deductible and any Copayments. Payment will be made at the rate shown under reimbursement rate in the Schedule of Benefits. No benefits will be paid in excess of the Maximum Benefit Amount or any listed limit of the Plan.

OUT-OF-POCKET MAXIMUM

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

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

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

MAXIMUM BENEFIT AMOUNT

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

COVERED CHARGES

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

- (1) Hospital Care.** The medical services and supplies furnished by a Hospital or Ambulatory Surgical Center or a Birthing Center. Covered charges for room and board will be payable as shown in the Schedule of Benefits. Hospital stays between 6 and 23 hours will be considered observation stays.

After 23 observation hours, a confinement will be considered an inpatient confinement when it is Medically Necessary as determined by the Claims Administrator.

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

Specialized care units. Such as intensive care or cardiac care units.

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

Group health plans generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

- (3) **Skilled Nursing Facility Care.** The room and board and nursing care furnished by a Skilled Nursing Facility will be payable if and when Skilled Nursing Care is determined to be Medically Necessary by the Claims Administrator. Custodial care, respite care, rest cures, domiciliary, or convalescent care are not covered. Preauthorization is required from the Claims Administrator.

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

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

- (5) **Private Duty Nursing Care.** The private duty nursing care by a licensed nurse (R.N., L.P.N. or L.V.N.).

(a) **Inpatient Nursing Care.** Inpatient private duty nursing is not covered.

(b) **Outpatient Nursing Care.** Outpatient private duty nursing care is not covered.

- (6) **Home Health Care Services and Supplies.** Charges for home health care services and supplies are covered only for care and treatment of an Injury or Sickness. The diagnosis, care and treatment must be certified by the attending Physician and be contained in a Home Health Care Plan.

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

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

- (7) **Hospice Care Services and Supplies.** Charges for hospice care services and supplies are covered only when the attending Physician has diagnosed the Covered Person's condition as being terminal, determined that the person is not expected to live more than six months and placed the person under a Hospice Care Plan. Inpatient hospice respite care is covered for up to five (5) days in a six (6) month period.

Covered charges for Hospice Care are payable as described in the Schedule of Benefits.

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

(a) Local Medically Necessary professional land or air **ambulance** service. A charge for this item will be a Covered Charge only if the service is to the nearest Hospital or Skilled

Nursing Facility where necessary treatment can be provided unless the Claims Administrator finds a longer trip was Medically Necessary.

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

Hospital services and general anesthesia for dental procedures are covered when determined to be Medically Necessary for a Member who is under the age of five (5), is severely disabled, or has a medical condition, and requires admission to a hospital or outpatient surgery facility and general anesthesia for dental care treatment. Preauthorization of hospitalization and anesthesia should not be construed as preauthorization and payment of dental care incident to the hospitalization and anesthesia benefits.

- (c) Treatment of **Behavioral Disorders and Substance Abuse**. Covered charges for care, supplies and treatment of Behavioral Disorders and Substance Abuse will be limited as follows:

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

Physician's visits are limited to one treatment per day.

Psychiatrists (M.D.), psychologists (Ph.D.), counselors (Ph.D.) or Masters of Social Work (M.S.W.) may bill the Plan directly. Other licensed behavioral health practitioners must be under the direction of and must bill the Plan through these professionals.

Biologically-Based Behavioral Illness Benefits

Coverage is provided for Biologically-Based Behavioral Illness. Biologically-Based Behavioral Illness means any behavioral or nervous condition caused by a biological disorder of the brain that results in a clinically significant syndrome that substantially limits the person's functioning. Specifically, the following diagnoses are considered Biologically-Based Behavioral Illness: schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorder, panic disorder, obsessive-compulsive disorder, attention deficit hyperactivity disorder, autism, and drug and alcoholism addiction.

Benefits for Biologically-Based Behavioral Illness must be accessed as described herein. Coverage, meaning Copayments, Coinsurance, Deductibles, Benefit Maximums, and Lifetime Maximums, for Biologically-Based Behavioral Illness will be the same as the coverage offered under the medical and surgical benefits for a similar illness, condition, or disorder at a similar place of service. The Plan may offer benefits for Biologically-Based Behavioral Illness that may differ from benefits offered for a physical illness, condition, or disorder if the benefits meet the medical criteria necessary to achieve the same outcomes as are achieved for a physical illness, condition, or disorder.

Your payment responsibility and any applicable Benefit Maximum will depend on the place of service. Consult the Schedule of Benefits to determine the amount of payment responsibility per visit and any applicable Benefit Maximum. Services for Biologically-Based Behavioral Illness include, but are not limited to the following:

- Preauthorized **Outpatient visits** to Providers or facilities as may be necessary and appropriate for short-term evaluative or crisis intervention services for a Biologically-Based Behavioral Illness; includes Medication Management Visits
- Preauthorized **Inpatient care (Acute or Partial Hospitalization)** at an authorized facility for a Biologically-Based Behavioral Illness.

- (d) **Blood**. When medically necessary, including;
- Blood and plasma processing fees.
 - Costs associated with drawing, preparation, and storage of Member's blood, blood plasma, or blood derivatives for use by the Member.

- Charges incurred in connection with the treatment of routine bleeding episodes associated with hemophilia and other congenital bleeding disorders. Covered charges include the purchase of blood products and blood infusion equipment required for home treatment of routine bleeding episodes associated with hemophilia and other congenital bleeding disorders when the home treatment program is under the supervision of the state-approved hemophilia treatment center.

- (e) **Cardiac rehabilitation** is covered according to the coverage guidelines used by the Claims Administrator.
- (f) Radiation or **chemotherapy** and treatment with radioactive substances. The materials and services of technicians are included. For coverage of a phase II, III, and IV clinical trial, the trial must be approved by the National Cancer Institute and the Claims Administrator.
- (g) **Clinical Trials** for Treatment Studies on Cancer, including ovarian cancer trials, are covered as described below. Medically Necessary Covered Services that are incurred by the Member as a result of the treatment being provided for purposes of a clinical trial are referred to as patient costs in this section. Patient costs incurred during Phase II, Phase III, or Phase IV clinical trials for treatment studies on cancer approved by the National Cancer Institute (NCI), an NCI cooperative group or an NCI center, the FDA in the form of an investigational new drug application, the Federal Department of Veterans Affairs, or an institutional review board of an institution in Virginia that has a multiple project assurance contract approved by the Office of Protection from Research Risks of the NCI are covered. The facility and personnel where this treatment is provided must be capable of such provision of care by virtue of their experience, training, and expertise. Phase I clinical trials are not covered.

Coverage under this benefit shall only apply if: (i) there is no clearly superior, non-investigational treatment alternative, (ii) the available clinical or preclinical data provides a reasonable expectation that the treatment will be at least as effective as the non-investigational alternative, and (iii) the Member, Member's treating physician or other treating Provider conclude that the Member's participation in the clinical trial would be appropriate, pursuant to procedures established by the Claims Administrator and disclosed in this Plan Document. Non-health care services that a Member may receive as a result of this treatment, costs related to managing the research associated with the clinical trial, and investigational drugs and devices are not covered. Benefits under the Plan will relate to the place of service where services are received.

- (h) **Diabetes treatment** and counseling is covered for in-person outpatient self-management training and education, including medical nutritional therapy required for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes, and non-insulin using diabetes. This coverage is provided if: (i) prescribed by a Provider legally authorized to prescribe such services under law and (ii) provided by a Provider who is a certified, registered, or licensed health care professional.

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

- (i) Peritoneal **Dialysis** and Hemodialysis.
- (j) Rental of **durable medical or surgical equipment** if deemed Medically Necessary. These items may be bought rather than rented, with the cost not to exceed the fair market value of the equipment at the time of purchase, but only if agreed to in advance by the Claims Administrator.

Benefit includes ostomy supplies, oxygen and respiratory equipment.

Equipment rental for Negative Pressure Wound Therapy is covered under the durable

medical equipment benefit and does not apply to the benefit maximum.

Orthotics are covered under this benefit. Covered orthotic devices must, (i) be a device added to the body to stabilize or immobilize a body part, prevent deformity or assist with function; and (ii) be semi-rigid and correct a diagnosed musculoskeletal malalignment of a weakened or diseased body part; or (iii) be rigid or semi-rigid and stop or limit motion of a weak or diseased body part. Foot orthotics are not covered.

Wigs for patients of chemotherapy or radiation therapy are covered under the durable medical equipment benefit; however, the benefit for such wigs is limited to a maximum purchase price of \$250 per Benefit Year. This maximum for wigs contributes to any Benefit Maximum for Durable Medical Equipment. Benefit payment for durable medical equipment and medical supplies is provided as stated in the Schedule of Benefits.

- (k) Diagnosis and Medically Necessary treatment of diseases and injuries of the **eye** to include the first pair of cataract lenses or glasses following cataract removal surgery or lenses for the treatment of Keratoconus.
- (l) **Infertility** is the inability to conceive after one year of intercourse without contraception. Care, supplies and services for the diagnosis and charges for surgical correction of physiological abnormalities of infertility. In-Vitro, GIFT, ZIFT, prescription drugs, cryopreservation of donor sperm and eggs, donor charges and services, infertility services when infertility is related to voluntary sterilization and artificial insemination is not covered.
- (m) Medically Necessary services for care and treatment of **jaw joint conditions, including Temporomandibular Joint syndrome**.

Coverage for diagnosis and treatment of Temporomandibular Joint Disorder (TMD) and Craniomandibular Disorder (CMD) including:

- Health history (medical and/or dental) pertinent to symptoms
- Clinical examination related to the presenting symptoms
- Imaging procedures, provided that radiographs must be diagnostic for Temporomandibular Disorders (TMD) and/or Craniomandibular Disorder(s) (CMD)
- Conventional diagnostic and therapeutic injections
- Physical medicine and physiotherapy, which shall include:
 - Ultrasound
 - Diathermy
 - High-Voltage Galvanic Stimulation
 - Transcutaneous Nerve Stimulation
- Surgery on the Temporomandibular Joint which includes, but is not limited to, arthrotomy and diagnostic arthroscopy. All other surgeries are excluded.

Charges for TMJ are subject to the limits as described in the Schedule of Benefits.

- (n) **Laboratory tests** are covered when obtained at the office of a physician or through a laboratory.
- (o) **Maternity** including obstetrical care, prenatal, delivery and postpartum care, in an inpatient setting and/or a home visit or visits in accordance with the medical criteria prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists is covered. A nurse midwife may provide obstetrical care. Obstetrical care does not include services for childbirth performed in a home setting.
- (p) A **Medical Emergency** is a sudden onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a Prudent Layperson to result in (i) serious jeopardy to the mental or physical health of the Member; (ii) danger of serious impairment of the Member's bodily functions; (iii) serious dysfunction of any of the Member's bodily organs; or (iv) in the case of a pregnant woman, serious jeopardy to the

health of the fetus. Screening and stabilization services provided in a hospital emergency room for a Medical Emergency may be received from either Participating or Non-Participating Providers.

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

The Claims Administrator reviews all information and documentation with respect to these claims in accordance with established medical criteria and guidelines. If this review results in the determination that the Member did not experience a Medical Emergency, the Member may be responsible for the entire bill. Claims resulting from a Medical Emergency are eligible for payment at the In-Network level of benefits. If a claim is denied when you believe a Medical Emergency existed, contact the Customer Service Department.

- (q) Injury to or care of **mouth, teeth and gums**. Charges for Injury to or care of the mouth, teeth, gums and alveolar processes will be Covered Charges under Medical Benefits only if that care is for the following oral surgical procedures:

Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth.

Emergency repair due to Injury to sound natural teeth, when such repair occurs within sixty (60) days of the Injury. Emergency stabilization may consist of: control of hemorrhage, treatment of fractures, maintenance of airway, control of pain, and return to basic function. No additional coverage will be allowed until a comprehensive treatment plan is provided. Treatment performed that is not deemed "emergency" will not be covered. The time limit for treatment to be performed shall not exceed six (6) months, unless written approval is received from the Claims Administrator. In certain situations, two or more dental treatment alternatives may produce comparable results. When alternative options may be utilized, the least costly method will be eligible for coverage. If, after review in accordance with established medical and dental guidelines, the services received were not Medical Necessary, coverage under the Plan may be denied. Coverage is not provided for injuries that occur while in the act of chewing or biting, or for cosmetic treatment or surgery performed mainly to improve appearance.

Surgery needed to correct accidental injuries to the jaws, cheeks, lips, tongue, floor and roof of the mouth.

Excision of benign bony growths of the jaw and hard palate.

External incision and drainage of cellulitis.

Incision of sensory sinuses, salivary glands or ducts.

Excision of completely bony impacted third molars. Partially impacted or soft tissue removal of third molars is not covered. Anesthesia services rendered in connection with the covered removal of impacted teeth are also covered if performed by a person licensed to do so.

No charge will be covered under Medical Benefits for dental and oral surgical procedures involving orthodontic care of the teeth, periodontal disease and preparing the mouth for the fitting of or continued use of dentures.

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

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

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

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

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

Benefit payments for Out-of-Network transplant charges are included under the Organ Transplant Maximum Benefit Limit shown in the Schedule of Benefits.

Benefit payments for donor screening charges are subject to a separate Lifetime Maximum Benefit limit of \$10,000 as shown in the Schedule of Benefits. The cost of any care, including complications, arising from an organ donation by a Covered Person when the recipient is not a Covered Person is excluded.

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

Transplant Services rendered by a Provider not in the Coventry Transplant Network.

The Plan uses a transplant network. Facilities in this network are contracted to perform specific transplant services. The Plan reserves the right to require the a Covered Member to obtain services from a contracted Provider who may be outside of the network service area if the services are to be covered by the Plan at the In-Network benefit level. Organ, tissue, and bone marrow transplants performed by a Non-Participating Provider will be subject to the Out-of-Network benefit level. Any procedures involving organ and tissue donor expenses when the recipient is a Covered Member are also limited to any applicable maximum benefit when performed Out-of-Network.

- (t) **Orthotic appliances** are covered and will accrue toward the Durable Medical Equipment benefit. Covered orthotic devices must, (i) be a device added to the body to stabilize or immobilize a body part, prevent deformity or assist with function; and (ii) be semi-rigid and correct a diagnosed musculoskeletal malalignment of a weakened or diseased body part; or (iii) be rigid or semi-rigid and stop or limit motion of a weak or diseased body part. Foot orthotics are not covered.
- (u) **Physical therapy** by a licensed physical therapist. The therapy must be in accord with a Physician's exact orders as to type, frequency and duration and for conditions which are subject to significant improvement through short-term therapy. Physical therapy rendered by a chiropractor is covered.
- (v) **Prescription Drugs** approved by the Food and Drug Administration for the specific use and which can, under federal or state law, be dispensed only pursuant to a Prescription Order (i.e. a legend medication) and has not been excluded from coverage by the Claims Administrator.

- (w) Routine **Preventive Care.** Covered charges under Medical Benefits are payable for routine Preventive Care as described in the Schedule of Benefits.

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

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

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

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

Hearing and vision screenings:

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

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

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

Mammogram: Recommended is one baseline screening for ages thirty-five (35) to thirty-nine (39); One mammogram annually for ages forty (40) and over.

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

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

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

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

- (x) The initial purchase, fitting and repair of fitted **prosthetic devices** which replace body parts.

Non-implantable breast prosthesis are covered and subject to the following limitations: (i) silicone prosthetics will be covered at one prosthesis every two years, and (ii) fabric, foam, or fiber prosthetics will be covered at two per Benefit Year.

- (y) **Reconstructive surgery.** Reconstructive surgery or procedures when performed to correct deformity caused by disease, trauma, or a previous therapeutic process that is considered a Covered Service. In the event a Member is undergoing a multi-stage reconstruction or fulfilling a specific waiting period that is medically indicated, then the Provider must submit a treatment plan for approval.

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

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

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

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

- (i) Nipple and areola reconstruction.
 - (ii) Medical complications resulting from the rupture of the prostheses/implant, and appropriate treatment, including removal of the prostheses/implant, upon Preauthorization.
- (z) **Speech therapy** by a licensed speech therapist. Therapy must be ordered by a Physician and follow either: (i) surgery for correction of a congenital condition of the oral cavity, throat or nasal complex (other than a frenectomy) of a person; (ii) an Injury; or (iii) a Sickness that is other than a learning or Behavioral Disorder.
- (aa) **Spinal Manipulation/Chiropractic services** by a licensed M.D., D.O. or D.C.
- (ab) **Sterilization** procedures. Reversal of sterilization is not covered.
- (ac) **Surgical dressings**, casts, and other devices used in the reduction of fractures and dislocations.
- (ad) **Termination of pregnancy** , including elective and non-elective services.
- (ae) **Treatment of morbid obesity** through gastric bypass surgery or other methods recognized by the National Institutes of Health as effective for the for the long term reversal of morbid obesity is covered if determined by the Claims Administrator to be Medically Necessary and if the treatment is Preauthorized.

To determine Medical Necessity, certain criteria has been established by the Claims Administrator including the inability to lose weight despite participation in a six-month, physician-supervised, multidisciplinary program within the last twelve months. The Claims Administrator may also require participation in an extensive physician-supervised program including dietary therapy, physical activity and behavior therapy as well as a comprehensive evaluation of the Member's ability to comply with post operative evaluation and treatment regimen, including lifestyle issues.

Dietary supplements and programs for weight reduction are not covered. Also not covered are medical or psychiatric services, office visit and associated charges for the following procedures: "mini" gastric bypass, gastric balloons, jejunal bypasses, gastroplasty, and biopancreatic diversion with duodenal switch (BPD-DS).

(af) Coverage of Well Newborn Nursery/Physician Care.

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

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

The benefit is limited to Maximum Allowable Charges for nursery care for the newborn child while Hospital confined as a result of the child's birth.

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

Group health plans generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Charges for Routine Physician Care. The benefit is limited to the Maximum Allowable Charges made by a Physician for the newborn child while Hospital confined as a result of the child's birth.

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

(ag) Diagnostic x-rays.

UTILIZATION MANAGEMENT SERVICES

Preauthorization

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

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

When a Covered Person receives care or intends to receive care from a Non-Network Provider, the Covered Person or family member must call the number on the Plan ID card to receive certification of certain services in order for those services to be covered under this Plan. This call must be made at least three (3) days in advance of services being rendered. If there is an **emergency** admission to a Medical Care Facility, the Covered Person or someone on the Covered Person's behalf such as a family member, the Medical Care Facility or attending Physician, must contact the Claims Administrator **within 24 hours** or the first business day after the admission.

General Policies

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

Benefits may be denied when using a Non-Network Provider if the Covered Person fails to call the Claims Administrator at least three (3) days prior to an elective admission or outpatient surgery or procedure or, in the event of a Medical Emergency, within twenty-four (24) hours after the date of the Medical Emergency or as soon as reasonably possible.

Preauthorization is required when a Covered Person needs a medical or surgical procedure, diagnostic test, supply or medication that requires Preauthorization and is a Covered Service, regardless of whether services are provided In- or Out-of-Network. The physician ordering the services should notify the Claims Administrator to get preauthorization. Payment for preauthorized services will be subject to the applicable limitations, exclusions, and conditions of Plan coverage. **The appropriate preauthorization must be obtained even when the Plan is the secondary carrier; otherwise, the claim may be denied.** For a complete listing of the services that require preauthorization, including those with coverage implications, please see the Preauthorization Exhibit at the end of this Summary Plan Description/Plan Document.

Preauthorization requirements are updated periodically. To verify preauthorization requirements, contact the Claims Administrator at the number printed on the back of the member ID card. The Claims Administrator reserves the right to require documentation of Medical Necessity and/or second opinions prior to its preauthorization of Covered Services. Notwithstanding any review conducted by the Claims Administrator before the provision of a health care service, all benefits are subject to the terms and conditions of this Summary Plan Description/Plan Document.

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

If a physician feels that there is a need for a Covered Person to be seen by physician or other medical provider who does not participate in the network and that the services may be eligible for In-Network benefits, then the physician must submit medical information to the Claims Administrator prior to the Covered Person receiving services. **Retroactive requests for consideration at the In-Network benefit level will not be considered.** Covered Services from an Out-of-Network provider are preauthorized by the Claims Administrator for In-Network Benefits only when the Claims Administrator does not have an In-Network provider who can provide the service. The physician must submit evidence that participating Plan providers are unable to perform the requested services. The Claims Administrator has the right to determine where the services can be provided for coverage when an In-Network provider cannot render the service.

A Covered Person has the right to appeal any Utilization Management Program payment decision according to the Complaint and Appeal Procedures.

UTILIZATION REVIEW

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

The program consists of:

- (a) Preauthorization of the Medical Necessity for the following non-emergency services before Medical and/or Surgical services are provided:

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

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

Note: The services above must be preauthorized or reimbursement from the Plan may be reduced. TO PREAUTHORIZE MEDICAL SERVICES CALL (804)270-9200 OR 1-800-235-2206 AND 1-800-975-8919 TO PREAUTHORIZE BEHAVIORAL HEALTH AND SUBSTANCE ABUSE TREATMENT.

- (b) Retrospective review of the Medical Necessity of the listed services provided on an emergency basis;

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

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

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

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

Here's how the program works.

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

To make a pre-service request for benefits that will be provided by a Non-Network Provider, the Covered Person or the Non-Network Provider on the Covered Person's behalf should contact the Claims Administrator's Preauthorization Department and provide the following information:

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

After the Claims Administrator receives the request, it will notify the provider of any additional information needed by the Plan to make its determination. The Claims Administrator will make its decision and notify the provider within 15 days after it receives the request for benefits.

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

A Covered Person or provider may make an urgent care request for benefits by contacting the Claims Administrator. The Claims Administrator will make its decision and notify the provider of that decision as quickly as possible, taking into account medical exigencies, but in no event later than 72 hours after it receives the request. In some cases, the Covered Person or the provider may not have provided the Claims Administrator with sufficient information to make a decision. If this is the case, the Claims Administrator will notify the provider of the additional information that it needs to make a determination. The Claims Administrator will give the provider a reasonable amount of time, to provide the information.

Concurrent Care Benefit Determinations

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

Notifications of Benefit Determinations

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

Admission/Continued Stay Review

In the event of an emergency hospitalization or outpatient surgery or procedure, the Claims Administrator must be contacted within 24 hours after the Medical Emergency or as soon as reasonably possible following the receipt of the services.

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

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

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

In the event that a Covered Person wants to stay in the Hospital longer than authorized by the Claims Administrator, no further benefits will be provided.

CASE MANAGEMENT

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

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

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

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

PRESCRIPTION DRUG BENEFIT

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

The Plan understands and agrees that Coventry Prescription Management Services, Inc. may receive a retrospective discount or rebate from a vendor or manufacturer related to the aggregate volume of services, supplies, equipment or pharmaceuticals purchased by persons enrolled in health care plans offered or administered by the Claims Administrator and its affiliates. Covered Members shall not share in such

retrospective volume-based discounts or rebates. However, such rebates will be considered by the Plan, in the aggregate, when determining prospective premium calculations for health care plans offered and/or administered by the Plan Administrator.

Covered Drugs means Prescription Drugs that are:

- listed in the Prescription Drug List or Non-Preferred Drugs that are covered pursuant to Schedule of Medical Benefits,
- Medically Necessary,
- prescribed by an Authorized Prescriber,
- dispensed by a Network Pharmacy (except as covered by Non-Network Pharmacies as described in this section) and
- approved by the Plan.

Covered Drugs also includes:

- Glucagon emergency kits, insulin, syringes and needles, oral legend agents for controlling blood sugar, test strips for glucose monitors and lancets are covered when obtained with a prescription from a Physician.
- Syringes are covered when the injectable drug is covered.
- Oral contraceptives, patches and injectables are covered when obtained with a prescription from a Physician.
- Over-the-Counter (OTC) Prilosec, Zador, Alaway, Zyrtec, Miralax and Claritin.
- Generic Over-the-Counter (OTC) nicotine replacement products when purchased with a prescription from a Physician.
- Pneumococcal and flu vaccines provided at a participating pharmacy.
- Pharmacologic therapy for the treatment of sexual dysfunction.

You must present your Plan Identification Card for each prescription purchase. Your card contains information needed to process your prescription. The pharmacist will ask you to pay your prescription Copayment or Coinsurance at the time it is filled. If you do not present your Plan Identification Card, you may be asked to pay the full retail price of your prescription and submit your itemized receipt for reimbursement.

Retail Prescription Drugs

Copayments and Coinsurance, and dispensing limitations:

Initial prescriptions and prescription refills are covered as specified on the "Schedule of Medical Benefits". The Participant is required to pay one Copayment per each Prescription Order or Refill to a Network Retail or Specialty Pharmacy at the time of service. Copayment amounts are not applied to:

- Pharmacy Deductible,
- Annual Maximum, or
- Ancillary Charges.

Retail Maintenance Benefit

At participating retail pharmacies, for maintenance medications, you will pay:

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

Mail-order Pharmacy

When applicable, the Participating Pharmacy contracted by the Claims Administrator to provide Maintenance Medications through the mail.

Mail-order Prescription Drugs

Prescription Drugs determined by the Claims Administrator to be Maintenance Medications and prescribed by a Prescribing Provider are Covered when obtained through the Mail-Order Pharmacy. The quantity of a Prescription Drug dispensed pursuant to a Prescription Order or Refill by the Mail-Order Pharmacy should not exceed that required for a ninety (90) day/cycle supply of approved Maintenance Medications. To access the Mail-Order Pharmacy program, the Participant shall mail the prescription (or refill request) to the Mail-Order Pharmacy in the designated mail-order prescription envelope (available through the Customer Service Department and the Pharmacy Benefits Manager).

The Participant shall pay the Mail-Order Pharmacy:

- (a) Applicable Prescription Drug Deductibles, Copayments, and amounts above the Annual Maximum as specified in Schedule of Benefit; or
- (b) One hundred percent (100%) of the cost of a product not Covered for payment; or for dispensed quantities above the approved amount, including amounts in excess of a ninety (90) day supply for our approved Maintenance Medications.
- (c) Participants are not required to obtain Maintenance Medications from the Mail-Order Pharmacy if a Pharmacy selected by the Participant agrees to provide pharmaceutical services under the same terms and conditions as those provided by the Mail-Order Pharmacy.

More information on mail-order exclusions, as determined by the Claims Administrator, is available online at www.southernthehealth.com. **You will need to allow at least a fourteen (14) day turnaround time to receive your mail order prescription.**

Prescription Drug Limitations

Certain prescription drugs may be subject to drug limitations based on Plan criteria. The purpose of these limitations is to encourage safe and cost-effective use of drug therapies. Any drug not approved for use by the Food and Drug Administration (FDA); any FDA approved drug prescribed for an off-label use whose effectiveness is unproven based on clinical evidence reported in peer-reviewed medical literature; or any drug that is classified as an Investigational New Drug (IND) by the FDA. As used herein, off-label prescribing means prescribing prescription drugs for treatments other than those in the labeling approved by the FDA.

Mandatory Generic Substitution

The Plan requires mandatory generic substitution. If a brand name Prescription Drug is dispensed, and an equivalent generic Prescription Drug is available, the Member shall pay an Ancillary Charge directly to the pharmacy in addition to the brand name Copayment and/or Coinsurance. The Ancillary Charge is the difference between the price of the brand name drug and the generic drug. Member payments shall not exceed the price of the prescription drug.

Self-Administered Injectables

Self-administered injectable prescription drugs that are not covered at a retail pharmacy are covered only when provided by a Specialty Pharmacy, unless otherwise negotiated between the Claims Administrator and retail pharmacy. Coverage is subject to a prior written order by your Physician.

The Claims Administrator will maintain a list of covered specialty injectable prescription drugs and the medical conditions for which they are approved for coverage. Some examples of specialty injectable prescription drugs include: Interferons, Erythropoietin and granulocyte colony stimulating factor (G-CSF). Coverage can be verified by calling the Customer Service Department at the number listed on the back of your Plan Identification Card.

Prior Authorization, Step Therapy and Specific Quantity Limits. Regardless of where a Prescription Order or Refill is filled, Covered Charges under this benefit may be subject to Prior Authorization and quantity limits, as described below.

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

- may require special medical tests before use, or
- are not recommended as a first-line treatment, or
- have a potential for misuse or abuse, or
- are not approved for use by the Food and Drug Administration (FDA); any FDA approved drug prescribed for an off-label use whose effectiveness is unproven based on clinical evidence reported in peer-reviewed medical literature; or any drug that is classified as an Investigational New Drug (IND) by the FDA. As used herein, off-label prescribing means prescribing prescription drugs for treatments other than those in the labeling approved by the FDA.

Step Therapy is a form of Prior Authorization based on previous pharmaceutical treatment. Drugs designated as stepped therapy will require Prior Authorization if the condition is not met when the pharmacist would attempt to transmit a prescription claim.

Drugs requiring Prior Authorization are identified in the Prescription Drug List with "PA" next to the name of the drug. Drugs requiring Step Therapy are identified in the Prescription Drug List with "ST" next to the name of the

drug. In order for Prescription Drugs that require Prior Authorization to be covered under this Plan, the Authorized Prescriber must call the Claims Administrator before you fill a Prescription Order or Refill for a drug requiring Prior Authorization.

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

- searching the Prescription Drug List on the Claims Administrator's web site, or
- contacting the Member Services Department.

In order for Prescription Drugs in excess of the specific quantity limit to be covered under this Plan, the Authorized Prescriber must call us before you fill a Prescription Order or Refill for a drug that exceeds the specific quantity limit.

Smoking Cessation Program

The Plan covers generic over-the-counter (OTC) nicotine replacement products at the Tier 1 (generic) Copayment provided you obtain a prescription from a doctor. A 30-day supply is available per prescription, and is covered up to 90 days of OTC nicotine replacement products.

Products include:

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

Members should talk with their doctor about the method that is right for them. This program excludes brand names. The mail order and retail maintenance benefits do not apply.

VISION BENEFIT

For Randolph College Employees, this vision discount benefit includes;

- 20% discount on prescription and non-prescription glasses, including sunglasses. This discount is available from any VSP doctor within 12 months of the last covered eye exam from a VSP doctor.
- Savings averaging 15% off VSP-contracted laser center prices for laser vision correction surgery or an additional 5% off the center's promotional price.

To locate a vision provider, visit www.vsp.com.

In the event that you require eye care other than services for eyeglasses or contact lenses or the vision examiner suggests a medical eye evaluation, you should contact your PCP. If your PCP is unable to provide the needed services, he or she will assist you in choosing another Physician.

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

DEFINED TERMS

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

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

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

Ancillary Charge means the charge the Covered Person is required to pay to a Network or Non-Network Pharmacy for Prescription Drugs when the Covered Person or the Covered Person's physician requests that a

Brand Name drug be dispensed when a Generic substitution is available. The Ancillary Charge, if any, is the difference between the Claims Administrator's contracted price for the Brand Name drug and the contracted price for the Generic Drug. The Covered Person must pay the Ancillary Charge directly to the Network or Non-Network Pharmacy at the time the Prescription Order or Refill is filled. The Ancillary Charge is in addition to the Pharmacy Coinsurance and/or Copayment charge.

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

- Copayments or Coinsurance,
- Self-Administered Injectable Drug Copayment or Coinsurance, or
- Ancillary Charges.

Authorized Prescriber means any:

- licensed dentist,
- licensed physician,
- licensed podiatrist,
- certified nurse midwife to the extent permitted by applicable law,
- certified nurse practitioner to the extent permitted by applicable law, or
- other individual authorized by law to prescribe prescription or nonprescription drugs or devices.

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

Benefit Year is January to December.

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

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

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

Claims Administrator means Southern Health Services, Inc.

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

Contract Year is January to December.

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

Cosmetic Services and Surgery means plastic or reconstructive surgery: (i) from which no significant improvements in physiologic function could be reasonably expected; or (ii) that does not meaningfully promote the proper function of the body or prevent or treat illness or disease; or (iii) done primarily to improve the appearance or diminish an undesired appearance of any portion of the body.

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

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

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

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

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

Custodial Care is care (including Room and Board needed to provide that care) that is given principally for personal hygiene or for assistance in daily activities and can, according to generally accepted medical standards, be performed by persons who have no medical training. Examples of Custodial Care are help in walking and getting out of bed; assistance in bathing, dressing, feeding; or supervision over medication which could normally be self-administered.

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

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

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

Employee means a person who is an Active, regular Employee of the Employer, regularly scheduled to work for the Employer in an Employee/Employer relationship.

Employer is Randolph College.

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

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

Experimental and/or Investigational a health product or service is deemed experimental or investigational if one or more of the following conditions are met:

- Any drug not approved for use by the FDA; any drug that is classified as IND (investigational new drug) by the FDA; any drug requiring pre-authorization that is proposed for off-label prescribing;
- Any health product or service that is subject to Institutional Review Board (IRB) review or approval;
- Any health product or service that is the subject of a clinical trial that meets criteria for Phase I, II or III as set forth by FDA regulations;
- Any health product or service whose effectiveness is unproven based on clinical evidence reported in peer-reviewed medical literature.

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

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

Formulary (or Prescription Drug List) means a list of Prescription Drugs approved for coverage under this Plan. This list is subject to periodic review and modification by the Claims Administrator. The Prescription Drug List is available for review:

- in the Network Provider's office,
- by contacting the Claims Administrator's Customer Services Department, or
- on the Claims Administrator's website.

Generic drug means a Prescription Drug which has the equivalency of the brand name drug with the same use and metabolic disintegration. This Plan will consider as a Generic drug any Food and Drug Administration approved generic pharmaceutical dispensed according to the professional standards of a licensed pharmacist and clearly designated by the pharmacist as being generic.

Genetic Information means information about genes, gene products and inherited characteristics that may derive from an individual or a family member. This includes information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories and direct analysis of genes or chromosomes.

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

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

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

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

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

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

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

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

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

- A facility operating legally as a psychiatric Hospital or residential treatment facility for mental health and licensed as such by the state in which the facility operates.
- A facility operating primarily for the treatment of Substance Abuse if it meets these tests: maintains permanent and full-time facilities for bed care and full-time confinement of at least 15 resident patients; has a Physician in regular attendance; continuously provides 24-hour a day nursing service by a registered nurse (R.N.); has a full-time psychiatrist or psychologist on the staff; and is primarily engaged in providing diagnostic and therapeutic services and facilities for treatment of Substance Abuse.

Illness means a bodily disorder, disease, physical sickness or Behavioral Disorder. Illness includes Pregnancy, childbirth, miscarriage or complications of Pregnancy.

Infertility means the inability to conceive after one year of unprotected sexual intercourse or the inability to sustain a successful pregnancy.

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

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

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

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

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

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

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

- **Out-of-Network Rate** means the amount Southern Health pays for Covered Services furnished by Out-of-Network providers, unless such services are Preauthorized at the In-Network level of benefits. The Out-of-Network rate is based on: a defined Virginia Medicare fee schedule, a fixed per diem rate, a Virginia St. Anthony's fee schedule, or a fixed percentage of billed charges. The type and place of service determines the applicable schedule/rate. Southern Health's Allowable Charge policy provides further details on the determination/calculation of Out-of-Network Rates. Members may contact Customer Service to request a copy of the current Allowable Charge policy or to inquire about specific services and the applicable Out-of-Network Rate.
- **In-Network:** The amount determined by the Claims Administrator that it will pay for a Covered Service. Allowable Charge is the amount that a Network Provider has agreed to accept as payment in full pursuant to its agreement with the Claims Administrator.

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

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

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

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

- Broken bone;
- Chest pain;
- Seizures or convulsions;
- Severe or Unusual Bleeding;
- Severe burns;
- Suspected poisoning;
- Trouble breathing;
- Vaginal bleeding during pregnancy.

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

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

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

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

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

Member is any individual who meets the eligibility requirements of the Plan and is enrolled for coverage under the Plan.

Morbid Obesity means (i) a weight that is at least 100 pounds over or twice the ideal weight for frame, age, height, and gender as specified in the 1983 Metropolitan Life Insurance tables, (ii) a body mass index (BMI) equal to or greater than 35 kilograms per meter squared with co-morbidity or coexisting medical conditions such as hypertension, cardiopulmonary conditions, sleep apnea, or diabetes, or (iii) a BMI of 40 kilograms per meter squared without such co-morbidity. As used herein, BMI equals weight in kilograms divided by height in meters squared.

Narrow Therapeutic Index. A drug is said to have a narrow therapeutic index when small variances in a Participant's blood levels can change the effectiveness or toxicity of the drug. Safe and effective use of these drugs requires careful dosage adjustment and patient monitoring, regardless of whether the generic or brand name product is used.

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

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

Non-Formulary (or Non-Preferred) Drugs means a Prescription Drug that is
§ not listed in the Prescription Drug List, and
§ not excluded from Coverage.

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

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

Partial Hospitalization is an outpatient program specifically designed for the diagnosis or active treatment of a Behavioral Disorder or Substance Abuse when there is reasonable expectation for improvement or when it is necessary to maintain a patient's functional level and prevent relapse; this program shall be administered in a psychiatric facility which is accredited by the Joint Commission on Accreditation of Health Care Organizations and shall be licensed to provide partial hospitalization services, if required, by the state in which the facility is providing these services. Treatment lasts less than 24 hours, but more than four hours a day and no charge is made for room and board.

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

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

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

Plan Administrator means Randolph College.

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

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

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

Prescription Drug means a drug approved by the FDA for a specific outpatient use and that is dispensed only pursuant to a Prescription Order or Refill (a Legend Medication) under applicable law. Prescription Drugs include contraceptive drugs and devices and some over-the-counter medications or disposable medical supplies specified by the Plan (for example, insulin and certain diabetic supplies).

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

Retired Employee is a former Active Employee of the Employer who was retired while employed by the Employer under the formal written plan of the Employer and elects to contribute to the Plan the contribution required from the Retired Employee.

Self-Administered Injectable Drugs means injectable Prescription Drugs that are commonly and customarily administered by the Covered Person. Examples of Self-Administered Injectable Drugs include but are not limited to the following: multiple sclerosis agents, growth hormones, colony stimulating factors given more than once monthly, chronic medications for hepatitis C, certain rheumatoid arthritis medications, certain injectable HIV drugs, certain osteoporosis agents, and heparin products. Self-Administered Injectable Drugs are obtained from a Specialty Pharmacy. The following are not considered Self-Administered Injectable Drugs because they are not obtained from a Specialty Pharmacy: insulin, glucagon, bee sting kits, Imitrex and injectable contraceptives.

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

Significant Break in Coverage is a break in coverage of 63 days or more. Waiting periods do not count towards a Significant Break in Coverage.

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

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

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

Specialty Pharmacy means a pharmacy that:

§ has a contract with the Claims Administrator, and

§ is designated as a Specialty Pharmacy by the Claims Administrator for Covered Persons to obtain Self-Administered Injectable Drugs.

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

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

Temporomandibular Joint (TMJ) syndrome is the treatment of jaw joint disorders including conditions of structures linking the jaw bone and skull and the complex of muscles, nerves and other tissues related to the temporomandibular joint. Care and treatment shall include, but are not limited to orthodontics, crowns, inlays, physical therapy and any appliance that is attached to or rests on the teeth.

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

PLAN EXCLUSIONS

The services, supplies, equipment, facilities and related charges listed below are excluded from payment under this Plan unless covered under an amendment to this Plan. Covered Persons may contact the Claims Administrator Customer Services Department to assist in determining whether their benefit or payment has been extended by an amendment or notice of material modification.

This Plan does not cover the following items:

- Any service or supply that is not Preauthorized in accordance with this Plan's utilization management policies and procedures; provided that Emergency Services, services received from an Obstetrician or Gynecologist may vary from these requirements to the extent expressly stated in this Plan;
- Any service or supply that is not Medically Necessary;
- Any service or supply that is not a Covered Charge or that is directly or indirectly a result of receiving a non-Covered Charge;
- Any service or supply for which a Covered Person has no financial liability or that was provided at no charge;
- Procedures and treatments that this Plan determines, in its sole and absolute discretion, to be Experimental or Investigational;
- Reconstruction or delayed procedures except as specified in the Schedule of Benefits and, in the case of traumatic injury, when a significant anatomical or functional improvement can be anticipated;
- Any services to the extent that payment for such services is, by law, covered by any governmental agency as a primary plan;
- Charges resulting from your failure to appropriately cancel a scheduled appointment;
- Court-ordered services or services that are a condition of probation or parole, to the extent permitted by law.

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

- 1) **Acupressure.**
- 2) **Acupuncture.**
- 3) **Autopsy.**
- 4) **Behavior modification.**
- 5) **Biofeedback.**
- 6) **Bionic Devices** (microprocessor controlled prosthetics) to include, but not limited to, C-Leg.
- 7) The drawing, preparation and storage of umbilical cord **blood** is not covered.
- 8) **Braces** and supports needed for athletic participation or employment.
- 9) **Clothing** or shoes of any type, including but not limited to orthopedic shoes, children's corrective shoes,

shoes used in conjunction with leg braces, and shoe inserts.

- 10) **Complications of non-covered treatments.** Care, services or treatment required as a result of complications from a treatment not covered under the Plan are not covered.
- 11) **Corrective Appliances** that do not require prescription specifications and/or are used primarily for recreational sports.
- 12) **Cosmetic Services and Surgery** and the complications incurred as a result of those services and surgeries.
- 13) **Custodial care.** Services or supplies provided mainly as a rest cure, maintenance or Custodial Care.
- 14) **Repair and maintenance of Durable Medical Equipment** and Corrective Appliances:
 - a) Repair and maintenance for routine servicing such as testing, cleaning, regulating and checking of equipment is not covered except as specified in the Schedule of Benefits.
 - b) Except as specified in the Schedule of Benefits, repair coverage is limited to: (i) adjustment required by wear or by condition change when prescribed by a Participating Provider; and (ii) repairs necessary to make the equipment/appliance serviceable unless the repair costs exceed the cost of the equipment/appliance.
- 15) Except as specified in the Schedule of Benefits, **replacement coverage for Durable Medical Equipment** or Corrective Appliances. Replacement resulting from malicious damage, culpable neglect, or wrongful disposition of the equipment or device on the part of the Participant is NOT covered.
- 16) **Educational or vocational testing.** Services for educational or vocational testing or training, and for special education, counseling or care for learning deficiencies or behavioral problems, whether or not associated with a manifest behavioral disorder or other disturbance.
- 17) **Elective home delivery** for childbirth.
- 18) **Equipment** or services primarily used for use in altering air quality or temperature.
- 19) **Equipment** primarily used for non-medical purposes.
- 20) **Excess charges.** The part of an expense for care and treatment of an Injury or Sickness that is in excess of the Allowable Charge.
- 21) **Exercise programs and equipment.** Exercise programs for treatment of any condition, except for Physician-supervised cardiac rehabilitation, pulmonary, occupational or physical therapy covered by this Plan.
- 22) **Experimental or Investigational, or not Medically Necessary.** Care and treatment that is either Experimental/Investigational or not Medically Necessary.
- 23) **Eye care.** Radial keratotomy or other eye surgery to correct refractive disorders. Also, routine eye examinations, including refractions, lenses for the eyes and exams for their fitting, except as stated in the Vision Benefit section of the Plan Document. This exclusion does not apply to aphakic patients and soft lenses or sclera shells intended for use as corneal bandages.
- 24) **Eye exercises and therapy.**
- 25) **Failure to provide information.** Failure to provide any additional documentation or information as may be requested by the Claims Administrator may result in no coverage.
- 26) **Food or food supplements,** tube feeding, medical foods, vitamins or other nutritional and over-the-counter electrolyte supplements.

- 27) Foot care.** Treatment of weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions (except open cutting operations), and treatment of corns, calluses or toenails (unless needed in treatment of a metabolic or peripheral-vascular disease).
- 28) Foreign travel.** Care, treatment or supplies out of the U.S. if travel is for the sole purpose of obtaining medical services. Otherwise, Medically Necessary services while traveling abroad is covered for accidental injury or illness occurs.
- 29) Genetic counseling** and genetic studies that are not required for diagnosis or treatment of genetic abnormalities according to Plan guidelines.
- 30) Government coverage.** Care, treatment or supplies furnished by a program or agency funded by any government. This does not apply to Medicaid or when otherwise prohibited by law.
- 31) Growth hormones,** unless Medically Necessary.
- 32) Hair loss.** Care and treatment for hair loss including wigs, hair transplants, hair analysis or any drug that promises hair growth, whether or not prescribed by a Physician except for wigs after chemotherapy or radiation.
- 33) Hearing aids and exams.** Charges for services or supplies in connection with hearing aids or exams for their fitting, except as may be covered under the well adult or well child sections of this Plan.
- 34) Home services** to help meet personal/family/domestic needs. Homemaker services, home health aide services, custodial care, respite care and private duty nursing are not covered.
- 35) Hospital employees.** Professional services billed by a Physician or nurse who is an employee of a Hospital or Skilled Nursing Facility and paid by the Hospital or facility for the service.
- 36) Hypnotherapy.**
- 37) Illegal acts.** Charges for services received as a result of Injury or Sickness occurring directly or indirectly, as a result of a Serious Illegal Act, or a riot or public disturbance. For purposes of this exclusion, the term "Serious Illegal Act" shall mean any act or series of acts that, if prosecuted as a criminal offense, a sentence to a term of imprisonment in excess of one year could be imposed. It is not necessary that criminal charges be filed, or, if filed, that a conviction result, or that a sentence of imprisonment for a term in excess of one year be imposed for this exclusion to apply. Proof beyond a reasonable doubt is not required. This exclusion does not apply if the Injury or Sickness resulted from an act of domestic violence or a medical (including both physical and behavioral health) condition.
- 38) Immunizations, physical exams and vaccinations** for travel or employment, insurance, governmental licensing, school, camp, adoption, marriage, athletic participation or those ordered by a third party.
- 39) Impotence.** Care, treatment, services, supplies such as sexual aids, vacuum devices and penile implants or medication in connection with treatment erectile dysfunction. However, penile implants are covered when an established medical condition is the cause of erectile dysfunction. Treatment of sexual dysfunction is limited to pharmacologic therapy and is covered under the Prescription Drug benefit.
- 40) Infertility.** In-Vitro, GIFT, ZIFT, prescription drugs, cryopreservation of donor sperm and eggs, donor charges and services, infertility services when infertility is related to voluntary sterilization and artificial insemination is not covered.
- 41) Marital or relationship counseling;** family counseling; vocational or employment counseling; and sex therapy. Care and treatment for any of these types of counseling.
- 42) Massage therapy.**
- 43) Medical Equipment, appliances, devices and supplies.** Coverage does not include benefits for medical equipment, appliances, devices and supplies that have both a therapeutic and non-therapeutic use. These include: elastic or leather braces or supports; cranial helmets; splints; canes; traction

apparatus; cervical collars; corsets; batteries and battery chargers; exercise equipment; office chairs; equipment or services for use in altering air quality or temperature including, but not limited to, air conditioners, filters, humidifiers, dehumidifiers, bed liners, and mattress covers; other special supplies, appliances, and equipment such as sun or heat lamps, whirlpool baths, and heating pads; rental or purchase of TENS units; personal hygiene, comfort, and convenience items including but not limited to grab/tub bars, tub benches, breast pumps, telephone, television, guest meals and accommodations, take home medications, and supplies; home improvement items, including but not limited to, escalators, elevators, ramps, stair glides or emergency alert equipment; and expenses incurred at a health spa, gym or similar facility. An office visit for the purpose of fitting for a non-covered device or supply is not covered.

- 44) **Milieu therapy**, the treatment of mental disorder or maladjustment by making substantial changes in a patient's immediate life circumstances and environment in a way that will enhance the effectiveness of other forms of therapy is not covered. Also known as "situation therapy".
- 45) **Napropathic services** provided by a practitioner of Naprapathy (a "Naprapath") are not covered. Naprapathy is a system of treatment by manipulation of connective tissue and adjoining structures and by dietary measures that is held to facilitate the recuperative and regenerative processes of the body.
- 46) **Newborn home deliveries.**
- 47) **No charge.** Care and treatment or portions of charges for care or treatment for which there would not have been a charge if no coverage had been in force.
- 48) **Non-compliance.** All charges in connection with treatments or medications where the patient either is in non-compliance with or is discharged from a Hospital or Skilled Nursing Facility against medical advice.
- 49) **Non-emergency Hospital admissions.** Care and treatment billed by a Hospital for non-Medical Emergency admissions on a Friday or a Saturday. This does not apply if surgery is performed within 24 hours of admission.
- 50) **Non-medical expenses** such as preparing medical reports, itemized bills or charges for mailing; for training, educational instructions or materials, even if they are performed or prescribed by a Physician; for legal fees and expenses incurred in obtaining medical treatment.
- 51) **No Physician recommendation.** Care, treatment, services or supplies not recommended and approved by a Physician; or treatment, services or supplies when the Covered Person is not under the regular care of a Physician. Regular care means ongoing medical supervision or treatment which is appropriate care for the Injury or Sickness.
- 52) **Not specified as covered.** Non-traditional medical services, treatments and supplies which are not specified as covered under this Plan.
- 53) **Obesity.** Care and treatment of obesity, weight loss or dietary control whether or not it is, in any case, a part of the treatment plan for another Sickness, except as stated in the Medical Benefits section. Specifically excluded are charges for gastric balloons, "mini" gastric bypass, stapling and intestinal bypass, bilopancreatic diversion with duodenal switch (BPD-DS), gastroplasty, including reversals. Medically Necessary non-surgical charges for Morbid Obesity will be covered. Surgical care and treatment of obesity, weight loss or dietary control is not covered Out-of-Network.
- 54) **Occupational.** Care and treatment of an Injury or Sickness that is occupational -- that is, arises from work for wage or profit including self-employment; provided the employer provides, or is required to provide workers' compensation or similar type coverage for such services.
- 55) **Oral Surgery** required as part of an orthodontic treatment program, required for correction of an occlusal defect, encompassing orthognathic or prognathic surgical procedures.
- 56) **Orthotics.** Charges in connection with orthotics, heel lifts, and arch supports. Foot orthotics are not covered.

- 57) Orthodontia** and related services.
- 58) Out-of-Network:** Charges in excess of the Maximum Allowable Amount.
- 59) Over-the-counter supplies** which do not require a prescription such as ACE wraps, elastic supports, splints, Band-Aids, antibiotic creams, Vita lights, magnetic mats and orthotics.
- 60) Personal comfort items.** Personal comfort items or other equipment, such as, but not limited to, air conditioners, air-purification units, humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, elastic bandages or stockings, nonprescription drugs and medicines, television and telephone, and first-aid supplies and non-hospital adjustable beds.
- 61) Plan design exclusions.** Charges excluded by the Plan design as mentioned in this document.
- 62) Private duty nursing.** Charges in connection with care, treatment or services of a private duty nurse, except as stated in the Medical Benefits section of this document.
- 63) Private inpatient room,** unless Medically Necessary or if a semi-private room is unavailable.
- 64) Psychiatric evaluation or therapy** when related to judicial or administrative proceedings or orders, when employer requested, or when required for school.
- 65) Rehabilitation services,** including but not limited to cognitive therapy, physical therapy, occupational therapy, and speech therapy for developmental delay, school-related problems, apraxic disorders (unless caused by accident or episodic illness), stuttering, autism, speech delay, articulation disorder, functional dysphonia, or speech problems resulting from psychoneurotic or personality disorders. Long-term rehabilitation therapy and long-term pulmonary rehabilitation is not covered.
- 66) Relative giving services.** Professional services performed by a person who ordinarily resides in the Covered Person's home or is related to the Covered Person as a Spouse, parent, child, brother or sister, whether the relationship is by blood or exists in law.
- 67) Replacement braces.** Replacement of braces of the leg, arm, back, neck, or artificial arms or legs, unless there is sufficient change in the Covered Person's physical condition to make the original device no longer functional.
- 68)** Charges related to **robotics** assistance during surgery are not covered.
- 69) Services before or after coverage.** Care, treatment or supplies for which a charge was incurred before a person was covered under this Plan or after coverage ceased under this Plan.
- 70) Services that are not Preauthorized when Preauthorization is required.**
- 71) Sex changes.** Care, services or treatment for non-congenital transsexualism, gender dysphoria or sexual reassignment or change. This exclusion includes medications, implants, hormone therapy, surgery, medical or psychiatric treatment.
- 72) Sleep disorders.** Care and treatment for sleep disorders unless deemed Medically Necessary.
- 73) Smoking cessation.** Care and treatment programs for smoking cessation. Smoking cessation products and medications are not covered, except as specified in the Pharmacy Benefits section of this Plan Document.
- 74) Sports medicine treatment** plans, surgery, Corrective Appliances, or artificial aids primarily intended to enhance athletic functions.
- 75) Jobst stockings,** elastic hose and graduated compression (TED) hose.
- 76) Surgery** performed solely to address psychological or emotional factors.
- 77) Surgical sterilization reversal.** Care and treatment for reversal of surgical sterilization.

- 78) Surrogate motherhood services and supplies**, including, but not limited to, all services and supplies relating to the conception and pregnancy of a Covered Person acting as a surrogate mother.
- 79) Testicular implants.**
- 80) Therapy.** The following types of habilitated therapy are not covered, although this list is not meant to be exclusive;
- a. Physical or Occupational Therapy for the purpose of behavioral modification or for improving performance in school or sports.
 - b. Occupational Therapy for the purpose of treating sensory hypersensitivity.
 - c. Sensory Integration Therapy.
- 81) Travel or accommodations.** Charges for travel or accommodations, whether or not recommended by a Physician, except for ambulance charges and transplant travel services defined as a Covered Charges.
- 82) Treatment of behavioral retardation**, unless covered as a biologically-based behavioral illness. Also, treatment for disorders relating to learning, motor skills, communication, and pervasive developmental conditions such as autism.
- 83) Treatment of drug abuse or alcoholism** when not rendered according to a written treatment plan approved and monitored by a licensed psychologist.
- 84) Treatment of drug abuse or alcoholism provided by** halfway houses, boot camps and wilderness programs.
- 85) Transplant services**, screening tests, and any related conditions or complications related to organ donation when a Covered Person is donating organ or tissue to a non-Covered Person.
- 86) Treatment of teeth**, the nerves or roots of the teeth (excepted as stated under Covered Charges) or for the repair or replacement of a denture. Dental implants are not covered.
- 87) Vocational Therapy.**
- 88) War.** Any loss that is due to a declared or undeclared act of war.
- 89) Work hardening programs.** Charges for or in connection if an Illness or Injury for which the Employee or Dependent is entitled to benefits under any Workers' Compensation or similar law.

In addition to the above, the following exclusions also apply to Prescription Drugs:

- Prescription drugs not obtained from a Network Pharmacy, unless obtained for an Emergency Medical Condition.
- Non-prescription drugs or medicine, except for covered diabetic supplies and syringes for covered injectable drugs as stated above in the "Outpatient Prescription Drugs" section.
- Prescription drugs that are not considered to be Medically Necessary, in accordance with accepted medical and surgical practices and standards approved by the Plan, including, but not limited to: botox, psoralens, tretinoin and oral antifungal agents for cosmetic use; anorexiant or weight loss medications; anabolic steroids; oral fluoride preparations; and hair removal or hair growth promoting medications.
- Devices of any type (except for contraceptive devices), even if such devices may require a prescription, including, but not limited to, therapeutic devices, artificial appliances, support garments, bandages, etc.
- which are prescribed for unapproved uses. Prescription drugs for cancer treatment are covered if the drug is approved by the Federal Food and Drug Administration and is recognized for the treatment of the specific type of cancer for which the drug has been prescribed in any one of the following established reference compendia: (1) the American Medical Association Drug Evaluations; (2) the American Hospital Preferred Service Drug Information; or (3) the United States Pharmacopeia Drug Information; or if not in the compendia, recommended for that

particular type of cancer in formal clinical studies, the results of which have been published in at least two peer reviewed professional medical journals published in the United States or Great Britain.

- Any charge for the administration of a drug.
- Replacement of lost, destroyed or stolen medication and any supplies for convenience.
- Prescriptions refilled before 75 percent of the previously dispensed supply should have been consumed when taken as prescribed.
- Any drug determined to be abused or otherwise misused by you.
- Dental prescriptions.
- Smoking cessation products, excluding those listed as specifically covered.
- Weight loss drugs.
- Prescription vitamins, except for those prescribed in conjunction with prenatal care or for infants.
- Drugs prescribed for cosmetic purposes (i.e. hair loss, hair growth, depigmenting agents).
- Drugs prescribed, oral or injectable, used for the primary purpose of, or in connection with treating infertility, fertilization and/or artificial insemination.
- Prescriptions which the Covered Individual is entitled to receive without charge under any Workers' Compensation law, occupational statute or any law, or regulation of similar purpose.
- Over-the-Counter (OTC) drug unless otherwise stated on the Prescription Drug List.
- Prescription drugs with over-the-counter equivalents or alternatives unless otherwise specified on the Prescription Drug List.

HOW TO SUBMIT A CLAIM

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

Claims for services rendered by Out-of-Network Providers that qualify as Benefits should be sent to:

Southern Health Services, Inc., Claims Department, P.O. Box 7704, London, KY 40742

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

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

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

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

WHEN CLAIMS SHOULD BE FILED

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

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

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

CLAIMS REVIEW PROCEDURE

Following is a description of how the Plan processes Claims for benefits. A Claim is defined as any request for a Plan benefit, made by a claimant or by a representative of a claimant, that complies with the Plan's reasonable procedure for making benefit Claims. The times listed are maximum times only. A period of time begins at the time the Claim is filed. Decisions will be made within a reasonable period of time appropriate to the circumstances. "Days" means calendar days.

There are different kinds of Claims and each one has a specific timetable for either approval, payment, request for further information, or denial of the Claim. If you have any questions regarding this procedure, please contact the Claims Administrator.

Informal Inquiry Process

Most Complaints begin as an informal inquiry. Participants should direct informal inquiries to the Plan via the Health Plan Customer Services Department Monday through Friday from 8:00 a.m. to 5:00 p.m. at the telephone number listed on their Member Identification Card.

A Customer Service Associate will review, research and resolve the inquiry. The Participant will be informed of the resolution. At the time of resolution, if the decision is adverse to the Participant, the Participant will be advised of his/her right to request a formal Complaint. Participants also have the right to bypass the informal inquiry procedures and immediately file a formal Complaint.

The definitions of the types of Claims are:

Urgent Care Claim

A Claim involving Urgent Care is any Claim for medical care or treatment where using the timetable for a non-urgent care determination could seriously jeopardize the life or health of the claimant; or the ability of the claimant to regain maximum function; or in the opinion of the attending or consulting Physician, would subject the claimant to severe pain that could not be adequately managed without the care or treatment that is the subject of the Claim.

A Physician with knowledge of the claimant's medical condition may determine if a Claim is one involving Urgent Care. If there is no such Physician, an individual acting on behalf of the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine may make the determination.

In the case of a Claim involving Urgent Care, the following timetable applies:

Notification to claimant of benefit determination 72 hours

Insufficient information on the Claim, or failure to follow the Plan's procedure for filing a Claim:

Notification to claimant, orally or in writing 24 hours

Response by claimant, orally or in writing	48 hours
Benefit determination, orally or in writing	48 hours
Ongoing courses of treatment, notification of:	
Reduction or termination before the end of treatment	72 hours
Determination as to extending course of treatment	24 hours

If there is an adverse benefit determination on a Claim involving Urgent Care, a request for an expedited appeal may be submitted orally or in writing by the claimant. All necessary information, including the Plan's benefit determination on review, may be transmitted between the Plan and the claimant by telephone, facsimile, or other similarly expeditious method.

Pre-Service Claim

A Pre-Service Claim means any Claim for a benefit under this Plan where the Plan conditions receipt of the benefit, in whole or in part, on approval in advance of obtaining medical care. These are, for example, Claims subject to pre-certification. Please see the Cost Management section of this booklet for further information about Pre-Service Claims.

In the case of a Pre-Service Claim, the following timetable applies:

Notification to claimant of benefit determination	15 days
Extension due to matters beyond the control of the Plan	15 days
Insufficient information on the Claim:	
Notification of	15 days
Response by claimant	45 days
Notification, orally or in writing, of failure to follow the Plan's procedures for filing a Claim	5 days
Ongoing courses of treatment:	
Reduction or termination before the end of the treatment	15 days
Request to extend course of treatment	15 days
Review of adverse benefit determination	15 days per benefit appeal
Reduction or termination before the end of the treatment	15 days
Request to extend course of treatment	15 days

Post-Service Claim

A Post-Service Claim means any Claim for a Plan benefit that is not a Claim involving Urgent Care or a Pre-Service Claim; in other words, a Claim that is a request for payment under the Plan for covered medical services already received by the claimant.

In the case of a Post-Service Claim, the following timetable applies:

Notification to claimant of benefit determination	30 days
Extension due to matters beyond the control of the Plan	15 days
Extension due to insufficient information on the Claim	15 days
Response by claimant following notice of insufficient information	45 days
Review of adverse benefit determination	30 days per benefit appeal

Notice to claimant of adverse benefit determinations

Except with Urgent Care Claims, when the notification may be oral followed by written or electronic notification within three days of the oral notification, the Plan Administrator shall provide written or electronic notification of any adverse benefit determination. The notice will state, in a manner calculated to be understood by the claimant:

- (1) The specific reason or reasons for the adverse determination.
- (2) Reference to the specific Plan provisions on which the determination was based.
- (3) A description of any additional material or information necessary for the claimant to perfect the Claim and an explanation of why such material or information is necessary.
- (4) A description of the Plan's review procedures and the time limits applicable to such procedures. This will include a statement of the claimant's right to bring a civil action under section 502 of ERISA following an adverse benefit determination on review.
- (5) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.
- (6) If the adverse benefit determination was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the adverse benefit determination and a copy will be provided free of charge to the claimant upon request.
- (7) If the adverse benefit determination is based on the Medical Necessity or Experimental or Investigational treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided free of charge, upon request.

Appeals

Your Plan maintains both complaint and appeal procedures, administered by Southern Health to resolve Member inquiries, complaints, and appeals. All claims of any nature against your Plan, Southern Health, their employees, agents, board members, or officers, whether filed by a Member or the Authorized Representative, must first proceed through the complaint and appeal procedures. It is expressly understood that no action or proceeding may be pursued in court until the administrative remedies as provided in the complaint and appeal procedures are exhausted.

Providers may also file complaints and appeals on their own behalf. They have a separate appeals process, which is outlined in their Southern Health Provider Manual.

No member who exercises the right to file a complaint or appeal shall be subject to termination or otherwise penalized due to the filing of a complaint or appeal.

Definitions relating to the Complaint and Appeal Procedure. For the purposes of this Section the following definitions apply:

Administrative Adverse Benefit Determination: Any Adverse Benefit Determination that is not an Adverse Decision.

Adverse Benefit Determination: A denial of a request for service or a failure to provide or make payment (in whole or in part) for a benefit. An Adverse Benefit Determination also includes any reduction or termination of a benefit. An Adverse Benefit Determination based in whole or in part on medical judgment, including the failure to authorize or cover services because they are determined to be Experimental/Investigational or not Medically Necessary, is also considered an Adverse Decision.

Adverse Decision: An Adverse Decision is a utilization review determination by Southern Health, on behalf of your Plan, that the health care service rendered or proposed to be rendered was or is not Medically Necessary and/or is Experimental/Investigational, when such determination may result in non-coverage of the health care service.

Appeal: The appeals procedures give Members the opportunity to ask your Plan to review any matter related to:

- Issues about the scope of coverage for health care services;
- Medical Necessity of services requested;
- Denial of care/services/claim; or
- Other Adverse Benefit Determinations, as defined in this Section.

Appellant: The Member or the following persons may be considered an Appellant: (1) the individual authorized by the Member in writing to act on the Member's behalf for the appeals process (2) the Member's spouse, parent, committee, legal guardian, or other individual authorized by law to act on the Member's behalf if the Member is not a minor but incompetent or incapacitated.

Authorized Representative: An Authorized Representative is an individual authorized in writing by the Member or state law to act on the Member's behalf in obtaining claim payment or during the appeal process. A Participating Provider may always act on the behalf of a Member. A Non-Participating Provider may also act on the Member's behalf with the Member's expressed written consent.

Complaint: A Complaint is an inquiry to Southern Health about Covered Services, Member rights or other issues or the communication of dissatisfaction about the quality of service or benefit or other issue which is not an Adverse Benefit Determination. Complaints do not involve utilization review decisions. The Complaint procedures give Members the opportunity to ask Southern Health to review any matter related to:

- The quality of health care service received
- General inquiries about Covered Services or benefit plan structure
- Member rights

Expedited Appeal: An Expedited Appeal is an appeal for which a requested service requires Preauthorization, an Adverse Benefit Determination has been rendered, the requested service has not been provided, and the application of non-Expedited Appeal time frames could seriously jeopardize: (a) the life or health of the Member, or in the case of a pregnant Member, the Member's unborn child; or (b) the Member's ability to regain maximum function. In determining whether an appeal involves should be expedited, Southern Health, on behalf of your Plan must apply the judgment of a Prudent Layperson who possess an average knowledge of health and medicine. An Expedited Appeal is also an appeal involving (a) care that the treating physician deems urgent in nature; (b) the treating physician determines that a delay in the care would subject the Member to severe pain that could not adequately be managed without the care or treatment that is being requested; or (c) the Member is a cancer patient and the delay would subject the Member to pain. Such appeal may be made by telephone, facsimile or other available similarly expeditious method. These appeals may also be called urgent care appeals.

Physician Advisor: A Physician Advisor is a physician licensed to practice medicine in Virginia or under a comparable licensing law of a state of the United States and who provides advice regarding the medical necessity of a service to Southern Health or your Group as part of your Plan's utilization review activities.

Post-service Appeal: A Post-service Appeal is an appeal for which an Adverse Benefit Determination has been rendered for a service that has already been provided.

Pre-service Appeal: A Pre-service Appeal is an appeal for which a requested service requires Preauthorization, an Adverse Benefit Determination has been rendered, and the service has not been provided.

Reconsideration: A review of an Adverse Decision by either Southern Health's Medical Director, a Physician Advisor, a peer of the treating provider who is licensed in the provider's same or similar specialty, or a panel of other appropriate health care providers with at least one Physician Advisor or peer of the treating health care provider on the panel. The Member or the Member's Authorized Representative may request the Reconsideration. However, Reconsiderations are not a required step in the Member Appeal Process. It is the Member's option whether to request a Reconsideration or to go straight to the Member UM Appeal Process.

Complaints

If You have a concern regarding a person, service, the quality of care, or the contractual benefits, You can call the toll-free number on Your ID card and explain Your concern to one of our Customer Service representatives. You can also express that concern in writing at the following address:

Southern Health Services, Inc.
Attention: Customer Service Department
P.O. Box 7135
London, Kentucky 40742

Complaints must be received within ninety (90) Calendar days of the date written notification of the issue that is the basis of the complaint or of the incident that gave rise to the complaint was received. All complaints will be initially addressed at staff level.

Communication and Resolution

A complaint that involves a physician or other contracted provider will require information from that provider in the resolution of the complaint. Complaints involving an institutional or ancillary provider will be forwarded to the provider for review through the provider's internal appeal process. Southern Health will monitor the provider's resolution process and will require the provider to keep Southern Health abreast of its decision.

Quality of Care or treatment and general provider services or access complaints are forwarded to the Quality Improvement Department. Complaints related to administrative issues or coverage decisions where Medical Necessity is not an issue are handled by Customer Service. If the complaint is not valid according to the applicable contract, a staff representative will contact the Member or the Member's Authorized Representative to explain the Plan's position. If the concern is valid according to the applicable contract, a staff representative will respond with a description of the corrective action that will be taken and initiate the appropriate steps to implement the action.

Complaint determinations will be made within thirty (30) Calendar days of receipt of the complaint.

Appeals

Appeals should be sent to the Southern Health Appeals Coordinator at the following address:

Southern Health Services, Inc.
Attention: Appeal Coordinator
9881 Mayland Drive
Richmond, VA 23233
(800) 627-4872
Fax Number: (804) 747-8836

The appeal must include the following:

- Member's name and mailing address
- Provider's name
- Date of the service if the service has already been provided, or if the service has not yet been provided, a description of the service for which Preauthorization was requested and denied
- An explanation of why Southern Health, on behalf of the Plan, should consider reversing the original decision
- A copy of any information that will support the Member's request
- In cases where the Member's Authorized Representative is appealing on the Member's behalf, a completed Southern Health Authorized Representative form.

Administrative Adverse Benefit Determination Appeals - Level I

Level I administrative Appeals must be received within one hundred eighty (180) Calendar days of the date the Member receives written notification of the denial. A letter notifying the Member that the appeal has been received will be sent within five (5) working days of its receipt.

A First Level Appeal Committee consisting of one to three Southern Health departmental managers or their representatives will review appeals of Adverse Administrative Decisions. None of these individuals will have been involved in the initial decision. If the appeal is a Pre-service Appeal, the Appellant will be notified of the First Level Appeal Committee's decision within fifteen (15) Calendar days of the date Southern Health received the appeal request. If the appeal is a Post-service Appeal, the Appellant will be notified of the First Level Appeal Committee's decision within thirty (30) Calendar days of the date Southern Health received the appeal request.

Adverse Administrative Decisions Appeals - Level II

For both Pre-service Appeals and Post-service Appeals of Adverse Administrative Decisions, if the Appellant is not satisfied with the Level I appeal decision, he or she may request in writing a Level II appeal within thirty-one (31) Calendar days of the date the Member received the notice of the Level I appeal decision.

The Second Level Appeal Committee is comprised of one to three Southern Health Director level or above staff. For Pre-service Appeals, Level II appeal hearings will be held and decision letters sent within fifteen (15) Calendar days of the date Southern Health received the second level appeal request. For Post-service Appeals, Level II appeal hearing will be held and decision letters sent within thirty (30) Calendar days of the date Southern Health received the second level appeal request. In both cases, decision letters will be sent no later than five (5) working days after the decision was made. The Appellant has the option to meet in person with the Second Level Appeal Committee or via phone or to have the case reviewed based on the available written documentation. This level constitutes the final attempt at resolution within the Southern Health Member Administrative Complaint and Appeal Procedures.

Adverse Decisions; Decisions Involving Utilization Review/ Medical Judgment Decisions

In cases where an Adverse Decision is rendered, the medical aspect of the decision will be reviewed to determine Medical Necessity or Experimental/Investigational. To assist in making a Medical Necessity or Experimental/Investigational determination, Southern Health, on behalf of Your Group, has developed standards and criteria that are objective, clinically valid, and compatible with established standards of health care. If the Member would like to review the complete utilization review procedures, please contact Southern Health's Customer Service Department. The Member's compliance with any portion of the utilization review process is not a guarantee of benefits or payment.

Reconsideration of an Adverse Decision

If a Member is dissatisfied with an Adverse Decision, he or she may request in writing an optional Reconsideration of the Adverse Decision or may choose to move directly to an appeal of an Adverse Decision. Should the Member choose a Reconsideration of an Adverse Decision, the Member still has a right to appeal as described below.

Requests for Reconsideration must be received within ninety (90) Calendar days of the date of the written notification of the denial. The request for Reconsideration should be sent to the same address as listed for appeals.

If the Member or the Member's Authorized Representative chooses to request a Reconsideration of a Medical Necessity determination, a decision is made by either Southern Health's Medical Director, a Physician Advisor, a peer of the treating provider who is licensed in that provider's same or similar specialty, or a panel of other appropriate health care providers with at least one Physician Advisor or peer of the treating health care provider on the panel. Notice of the decision will be provided to both the Member or the Member's Authorized Representative and the Member's provider in writing within two (2) working days of the decision, but no longer than ten (10) working days following Southern Health's receipt of the request. This notification will include the criteria used in making the decision, the clinical reason for the Adverse Decision, alternate length of treatment of any alternate treatment recommended, and the ability to appeal this decision.

Appeals of an Adverse Decision

If the Member is not satisfied with the Adverse Decision or with the outcome of the Reconsideration, the Member or the Member's Authorized Representative may request an appeal within one hundred eighty (180) Calendar days of the date the Member received the initial notice of the Adverse Decision.

The appeal will be reviewed by a panel that includes a Physician Advisor or peer of the treating provider who is licensed in that provider's same or similar specialty and (i) did not take part in any of the previous reviews; (ii) is not employed by nor a director of Southern Health; and (iii) is either licensed in Virginia as a peer of the treating provider or under comparable law in a state within the United States as a peer of the treating provider.

For Pre-service Appeals, the Appellant and the treating provider will be notified of the results of this review within thirty (30) Calendar days of the date Southern Health received the request for the appeal.

For Post-service Appeals, the Appellant and the treating provider will be notified of results of this review within sixty (60) Calendar days of the date Southern Health received the request for the appeal. Any final Adverse Decision will state the criteria used in and the clinical reason for the decision. The Member has the right to request the criteria which will be provided at no cost to the Member.

Expedited Appeals

When appropriate, the Member or the Member's Authorized Representative may request an Expedited Appeal. Southern Health will immediately notify the Appellant of the decision to deny a request for Expedited Appeal of an Adverse Decision by telephone or facsimile.

If Southern Health, on behalf of the Plan, determines that it will consider the Expedited Appeal, the decision will be made within one (1) working day after receipt of all information needed to make the decision, and no later than seventy-two (72) hours of the time of the request regardless of whether or not all required information has been received. However, a case relating to prescriptions for the alleviation of cancer pain shall be determined in twenty-four (24) hours or less from the time of the request.

Member's Rights Under ERISA

If You are a participant or beneficiary of an employee welfare benefit plan under ERISA, You may have the right to bring a civil action under ERISA Section 502(a) after completing the appeal process described above. Please request from Your employer Your Summary Plan Description for a complete statement of Your rights.

Exercising the Member's right to an appeal as discussed in this Section 5 does not affect the Member's ability to bring civil action under Section 502(a) of the Employee Retirement Income Security Act of 1974 (ERISA). The final decision under civil action will be binding even if it is different from the final decision under the above appeal process.

COORDINATION OF BENEFITS

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

The plan that pays first according to the rules will pay as if there were no other plan involved. The secondary and subsequent plans will pay the balance up to each one's plan formula minus whatever the primary plan paid. This is called non-duplication of benefits. The total reimbursement will never be more than the amount that would have been paid if the secondary plan had been the primary plan -- 50% or 80% or 100% -- whatever it may be. The balance due, if any, is the responsibility of the Covered Person.

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

- (1) Group or group-type plans, including franchise or blanket benefit plans.
- (2) Blue Cross and Blue Shield group plans.
- (3) Group practice and other group prepayment plans.
- (4) Federal government plans or programs. This includes, but is not limited to, Medicare and Tricare.

- (5) Other plans required or provided by law. This does not include Medicaid or any benefit plan like it that, by its terms, does not allow coordination.
- (6) No Fault Auto Insurance, by whatever name it is called, when not prohibited by law.

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

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

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

Automobile limitations. When medical payments are available under vehicle insurance, the Plan shall pay excess benefits only, without reimbursement for vehicle plan Deductibles. This Plan shall always be considered the secondary carrier regardless of the individual's election under PIP (personal injury protection) coverage with the auto carrier.

Which Plan pays First? Order of Benefit Determination Rules

When a Member is covered by 2 plans, and	Then	Plan Primary	Plan Secondary
If one plan does not contain a COB provision	The plan without COB provision is The plan with COB provision is	ö	ö
The Member is the subscriber under one plan and dependent under the other	The plan covering the Member as the subscriber is The plan covering the person as a dependent is	ö	ö
The Member is the subscriber under a retiree plan and dependent under an active plan	The plan covering the Member as the subscriber is The plan covering the person as a dependent is	ö	ö
The Member is a subscriber in two active group plans	The plan that has been in effect longer is The plan that has been in effect the shorter amount of time is	ö	ö
The Member is a subscriber under both an active employee plan and a retiree plan	The plan which the subscriber is an active employee is The retiree plan is	ö	ö
The Member is an active employee on one plan and enrolled as a COBRA subscriber	The plan which the subscriber is an active employee is The COBRA plan is	ö	ö
The Member is covered as a dependent child under both plans	The plan of the parent whose birthday occurs earlier in the Calendar year (known as the birthday rule) is The plan of the parent whose birthday is later in the Calendar year is NOTE: If the parents have the same birthday (MM/DD), the plan that has been in effect longer is primary	ö	ö

The Member is covered as a dependent child under both a group plan and Medicaid	The Group Plan is Medicaid is	Ö	Ö
The Member is covered as a dependent child and coverage is specified in a court decree	The plan of the parent primarily responsible for health coverage under the court decree is The plan of the other parent is	Ö	Ö
The Member is covered as a dependent child and coverage is not specified in a court decree	The custodial parent or spouse of custodial parent's plan is The non-custodial parent's plan is	Ö	Ö
The Member is covered as a dependent child and the parents share joint custody	The plan of the parent whose birthday occurs earlier in the Calendar year is The plan of the parent whose birthday is later in the Calendar year is NOTE: If the parents have the same birthday (MM/DD), the plan that has been in effect longer is primary	Ö	Ö

Coordination of Benefits with Medicare for members under 65 with a Disability

When a Member is covered by Medicare and a group plan, and	Then	Plan Primary	Medicare Primary
Is a Member who is qualified for Medicare coverage due solely to End Stage Renal Disease (ESRD)	For the first 30-months after Medicare becomes effective Upon completion of the 30-months after Medicare becomes effective	Ö	Ö
Is a disabled Subscriber who is an active employee	If the employer employs 100 employees or more If the employer employs fewer than 100 employees	Ö	Ö
Is the disabled spouse or dependent child of an active full-time Subscriber	If the employer employs 100 employees or more If the employer employs fewer than 100 employees	Ö	Ö
Is a person who becomes qualified for Medicare Coverage due to ESRD after already being enrolled in Medicare due to disability	If Medicare had been secondary to the group plan before ESRD entitlement, then for the first 30 months following ESRD entitlement If Medicare had been primary to the group plan before ESRD entitlement	Ö	Ö
Disabled and Subscriber not actively employed by the employer group			Ö

Coordination of Benefits with Medicare for Members 65 and Over

When a Member is covered by Medicare and a group plan, and	Then	Plan Primary	Medicare Primary
The member is age 65 or over, and is the Subscriber or the Subscriber's spouse, and the Subscriber is actively working for employer group	If the employer group has less than 20 employees If the employer group has 20 or more employees	Ö	Ö

Is a person who becomes qualified for Medicare Coverage due to ESRD after already being enrolled in Medicare due to age	If Medicare had been secondary to the group plan before ESRD entitlement, then for the first 30 months following ESRD entitlement If Medicare had been primary to the group plan before ESRD entitlement	0	
The member is age 65 or over, is the Subscriber or the Subscriber's spouse and not actively working for the group			0

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

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

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

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

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

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

THIRD PARTY RECOVERY PROVISION

RIGHT OF SUBROGATION AND REIMBURSEMENT

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

1. In the event that benefits are provided under this Plan, the Plan shall be subrogated to all of the Participant's (the term Participant includes any person receiving benefits hereunder including all dependents) rights of recovery against any person or organization to the extent of the benefits provided. The Participant shall execute and deliver instruments and papers and do whatever else is necessary to secure such rights. The Participant shall do nothing after loss to prejudice such rights. The Participant hereby agrees to cooperate with the Plan and/or any representatives of the Plan in completing such forms and in giving such information surrounding any accident as the Plan or its representatives deem necessary to fully investigate the incident.
2. The Plan is also granted a right of reimbursement from the proceeds of any recovery whether by settlement, judgment, or otherwise. This right of reimbursement is cumulative with and not exclusive of the subrogation right granted in paragraph 1, but only to the extent of the benefits provided by the Plan.

3. The Plan, by providing benefits hereunder, is hereby granted a lien on the proceeds of any settlement, judgment or other payment intended for, payable to, or received by the Participant or his/her representatives, and the Participant hereby consents to said lien and agrees to take whatever steps are necessary to help the company secure said lien. The Participant agrees that said lien shall constitute a charge upon the proceeds of any recovery and the Plan shall be entitled to assert security interest thereon. By the acceptance of benefits under the Plan, the Participant and his/her representatives agree to hold the proceeds of any settlement in trust for the benefit of the Plan to the extent of 100% of all benefits paid on behalf of the participant.
4. By accepting benefits hereunder, the Participant hereby grants a lien and assigns to the Plan an amount equal to the benefits paid against any recovery made by or on behalf of the Participant. This assignment is binding on any attorney who represents the Participant whether or not an agent of the Participant and on any insurance company or other financially responsible party against whom a Participant may have a claim provided said attorney, insurance carriers or others have been notified by the Plan or its agents.
5. The subrogation and reimbursement rights and liens apply to any recoveries made by the Participant as a result of the injuries sustained, including but not limited to the following:
 - a. Payments made directly by the third party tortfeasor, or any insurance company on behalf of the third party tortfeasor, or any other payments on behalf of the third party tortfeasor.
 - b. Any payments or settlements or judgment or arbitration awards paid by any insurance company under an uninsured or underinsured motorist coverage, whether on behalf of a Participant or other person.
 - c. Any other payments from any source designed or intended to compensate a Participant for injuries sustained as the result of negligence or alleged negligence of a third party.
 - d. Any worker's compensation award or settlement.
 - e. Any recovery made pursuant to no-fault insurance.
 - f. Any medical payments made as a result of such coverage in any automobile or homeowners insurance policy.
6. No adult Participant hereunder may assign any rights that it may have to recover medical expenses from any tortfeasor or other person or entity to any minor child or children of said adult Participant without the prior express written consent of the Plan. The Plan's right to recover (whether by subrogation or reimbursement) shall apply to decedents', minors', and incompetent or disabled persons' settlements or recoveries.
7. No Participant shall make any settlement, which specifically reduces or excludes, or attempts to reduce or exclude the benefits provided by the Plan.
8. The Plan's right of recovery shall be a prior lien against any proceeds recovered by the Participant, which right shall not be defeated nor reduced by the application of any so-called "Made-Whole Doctrine", "Rimes Doctrine", or any other such doctrine purporting to defeat the Plan's recovery rights by allocating the proceeds exclusively to non-medical expense damages.
9. No Participant hereunder shall incur any expenses on behalf of the Plan in pursuit of the Plan's rights hereunder, specifically, no court costs nor attorneys fees may be deducted from the Plan's recovery without the prior express written consent of the Plan. This right shall not be defeated by any so-called "Fund Doctrine", or "Common Fund Doctrine", or "Attorney's Fund Doctrine".
10. The Plan shall recover the full amount of benefits provided hereunder without regard to any claim of fault on the part of any Participant, whether under comparative negligence or otherwise.
11. The benefits under this Plan are secondary to any coverage under no-fault or similar insurance.

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

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

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

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

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

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

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

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

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

CONTINUATION COVERAGE RIGHTS UNDER COBRA

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

The Plan Administrator is Randolph College, 2500 Rivermont Avenue, Lynchburg, Virginia, 24503, (434) 947-8114. The Plan Administrator is responsible for administering COBRA continuation coverage. Complete instructions on COBRA, as well as election forms and other information, will be provided by the Plan Administrator or its designee to Plan Participants who become Qualified Beneficiaries under COBRA.

What is COBRA continuation coverage? COBRA continuation coverage is the temporary extension of group health plan coverage that must be offered to certain Plan Participants and their eligible family members (called "Qualified Beneficiaries") at group rates. The right to COBRA continuation coverage is triggered by the occurrence of a life event that results in the loss of coverage under the terms of the Plan (the "Qualifying Event"). The coverage must be identical to the Plan coverage that the Qualified Beneficiary had immediately before the Qualifying Event, or if the coverage has been changed, the coverage must be identical to the

coverage provided to similarly situated active employees who have not experienced a Qualifying Event (in other words, similarly situated non-COBRA beneficiaries).

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

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

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

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

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

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

- (1) The death of a covered Employee.
- (2) The termination (other than by reason of the Employee's gross misconduct), or reduction of hours, of a covered Employee's employment.
- (3) The divorce or legal separation of a covered Employee from the Employee's Spouse. If the Employee reduces or eliminates the Employee's Spouse's Plan coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a Qualifying Event even though the Spouse's coverage was reduced or eliminated before the divorce or legal separation.
- (4) A covered Employee's enrollment in any part of the Medicare program.

- (5) A Dependent child's ceasing to satisfy the Plan's requirements for a Dependent child (for example, attainment of the maximum age for dependency under the Plan).
- (6) A proceeding in bankruptcy under Title 11 of the U.S. Code with respect to an Employer from whose employment a covered Employee retired at any time.

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

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

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

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

What is the election period and how long must it last? The election period is the time period within which the Qualified Beneficiary must elect COBRA continuation coverage under the Plan. The election period must begin not later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event and ends 60 days after the later of the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event or the date notice is provided to the Qualified Beneficiary of her or his right to elect COBRA continuation coverage. If coverage is not elected within the 60 day period, all rights to elect COBRA continuation coverage are forfeited.

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

The Trade Act of 2002 also created a new tax credit for certain TAA-eligible individuals and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC)

(eligible individuals). Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. If you have questions about these new tax provisions, you may call the Health Coverage Tax Credit Consumer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact.

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

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

IMPORTANT:

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), you or someone on your behalf must notify the Plan Administrator or its designee in writing within 60 days after the Qualifying Event occurs, using the procedures specified below. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator or its designee during the 60-day notice period, any spouse or dependent child who loses coverage will not be offered the option to elect continuation coverage. You must send this notice to the Plan Sponsor.

NOTICE PROCEDURES:

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

Randolph College
2500 Rivermont Avenue
Lynchburg, Virginia 24503

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

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

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

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

Once the Plan Administrator or its designee receives ***timely notice*** that a Qualifying Event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage for their spouses, and parents may elect COBRA continuation coverage on behalf of their children. For each Qualified Beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that plan coverage would otherwise have been lost. If you or your spouse or

dependent children do not elect continuation coverage within the 60-day election period described above, the right to elect continuation coverage will be lost.

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

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

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

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

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

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

continuation coverage available to the Qualified Beneficiary ceases, the Plan is not obligated to make coverage available to the individual who is not a Qualified Beneficiary.

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

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

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

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

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

Must the Plan allow payment for COBRA continuation coverage to be made in monthly installments?

Yes. The Plan is also permitted to allow for payment at other intervals.

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

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

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

IF YOU HAVE QUESTIONS

If you have questions about your COBRA continuation coverage, you should contact the Plan Sponsor. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

KEEP YOUR PLAN ADMINISTRATOR INFORMED OF ADDRESS CHANGES

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

RESPONSIBILITIES FOR PLAN ADMINISTRATION

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

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

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

DUTIES OF THE PLAN ADMINISTRATOR.

- (1) To administer the Plan in accordance with its terms.

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

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

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

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

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

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

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

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

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

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

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

 - (a) **Updates Required.** The Employer shall amend the Plan promptly with respect to any changes in the members of its workforce who are authorized to receive Protected Health Information.
 - (b) **Use and Disclosure Restricted.** An authorized member of the Employer's workforce who receives Protected Health Information shall use or disclose the Protected Health Information only to the extent necessary to perform his or her duties with respect to the Plan.
 - (c) **Resolution of Issues of Noncompliance.** In the event that any member of the Employer's workforce uses or discloses Protected Health Information other than as permitted by the Privacy Standards, the incident shall be reported to the privacy official. The privacy official shall take appropriate action, including:

 - (i) Investigation of the incident to determine whether the breach occurred inadvertently, through negligence, or deliberately; whether there is a pattern of breaches; and the degree of harm caused by the breach;
 - (ii) Applying appropriate sanctions against the persons causing the breach, which, depending upon the nature of the breach, may include, oral or written reprimand, additional training, or termination of employment;
 - (iii) Mitigating any harm caused by the breach, to the extent practicable; and
 - (iv) Documentation of the incident and all actions taken to resolve the issue and mitigate any damages.
- (4) **Certification of Employer.** The Employer must provide certification to the Plan that it agrees to:

 - (a) Not use or further disclose the Protected Health Information other than as permitted or required by the Plan documents or as required by law;

- (b) Ensure that any agent or subcontractor, to whom it provides Protected Health Information received from the Plan, agrees to the same restrictions and conditions that apply to the Employer with respect to such information;
- (c) Not use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer;
- (d) Report to the Plan any use or disclosure of the Protected Health Information of which it becomes aware that is inconsistent with the uses or disclosures hereunder or required by law;
- (e) Make available Protected Health Information to individual Plan members in accordance with Section 164.524 of the Privacy Standards;
- (f) Make available Protected Health Information for amendment by individual Plan members and incorporate any amendments to Protected Health Information in accordance with Section 164.526 of the Privacy Standards;
- (g) Make available the Protected Health Information required to provide any accounting of disclosures to individual Plan members in accordance with Section 164.528 of the Privacy Standards;
- (h) Make its internal practices, books and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Department of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Standards;
- (i) If feasible, return or destroy all Protected Health Information received from the Plan that the Employer still maintains in any form, and retain no copies of such information when no longer needed for the purpose of which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information unfeasible; and
- (j) Ensure the adequate separation between the Plan and member of the Employer's workforce, as required by Section 164.504(f)(2)(iii) of the Privacy Standards.

The following members of Randolph College's workforce are designated as authorized to receive Protected Health Information from Randolph College Health Benefit Plan ("the Plan") in order to perform their duties with respect to the Plan: VP of Human Resources and designated staff.

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

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

FUNDING THE PLAN AND PAYMENT OF BENEFITS

The cost of the Plan is funded as follows:

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

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

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

PLAN IS NOT AN EMPLOYMENT CONTRACT

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

CLERICAL ERROR

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

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

AMENDING AND TERMINATING THE PLAN

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

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

CERTAIN PLAN PARTICIPANTS RIGHTS UNDER ERISA

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

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

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

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

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

Reduction or elimination of exclusionary periods of coverage for Pre-Existing Conditions under this group health Plan, if an Employee or dependent has Creditable Coverage from another plan. The Employee or dependent should be provided a certificate of Creditable Coverage, free of charge, from the group health plan or health insurance issuer when coverage is lost under the plan, when a person

becomes entitled to elect COBRA continuation coverage, when COBRA continuation coverage ceases, if a person requests it before losing coverage, or if a person requests it up to 24 months after losing coverage. Without evidence of Creditable Coverage, a Plan Participant may be subject to a Pre-Existing Conditions exclusion for 12 months (18 months for Late Enrollees) after the Enrollment Date of coverage.

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

Under ERISA, there are steps a Plan Participant can take to enforce the above rights. For instance, if a Plan Participant requests a copy of Plan documents or the latest annual report from the Plan and does not receive them within 30 days, he or she may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and to pay the Plan Participant up to \$110 a day until he or she receives the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If the Plan Participant has a claim for benefits which is denied or ignored, in whole or in part, the participant may file suit in state or federal court.

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

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

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

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

GENERAL PLAN INFORMATION

TYPE OF ADMINISTRATION

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

PLAN NAME

Randolph College Health Benefit Plan

PLAN NUMBER: 501

TAX ID NUMBER: 54-0505941

PLAN EFFECTIVE DATE: July 1, 2007; Restated January 1, 2009

PLAN YEAR ENDS: December 31

EMPLOYER INFORMATION

Randolph College
2500 Rivermont Avenue
Lynchburg, Virginia 24503
(434) 947-8114

PLAN ADMINISTRATOR

VP for Finance and Administration
Randolph College
2500 Rivermont Avenue
Lynchburg, Virginia 24503
(434) 947-8114

NAMED FIDUCIARY

Randolph College
2500 Rivermont Avenue
Lynchburg, Virginia 24503

AGENT FOR SERVICE OF LEGAL PROCESS

Plan Administrator
Randolph College
2500 Rivermont Avenue
Lynchburg, Virginia 24503

CLAIMS ADMINISTRATOR

Southern Health Services, Inc.
9881 Mayland Drive
Richmond, Virginia 23233
(800) 627-4872

BY THIS AGREEMENT, Randolph College Health Benefit Plan is hereby adopted as shown.

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

By: _____
 Randolph College

Date: _____

Witness: _____

Date: _____

**PREAUTHORIZATION EXHIBIT
RANDOLPH COLLEGE HEALTH BENEFIT PLAN
Administered by
Southern Health Services, Inc.**

SERVICES REQUIRING PREAUTHORIZATION (effective January 1, 2009)

Preauthorization is the process for authorizing the non-emergency use of facilities, diagnostic testing, and other health services before care is provided. This list is subject to change.

- Automatic Internal Cardiac Defibrillator (AICD)
- Behavioral Health and Substance Abuse Services: inpatient or outpatient Behavioral Health services or Substance Abuse treatment or rehabilitation*
- Bi-ventricular Pacemaker
- Clinical Trials
- CT Scans
- Dental Treatment for Dental Accidents
- DEXA Scans received by members under the age of 60
- Durable Medical Equipment (DME): all rentals of DME and purchase of DME costing over \$250, (except ostomy supplies)
- Genetic Testing and Genetic Counseling
- Home Health Care (Nursing, Infusion, Respiratory, etc.)
- Hospital Observation Stays
- Injectable and Self-Administered Injectable Drugs, if covered under Medical and Surgical Benefits instead of Prescription Drug Benefits
- Inpatient Admission Stays: includes Acute, Skilled Nursing Facility Care and Inpatient Hospice
- Insulin Pump and Supplies
- Intensity-Modulated Radiation Therapy (IMRT)
- Magnetic Resonance Imaging (MRI)/Magnetic Resonance Angiogram (MRA)/Positive Emission Tomography (PET Scan)
- Non-emergency Ambulance Transportation
- Non-Implanted Prosthetic Devices
- Nuclear Imaging Performed in Conjunction with Exercise Stress Testing
- Oral Surgery
- Outpatient Surgery (Hospital or Freestanding Surgical Center)
- Pain Management Services/Program, including Epidural Steroid Injections
- Polysomnograms (Sleep Apnea Studies)
- Prenatal Services - Notification Only
- Psychological or Neuropsychological Testing
- Rehabilitative Services: includes Cardiac Rehabilitation, Pulmonary Rehabilitation, Physical, Occupational, or Speech Therapy whether received inpatient or outpatient
- Services Related to the Diagnosis of Infertility or the Diagnosis and Treatment of Infertility if an employer group has elected the Infertility Rider
- Transplant Consultations, Evaluations and Testing/Transplant Procedures

Note: The services above must be preauthorized or reimbursement from the Plan may be reduced. TO PREAUTHORIZE MEDICAL SERVICES CALL (804) 270-9200 OR 1-800-235-2206 AND 1-800-975-8919 TO PREAUTHORIZE BEHAVIORAL HEALTH AND SUBSTANCE ABUSE TREATMENT.

In addition, the following specific services require preauthorization regardless of the place of service.

CPT or HCPCS Code	Description
77520, 77522, 77523, 77525	<i>Proton Treatment Delivery</i>
76977	<i>Ultrasound bone density measurement and interpretation, peripheral site (s), any method</i>
96000	<i>Comprehensive computer-based motion analysis by video-taping and 3-D kinematics</i>
96001	<i>Comprehensive computer-based motion analysis by video-taping and 3-D kinematics; with dynamic plantar pressure measurements during walking</i>
96004	<i>Physician review and interpretation of comprehensive computer-based motion analysis, dynamic plantar pressure measurements, dynamic surface electromyography during walking or other functional activities, and dynamic fine wire electromyography, with written reports</i>
93025	<i>Microvolt T-wave alternans for assessment of ventricular arrhythmias</i>
93701	<i>Thoracic Electrical Bioimpedance</i>
93760	<i>Thermogram; cephalic</i>
93762	<i>Thermogram; peripheral</i>
95250	<i>Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for up to 72 hours; sensor placement, hook-up, calibration of monitor, patient training, removal of sensor, and printout of recording.</i>
95251	<i>Physician interpretation and report for 95250</i>
96920 - 96922	<i>Laser treatment for inflammatory skin disease (psoriasis)</i>
Category Three Codes (CPT codes ending in "T")	<i>Temporary codes for emerging technology</i>
G0166	<i>External Counterpulsation, per treatment session</i>
G0302 – G0305	<i>Preoperative pulmonary surgery services for the preparation for LVRS, complete course of services</i>
M0075	<i>Cellular Therapy</i>
M0076	<i>Prolotherapy</i>
M0100	<i>Intragastric hypothermia using gastric freezing</i>
M0300	<i>IV Chelation therapy (chemical endarterectomy)</i>
M0301	<i>Fabric wrapping of abdominal aneurysm</i>
Q3031	<i>Collagen skin test</i>
S0345 –S0347	<i>Electrocardiographic monitoring utilizing a home computerized telemetry station with automatic activation and real-time notification of monitoring station, 24-hour attended monitoring, including physician review and interpretation</i>
S2107	<i>Adoptive immunotherapy, i.e., development of specific antitumor reactivity (e.g. tumor-infiltrating lymphocyte therapy) per course of treatment</i>
S3650	<i>Saliva test, hormone level; during menopause</i>
S3652	<i>Saliva test, hormone level; to assess preterm labor risk</i>
S3708	<i>Gastrointestinal fat absorption study</i>
S3900	<i>Surface electromyography (EMG)</i>
S3902	<i>Ballistocardiogram</i>
S3904	<i>Masters two step</i>
S3905	<i>Noninvasive electrodiagnostic testing with automatic computerized hand-held device to stimulate and measure neuromuscular signals in diagnosing and evaluating systematic entrapment neuropathies</i>
S9015	<i>Automated EEG monitoring</i>
S9025	<i>Omniscardiogram/ cardiointegram</i>
S9090	<i>Vertebral axial decompression, per session</i>
U256	<i>Experimental Drugs</i>

Your Privacy Matters

In compliance with the Health Insurance Portability and Accountability Act (HIPAA), Randolph College Health Benefit Plan (“the Plan”) is sending you important information about how your medical and personal information may be used and about how you can access this information. Please review the Notice of Privacy Practices carefully. If you have any question, please call the Member Services number on the back of your membership identification card.

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL AND PERSONAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

A. Our Commitment to Your Privacy

We understand the importance of keeping your personal and health information secure and private. We are required by law to provide you with this notice. This notice informs you of your rights about the privacy of your personal information and how we may use and share your personal information. We will make sure that your personal information is only used and shared in the manner described. We may, at times, update this notice. Changes to this notice will apply to the information that we already have about you as well as any information that we may receive or create in the future. You may request a copy of this notice at any time. Throughout this notice, examples are provided. Please note that all of these examples may not apply to the services the Plan provides to your particular health benefit plan.

B. What Types of Personal Information Do We Collect?

To best service your benefits, we need information about you. This information may come from you, your employer, or other payors or health benefits plan sponsors, and our affiliates. Examples include your name, address, phone number, Social Security number, date of birth, marital status, employment information, or medical history. We also receive information from health care providers and others about you. Examples include the health care services you receive. This information may be in the form of health care claims and encounters, medical information, or a service request. We may receive your information in writing, by telephone, or electronically.

C. How Do We Protect the Privacy of Your Personal Information?

Keeping your information safe is one of our most important duties. We limit access to your personal information to those who need it. We maintain appropriate safeguards to protect it. For example, we protect access to our buildings and computer systems. Our Privacy Office also assures the training of our staff on our privacy and security policies.

D. How Do We Use and Share Your Information for Treatment, Payment, and Health Care Operations?

To properly service your benefits, we may use and share your personal information for “treatment,” “payment,” and “health care operations.” Below we provide examples of each. We may limit the amount of information we share about you as required by law. For example, HIV/AIDS, substance abuse, and genetic information may be further protected by law. Our privacy policies will always reflect the most protective laws that apply.

- **Treatment:** We may use and share your personal information with health care providers for coordination and management of your care. Providers include physicians, hospitals, and other caregivers who provide services to you.
- **Payment:** We may use and share your personal information to determine your eligibility, coordinate care, review medical necessity, pay claims, obtain external review, and respond to complaints. For example, we may use information from your health care provider to help process your claims. We may also use and share your personal information to obtain payment from others that may be responsible for such costs.
- **Health care operations:** We may use and share your personal information as part of our operations in servicing your benefits. Operations include credentialing of providers; quality improvement activities; accreditation by independent organizations; responses to your questions, or grievance or external review programs; and disease management, case management, and care coordination. We may also use and share information for our general administrative activities such as pharmacy benefits administration; detection and investigation of fraud; auditing; underwriting and rate-making; securing and servicing reinsurance policies; or in the sale, transfer, or merger of all or a part of the Plan with another entity. For

example, we may use or share your personal information in order to evaluate the quality of health care delivered, to remind you about preventive care, or to inform you about a disease management program. We may also share your personal information with providers and other health plans for their treatment, payment, and certain health care operation purposes. For example, we may share personal information with other health plans identified by you or your plan sponsor when those plans may be responsible to pay for certain health care benefits.

E. What Other Ways Do We Use or Share Your Information?

We may also use or share your personal information for the following:

- **Health care oversight and law enforcement:** To comply with federal or state oversight agencies. These may include your state department of insurance or the U.S. Department of Labor.
- **Legal proceedings:** To comply with a court order or other lawful process.
- **Treatment options:** To inform you about treatment options or health-related benefits or services.
- **Plan sponsors:** To permit the sponsor of your health plan to service your benefits. Please see your plan documents for more information.
- **Research:** To researchers where all procedures required by law have been taken to protect the privacy of the data.
- **Others involved in your health care:** We may share certain personal information with a relative, such as your spouse, close personal friend, or others you have identified as being involved in your care or payment for that care. For example, to those individuals with knowledge of a specific claim, we may confirm certain information about it. Also, we may mail an explanation of benefits to the subscriber. Your family may also have access to such information on our Web site. If you do not want this information to be shared, please tell us in writing.
- **Personal representatives:** We may share personal information with those having a relationship that gives them the right to act on your behalf. Examples include parents of an unemancipated minor or those having a Power of Attorney.
- **Business associates:** To persons providing services to us and who assure us that they will protect the information. Examples may include those companies providing your pharmacy or behavioral health benefits.
- **Other situations:** We also may share personal information in certain public interest situations. Examples include protecting victims of abuse or neglect; preventing a serious threat to health or safety; tracking diseases or medical devices; or informing military or veteran authorities if you are an armed forces member. We may also share your information with coroners; for workers' compensation; for national security; and as required by law.

F. What About Other Sharing of Information and What Happens If You Are No Longer Enrolled?

We will obtain your written permission to use or share your health information for reasons not identified by this notice and not otherwise permitted or required by law. If you withdraw your permission, we will no longer use or share your health information for those reasons.

We do not destroy your information when your coverage ends. It is necessary to use and share your information, for many of the purposes described above, even after your coverage ends.

However, we will continue to protect your information regardless of your coverage status.

G. Rights Established by Law

- **Requesting restrictions:** You can request a restriction on the use or sharing of your health information for treatment, payment, or health care operations. However, we may not agree to a requested restriction.
- **Confidential communications:** You can request that we communicate with you about your health and related issues in a certain way, or at a certain location. For example, you may ask that we contact you by mail, rather than by telephone, or at work, rather than at home. We will accommodate reasonable requests.
- **Access and copies:** You can inspect and obtain a copy of certain health information. We may charge a fee for the costs of copying, mailing, labor, and supplies related to your request. We may deny your request to inspect or copy in some situations. In some cases denials allow for a review of our decision. We will notify you of any costs pertaining to these requests, and you may withdraw your request before you incur any costs.
- **Amendment:** You may ask us to amend your health information if you believe it is incorrect or incomplete. You must provide us with a reason that supports your request. We may deny your request if the information is accurate, or as otherwise allowed by law. You may send a statement of disagreement.
- **Accounting of disclosures:** You may request a report of certain times we have shared your information. Examples include sharing your information in response to court orders or with government agencies that

license us. All requests for an accounting of disclosures must state a time period that may not include a date earlier than six years prior to the date of the request and may not include dates before April 14, 2003. We will notify you of any costs pertaining to these requests, and you may withdraw your request before you incur any costs.

H. To Receive More Information or File a Complaint

Please contact Member Services to find out how to exercise any of your rights listed in this notice, or if you have any questions about this notice. The telephone number or address is listed in your benefit documents or on your membership card. If you believe we have not followed the terms of this notice, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. To file a complaint with the Secretary, write to 200 Independence Avenue, S.W. Washington, D.C. 20201 or call 1-877-696-6775. You will not be penalized for filing a complaint. To contact us, please follow the complaint, grievance, or appeal process in your benefit documents.