INTRODUCTION

Swarthmore College (the “College”) maintains the Swarthmore College Medical Insurance Plan for Retirees (the “Retiree Medical Plan”), which is a benefit under the Swarthmore College Flexible Benefit Plan, to provide certain medical benefits to eligible retirees and their dependents. The College has entered into contracts with certain carriers, including insurance companies and health maintenance organizations (HMOs) to provide these medical benefits. Each of the carriers has prepared materials describing its benefit option or options. These materials are available to you upon request.

It is important to review the descriptive materials prepared by your carrier to understand your benefits. The Retiree Medical Plan will provide benefits only to the extent they are covered by your carrier under the medical benefits option you select. If you would like to obtain a copy of any of these materials, please contact the Human Resources Office. Alternatively, you may contact the carrier directly.

This Summary Plan Description (the “SPD”) incorporates the materials prepared by the carriers for describing the benefits available to their subscribers. In the event of any conflict between a provision of this SPD and the carriers’ descriptive materials, the carriers’ descriptive materials will govern with respect to the particular provision. This SPD supersedes any prior communications regarding the Retiree Medical Plan which may be contradictory to the provisions of this document. Further, if any provision of the SPD conflicts with the terms of the official Retiree Medical Plan document, the Retiree Medical Plan document will govern.

The portion of the Retiree Medical Plan that covers Medicare eligible individuals is intended to be exempt from the Patient Protection and Affordable Care Act (the “Affordable Care Act”) as a retiree-only plan. The portion of the Retiree Medical Plan that covers non-Medicare eligible individuals is intended to be a “grandfathered health plan” under the Affordable Care Act. As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections under the Affordable Care Act that apply to other plans (e.g., the requirement for the provision of preventive health services without any cost sharing). However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act (e.g., the elimination of lifetime limits on benefits).

Questions regarding which protections apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator via mail at 500 College Avenue; Swarthmore, PA 19081 or via telephone at (610) 328-8397. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.
COMMITMENT TO PRIVACY

The College is committed to protecting your privacy under the Retiree Medical Plan. In accordance with applicable law, the College will take appropriate measures to keep your personal health information confidential and will only use or disclose your information to administer benefits under the Retiree Medical Plan or to comply with applicable legal requirements.

ELIGIBILITY

The eligibility rules under the Retiree Medical Plan differ depending on whether you are eligible for Medicare.

1. Retirees Eligible for Medicare

Retirees. You are eligible to participate in the Retiree Medical Plan if

- You retire from employment with the College at or after you attain age 60 and after completing at least 10 years of participation in the Swarthmore College Regular Retirement Plan; and

- Immediately prior to your retirement from the College, you were eligible to participate in the Swarthmore College Flexible Benefit Plan.

You may participate in the Retiree Medical Plan as of the first calendar day of the month following the month in which you retire.

Dependents. If you are a Medicare eligible participant then certain individuals may be eligible for coverage under the Retiree Medical Plan as your dependents. These individuals include your

These individuals include your

a. Legally married spouse;

b. Domestic partner; and

c. Children that

i. Are under age 26 (married or unmarried; student or not) and are not currently eligible for another employer-sponsored health plan. Your children include your biological and adopted children, children placed with you for adoption and other children who are treated as dependents under the particular option you elect; or

ii. Have been continuously disabled and incapable of self-support since ceasing to qualify as a dependent under a., above. If your child is disabled, you should notify the Human Resources
Department. Even if you have already provided this notice, you should provide it again within 31 days of the date that your child would lose coverage because of age, to confirm that the child will remain covered under the Retiree Medical Plan and the option you have selected. You may be required to provide proof of the child’s disability. Your carrier may require that your child submit to a medical examination by a provider chosen and paid for by the carrier or require other proof of a child’s ongoing disability.

Subject to applicable law, an individual will not be eligible for coverage as your dependent if he or she is: (1) a member of the armed forces of any country; (2) covered under the Swarthmore College Flexible Benefit Plan as an employee or another employee’s dependent; or (3) covered under the Retiree Medical Plan as a retiree.

Your dependents will become eligible for coverage when you become eligible. If an individual is not your dependent when you become eligible, he or she will become eligible for coverage when he or she becomes your dependent. For example, your fiancé will become eligible when you become married to him or her. See the Section on “Enrollment” for more specific information on the effective date of coverage following a special enrollment event.

**Domestic Partners.** An individual is considered to be your domestic partner if, during the preceding six months, you and the individual are and continue to be:

a. Jointly responsible for the basic living expenses and welfare of the other partner;
b. Not related by adoption or blood;
c. Each eighteen (18) years of age or older, residing with the other partner;
d. The sole domestic partner of the other partner with whom he/she has a close committed relationship;
e. Meet or agree to meet the requirements of any applicable federal, state or local laws or ordinances regarding domestic partnerships; and
f. Demonstrate financial interdependence in a manner prescribed by the College in accordance with the College’s domestic partner policy.

The College reserves the right to require you and your domestic partner to complete an affidavit of your domestic partner relationship and/or other similar documents as a condition of eligibility for Retiree Medical Plan coverage. Particular insurance carriers may have further requirements.

It is important to understand that you may be subject to federal, state and local income tax on the amounts contributed by you and the College for your domestic partner’s coverage under the Retiree Medical Plan. You should contact the Human Resources Office for more information.
2. **Retirees Not Eligible for Medicare**

*Retirees.* You are eligible to participate in the Retiree Medical Plan if

- You retire from employment with the College at or after you attain age 60 and after completing at least 10 years of participation in the Swarthmore College Regular Retirement Plan; and

- Immediately prior to your retirement from the College, you were eligible to participate in the Swarthmore College Flexible Benefit Plan.

You may participate in the Retiree Medical Plan as of the first calendar day of the month following the month in which you retire.

*Dependents.* If you are a non-Medicare eligible participant then certain individuals may be eligible for coverage under the Retiree Medical Plan as your dependents. These individuals include your

a. Legally married spouse;

b. Domestic partner; and

c. Children that

i. Are under age 26 (married or unmarried; student or not) and are not currently eligible for another employer-sponsored health plan. Your children include your biological and adopted children, children placed with you for adoption and other children who are treated as dependents under the particular option you elect; or

ii. Have been continuously disabled and incapable of self-support since ceasing to qualify as a dependent under a., above. If your child is disabled, you should notify the Human Resources Department. Even if you have already provided this notice, you should provide it again within 31 days of the date that your child would lose coverage because of age, to confirm that the child will remain covered under the Retiree Medical Plan and the option you have selected. You may be required to provide proof of the child’s disability. Your carrier may require that your child submit to a medical examination by a provider chosen and paid for by the carrier or require other proof of a child’s ongoing disability.

Subject to applicable law, an individual will not be eligible for coverage as your dependent if he or she is: (1) a member of the armed forces of any country; (2) covered under the Swarthmore College Flexible Benefit Plan as an employee or another employee’s dependent; or (3) covered under the Retiree Medical Plan as a retiree.
Your dependents will become eligible for coverage when you become eligible. If an individual is not your dependent when you become eligible, he or she will become eligible for coverage when he or she becomes your dependent. For example, your fiancé will become eligible when you become married to him or her. See the Section on “Enrollment” for more specific information on the effective date of coverage following a special enrollment event.

**Domestic Partners.** An individual is considered to be your domestic partner if, during the preceding six months, you and the individual are and continue to be:

- g. Jointly responsible for the basic living expenses and welfare of the other partner;
- h. Not related by adoption or blood;
- i. Each eighteen (18) years of age or older, residing with the other partner;
- j. The sole domestic partner of the other partner with whom he/she has a close committed relationship;
- k. Meet or agree to meet the requirements of any applicable federal, state or local laws or ordinances regarding domestic partnerships; and
- l. Demonstrate financial interdependence in a manner prescribed by the College in accordance with the College’s domestic partner policy.

The College reserves the right to require you and your domestic partner to complete an affidavit of your domestic partner relationship and/or other similar documents as a condition of eligibility for Retiree Medical Plan coverage. Particular insurance carriers may have further requirements.

It is important to understand that you may be subject to federal, state and local income tax on the amounts contributed by you and the College for your domestic partner’s coverage under the Retiree Medical Plan. You should contact the Human Resources Office for more information.

**ENROLLMENT**

To choose your option under the Retiree Medical Plan, you must enroll by completing and returning the forms provided to you by the Human Resources Office. You may enroll yourself and your eligible dependents whom you wish to cover. You may only enroll your dependents under the same option that you elect for yourself. However, if you are a retiree who is over age sixty-five (65) and has dependent(s) then you may enroll such dependent(s) in the benefit option(s) available to retiree(s) who are under age sixty-five (65). Your enrollment forms must be completed and returned to the Human Resources Office within 60 days of the date you are first eligible to participate. Otherwise, YOU WILL NOT HAVE COVERAGE and you will have to wait to enroll during the next annual open enrollment period or following a “life event,” “special enrollment event,” or “other mid-year change” as described below.
Annual Open Enrollment. During the annual open enrollment, you may change your coverage and benefits, regardless of the reason. Any changes you make will become effective on the first day of the next Plan Year, which is the start of the next annual period of coverage. Normally, this is the only time you can change your benefits unless you have a life event, a special enrollment event, or other mid-year change, all of which are described below.

Life Events. You may change your elections during the year only if you have a life event (as described below) which results in you or your dependent gaining or losing eligibility for health coverage and the election change corresponds with that gain or loss of coverage. Life events include changes in the following:

- **Legal Marital Status.** Events that change your legal marital status, including marriage, death of your spouse, divorce, legal separation or annulment;

- **Domestic Partnership Status.** Events that change your domestic partnership status, including the establishment of a domestic partnership, termination of a domestic partnership, or death of your domestic partner;

- **Employment Status.** Events that change the employment status of any of your dependents which results in a dependent becoming eligible or ceasing to be eligible under the Swarthmore College Flexible Benefit Plan or another employer’s health plan. These events include:
  
  - Termination or commencement of employment,
  - A reduction or increase in hours of employment (including a switch between part-time and full-time),
  - A strike or lockout,
  - Commencement or return from a leave of absence, and
  - A change in worksite,
  - And any other change in employment status that results in your dependent becoming eligible or ceasing to be eligible under the Swarthmore College Flexible Benefit Plan or another employer’s health plan.

- **Residence.** A change in the place of residence for you or your dependent.

- **Worksite.** A change in the place of work for your dependent.
• **Change in the Number of Children.** An event that changes the number of children you have, including the birth, death or adoption of a child.

**Special Enrollment Events.** A special enrollment event occurs when:

- You get married;
- You enter into a domestic partnership, provided that you have completed an affidavit of your domestic partnership and/or similar documents as required by the College;
- An event occurs that changes the number of children you have, including the birth, death or adoption of a child.
- In certain circumstances, your dependent loses other coverage (COBRA coverage is exhausted, he or she ceases to be eligible for non-COBRA health coverage, or another employer terminates its contribution toward your dependent’s other health coverage);
- If you are eligible for coverage but not enrolled in the Retiree Medical Plan and you or your dependent’s Medicaid or state Children’s Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility, you and your eligible dependents may enroll in the Retiree Medical Plan;** or
- If you or your dependents become eligible for a premium assistance subsidy under Medicaid or CHIP, you and your eligible dependents may enroll in the Retiree Medical Plan.**

**Other Mid-Year Changes.** Other mid-year changes that will enable you to change your elections include:

- **Significant Cost Increases.** If the cost of benefits significantly increases during a Plan Year, as determined by the College, you may elect coverage under another benefit option, if any, that offers similar coverage, as determined by the College.
- **Coverage Changes.** If coverage under a benefit option is significantly curtailed during a year, as determined by the College, you may revoke your election or elect coverage under another benefit option that offers similar coverage. If the College adds a new benefit option during a year, you may elect the new benefit option.
- **Changes Under Another Employer’s Health Plan.** Your dependent may also change his or her elections to correspond to certain changes that your dependent makes to his or her benefit elections under a health benefit plan offered by his or her employer.
• **Loss of Coverage Under A Governmental or Educational Institution Plan.** If you or your dependent loses coverage under any group health plan sponsored by a governmental or educational institution, a corresponding election change is permitted.

• **Medicare/Medicaid Coverage.** If you or your dependent becomes entitled to Medicare or Medicaid, or loses eligibility for Medicare or Medicaid, a corresponding election change is permitted.

To make a change to your elections due to a life event, a special enrollment event, or another mid-year change, you must submit the properly completed form or forms to the Human Resources Office within 30 days of the date of the event (unless denoted with a “**” above, in which case you have 60 days from the date of the event to contact the Human Resources Office). Your election change will take effect as of the first calendar day of the month after your enrollment forms are received by the Human Resources Office. In addition, any change in election you make under the Retiree Medical Plan must be consistent with the change or event that you or your dependent experienced.

**BENEFITS**

You have a choice of options available to you under the Retiree Medical Plan.

<table>
<thead>
<tr>
<th>Benefit Option</th>
<th>Type of Option</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blue Cross Plan 65 Special (With or Without Major Medical)</td>
<td>Indemnity (NOTE: This option has been closed to new participants effective as of June 1, 2010)</td>
</tr>
<tr>
<td>Keystone Health Plan East</td>
<td>HMO</td>
</tr>
<tr>
<td>Keystone Point of Service</td>
<td>HMO</td>
</tr>
<tr>
<td>Personal Choice</td>
<td>PPO</td>
</tr>
<tr>
<td>Medigap Security 65</td>
<td>Indemnity</td>
</tr>
</tbody>
</table>

The benefits available under each of these options are described in the materials prepared by the applicable carrier. These materials include information about:

• The nature of covered services;

• The conditions pertaining to eligibility under the option (other than the general eligibility requirements for participation in the Retiree Medical Plan, which are described in this SPD);

• Circumstances in which coverage or benefits under the option may be denied or terminated;
• The procedures to be followed in obtaining covered services; and

• The procedures available for the review of claims that have been denied in whole or in part.

If, for any reason, you have not received these materials or you would like another copy, you may obtain the materials free of charge by contacting the carrier or the Human Resources Office.

Your benefit election under the Retiree Medical Plan will remain in effect from year to year, subject to changes in the option you have selected and the cost of that option unless you change your election during an open enrollment period or following a life event or special enrollment event.

Types of Coverage

The options under the Retiree Medical Plan include a preferred provider organization (PPO) and health maintenance organizations (HMOs), a traditional indemnity plan and Medigap Security. PPOs and HMOs provide coverage in connection with a network of physicians, hospitals and other health care providers.

**PPO.** If you receive covered services from a provider within the network, you will generally be reimbursed at a rate greater than the rate that would apply for services provided outside of the network. Benefits, in a reduced amount, will typically be provided for covered out-of-network services.

**HMO.** An HMO differs from a PPO in two major respects. First, you must select a primary care physician who will generally be responsible for furnishing or coordinating your care. Second, if you receive care from a provider outside of the network, coverage for that care will not routinely be provided. The Point of Service (POS) plan is a type of HMO that provides some benefits for providers outside of the network.

Primary care physicians and other health care providers in PPOs or HMOs often enter into financial agreements with the organization establishing the network. These agreements frequently set forth particular ways of paying the provider. For instance, a provider could receive a specified amount for each service the provider performs, a salary, or a fee for each enrollee who designates him or her as a primary care physician. Some agreements may include financial incentive arrangements that pay a provider a larger or smaller amount based on certain factors, such as patient satisfaction, quality of care, and the control of costs and use of services. For more information about these arrangements, contact your carrier.

**Indemnity.** The Blue Cross Plan is a traditional indemnity program. Benefits paid by this option are generally based on what are called “usual, customary and reasonable” (“UCR”) charges. This means that your maximum coverage or reimbursement is based on schedules of average fees charges in the area for similar services and supplies. Blue Shield participating physicians accept the UCR charges as payment in full. The UCR rates are periodically revised and updated by Independence Blue Cross and Pennsylvania Blue Shield. The College also offers Medicare supplemental plans (Medigap) through Independence Blue Cross that provide gap
coverage for hospital (Blue Cross) in conjunction with Medicare Part A and medical (Blue Shield) in conjunction with Medicare Part B. Medicare Supplemental plans without separate drug coverage or Major Medical coverage do not provide prescription drug coverage.

Currently, enrollees in the 65 Special Plan with or without Major Medical may continue to participate in the plan on a grandfathered basis. New participants may only enroll in the Medigap Security 65 plan.

If you would like additional information about a particular option, please refer to the materials provided by the applicable insurance carrier or contact the carrier directly.

Whether you elect coverage under the PPO, HMO, or indemnity option (e.g., Medigap Security), you, in consultation with your physician, have the responsibility for making decisions regarding your medical care. However, the decisions you make may affect the coverage or benefits you receive.

**FEDERALLY MANDATED BENEFITS**

**Maternity Hospital Stay.** Some or all of the Retiree Medical Plan options cover expenses incurred in connection with pregnancy and childbirth. Under federal law, these options may not generally restrict benefits for any hospital stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or less than 96 hours following a caesarian 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, under federal law, no option or carrier under the Retiree Medical Plan may require that a provider obtain authorization from the Retiree Medical Plan for providing a hospital maternity stay that does not exceed 48 hours or 96 hours, as applicable.

**Women’s Health and Cancer Rights Act.** Some or all of the options under the Retiree Medical Plan provide medical and surgical benefits with respect to a mastectomy. As required by the Women’s Health and Cancer Rights Act, a woman who receives benefits under the Retiree Medical Plan for a mastectomy and who elects breast reconstruction after the mastectomy will also receive coverage for the following expenses at their usual rates:

- Reconstruction of the breast on which a mastectomy has been performed and surgery and reconstruction of the other breast to produce a symmetrical appearance; and

- Appropriate prostheses; and

- Treatment of physical complications for all stages of a mastectomy, including lymphedemas.
**Mental Health Parity.** The federal mental health parity rules require that a group health plan, such as the Retiree Medical Plan, with annual or lifetime dollar limits for medical and surgical benefits apply those same (or higher) dollar limits for mental health benefits.

- The Retiree Medical Plan must ensure that the financial requirements and treatment limitations that apply to the mental health or substance abuse benefits are no more restrictive than the most common or frequent financial requirements or treatment limitations that apply to substantially all medical and surgical benefits covered under the Retiree Medical Plan. “Financial requirements” include deductibles, co-payments, co-insurance, and out-of-pocket expenses. “Treatment limitations” include annual, episodic and lifetime visit limits.

- If you have any questions regarding the mental health parity rules and how they may apply to you or your eligible dependents, please contact the Human Resources Department.

**Military Leave of Absence.** An individual who is performing services in the uniformed services of the United States may elect to continue coverage for a period of up to 24 months.

- You should consult with the Human Resources Department for more information on this.

**Genetic Information Nondiscrimination Act.** The Retiree Medical Plan and the College are in compliance with the Genetic Information Nondiscrimination Act.

**CONTRIBUTIONS AND FUNDING**

Benefits under the Retiree Medical Plan are funded entirely through the payment of insurance premiums. The College will contribute toward these premium payments, but retirees will be required to pay part of the cost. When you select a Retiree Medical Plan option, you agree to contribute an amount established by the College. Before each annual open enrollment period (and at interim times, as relevant), the College will make information available to you about the amount that you must contribute toward the cost of each option. The amount of your contribution will depend on the option and the level of coverage (e.g., employee only, or employee and spouse/domestic partner) that you select. You may meet your contribution obligation by paying your share of the contribution by check each month. If you have elected coverage for your domestic partner, you will need to make special arrangements to meet your contribution obligation, and you should contact the Human Resources Office. The College reserves the right to change or modify the amount to be paid by retirees toward the cost of insurance premiums at a future time.

Benefits under the Retiree Medical Plan are provided entirely by the carrier of the option you elect. The College has no responsibility for benefit payments under the Retiree Medical Plan other than through the payment of the applicable insurance premium.
CLAIMS AND APPEALS

The specific procedures for submitting a claim for coverage or benefits under the Retiree Medical Plan and for appealing the denial of any claim are set forth in the materials prepared by your carrier. In many cases, you will not be required to file a claim for benefits. These claims will ordinarily be processed internally after you present your identification card to a network provider. If you submit a claim that is denied, your carrier will be responsible for notifying you of the reasons for the denial and providing you an opportunity to appeal the claim determination.

Please keep in mind that the specific procedures for processing claims and appeals under the Retiree Medical Plan are established by the applicable insurance carrier and are described in detail in the materials provided by the carrier. The minimum standards described below will apply only to the extent that they provide a claimant with greater rights than the procedures established by the applicable carrier.

Initial Claims

General Rules

The applicable insurance carrier will be responsible for processing your claims and/or making benefit determinations. Determinations will be made on a consistent basis where circumstances are the same, and in accordance with the terms of the Retiree Medical Plan and any applicable internal guidelines that are maintained under the Retiree Medical Plan by the applicable carrier. The Retiree Medical Plan will not charge for or otherwise unduly inhibit or hamper the filing or processing of a claim. Subject to reasonable verification procedures that a carrier may establish, a personal representative may act on a claimant’s behalf in filing and pursuing a claim.

Types of Claims

There are several different types of claims that you may bring under the Retiree Medical Plan. The Retiree Medical Plan’s procedures for evaluating claims (for example, the time limits for responding to claims and appeals) depend upon the particular type of claim. The types of claims that you generally may bring under the Retiree Medical Plan are as follows:

- **Pre-Service Claim** - A “pre-service claim” is a claim for a particular benefit under the Retiree Medical Plan that is conditioned upon receiving prior approval in advance of receiving the benefit. A pre-service claim must contain, at a minimum, the name of the individual for whom benefits are being claimed, a specific medical condition or symptom, and a specific treatment, service or product for which approval is being requested.

- **Post-Service Claim** - A “post-service claim” is a claim for payment for a particular benefit or for a particular service after the benefit or service has been provided. A post-service claim must contain the information requested on a claim form provided by the applicable provider.
• **Urgent Care Claim** - An “urgent care claim” is a claim for benefits or services involving a sudden and urgent need for such benefits or services. A claim will be regarded as urgent if application of the ordinary pre-service timeframe could seriously jeopardize your life, health or ability to regain maximum function or, in the opinion of a physician with knowledge of your claim, could subject you to pain that could not be controlled without the care or treatment that requires approval. If your physician determines that the claim involves urgent care, it will be treated as urgent. Otherwise, urgency will be determined based on what a prudent person with average knowledge of health and science would have concluded.

• **Concurrent Care Review Claim** - A “concurrent care review claim” is a claim relating to the continuation/reduction of an ongoing course of treatment.

**Timing of Notifications**

Your claims will be evaluated and processed within a timeframe that depends on the nature of the claim. Different timeframes apply depending on whether the claim is urgent, pre-service (but not urgent) or post-service.

The timeframes for each type of claim are set forth in the following chart:

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<thead>
<tr>
<th>PROCEDURE</th>
<th>NATURE OF CLAIM</th>
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<tbody>
<tr>
<td></td>
<td>Urgent</td>
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<tr>
<td>Carrier provides notice of incomplete filing</td>
<td>24 hours</td>
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<tr>
<td>Carrier provides notice of initial determination</td>
<td>72 hours</td>
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<tr>
<td>(or need for an extension)</td>
<td></td>
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<tr>
<td>Claimant provides additional information (where</td>
<td>48 hours</td>
</tr>
<tr>
<td>required)</td>
<td></td>
</tr>
<tr>
<td>Carrier provides notice of initial determination</td>
<td>48 hours</td>
</tr>
<tr>
<td>after extension begins or additional information</td>
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<tr>
<td>received, as applicable</td>
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* Except where more information is requested, the 15-day period may be increased by unused time from the period for providing notice of the need for extension. Where more information is requested, the determination will be made within 15 days of receipt. If the additional information is not provided on time, the determination will be made within 15 days of the end of the period for the information to be provided.
The carrier will make determinations with respect to urgent claims as soon as possible within the maximum limits. Certain extensions may be available if an extension is necessary due to matters beyond the control of the carrier if the carrier provides notice to the claimant before the expiration of the initial timeframe for providing a response. The carrier will make other determinations within a reasonable period that does not exceed the maximum.

If you do not file an urgent or pre-service claim properly, you will receive a notice that directs you how to file it properly. However, this notice will be sent only if the claim is filed with the correct person or office and specifies the claimant’s name, medical condition or symptom, and the treatment, service or procedure for which approval is sought. This notice will be provided within 24 hours of an urgent claim and within 5 days for any other pre-service claim.

**Denial Notice**

If all or part of your claim is denied, you will receive a written Explanation of Benefits (EOB) statement of other claim denial notice. In an urgent situation, you may be notified orally of a denial within the appropriate timeframe, with written confirmation sent within three days. The notice will include the following:

- **Reason for the Denial** - the specific reason or reasons for the denial;
- **Reference to Plan Provisions** - reference to the specific Retiree Medical Plan provisions on which the denial is based;
- **Description of Additional Material** - a description of any additional material or information necessary for you to perfect your claim and an explanation as to why such information is necessary;
- **Description of Any Internal Rules** - a copy of any internal rule, guideline, protocol, or other similar criterion relied upon in making the initial determination or a statement that such a rule, guideline, protocol, or other criterion was relied upon in making the appeal determination and that a copy of such rule will be provided to you free of charge at your request; and
- **Description of Claims Appeals Procedures** - a description of the Retiree Medical Plan’s appeals procedures and the time limits applicable for such procedures (such description will include a statement that you are eligible to bring a civil action in Federal court under Section 502 of ERISA to appeal any adverse decision on appeal and a description of any expedited review process for urgent care claims).

All determinations will be final and binding to the extent they are not appealed in accordance with the standard appeals procedure.
Appealing a Denied Claim

Submitting the Appeal

If you disagree with a claim decision, you can apply for a claim review. You must send your request for review within 180 days after receiving the claim denial notice. You should state the reason(s) you believe your claim was improperly denied and submit all comments, documents, records, and other information relating to the claim that you believe is appropriate.

In deciding whether to appeal a denial, you may, on request and free of charge, obtain access to and copies of all documents, records or other information relevant to your claim from the applicable carrier.

To file an appeal, you must notify the appropriate insurance carrier.
General Rules

Although certain aspects of the procedures may differ depending on your carrier, many of the basic rules will apply to all appeals.

The Retiree Medical Plan will not charge or otherwise unduly inhibit or hamper submission or processing of an appeal. Subject to reasonable verification procedures, a personal representative may act on your behalf in filing or pursuing an appeal.

Claims will be reviewed fully and fairly, taking into account the comments and information you have submitted. The review will be conducted by one or more individuals who are not the same as or subordinate to the individuals who made the initial determination (or any prior determination on appeal). The determination will be made independently, without deference to the initial claims determination. Determinations will be made on a consistent basis in like circumstances. They will be made in accordance with the terms of the Retiree Medical Plan and any applicable internal guidelines maintained under the Retiree Medical Plan by the applicable carrier.

Where a determination requires medical judgment, the claims reviewer will consult a health care professional with appropriate experience and training in the applicable field of medicine. This consultant will not be, or be subordinate to, any consultant previously involved with the internal claim decision or any prior level of review. The carrier will provide for the identification of medical experts whom it consults, whether or not it relied on their judgments.

Timing and Notification

If you appeal a denied claim for benefits, the appeals administrator will respond to your claim within the following time periods:

- **Post-Service Claim** - Within 60 days after receipt of the appeal.
- **Pre-Service Claim** - Within 30 days after receipt of the appeal.
- **Urgent Care Claim** - Within 72 hours after receipt of the appeal. Urgent care claim determinations on appeal may be transmitted by telephone, fax, or other expeditious methods.

Certain carriers may provide for two levels of standard appeals. Your carrier will have more information regarding your rights, if any, to a second level appeal. All decisions on appeal shall be final and binding to the extent they are not appealed to a second level (if available) or in accordance with the voluntary appeal provisions described below.

Concurrent Review

In circumstances involving concurrent review initiated by a carrier, the applicable carrier will notify you of any determination to reduce or terminate an approved course of treatment sufficiently in advance of the end of that treatment or program to allow you to appeal the decision and obtain a determination on appeal before benefits are reduced or terminated.
You may request from a carrier an extension of an approved course of treatment. Where urgent care is involved and you make this request at least 24 hours before the expiration of the approved period, the carrier will respond within 24 hours after receipt of the request.

A determination to reduce or terminate a stay or program or deny an extension will, like other claim or appeal determinations, cause benefits to be reduced, terminated, or denied. Thus, to the extent applicable, and apart from the specific timeframes described above, concurrent reviews will be subject to the standards for notification of determinations and, the rules governing the appeal of claims determinations described above.

**Voluntary Appeals**

Certain carriers may make an additional, voluntary level of appeal available to you if your claim has been denied, in whole or in part, in an initial determination and after one or two levels of standard appeals, as applicable. Your carrier will have more information regarding your rights to a voluntary appeal.

You must complete the initial claims review process and all levels of standard appeal with your carrier before you can file a voluntary appeal. Subject to verification procedures that the carrier may establish, a personal representative may act on your behalf in filing and pursuing a voluntary appeal. There is no charge for pursuing a voluntary appeal. You are not required to undertake a voluntary appeal before pursuing legal action.

**TERMINATION OF COVERAGE**

Your coverage under the Retiree Medical Plan will terminate when:

- The Retiree Medical Plan terminates or is amended to stop providing coverage for a classification of retirees that includes you.*
- You elect to stop receiving coverage under the Retiree Medical Plan.
- You stop making contributions required for coverage under the option that you select under the Retiree Medical Plan.
- You die.
- Subject to applicable law, you become an active member of the armed forces of any country on full-time duty.

* If your coverage under a particular option terminates, you will be eligible to elect coverage under another option available in your location, if any. However, the College reserves the right to terminate your coverage under the Retiree Medical Plan if your coverage under an option terminates because of a violation of that option’s rules for coverage (for example, if you file false claims under that option).
• You become reemployed by the College. For more details regarding reemployment, please contact the Human Resources Office.

The coverage of your dependents will terminate when your coverage terminates. It will terminate earlier if you elect to waive coverage for the dependent, if you stop making contributions required for the dependent’s coverage, or if the dependent ceases to qualify for coverage under the eligibility provisions of this SPD.

In most events, coverage will terminate as of the end of the month in which the terminating event occurs. However, if the Retiree Medical Plan terminates, coverage will terminate immediately upon that event.

CONTINUATION COVERAGE

Under a federal law, commonly referred to as COBRA, you and your dependent will have the opportunity to continue health coverage for a limited time at group rates in certain instances where your coverage or your dependent’s coverage under the Retiree Medical Plan would otherwise cease.

Your dependents have the right to elect continuation coverage if they lose health coverage under the Retiree Medical Plan for any of the following reasons:

• You die;

• You and your spouse divorce or legally separate;* or

• You become entitled to Medicare (date of enrollment in Part A or Part B whichever occurs earlier).

If one of the events mentioned above occur your dependent may continue the same coverage he or she had at the time of the event, subject to any future changes to the Retiree Medical Plan, for up to 36 months or the date of his or her Medicare entitlement, if earlier.

Under COBRA, you have the responsibility to inform the College of a divorce or legal separation within 60 days of the date of the event or, if later, the date coverage would be lost because of that event. Upon receiving this notice or upon the occurrence of any of the other events that entitle your dependents to elect continuation coverage, the College will provide him or her with detailed information about his or her COBRA rights, including instructions for electing continuation coverage. Under the law, he or she will have 60 days to inform the College (or a third party administrator acting on behalf of the College) that he or she wants continuation coverage. The 60-day period starts on the date he or she is notified of his or her rights to COBRA coverage, or, from the date his or her coverage under the Retiree Medical Plan ends, whichever is later. Once the 60-day period ends, he or she will no longer eligible to elect continuation coverage.

* Dissolution of a domestic partnership is not a qualifying event for COBRA purposes.
If your dependent does not choose to continue coverage, his or her coverage under the Retiree Medical Plan will cease as of its ordinary termination date. See the Section on “Termination of Coverage.” If he or she chooses to continue coverage, the College will provide him or her with coverage which (as of the time coverage is provided) is identical to the coverage the College provides similarly situated dependents, as the case may be.

COBRA provides that continuation coverage may be discontinued for any of the following reasons:

- The College no longer provides group health coverage for retirees;
- The premium for continuation coverage is not paid on a timely basis;
- The individual continuing coverage under COBRA becomes covered under another employer’s group health plan that does not limit or exclude coverage for a pre-existing medical condition applicable to that individual; or
- The individual continuing coverage under COBRA becomes entitled to Medicare.

Continuation coverage may also be cut short for other generally applicable reasons under the Retiree Medical Plan.

Cost
Your dependents must pay the full COBRA premium. The COBRA premium may equal up to 102% of the total insurance premium for the coverage your dependent(s) selects. The cost of group health coverage may change during the period of continuation coverage.

The initial payment for continuation coverage is due 45 days from the date an election to continue coverage is sent to the College. The initial payment extends back to when coverage is first lost and may need to cover more than one month. Thereafter, payment is required on a monthly basis, with a grace period of 30 days.

Conversion
At the end of the continuation coverage period, an individual may convert his or her group health coverage under the Retiree Medical Plan to individual coverage provided conversion privileges are available under the option you elect. This individual coverage may not be the same as the coverage you have under the Retiree Medical Plan and the cost of the coverage to you may differ. For more information about your rights to conversion, see the materials provided by your carrier or contact your carrier directly.

Special Rules and Questions
In certain instances, special rules might apply under COBRA. If you have any questions regarding your rights and obligations under COBRA, please contact the Human Resources Office.
CERTIFICATE OF CREDITABLE COVERAGE

Under federal law, you and your dependents are entitled to information about “creditable coverage” under the Retiree Medical Plan upon a loss of coverage. This information may enable you to reduce or eliminate the length of time that a pre-existing condition exclusion applies to you under another health plan or insurance policy. At certain times, the College or the carrier of the option you chose will provide a certification of creditable coverage to you automatically. The College will also provide a certification of creditable coverage to you, upon request, within 24 months of the date that you or your dependents lose coverage (or continuation coverage under COBRA). Requests must be submitted in writing to the Human Resources Office.

A certification of credible coverage is a form that provides specific information about you and/or your dependent(s) who lost coverage. The form will include:

- The date on which it was produced;
- The name of the Retiree Medical Plan;
- Your name;
- The name of your dependents covered by the Retiree Medical Plan (if any); and
- The coverage effective and termination dates.

MEDICARE PARTS A AND B

The Federal government provides medical benefits for people ages 65 and older in two parts: Medicare Part A – Hospital Benefits, and Medicare Part B – Medical Benefits. In order to be eligible for Medicare, an individual must have attained age 65. In general, your spouse or domestic partner is not automatically eligible for Medicare when you attain age 65 - he or she must attain age 65 to be eligible for Medicare. However, you or your spouse or domestic partner may be eligible for Medicare prior to age 65 due to a disability.

**Medicare Part A – Hospital Benefits**

You and your spouse or domestic partner are automatically entitled to Medicare Part A benefits at age 65 if you are receiving Social Security benefits. You and the College paid for Medicare Part A benefits through the FICA taxes (Social Security and Medicare taxes) assessed during your working years. Medicare Part A benefits help cover charges for:

- Inpatient hospital services;
- Inpatient care in a skilled nursing facility after a hospital stay;
- Care in the home by a home health care agency; and
- Hospice care

Medicare Part A coverage is subject to deductible and copayment amounts.
Medicare Part B – Medical Benefits

If you and your spouse or domestic partner is entitled to Medicare Part A benefits, you each may also elect Medicare Part B benefits. If elected, payment for Medicare Part B coverage will be deducted monthly from your Social Security check. You will not be reimbursed by the College for your Medicare Part B premiums.

Medicare Part B coverage helps cover charges for:

- Physician’s services;
- Hospital outpatient services;
- Outpatient physical therapy and speech pathology services;
- Home health care (for example, physician charge, physical therapist charge); and
- Many other health services and supplies which are not covered by Medicare Part A.

Medicare Part B coverage is subject to deductible and copayment amounts.

Medicare Enrollment

Eligibility for Medicare Part A and B benefits is automatic at age 65. However, coverage is not automatic. You and your spouse or domestic partner must enroll for Medicare.

COORDINATION OF BENEFITS

About Coordination of Benefits

If you and your dependents have health care coverage under more than one group plan, the Retiree Medical Plan’s Coordination of Benefits (COB) feature will apply. The purpose of coordinating benefits is to avoid increased costs that result from health care overpayments.

If you are covered by another group health plan or program that duplicates benefits under the Retiree Medical Plan, one of these plans will be primary and will be responsible for paying benefits first, and the other plan will be secondary and will be responsible for paying second. When the Retiree Medical Plan is the secondary payer, the benefits payable under the Retiree Medical Plan will be reduced to an amount which, together with all other Plan benefits, will not exceed 100% of eligible expenses covered under the Retiree Medical Plan or any such other group plan.

In situations where there other plan is Medicare, the Retiree Medical Plan will consider only the actual amount (Medicare-approved amount) charged by the provider according to Retiree Medical Plan provisions. Federal law limits the amount that non-Medicare participating providers can charge Medicare beneficiaries for services and/or supplies; this is referred to as the Medicare Limiting Charge.
Medicare recipients continue to be responsible for deductibles and coinsurance; however, they are not responsible for the amount a non-Medicare participating physician charges that is above the Medicare Limiting Charge.

To make sure you receive all of the benefits for which you are eligible, you should file your claims with each health care plan. Send your claims to the primary plan first (see below). Be sure to include all group plan information on your claim form so the health care plan can coordinate your benefits.

**Primary Plan**
If you have an allowable expense (any reasonable, customary and medically necessary expense) under two group health care plans, the primary plan will pay your claim first. The secondary plan may pay none, some, or all of the difference between what was paid by the primary plan and the remainder of your allowable expense.

If you or your dependents are covered under another employer’s active plan, the plan covering you as an active employee is considered primary. The Retiree Medical Plan would be considered the secondary plan for the retiree or dependent.

If you are covered as a retiree or survivor under the Retiree Medical Plan and as a dependent under another employer’s active plan, the plan covering you as a dependent of an active employee is the primary plan and the Retiree Medical Plan would be considered the secondary plan for the retiree or survivor.

**Medical Care Coverage From An Automobile Policy**
If your individual automobile policy includes medical coverage, the automobile policy is considered primary and pays benefits first. The College, as secondary payor, covers reasonable expenses not covered by the automobile medical policy, including regular deductibles imposed by Personal Injury Protection (PIP).

If you decide not to elect your automobile PIP coverage as primary, the College will not assume liability as the primary payor to cover treatment of injuries resulting from a motor vehicle accident.

**Medicare**
If you or your spouse or domestic partner is also eligible for Medicare, Medicare is primary and your Retiree Medical Plan coverage is secondary.

However, if you are covered by your spouse’s or domestic partner’s active group plan, your spouse’s or domestic partner’s plan pays first, Medicare pays second and the Retiree Medical Plan pays last.

**RECOVERY OF THIRD PARTY PAYMENTS**
Whenever the Retiree Medical Plan pays for eligible expenses, and you have the right to recover expenses incurred for care from another person or organization which caused the injury or illness, the insurance carrier has the right to recover the amount that was paid on your behalf.
AMENDMENT AND TERMINATION

The College expressly reserves the right to amend or terminate the Retiree Medical Plan, in whole or in part, at any time and for any reason, by written action of the board of managers of the College or its delegate. This right includes the authority to amend or terminate any of the benefit options available under the Plan or make any other modification. No amendment or termination of the Retiree Medical Plan shall adversely affect the rights of a participant to benefits for claims incurred before the amendment or termination.

In addition, the applicable carrier for an option may amend or terminate that option pursuant to its rights under its contract with the College.

LIMITATIONS

Nothing in this Summary Plan Description is intended to provide any guaranty of employment or a continuing relationship with the College. Although coverage and benefits under the Retiree Medical Plan described in the SPD are frequently provided on a tax-favored basis, nothing in these SPD is intended to provide a guaranty of any particular tax consequences with respect to the coverage or benefits provided.

BASIC INFORMATION

Name of Plan: The Swarthmore College Medical Insurance Plan for Retirees is part of the Swarthmore College Flexible Benefit Plan

Plan Year: November 1st to October 31st

Plan Number: 502

Type of Plan: Group health benefits plan

Plan Sponsor and Administrator: Swarthmore College
500 College Avenue
Swarthmore, PA 19081
(610) 328-8397

Employer Identification Number 23-1352683

Plan Administrator: Benefit Plan Administrative Committee
Swarthmore College
500 College Avenue
Swarthmore, PA 19081
(610) 328-8397

Agent for service of legal process: Benefit Plan Administrative Committee, 500 College Avenue, Swarthmore, PA 19081
Type of Administration: Each option under the plan is administered by the applicable insurance or HMO carrier.

Carrier Information: Each of the carriers finances and administers the benefits provided under its option. The administrative services furnished by these carriers include:

- The establishment, maintenance, and management of a network of providers;
- The processing and payment or notification of denial (as applicable) of claims and appeals from denial claims;
- The provision of utilization review services;
- The maintenance of records and reporting of information;
- Various customer services.

ERISA RIGHTS

As a participant in the Swarthmore College Medical Insurance Plan for Retirees, which is part of the Swarthmore College Flexible Benefit Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Retiree Medical Plan participants shall be entitled to:

**Receive Information About Your Plan and Benefits**

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

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

Receive a summary of the Retiree Medical Plan’s annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue group health coverage for yourself, spouse or dependents if there is a loss of coverage under the Retiree Medical Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Retiree Medical Plan on the rules governing your COBRA continuation coverage rights.
Reduction or elimination of exclusionary periods of coverage for preexisting conditions under the Retiree Medical Plan if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your Retiree Medical Plan or health insurance issuer when you lose coverage under the Retiree Medical Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

**Prudent Actions by Plan Fiduciary**

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

**Enforce Your Rights**

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of the plan documents or the latest annual report from the Retiree Medical Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. After you have exhausted the claims procedures provided under the Retiree Medical Plan (as outlined above in this SPD and in the materials provided by the applicable insurance carrier), you may file suit in a state or Federal court if you have a claim for benefits which is denied or ignored, in whole or in part. In addition, if you disagree with the Retiree Medical Plan’s decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. The court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

**Assistance With Your Questions**

If you have any questions about your Retiree Medical Plan, you should contact the Human Resources Office. If you have any questions about this statement or about your rights
under ERISA, or if you need assistance in obtaining documents from the plan administrator, you
should contact the nearest office of the Employee Benefits Security Administration, U.S.
Department of Labor, listed in your telephone directory or the Division of Technical Assistance
and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200
Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications
about your rights and responsibilities under ERISA by calling the publications hotline of the
Employee Benefits Security Administration.