

BRAREN-WALSH & ASSOCIATES, INC.
HEALTH MANAGEMENT SERVICES

June 5, 1997

SPD
PWBA, Room N-5644
U.S. Department of Labor
200 Constitution Avenue, NW
Washington, DC 20210

**RE: Chronicle of Higher Education Health Care Plan #501
EIN: 52-1131774**

Dear Reader:

I have enclosed the amended pages (effective March 1, 1996) to the SPD for the above-captioned plan.

Please call me with any questions.

Sincerely,



Heidi L. Braren-Walsh
President

Enclosures

c: Pam Poolson
Assistant Manager, Staff Services

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PLAN AMENDMENT

To be attached to and made part of the **Booklet** which describes the Benefits available to **Employees** of:

THE CHRONICLE OF HIGHER EDUCATION

This **Booklet** is amended as of MARCH 1, 1996, by deleting the section(s) listed below and substituting the attached section(s):

HOW TO FILE CLAIMS

This amendment overrides anything to the contrary contained in the **Booklet**.

DOL-PWGA
PUBLIC DISCLOSURE
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HOW TO FILE YOUR CLAIMS

LIFE INSURANCE

In the event of your death the Plan Administrator will contact your beneficiary to explain what is required before payment of the **Proceeds** can be made. The Plan Administrator will provide the necessary claim forms and instructions for completing them. If prompt contact is not made by the Plan Administrator, your beneficiary should take the initiative in making contact.

The **Proceeds** payable on your death will be paid to your beneficiary in a lump sum unless, by written notice to **us**, you have requested that it be payable on an installment basis as provided in this **Booklet** or be left on deposit with **us**. If you have not elected an alternative method of settlement, your beneficiary may elect one of the settlement options at your death.

AD&D INSURANCE

In the event of accidental dismemberment or loss of sight, ask your Plan Administrator for the appropriate claim forms. Ensure that these are properly completed and then return them to the Plan Administrator.

In the event of your accidental death, the Plan Administrator will contact your beneficiary to explain what is required before payment of the insurance money can be made. The Plan Administrator will provide the necessary claim forms and instructions for completing them. If prompt contact is not made by the Plan Administrator, your beneficiary should take the initiative in making contact.

HOW TO FILE YOUR CLAIMS (Continued)

HOSPITAL

Have the **Hospital** Admitting Clerk complete a **Hospital** Claim Report and attach their billing. Be sure this form includes the name of your **Employer**. The **Hospital** will forward the form directly to the Benefit Payments Office shown on the Claim Report and payment will be made directly to you or, if you so elect, to the **Hospital**.

MEDICAL

Ask your **Doctor** to complete an itemized Physician's Statement and attach his billing. Be sure the name of your **Employer** is included on this form. The **Doctor** will forward the form directly to the Benefit Payments Office shown on the Claim Report and payment will be made directly to you or, if you so elect, to the **Doctor**.

DENTALCARE

Ask your **Dentist** to complete a dental form (available from your Plan Administrator) and attach his billing. Be sure the name of your **Employer** is included on this form. The **Dentist** will forward the form directly to you or, if you so elect, to the Benefit Payments Office shown on the Claim Report and payment will be made directly to you or, if you so elect, to the **Dentist**.

VISIONCARE

Ask your **Doctor**, Ophthalmologist or Optometrist to complete a vision-care claim form (available from your Plan Administrator) and forward directly to the Benefit Payments Office shown on the Claim Report. Be sure the name of your **Employer** is included on this form. Payment will be made directly to you or, if you so elect, to your **Doctor**, Ophthalmologist or Optometrist.

HOW TO FILE YOUR CLAIMS (Continued)

PRESCRIPTION DRUGS

Your Plan Administrator will provide you with a PCS identification card when you first become covered under the group plan. Present your PCS card when purchasing drugs at any of the participating pharmacies. You can obtain a list of the participating pharmacies from your Plan Administrator. Sign the pharmacy claim voucher (the pharmacy has this voucher) and pay the Pharmacist the amount, if any, shown as the "Co-Pay Amount" in your **Booklet**.

When purchasing drugs at a non-participating pharmacy, you will be required to pay the full price of the prescription. For reimbursement, ask your Plan Administrator for a PCS Prescription Drug Claim Form. Complete this claim form and mail it to the PCS address shown on the claim form. Benefit payments will be sent to you.

MAIL ORDER DRUGS

Your Mail Order Drug brochure includes an Order Form or you may obtain one from your Plan Administrator. Complete this Order Form and send it with the prescription and Co-Pay Amount shown in your **Booklet** to the Mail Order Vendor shown on the claim form. Another Order Form will be sent to you when your prescription is returned.

IF YOU INCUR EXPENSES OUTSIDE THE UNITED STATES

If you incur expenses outside the United States, you must pay the bill and file a claim to be reimbursed.

- The claim must be translated into English.
- The charges must be in U.S. currency. You are responsible for finding out the exchange rate and determining the correct amount of U.S. dollars.
- Along with the claim, you must send a receipt showing that you have paid the bill.

CO-ORDINATION OF BENEFITS (COB)

The COB provision is designed to correct overcoverage which occurs when a person has health coverage for the same expenses under two or more of the plans listed below. Should this type of duplication occur, the benefits under this Plan will be co-ordinated with those of the other plans so that the total benefits from all plans will not exceed the expenses actually incurred.

The benefits provided by the plans listed below are considered in determining duplication of coverage:

- This Plan;
- Any other group insurance or prepayment plan, including automobile "fault" or "no-fault" insurance; Health Maintenance Organizations (HMOs); Blue Cross/Blue Shield;
- Any labor-management trustee plan, union welfare plan, employer organization plan or employee benefit organization plan;
- Any government plan or statute providing benefits for which COB is not prohibited by law;
- Any individual automobile "no-fault" insurance plan.

ORDER OF BENEFIT DETERMINATION

Certain rules are used to determine which of the plans will pay benefits first. This is done by using the **first** of the following rules which applies:

- A plan with no COB provision will determine its benefits before a plan with a COB provision.
- A plan that covers a person other than as a **Dependent** will determine its benefits before a plan that covers such person as a **Dependent**.
- When a claim is made for a **Dependent** child who is covered by more than one plan:

CO-ORDINATION OF BENEFITS (COB) (Continued)

- the benefits of the plan of the parent whose birthday falls earlier in a year will be determined before the benefits of the plan of the parent whose birthday falls later in that year; but
- if both parents have the same birthday, the benefits of the plan which covered the parent longer will be determined before those of the plan which covered the other parent for a shorter period of time.

This method of determining the order of benefits will be referred to as the "Birthday Rule". The Birthday Rule will be used to determine the order of benefits for **Dependent** children in all cases except those described below.

- If the other plan does not have the Birthday Rule, then the plan which covers the child as a **Dependent** of the male parent will pay its benefits first.
- If the parents are legally separated or divorced, benefits for the child will be determined in this order:
 - * first, the plan of the parent with custody of the child will pay its benefits;
 - * then, the plan of the spouse of the parent with custody of the child will pay its benefits; and
 - * finally, the plan of the parent not having custody of the child will pay its benefits.

However, if there is a court decree stating which parent is responsible for the health care expenses of the child, then a plan covering the child as a **Dependent** of that parent will determine its benefits before any other plan.

- A plan that covers a person as:
 - a laid-off **Employee**; or
 - a **Retired Employee**; or
 - a **Dependent** of such **Employee**;will determine its benefits **after** the plan that does not cover such person as:
 - a laid-off **Employee**; or
 - a **Retired Employee**; or
 - a **Dependent** of such **Employee**.

If one of the plans does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule will not apply.

CO-ORDINATION OF BENEFITS (COB) (Continued)

- If none of the above rules establishes the order of payment, a plan under which the person has been covered for the longer time will determine its benefits before a plan covering that person for a shorter time.

Two successive plans of the same group will be considered one plan if the person was eligible for coverage under the new plan within 24 hours after the old plan terminated. A change in the amount or scope of benefits, or a change in the carrier, or a change from one type of plan to another (e.g. single employer plan to multiple employer plan) **will not** constitute the start of a new plan.

When the COB provision reduces the benefits payable under this Plan:

- each benefit will be reduced proportionately; and
- only the reduced amount will be charged against any benefit limits under this Plan.

The COB provision is applied throughout the calendar year. If there is any reduction of the benefits provided under a specific Benefit Provision of this Plan because of duplicate coverage, similar benefits may be payable later in that year if more Allowable Expenses are incurred under the same Benefit Provision. "Allowable Expense" means any necessary, **Usual and Customary** item of expense at least part of which is covered under at least one of the plans covering the person for whom claim is made or service provided. In no event will Allowable Expense include the difference between the cost of a private hospital room and a semi-private hospital room unless the patient's stay in a private hospital room is **Medically Necessary**.

Benefits under a governmental plan will be taken into consideration without expanding the definition of "Allowable Expense" beyond the hospital, medical and surgical benefits as may be provided by such governmental plan.

When a plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered will be deemed to be both an Allowable Expense and a benefit paid.

PROVISION FOR SUBROGATION AND RIGHT OF RECOVERY

A third party may be liable or legally responsible for expenses incurred by a **Covered Person** for an **Illness**, a sickness, or a bodily injury.

Benefits may also be payable under this **Booklet** for such expenses. When this happens, the Company may, at its option:

- take over the **Covered Person's** right to receive payment from the third party, the third party's insurer or guarantor, or uninsured and/or underinsured motorist insurance.

The **Covered Person** or his or her legal representative will:

- transfer to the Company any rights he or she may have to take legal action arising from the **Illness**, sickness or bodily injury to recover any sums paid under this **Booklet** on behalf of the **Covered Person**; and
 - cooperate fully with the Company in asserting its right to subrogate. This means the **Covered Person** or his or her legal representative must supply the Company with all information and sign and return all documents reasonably necessary to carry out the Company's right to recover any sums paid under the **Booklet** which are subject to this provision.
- recover from the **Covered Person** or his or her legal representative any benefits paid under the **Booklet** from payment which the **Covered Person** is entitled to receive from the third party, the third party's insurer or guarantor, or uninsured and/or underinsured motorist insurance.

The Company will have a first lien upon any recovery, whether by settlement, judgment, mediation or arbitration, that the **Covered Person** receives from any of the sources listed above. This lien will not exceed:

- the amount of benefits paid by the Company for the **Illness**, sickness or bodily injury; or
- the amount received from the third party, the third party's insurer or guarantor, or uninsured and/or underinsured motorist insurance.

PROVISION FOR SUBROGATION AND RIGHT OF RECOVERY (Continued)

The **Covered Person** or his or her legal representative must cooperate fully with the Company in asserting its recovery rights. The **Covered Person** or his or her legal representative will, upon request from the Company, provide all information and sign and return all documents necessary to exercise the Company's recovery rights under this provision.

If the **Covered Person** or his or her legal representative:

- makes any recovery from any of the sources described above; and
- fails to reimburse the Company fully for any benefits paid which arise from the **Illness**, sickness or bodily injury;

then :

- the **Covered Person** or his or her legal representative will be personally liable to the Company for the amount of benefits paid under this **Booklet**; and
- the Company may reduce future benefits payable under this **Booklet** for an **Illness**, a sickness, or bodily injury by the payment that the **Covered Person** or his or her legal representative has received from the third party, third party insurer or guarantor, or uninsured and/or underinsured motorist insurance.

- the Company's first lien rights will not be reduced due to the **Covered Person's** own negligence or due to attorney's fees and costs.

For example, if you were injured while traveling in a car and you have filed or will be filing claims with the Company, the Company is entitled to recover from you or your legal representative when you are paid by any of the sources listed above for injuries arising from the accident.

DENIAL OF CLAIM

NOTICE OF DENIAL OF CLAIM

If any benefits are denied, either in whole or in part, notification of the specific reason or reasons for the denial will be given along with reference to the pertinent plan provisions on which the denial is based. Guidance as to the additional material or information required to perfect the claim will also be given.

Notice of any decision denying the claim must be furnished within 90 days after the claim is filed. If special circumstances require an extension of time to act on the claim, another 90 days will be allowed. If such an extension is required, notification will be given by the Plan Administrator before the end of the initial 90-day period. If the claim is not processed or a notice is not given within these time periods, the claim will be deemed to have been denied for the purpose of proceeding to the claim review procedure described below.

APPEAL OF A CLAIM DENIAL

If there are any questions about a claim payment, the Plan Administrator should be contacted. If it is desired to initiate a claim review procedure because there is disagreement with the reasons why the claim was denied, the Plan Administrator should be notified in writing within 60 days after receipt of the written claim denial. A request for a review of the claim and examination of any pertinent documents may be made by the claimant or anyone authorized to act on his or her behalf. The reasons why it is believed that the claim should not have been denied, as well as any data, questions or appropriate comments, should be submitted in writing.

DECISION ON REVIEW

Notification of the final decision will be given 60 days after receipt of a request for review unless special circumstances, such as a Peer Review Board review of the claim, require an extension of time for processing, in which event a further 60 days will be allowed.

ERISA GENERAL INFORMATION

- Name of Plan:

Health and Welfare Plan for **Employees** of THE CHRONICLE OF HIGHER EDUCATION .

- Policyholder/**Employer**:

THE CHRONICLE OF HIGHER EDUCATION
1255 23RD STREET N.W., SUITE 700
WASHINGTON, DC 20037

- Employer Identification Number (EIN) assigned to the Plan Sponsor by IRS:

521131774

- Plan number assigned by the Plan Sponsor/**Employer**:

501

- Type of Plan:

Life Insurance
Accidental Death, Dismemberment and Loss of Sight Insurance
Hospital Benefits
Medical Benefits
Dentalcare Benefits
Visioncare Benefits
Prescription Drug Benefits
Flexible Benefits Account

- Funding:

Great-West Life & Annuity Insurance Company completely funds the following benefits:

Life Insurance
Accidental Death, Dismemberment and Loss of Sight Insurance

ERISA GENERAL INFORMATION (Continued)

The **Employer** completely funds the following benefits:

Hospital Benefits
Medical Benefits
Dentalcare Benefits
Visioncare Benefits
Prescription Drug Benefits

- **Type of Administration:**

Contract Administration

- **Plan Administrator:**

LISA BIRCHARD
OFFICE MANAGER
THE CHRONICLE OF HIGHER EDUCATION
1255 23RD STREET N.W., SUITE 700
WASHINGTON, DC 20037
202 466-1029

- **Agent for service of legal process:**

PRENTICE HALL LEGAL & FINANCIAL
PRENTICE HALL LEGAL & FINANCIAL
SERVICES
15 COLUMBUS CIRCLE
NEW YORK, NY 10023-7773

Service of legal process may also be made upon the plan administrator.

ERISA GENERAL INFORMATION (Continued)

- The eligibility requirements, termination provisions and a description of the circumstances which may result in disqualification, ineligibility, or denial or loss of any benefits are described in this **Booklet**.
- The sources of contributions to the plan:

Employee Coverages -	0% Employee	100% Employer
Dependent Coverages -	0% Employee	100% Employer
Flexible Benefits Account -	100% Employee	0% Employer

- The date of the end of the year for purposes of maintaining the plan's fiscal records:

FEBRUARY 28

- Claims - The procedures to be followed in presenting claims for benefits under the plan and the remedies for the redress of claims which are denied in whole or in part are described in this **Booklet**.
- Statement of ERISA Rights:

As a participant in this plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

- Examine, without charge, at the plan administrator's office and at other specified locations, such as work sites and union halls, all plan documents, including insurance contracts, collective bargaining agreements and copies of all documents filed by the plan with the U.S. Department of Labor, such as detailed annual reports and plan descriptions.
- Obtain copies of all plan documents and other plan information upon written request to the plan administrator. The administrator may make a reasonable charge for the copies.

ERISA GENERAL INFORMATION (Continued)

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

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the **Employee** benefit plan. The people who operate your plan, called "fiduciaries" of the 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. If your claim for a welfare benefit is denied in whole or in part you must receive a written explanation of the reason for the denial. You have the right to have the plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to \$100 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that plan fiduciaries misuse the plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay the court costs and legal fees. If you are successful 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 (e.g. if it finds your claim is frivolous). If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest Area Office of the U.S. Labor-Management Services Administration, Department of Labor.

PLAN MODIFICATION/TERMINATION

The **Employer** intends to provide benefits under the **Plan** indefinitely. However, the **Employer** may at any time:

- change the contributions you must pay for benefits; or
- amend or terminate the benefits provided to you in the **Plan**.

If your **Employer**, through its acting management, decides that the **Plan** benefits should be amended or the **Plan** terminated for any reason, a designated representative of the **Employer** will prepare a written notice approved and signed by the Plan Administrator or any other person to whom the **Employer** gives authority to amend or terminate **Plan** benefits. The notice will be given to you within the time allowed by federal law. Your Plan Administrator can tell you who is responsible for approving **Plan** amendments or a **Plan** termination and the time in which notice of amendments or termination must be provided to you.

If the **Plan** is amended or terminated it will not affect the payment of any claims for expenses incurred prior to the time the change is made.