Amendment 03
Effective July 1, 2014
KENYON COLLEGE

The Health Benefit Summary Plan Description is amended as follows:

1. **The INTRODUCTION is amended to revise the following:**

This document summarizes the benefits and limitations of the Plan and will serve as the SPD and Plan document. Therefore it will be referred to as both the Summary Plan Description ("SPD") and Plan document. It is being furnished to You in accordance with ERISA.

2. **The MEDICAL SCHEDULE OF BENEFITS, Benefit Plan(s) 001 is amended to revise the following:**

All health benefits shown on this Schedule of Benefits are subject to the following: Deductibles, Co-pays, Coinsurance rates, and out-of-pocket maximums, if any and benefit exclusions described more fully herein. Refer to the Out-of-Pocket Expenses section of this SPD for more details.

Important: Prior authorization may be required before benefits will be considered for payment. See pages 64 and 65 for details. Failure to obtain prior authorization may result in a penalty or increased out-of-pocket costs. Refer to the Care Management section of this SPD for a description of these services and prior authorization procedures.

Home Health Care Benefits: ***Note: A Home Health Care Visit Will Be Considered A Periodic Visit By Either A Nurse Or Qualified Therapist, As The Case May Be, Or Up To Four (4) Hours Of Home Health Care Services.***		

3. **The MEDICAL SCHEDULE OF BENEFITS, Benefit Plan(s) 001 is amended to delete the following:**

Individual Annual Maximum ***Note: The Plan Guarantees A Minimum Of $2,000,000 Of This Maximum Will Be For Essential Benefits.***	$2,000,000

4. **The MEDICAL SCHEDULE OF BENEFITS, Benefit Plan(s) 001 is amended to add the following:**

Hospital Services: **Outpatient Imaging Charges:** • Paid By Plan After Deductible	80%	60%

5. **The TRANSPLANT SCHEDULE OF BENEFITS, Benefit Plan(s) 001 is amended to revise the following:**

Travel And Housing At Designated Transplant Facility At Contract Effective Date/Pre-Transplant Evaluation And Up To One Year From Date Of Transplant.	

Travel And Housing At Non-designated Transplant Facility At Contract Effective Date/Pre-Transplant Evaluation And Up To One Year From Date Of Transplant.	

6. **The MEDICAL SCHEDULE OF BENEFITS, Benefit Plan(s) 002 is amended to revise the following:**

All health benefits shown on this Schedule of Benefits are subject to the following: Deductibles, Co-pays, Coinsurance rates, and out-of-pocket maximums, if any and benefit exclusions described more fully herein. Refer to the Out-of-Pocket Expenses section of this SPD for more details.

Important: Prior authorization may be required before benefits will be considered for payment. See pages 64 and 65 for details. Failure to obtain prior authorization may result in a penalty or increased out-of-pocket costs. Refer to the Care Management section of this SPD for a description of these services and prior authorization procedures.

Home Health Care Benefits: ***Note: A Home Health Care Visit Will Be Considered A Periodic Visit By Either A Nurse Or Qualified Therapist, As The Case May Be, Or Up To Four (4) Hours Of Home Health Care Services.***		

7. **The MEDICAL SCHEDULE OF BENEFITS, Benefit Plan(s) 002 is amended to delete the following:**

Individual Annual Maximum ***Note: The Plan Guarantees A Minimum Of $2,000,000 Of This Maximum Will Be For Essential Benefits.***	$2,000,000

8. **The MEDICAL SCHEDULE OF BENEFITS, Benefit Plan(s) 002 is amended to add the following:**

Hospital Services: **Outpatient Imaging Charges:** • Paid By Plan After Deductible	70%	50%

9. **The TRANSPLANT SCHEDULE OF BENEFITS, Benefit Plan(s) 002 is amended to revise the following:**

Travel And Housing At Designated Transplant Facility At Contract Effective Date/Pre-Transplant Evaluation And Up To One Year From Date Of Transplant.	

Travel And Housing At Non-designated Transplant Facility At Contract Effective Date/Pre-Transplant Evaluation And Up To One Year From Date Of Transplant.	

10. The INDIVIDUAL ANNUAL MAXIMUM BENEFIT portion of the OUT-OF-POCKET EXPENSES AND MAXIMUMS provision is deleted.

11. The ELIGIBILITY AND ENROLLMENT provision is amended to revise the following:

ELIGIBILITY REQUIREMENTS

An **eligible Dependent** includes:

- Your legal spouse, as defined by the state in which You reside, provided he or she is not covered as an Employee under this Plan. For purposes of eligibility under this Plan, a legal spouse does not include a common-law marriage spouse, even if such partnership is recognized as a legal marriage in the state in which the couple resides. An eligible Dependent does not include an individual from whom You have obtained a legal separation or divorce. Documentation on a Covered Person's marital status may be required by the Plan Administrator.

ANNUAL OPEN ENROLLMENT PERIOD

Coverage Waiting Periods are waived during the annual plan change opportunity period for covered Employees, covered Retirees and covered Dependents changing from one Plan to another Plan or changing coverage levels within the Plan.

12. The ELIGIBILITY AND ENROLLMENT provision is amended to add the following:

ELIGIBILITY REQUIREMENTS

Note: An Employee must be covered under this Plan in order for Dependents to qualify for and obtain coverage.

13. The PRE-EXISTING CONDITION PROVISION is deleted.

14. The HIPAA PORTABILITY RIGHTS provision is deleted.

15. The COBRA CONTINUATION OF COVERAGE provision is amended to delete the following:

SPECIAL NOTICE (Read This If Thinking Of Declining COBRA Continuation Coverage)

If You or Your Dependent will be obtaining **group health coverage** through a new employer, keep in mind that HIPAA requires employers to reduce Pre-Existing Condition exclusion periods if there is less than a 63-day break in health coverage (Creditable Coverage).

16. The COBRA CONTINUATION OF COVERAGE provision is amended to revise the following:

EARLY TERMINATION OF COBRA CONTINUATION

- After electing COBRA continuation coverage, the Qualified Beneficiary becomes covered under another group health plan.

SPECIAL NOTICE (Read This If Thinking Of Declining COBRA Continuation Coverage)

At the time of a COBRA Qualifying Event, a Qualified Beneficiary has two primary options. The first is to waive his or her right to COBRA and make an election for coverage, whether group health coverage or insurance coverage through the individual market or the exchanges, in accordance with his or her HIPAA special enrollment rights. Please refer to the Special Enrollment section for further details. The second option is to elect COBRA continuation coverage. If COBRA continuation coverage is elected, the continuation coverage must be maintained (by paying the cost of the coverage) for the duration of the COBRA continuation period. If the continuation coverage is not exhausted and maintained for the duration of the COBRA continuation period, the Qualified Beneficiary will lose his or her special enrollment rights. It is important to note that losing HIPAA special enrollment rights may have adverse effects for the Qualified Beneficiary as it will make it difficult to obtain coverage, whether group health coverage or insurance coverage through the individual market or the exchange. After COBRA continuation coverage is exhausted, the Qualified Beneficiary will have the option of electing other group health coverage or insurance coverage through the individual market or the exchange, in accordance with his or her HIPAA special enrollment rights.

17. The HEALTH COVERAGE TAX CREDIT PROGRAM (HCTC) portion of the COBRA CONTINUATION OF COVERAGE provision is deleted.

18. The UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994 provision is amended to revise the following:

INTRODUCTION

Employers are required to offer COBRA-like health care continuation coverage to persons in the armed service if the absence for military duty would result in a loss of coverage. Employees on leave for military service must be treated as if they are on leave of absence and are entitled to any other rights and benefits accorded to similarly situated Employees on leave of absence or furlough. If an employer has different types of benefits available depending on the type of leave of absence, the most favorable comparable leave benefits must apply to Employees on military leave. Reinstatement following a military leave of absence cannot be subject to Waiting Periods.

19. The PROVIDER NETWORK provision is amended to revise the following:

- **The program for Transplant Services at Designated Transplant Facilities is:**

20. The COVERED MEDICAL BENEFITS provision is amended to revise the following:

Autism Spectrum Disorders (ASD) Treatment, when Medical Necessity is met.

(ASD includes Autistic Disorder, Asperger's Syndrome, Childhood Disintegrative Disorder, Rett Syndrome and Pervasive Developmental Disorders).

ASD Treatment may include any of the following services: Diagnosis and Assessment; Psychological, Psychiatric, and Pharmaceutical (medication management) care; Speech Therapy, Occupational Therapy, and Physical Therapy; or Applied Behavioral Analysis (ABA) Therapy.

Treatment is prescribed and provided by a licensed healthcare professional practicing within the scope of their license (if ABA therapy, preferably a Board Certified Behavior Analyst, BCBA).

If ABA Therapy meets Medical Necessity, frequency and duration will be subject to current UMR guidelines, for example ABA treatment up to 25 hours per week for 3-6 months. Treatment plans specific to ABA Therapy with goals-progress and updates are required at least every 6 months for review of ongoing therapy to evaluate continued Medical Necessity.

Treatment is subject to all other plan provisions as applicable (such as Prescription benefit coverage, Behavioral/Mental Health coverage and/or coverage of therapy services).

Does not include services or treatment identified elsewhere in the Plan as non-covered or excluded (such as Investigational/Experimental or Unproven, custodial, nutrition-diet supplements, educational or services that should be provided through the school district).

Durable Medical Equipment subject to all of the following:

- The equipment is subject to review under the Care Management provision of this SPD, if applicable.

Extended Care Facility Services for both mental and physical health diagnosis. Charges will be paid under the applicable diagnostic code. The Covered Person must obtain prior authorization for services in advance. (Refer to the Care Management section of this SPD). The following benefits are covered:

21. The HOME HEALTH CARE BENEFITS provision is amended to revise the following:

Home Health Care services are provided for patients when Medically Necessary as determined by the Utilization Review Organization.

Covered Persons must obtain prior authorization before receiving services. Please refer to the Care Management section of this SPD for more details. Covered services may include:

- Nutrition counseling provided by or under the supervision of a Qualified dietician.

22. The TRANSPLANT BENEFITS provision is amended to revise the following:

Refer to the Care Management section of this SPD for prior authorization requirements

COVERED EXPENSES

- Pancreas, if the transplant meets the criteria determined by Care Management.

23. The PRESCRIPTION DRUG BENEFITS provision is amended to revise the following:

DEFINITIONS

Prescription Drug means any drug that, under Federal Drug Administration (FDA) or state law requires a written Prescription by a Physician. Drugs that are available without a Prescription are considered non-legend drugs.

24. The MENTAL HEALTH BENEFITS provision is amended to revise the following:

COVERED BENEFITS

- This Plan also covers services provided at a residential treatment facility that is licensed by the state in which it operates and that provides treatment for Mental Health Disorders. There is an MD/psychiatrist on staff. Coverage does not include services provided at a group home. Treatment in a residential treatment facility is not for the purpose of providing custodial care. If outside the United States, the residential treatment facility must be licensed or approved by the foreign government or an accreditation or licensing body working in that foreign country.

25. The MENTAL HEALTH BENEFITS provision is amended to delete the following:

COVERED BENEFITS

- The Covered Person must have the ability to accept treatment.

26. The SUBSTANCE ABUSE AND CHEMICAL DEPENDENCY BENEFITS provision is amended to revise the following:

COVERED BENEFITS

- This Plan also covers services provided at a residential treatment facility that is licensed by the state in which it operates and that provides treatment for substance abuse and chemical dependency disorders. Coverage does not include services provided at a group home. If outside the United States, the residential treatment facility must be licensed or approved by the foreign government or an accreditation or licensing body working in that foreign country.

27. The SUBSTANCE ABUSE AND CHEMICAL DEPENDENCY BENEFITS provision is amended to delete the following:

COVERED BENEFITS

- The Covered Person must have the ability to accept treatment.

28. The UTILIZATION MANAGEMENT provision is deleted and replaced with the CARE MANAGEMENT provision.

CARE MANAGEMENT

Utilization Management

Utilization Management is the process of evaluating whether services, supplies or treatment is Medically Necessary and appropriate to help ensure cost-effective care. Utilization Management can determine Medical Necessity, shorten Hospital stays, improve the quality of care, and reduce costs to the Covered Person and the Plan. The Utilization Management procedures include certain Prior Authorization requirements.

The benefit amounts payable under the Schedule of Benefits of this SPD may be affected if the requirements described for Utilization Management are not satisfied. Covered Persons should call the phone number on the back of the Plan identification card to request Prior Authorization at least two weeks prior to a scheduled procedure in order to allow for fact-gathering and independent medical review, if necessary.

Special Notes: The Covered Person will not be penalized for failure to obtain Prior Authorization if a Prudent Layperson, who possesses an average knowledge of health and medicine, could reasonably expect that the absence of immediate medical attention would jeopardize the life or long-term health of the individual. However, Covered Persons who have received care on this basis must contact the Utilization Review Organization (see below) as soon as possible within 24 hours of the first business day after receiving care or after Hospital admittance. The Utilization Review Organization will then review services provided within 48 hours of being contacted.

This Plan complies with the Newborns and Mothers Health Protection Act. Prior Authorization is not required to certify Medical Necessity for a Hospital or Birthing Center stay of 48 hours or less following a normal vaginal delivery or 96 hours or less following a Cesarean section. Prior Authorization may be required for a stay beyond 48 hours following a vaginal delivery or 96 hours following a Cesarean section.

UTILIZATION REVIEW ORGANIZATION

The Utilization Review Organization is: **UMR CARE MANAGEMENT**

DEFINITIONS

The following terms are used for the purpose of the Care Management section of this SPD. Refer to the Glossary of Terms section of this SPD for additional definitions.

Prior Authorization is the process of determining benefit coverage prior to a service being rendered to an individual member. A determination is made based on Medical Necessity criteria for services, tests or procedures that are appropriate and cost-effective for the member. This member-centric review evaluates the clinical appropriateness of requested services in terms of the type, frequency, extent and duration of stay.

Utilization Management means an assessment of the facility in which the treatment is being provided. It also includes a formal assessment of the Medical Necessity, effectiveness and appropriateness of health care services and treatment plans. Such assessment may be conducted on a prospective basis (prior to treatment), concurrent basis (during treatment), or retrospective basis (following treatment).

SERVICES REQUIRING PRIOR AUTHORIZATION

Call the Utilization Review Organization **before** receiving services for the following:

- Inpatient stays in Hospitals, Extended Care Facilities, or residential treatment facilities.
- Partial hospitalizations.
- Organ and tissue transplants.
- Home Health Care.
- Durable Medical Equipment, excluding braces and orthotics, purchase or rental over $2,000.
- Inpatient stays in a Hospital or Birthing Center that are longer than 48 hours following normal vaginal deliveries or 96 hours following Cesarean sections.
- Chemotherapy.
- Dialysis.

Note that if a Covered Person receives Prior Authorization for one facility, but then is transferred to another facility, Prior Authorization is also needed before going to the new facility, except in the case of an Emergency (see Special Notes above).

PENALTIES FOR NOT OBTAINING PRIOR AUTHORIZATION

A non-Prior Authorization penalty is the amount that must be paid by a Covered Person who does not call for Prior Authorization prior to receiving certain services. A penalty of up to $500 will be applied to applicable claims if a Covered Person receives services but does not obtain the required Prior Authorization for:

- Inpatient stays in Hospitals, Extended Care Facilities, or residential treatment facilities.
- Partial hospitalizations.
- Organ and tissue transplants.
- Inpatient stays in a Hospital or Birthing Center that are longer than 48 hours following normal vaginal deliveries or 96 hours following Cesarean sections.
- Chemotherapy.

The phone number to call for Prior Authorization is listed on the back of the Plan identification card.

The fact that a Covered Person receives Prior Authorization from the Utilization Review Organization does not guarantee that this Plan will pay for the medical care. The Covered Person must be eligible for coverage on the date services are provided. Coverage is also subject to all provisions described in this SPD.

Medical Director Oversight. A UMR Care Management medical director oversees the concurrent review process. Should a case have unique circumstances that raise questions for the Utilization Management specialist handling the case, the medical director will review the case to determine Medical Necessity using evidence-based clinical criteria.

Case Management Referrals. During the Prior Authorization review process, cases are analyzed for a number of criteria used to trigger case to case management for review. Case management opportunities are identified by using a system-integrated, automated diagnosis-based trigger list during the Prior Authorization review process. Other case management trigger points including the following criteria: length of stay, level of care, readmission and utilization, as well as employer or self-referrals. Information is easily passed from Utilization Management to case management through our fully-integrated care management software system.

All Prior Authorization requests are used to identify the member's needs. Our goal is to intervene in the process as early as possible to determine the resources necessary to deliver clinical care in the most appropriate care setting.

Retrospective Review. Retrospective review is conducted by Plan Administrator request as long as the request is received within 30 days of the original determination. Retrospective reviews are performed according to our standard Prior Authorization policies and procedures.

Disease Management Program

The **Disease Management Program** identifies those individuals who have a certain chronic disease and would benefit from this program. Condition coaches telephonically work with Covered Persons to help them improve their chronic disease and maintain quality of life. Our unique approach to Disease Management identifies individuals with one or more of the seven targeted chronic conditions (asthma, coronary artery disease, congestive heart failure, Chronic Obstructive Pulmonary Disease (COPD), diabetes, hypertension and depression – as a co-morbidity linked to another chronic condition we manage). Built within our system is a predictive modeling tool, Aerial Analytics and Clinical Intelligence Rules that takes up to two years' worth of medical and pharmacy claims data and then identifies those Covered Persons who are eligible to participate in the coaching program. If claims history is not available, Disease Management candidates are initially identified using a Health Condition Survey. The survey is a general screening questionnaire sent to all Covered Persons age 18 and over that asks a few questions about each of the conditions managed in the program. Once claims data is available, the predictive modeling tool is used to identify candidates for the program. Program participants can also be identified through referrals from the Prior Authorization process, Covered Person self-referral, other Care Management Programs, NurseLine referrals, the employer or the Covered Person's Physician.

In addition to the telephonic services, UMR disease management also provides Targeted Member Messages (TMMs). Each TMM provides a timely, personalized evaluation of a member's current health care recommendations. It is sent to each member's home via U.S. Mail. Members most likely to benefit from TMM/HealtheNotes are targeted to receive the reports. The reports provide health claims-based information and suggestions, and encourages members to take active roles in their health care and related spending choices. Members can review the informative report to help them understand their health care needs, take the reports with them to their medical appointments to discuss with their providers, and refer to them when making benefit plan elections.

HealtheNotes provides useful, personalized information based on an individual plan member's health care utilization, including information on provider visits, prescriptions and health screenings.

The TMM/HealtheNotes is a vital educational tool in the Disease Management Program for managing a Covered Person's chronic condition(s). It assists in our efforts to significantly improve the quality of life for Covered Persons while simultaneously reducing overall healthcare costs.

Maternity Management

Maternity Management provides prenatal education and high-risk pregnancy identification to help mothers carry their babies to term. This program increases the number of healthy, full-term deliveries and decreases the cost of a long term hospital stay for both the mother and/or baby. Program members are contacted via telephone at least once each trimester and once postpartum. A comprehensive assessment is performed at that time to determine the member's risk level and educational needs. The program uses incentives in order to increase participation. The standard incentive is a gift card. Covered Persons who enroll via the web receive a special edition pregnancy information guide. UMR's pre-pregnancy coaching program helps women learn about risks and take action to prevent serious and costly medical complications before they become pregnant. Women with pre-existing health conditions, such as diabetes and high blood pressure, not only face risks to their babies, but also to themselves while they're pregnant. Members self-enroll in the pre-pregnancy coaching program by calling our toll-free number. They are then contacted by a nurse case manager who has extensive clinical background in obstetrics/gynecology. The nurse completes a pre-pregnancy assessment to determine risk level, if any, and provides them with education and materials based on their needs. The nurse also helps members understand their Plan's benefit information.

Case Management

Case Management services are designed to identify catastrophic and complex Illnesses, transplants and trauma cases. UMR Care Management's nurse case managers identify, coordinate and negotiate rates for out-of-network services (where appropriate and allowed under the Plan) and help manage related costs by finding alternatives to costly Inpatient stays. Opportunities are identified by using a system-integrated, automated diagnosis-based trigger list during the Prior Authorization review process. Other case management trigger points include the following criteria: length of stay, level of care, readmission and utilization, as well as employer or self-referrals. UMR Care Management works directly with the patient, the patient's family members, the treating Physician and the facility to mobilize appropriate resources for the Covered Person's care. Our philosophy is that quality care from the beginning of the serious Illness helps avoid major complications in the future. The Covered Person may request that the Plan provide services and the Plan may also contact the Covered Person if the Plan believes case management services may be beneficial.

NurseLine

NurseLine service is a health information line that is available 24 hours per day, seven days a week that assists Covered Persons with medical-related questions and concerns. NurseLine gives Covered Persons access to highly trained registered nurses so they can receive guidance and support when making decisions about their health and/or the health of their Dependents.

29. The COORDINATION OF BENEFITS provision is amended to add the following:

The Plan will coordinate benefits with the following types of medical or dental plans:

- This Plan does not, however, coordinate benefits with individual health or dental plans.

ORDER OF BENEFIT DETERMINATION RULES

- If an active Employee is on leave due to active duty in the military in excess of 30 days, the plan that covers the person as an active Employee, member, or subscriber is considered primary.

30. The GENERAL EXCLUSIONS provision is amended to delete the following:

Pre-Existing Conditions exclusions, as specified in the Pre-Existing Condition Provision section of this SPD.

31. The CLAIMS AND APPEAL PROCEDURES provision is amended to revise the following:

TYPE OF CLAIMS AND DEFINITIONS

Note that this Plan does not require prior authorization for urgent or Emergency care claims; however, Covered Persons may be required to notify the Plan following stabilization. Please refer to the Care Management section of this SPD for more details. A condition is considered to be an urgent or Emergency care situation if a sudden and serious condition occurs such that a Prudent Layperson could expect the patient's life would be jeopardized, the patient would suffer severe pain, or serious impairment of the patient's bodily functions would result unless immediate medical care is rendered. Examples of an urgent or Emergency care situation may include, but are not limited to: chest pain; hemorrhaging; syncope; fever equal to or greater than 103° F; presence of a foreign body in the throat, eye, or internal cavity; or a severe allergic reaction.

PERSONAL REPRESENTATIVE

If a Covered Person chooses to use a Personal Representative, the Covered Person must submit proper documentation to the Plan stating the following: The name of the Personal Representative, the date and duration of the appointment and any other pertinent information. In addition, the Covered Person must agree to grant his or her Personal Representative access to his or her Protected Health Information. The Covered Person should contact the Claim Administrator to obtain the proper forms. All forms must be signed by the Covered Person in order to be considered official.

32. The CLAIMS AND APPEAL PROCEDURES provision is amended to revise the following:

APPEALS PROCEDURE FOR ADVERSE BENEFIT DETERMINATIONS

First Level of Appeal:

- After the claim has been reviewed, the Covered Person will receive written notification letting him or her know if the claim is being approved or denied. In the event of new or additional evidence, or any new rationale relied upon during the appeal process in connection with a claim that is being appealed, the Plan will automatically provide the relevant information to You. The notification will provide the Covered Person with the information outlined under the "Adverse Benefit Determination" section above. It will also notify the Covered Person of his or her right to file suit under ERISA after he or she has completed all mandatory appeal levels described in this SPD.

Second Level of Appeal:

- After the claim has been reviewed, the Covered Person will receive written notification letting him or her know if the claim is being approved or denied. In the event of new or additional evidence, or any new rationale relied upon during the appeal process in connection with a claim that is being appealed, the Plan will automatically provide the relevant information to You. The notification will provide the Covered Person with the information outlined under the "Adverse Benefit Determination" section above. It will also notify the Covered Person of his or her right to file suit under ERISA after he or she has completed all mandatory appeal levels described in this SPD.

33. The OTHER FEDERAL PROVISIONS is amended to revise the following:

FAMILY AND MEDICAL LEAVE ACT (FMLA)

An Employee may choose not to retain group health coverage during an FMLA leave. When the Employee returns to work following the FMLA leave, the Employee's coverage will usually be restored to the level the Employee would have had if the FMLA leave had not been taken. For more information, please contact Your Human Resources or Personnel office.

34. The HIPAA ADMINISTRATIVE SIMPLIFICATION MEDICAL PRIVACY AND SECURITY PROVISION is amended to revise the following:

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION UNDER HIPAA PRIVACY AND SECURITY REGULATIONS

- The Plan Sponsor will promptly report to this Plan any breach or impermissible or improper Use or Disclosure of PHI not authorized by the Plan documents;

- The Plan Sponsor will report to the Plan any breach or security incident with respect to Electronic PHI of which the Plan Sponsor becomes aware;

35. The HIPAA ADMINISTRATIVE SIMPLIFICATION MEDICAL PRIVACY AND SECURITY PROVISION is amended to add the following:

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION UNDER HIPAA PRIVACY AND SECURITY REGULATIONS

- The Plan Sponsor and the Plan will not use genetic information for underwriting purposes. For example, underwriting purposes will include determining eligibility, coverage, or payment under the Plan, with the exception of determining medical appropriateness of a treatment;

36. The PRE-EXISTING CONDITIONS EXCLUSION PERIOD portion of the STATEMENT OF ERISA RIGHTS provision is deleted.

37. The GLOSSARY OF TERMS provision is amended to revise the following:

Essential Health Benefit means any medical expense that falls under the following categories, as defined under the Patient Protection and Affordable Care Act; ambulatory patient services; Emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; Prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and Pediatric Services, including oral and vision care, if applicable.

38. The GLOSSARY OF TERMS provision is amended to add the following:

Life-Threatening Disease or Condition means a condition likely to cause death within one year of the request for treatment.

Pediatric Services means services provided to individuals under the age of 19.

39. The GLOSSARY OF TERMS provision is amended to delete the following:

Certificate of Creditable Coverage

Creditable Coverage

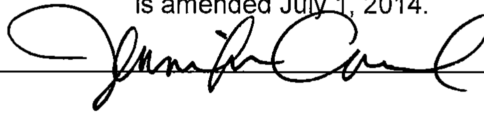
Pre-Existing Condition

Significant Break in Coverage

BY THIS AGREEMENT,

The KENYON COLLEGE Health Benefit Summary Plan Description

is amended July 1, 2014.

Authorized Signature 

Print Name JENNIFER CABRAL

Title DIRECTOR OF HUMAN RESOURCES

Date 4-2-15

IMPORTANT NOTICE:

The employer agrees to all provisions of this amendment as the basis for Plan administration. Except as specifically stated above, nothing in this amendment will alter or amend the summary plan description.

Any applicable stop loss policies typically rely on formally approved amendments or updated summary plan descriptions when determining whether reimbursement is appropriate. Failure to notify the stop loss carrier of plan changes may result in a stop loss gap or lapse in coverage. Notice to the stop loss carrier of all plan changes is required.

Please sign and return this amendment to your UMR strategic account executive as soon as possible. Note, however, that since the corresponding system changes have been implemented, these changes are considered final, regardless of whether or not a signature is received. If you have any questions, please contact your UMR strategic account executive.

Contingent upon your signed approval of the initial plan document, this amendment will be posted to the UMR member portal upon UMR's receipt of your signature, or within 14 days of your receipt of the amendment if a signature is not received by UMR. Please note that UMR will not print amendments or booklets until a signature is received.

Remember to keep a copy for your records.