

Amendment 02
Effective July 1, 2014
KENYON COLLEGE

The Dental 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 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.

3. 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.

4. 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).

5. 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 dental 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.

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

7. The COVERED EXPENSES – PREVENTIVE AND DIAGNOSTIC SERVICES provision is amended to add the following:

Diagnostic Services

Clinical Oral Evaluations

- D0190 Screening of a patient – a screening, including state or federally mandated screenings, to determine an individual's need to be seen by a dentist for diagnosis.
- D0191 Assessment of a patient - a limited clinical inspection that is performed to identify possible signs of oral or systemic disease, malformation, or injury, and the potential need for referral for diagnosis and treatment.

Preventive Services

Cleaning and Fluoride Treatments

- D1208 Topical application of fluoride - through 17 years of age (limited to two treatments per plan year)

8. The COVERED EXPENSES – PREVENTIVE AND DIAGNOSTIC SERVICES provision is amended to revise the following:

Diagnostic Services

X Rays

- D0210 Intraoral - complete series of radiographic images (including bitewings) (limited to one series every 36 consecutive months, combined with D0330) (a full mouth series includes 4 bitewings and 12 or more periapical x-rays) (not performed in conjunction with orthodontic treatment)
- D0220 Intraoral - periapical - first radiographic image
- D0230 Intraoral - periapical - each additional radiographic image (up to 12) (benefits not to exceed a full mouth series)
- D0240 Intraoral - occlusal radiographic image

- D0250 Extraoral - first radiographic image
- D0260 Extraoral - each additional radiographic image
- D0270 Bitewing - single radiographic image (limited to two visits per year with a maximum of 8 radiographic images per visit)
- D0272 Bitewing - two radiographic images (limited to two visits per year with a maximum of 8 radiographic images per visit)
- D0273 Bitewing - three radiographic images (limited to two visits per year with a maximum of 8 radiographic images per visit)
- D0274 Bitewing - four radiographic images (limited to two visits per year with a maximum of 8 radiographic images per visit)
- D0277 Vertical bitewings - 7 to 8 radiographic images (limited to two visits per year with a maximum of 8 radiographic images per visit)
- D0290 Posterior - anterior or lateral skull and facial bone survey radiographic image

- D0330 Panoramic radiographic image, including bitewings and periapicals if necessary - (limited to one every 36 consecutive months, combined with D0210) (not performed in conjunction with orthodontic treatment)

9. The COVERED EXPENSES – PREVENTIVE AND DIAGNOSTIC SERVICES provision is amended to delete the following:

Preventive Services:

Cleaning and Fluoride Treatments

- D1203 Topical application of fluoride (prophylaxis not included) - Child under age 12 (limited to two treatments per plan year)
- D1204 Topical application of fluoride (prophylaxis not included) - Adult - 12 through 13 years of age (limited to two treatments per plan year)

10. The COVERED EXPENSES – BASIC SERVICES provision is amended to revise the following:

Crowns

- D2799 Provisional crown – further treatment or completion of diagnosis necessary prior to final impression

Other Basic Restorative Services

- D2940 Protective restoration

Endodontic Therapy (including Treatment Plan, clinical procedures and follow-up care)

- D3352 Apexification/recalcification/pulpal regeneration - interim medication replacement (apical closure/calific repair of perforations, root resorption, pulp space disinfection, etc.).

11. The COVERED EXPENSES – BASIC SERVICES provision is amended to add the following:

Surgical Services (including the usual postoperative services)

- D4212 Gingivectomy or gingivoplasty - to allow access for restorative procedure, per tooth

- D4277 Free soft tissue graft procedure (including donor site surgery), first tooth or edentulous tooth position in graft
- D4278 Free soft tissue graft procedure (including donor site surgery), each additional contiguous tooth or edentulous tooth position in same graft site

Other Repair Procedures

- D7921 Collection and application of autologous blood and concentrate product
- D7952 Sinus augmentation via a vertical approach

12. The COVERED EXPENSES – BASIC SERVICES provision is amended to delete the following:

Surgical Services (including the usual postoperative services)

- D4271 Free soft tissue graft procedure (including donor site surgery)

13. The COVERED EXPENSES – MAJOR SERVICES provision is amended to add the following:

Other Restorative Services

- D2929 Prefabricated porcelain/ceramic crown--primary tooth
- D2981 Inlay repair necessitated by restorative material failure
- D2982 Onlay repair necessitated by restorative material failure
- D2983 Veneer repair necessitated by restorative material failure
- D2990 Resin infiltration of incipient smooth surface lesions

Other Implant Services

- D6051 Interim abutment
- D6101 Debridement of a periimplant defect and surface cleaning of exposed implant surfaces, including flap entry and closure
- D6102 Debridement and osseous contouring of a periimplant defect; includes surface cleaning of exposed implant surfaces and flap entry and closure
- D6103 Bone graft for repair of periimplant defect – not including flap entry and closure or, when indicated, placement of a barrier membrane or biologic materials to aid in osseous regeneration
- D6104 Bone graft at time of implant placement

Other Fixed Partial Denture Services

- D6975 Coping

14. The COVERED EXPENSES – MAJOR SERVICES provision is amended to revise the following:

Implant Services

- D6057 Custom fabricated abutment - includes placement

Fixed Partial Denture Pontics

- D6253 Provisional pontic – further treatment or completion of diagnosis necessary prior to final impression

Fixed Partial Denture Retainers

- D6793 Provisional retainer crown – further treatment or completion of diagnosis necessary prior to final impression

Other Fixed Partial Denture Services

- D6980 Fixed partial denture repair, by report necessitated by restorative material failure

15. The COVERED EXPENSES – MAJOR SERVICES provision is amended to delete the following:

Fixed Partial Denture Pontics

- D6254 Interim pontic

Fixed Partial Denture Retainers

- D6795 Interim retainer crown

Other Fixed Partial Denture Services

- D6970 Cast post and core in addition to fixed partial denture retainer
D6972 Prefabricated post and core in addition to fixed partial denture retainer
D6976 Each additional cast post - same tooth
D6977 Each additional prefabricated post - same tooth

16. The COVERED EXPENSES – ORTHODONTIC provision is amended to revise the following:

Radiographs/Diagnostic Imaging

- D0330 Panoramic radiographic image, including bitewings and periapicals if necessary (performed in conjunction with orthodontic treatment)
D0340 Cephalometric radiographic image

17. 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.

18. The RIGHT OF SUBROGATION, REIMBURSEMENT, AND OFFSET provision is amended to revise the following:

RIGHT OF SUBROGATION, REIMBURSEMENT, AND OFFSET

The Plan has a right to subrogation and reimbursement.

Subrogation applies when the Plan has paid Covered Expenses on Your behalf for an Illness or Injury for which a third party is considered responsible. The right to subrogation means that the Plan is substituted to and will succeed to any and all legal claims that You may be entitled to pursue against any third party for the Covered Expenses that the Plan has paid that are related to the Illness or Injury for which a third party is considered responsible.

The right to reimbursement means that if a third party causes or is alleged to have caused an Illness or Injury for which You receive a settlement, judgment, or other recovery from any third party, You must use those proceeds to fully return to the Plan 100% of any covered benefit you received for that Illness or Injury.

The following persons and entities are considered third parties:

- A person or entity alleged to have caused You to suffer an Illness, Injury, or damages, or who is legally responsible for the Illness, Injury, or damages.
- Any insurer or other indemnifier of any person or entity alleged to have caused or who caused the Illness, Injury, or damages.
- The Plan Sponsor.
- Any person or entity who is or may be obligated to provide benefits or payments to You, including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners', or otherwise), Workers' Compensation coverage, other insurance carriers, or third party administrators.
- Any person or entity that is liable for payment to You on any equitable or legal liability theory.

You agree as follows:

- You will cooperate with the Plan in protecting the Plan's legal and equitable rights to subrogation and reimbursement in a timely manner, including, but not limited to:
 - Notifying the Plan, in writing, of any potential legal claim(s) You may have against any third party for acts that caused Covered Expenses to be paid or become payable.
 - Providing any relevant information requested by the Plan.
 - Signing and/or delivering such documents as the Plan or our agents reasonably request to secure the subrogation and reimbursement claim.
 - Responding to requests for information about any accident or Injuries.
 - Making court appearances.
 - Obtaining our consent or our agents' consent before releasing any party from liability or payment of medical expenses.
 - Complying with the terms of this section.

Your failure to cooperate with the Plan is considered a breach of contract. As such, the Plan has the right to terminate Your covered benefits, deny future covered benefits, take legal action against You, and/or set off from any future covered benefits the value of covered benefits we have paid relating to any Illness or Injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to You or Your representative not cooperating with the Plan. If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by You or Your representative, the Plan has the right to recover those fees and costs from You. You will also be required to pay interest on any amounts You hold that should have been returned to the Plan.

- The Plan has a first priority right to receive payment on any claim against a third party before You receive payment from that third party. Further, our first priority right to payment is superior to any and all claims, debts, or liens asserted by any medical providers, including, but not limited to, Hospitals or Emergency treatment facilities, that assert a right to payment from funds payable from or recovered from an allegedly responsible third party and/or insurance carrier.
- The Plan's subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to You or Your representative, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, and punitive damages. The Plan is not required to help You to pursue Your claim for damages or personal Injuries and no amount of associated costs, including attorneys' fees, will be deducted from our recovery without the Plan's express written consent. No so-called "fund doctrine" or "common-fund doctrine" or "attorney's fund doctrine" will defeat this right.
- Regardless of whether You have been fully compensated or made whole, the Plan may collect from You the proceeds of any full or partial recovery that You or Your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, no matter how those proceeds are captioned or characterized. Proceeds from which the Plan may collect include, but are not limited to, economic, non-economic, and punitive damages. No "collateral source" rule, any "made-whole doctrine" or "make-whole doctrine," claim of unjust enrichment, nor any other equitable limitation will limit our subrogation and reimbursement rights.
- Benefits paid by the Plan may also be considered to be benefits advanced.
- If You receive any payment from any party as a result of Illness or Injury, and the Plan alleges some or all of those funds are due and owed to the Plan, You will hold those funds in trust, either in a separate bank account in Your name or in Your attorney's trust account. You agree that You will serve as a trustee over those funds to the extent of the benefits the Plan has paid.
- The Plan's rights to recovery will not be reduced due to Your own negligence.
- Upon our request, You will assign to us all rights of recovery against third parties, to the extent of the Covered Expenses the Plan has paid for the Illness or Injury.
- The Plan may, at its option, take necessary and appropriate action to preserve the Plan's rights under these subrogation provisions, including, but not limited to, providing or exchanging medical payment information with an insurer, the insurer's legal representative, or other third party and filing suit in Your name, which does not obligate the Plan in any way to pay You part of any recovery the Plan might obtain.
- You may not accept any settlement that does not fully reimburse the Plan, without its written approval.
- The Plan has the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.
- In the case of Your wrongful death or survival claim, the provisions of this section apply to Your estate, the personal representative of Your estate, and Your heirs or beneficiaries.

- No allocation of damages, settlement funds, or any other recovery, by You, Your estate, the personal representative of Your estate, Your heirs, Your beneficiaries, or any other person or party will be valid if it does not reimburse the Plan for 100% of its interest unless the Plan provides written consent to the allocation.
- The provisions of this section apply to the parents, guardian, or other representative of a Dependent Child who incurs an Illness or Injury caused by a third party. If a parent or guardian may bring a claim for damages arising out of a minor's Illness or Injury, the terms of this subrogation and reimbursement clause will apply to that claim.
- If a third party causes or is alleged to have caused You to suffer an Illness or Injury while You are covered under this Plan, the provisions of this section continue to apply, even after You are no longer covered.
- The Plan and all administrators administering the terms and conditions of the Plan's subrogation and reimbursement rights have such powers and duties as are necessary to discharge its duties and functions, including the exercise of its discretionary authority to (1) construe and enforce the terms of the Plan's subrogation and reimbursement rights and (2) make determinations with respect to the subrogation amounts and reimbursements owed to the Plan.

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

PERSONAL REPRESENTATIVE

Personal Representative means a person (or provider) who can contact the Plan on the Covered Person's behalf to help with claims, appeals or other benefit issues. A minor Dependent must have the signature of a parent or Legal Guardian in order to appoint a third party as a 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.

20. The CLAIMS AND APPEAL PROCEDURES provision is amended to delete the following:

TIMELINES FOR INITIAL BENEFIT DETERMINATION

UMR will process a Covered Person's claims within 30 calendar days, but the Plan can have an additional 15 day extension when necessary for reasons beyond control of the Plan if written notice is provided to the Covered Person within the original 30 day period. The Covered Person may voluntarily extend these timelines.

21. 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 You of Your right to file suit under ERISA after You have 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 You of Your right to file suit under ERISA after You have completed all mandatory appeal levels described in this SPD.

22. 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;

23. 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;

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

Essential Health Benefits (as related to Dental Expenses) means routine oral exams, routine X-rays, routine cleanings, and sealants applied to specific molars as defined under the Patient Protection and Affordable Care Act.

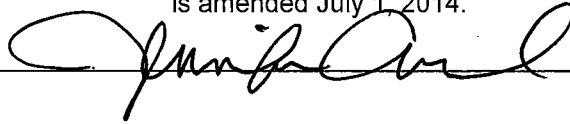
Pediatric Dental Services means services provided to individuals under the age of 19.

BY THIS AGREEMENT,

The KENYON COLLEGE Dental 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.