DRURY UNIVERSITY

EMPLOYEE HEALTHCARE PLAN
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INTRODUCTION

The Drury University Employee Healthcare Plan (“Plan”) is a self-funded health benefit plan established to provide medical and vision benefits for employees of Drury University (“Employer”). This Plan represents the efforts of the Employer to provide its employees and their dependents with the best possible health benefits at an affordable cost.

This booklet provides you with a description of all benefit provisions in the Plan, your rights under federal law, how you establish and/or lose eligibility, and how to appeal if a claim is not handled satisfactorily. Thus, we are asking you to review this booklet and familiarize yourself with the rules and requirements and the benefits to which you may be entitled.

In reviewing this booklet, you will note that a number of terms and phrases are capitalized. This usually means that there is a definition of these terms contained in the Definitions Section of the Plan. It will be helpful to refer to these definitions as you review your benefits.

If you would like to contact the Contract Administrator, you may do so between 8:00 A.M. and 5:00 P.M., Central Time, Monday through Friday, using the telephone numbers listed on the General Information page. However, any information that you obtain over the phone in this manner concerning your rights and benefits may not be relied upon as a guarantee of your rights or that benefits will be paid in that manner. The availability of benefits is determined solely on the basis of the terms of the Plan as contained in this booklet. A final determination of your rights and benefits cannot be made until all necessary documentation and information is submitted to the Contract Administrator and your claim is fully adjudicated.
GENERAL INFORMATION

The following information, together with the information contained in this booklet, form the master plan and SUMMARY PLAN DESCRIPTION of the Plan.

1. Name of Plan:

   Drury University Employee Healthcare Plan

2. Name and Address of Plan Sponsor and Plan Administrator:

   Drury University
   900 North Benton Avenue
   Springfield, MO 65802
   (417) 873-7879
   (800) 922-2274

3. Employer Identification Number (EIN): 20-1152045

4. Plan Number: 501

5. Type of Plan:

   Welfare benefit plan providing medical and vision benefits.

6. Funding:

   The Plan is self-funded by Drury University

7. Contract Administrator:

   HCH Administration, Inc.
   Post Office Box 1986
   Peoria, IL 61656-1986
   (309) 673-7330
   (800) 322-1516
   (800) 447-3227 (customer service)
   e-mail: customerservice@hchadmin.com

8. Utilization Review Administrator:

   HCH Administration, Inc.
   24-hour Pre-Certification Number: (800) 851-4630
9. COBRA Notice Coordinator:

Infinisource
15 E. Washington Street
PO Box 889
Coldwater, MI 49036
(800) 300-3838

10. Agent for Service of Legal Process:

David N. Schellenberg
Elias, Meginnes, Riffle & Seghetti, P.C.
416 Main Street, Suite 1400
Peoria, IL 61602
(309) 637-6000

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

11. Sources of Contributions to the Plan:

The cost of providing benefits under the Plan is shared by the Employer and Employees. A schedule will be distributed periodically setting forth the contributions required of the Employees participating in the Plan.

12. Fiscal Year of the Plan:

June 1 through May 31

13. Effective Date of the Plan:

June 1, 2003

14. Effective Date of Plan Restatement:

June 1, 2010
### SUMMARY OF BENEFITS
#### MEDICAL PLAN

<table>
<thead>
<tr>
<th></th>
<th>PPO PROVIDERS</th>
<th>NON-PPO PROVIDERS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Per Person</td>
<td>Per Person</td>
</tr>
<tr>
<td>Deductible, per calendar year</td>
<td>$500</td>
<td>$2,000</td>
</tr>
<tr>
<td></td>
<td>Per Family Unit</td>
<td>$1,000</td>
</tr>
</tbody>
</table>

Note: The maximums listed below are the total for PPO and Non-PPO expenses. For example, if a maximum of 120 days is listed under a service, the calendar year maximum is 120 days total, which may be split between PPO and Non-PPO Providers.

The calendar year deductible is waived for the following:
- Routine preventative care payable at 100%
- Outpatient LabOne services
- Allergy injections
- Ambulance
- Smoking cessation

The PPO and Non-PPO deductibles are calculated on a separate basis.

### MAXIMUM OUT-OF-POCKET AMOUNT, PER CALENDAR YEAR

<table>
<thead>
<tr>
<th></th>
<th>Per Person (excluding deductible)</th>
<th>Per Family Unit (excluding deductible)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$2,000</td>
<td>Unlimited</td>
</tr>
<tr>
<td></td>
<td>$4,000</td>
<td>Unlimited</td>
</tr>
</tbody>
</table>

The Plan will pay the designated percentage of covered charges until out-of-pocket amounts are reached, at which time the Plan will pay 100% of the remainder of covered charges for the rest of the calendar year. There is no out-of-pocket limit for the following:
- Prescription drug card benefits
- Utilization Review Penalty
- Plan Exclusions or limitations
- Deductibles
- Copayments

The PPO and Non-PPO deductibles are calculated on a separate basis.

### LIFETIME MAXIMUMS

<table>
<thead>
<tr>
<th></th>
<th>$2,000,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Benefits</td>
<td></td>
</tr>
<tr>
<td>Home Health Care</td>
<td>$50,000</td>
</tr>
<tr>
<td>Treatment of TMJ</td>
<td>$5,000</td>
</tr>
<tr>
<td>Scalp Hair Prosthesis</td>
<td>$250</td>
</tr>
<tr>
<td>Transplants</td>
<td>$300,000</td>
</tr>
</tbody>
</table>

### Routine Care

<table>
<thead>
<tr>
<th></th>
<th>$20 copay then 100%</th>
<th>Not Covered</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care Physician</td>
<td>$20 copay then 100%</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Specialist Physician</td>
<td>$40 copay then 100%</td>
<td></td>
</tr>
<tr>
<td>Routine eye exams</td>
<td>$15 copay then 100%</td>
<td>60%</td>
</tr>
<tr>
<td>Routine hearing exams</td>
<td>$15 copay then 100%</td>
<td>60%</td>
</tr>
<tr>
<td>Routine colonoscopy</td>
<td>$100 copay then 100%</td>
<td>60%</td>
</tr>
</tbody>
</table>

### Hospital Services

<table>
<thead>
<tr>
<th></th>
<th>$200 copay per occurrence then 90%</th>
<th>$600 copay per occurrence then 60%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Room and Board</td>
<td>$200 copay per occurrence then 90%</td>
<td>$600 copay per occurrence then 60%</td>
</tr>
<tr>
<td>Intensive Care Unit</td>
<td>$200 copay per occurrence then 90%</td>
<td>$600 copay per occurrence then 60%</td>
</tr>
<tr>
<td>Other Inpatient</td>
<td>$200 copay per occurrence then 90%</td>
<td>$600 copay per occurrence then 60%</td>
</tr>
<tr>
<td>Outpatient Surgery, Diagnostic and Pre-Admission testing</td>
<td>$100 copay per occurrence then 90%</td>
<td>$300 copay per occurrence then 60%</td>
</tr>
<tr>
<td>Service Description</td>
<td>PPO PROVIDERS</td>
<td>NON-PPO PROVIDERS</td>
</tr>
<tr>
<td>----------------------------------------------------------</td>
<td>---------------</td>
<td>-------------------</td>
</tr>
<tr>
<td>Outpatient therapies (physical, speech and occupational therapy)</td>
<td>90%</td>
<td>60%</td>
</tr>
<tr>
<td>Inpatient Hospice Facility</td>
<td>$200 copay per occurrence then 90%</td>
<td>$600 copay per occurrence then 60%</td>
</tr>
<tr>
<td>Outpatient Emergency Room 1</td>
<td>$100 copay then 90%</td>
<td>$100 copay then 60%</td>
</tr>
<tr>
<td>Ambulatory Surgical Facility</td>
<td>$100 copay per occurrence then 90%</td>
<td>$300 copay per occurrence then 60%</td>
</tr>
<tr>
<td>Skilled Nursing Facility/Rehabilitation (120 days per calendar year maximum)</td>
<td>$200 copay per occurrence then 90%</td>
<td>$600 copay per occurrence then 60%</td>
</tr>
</tbody>
</table>

**Physician Services**

<table>
<thead>
<tr>
<th>Service Description</th>
<th>PPO PROVIDERS</th>
<th>NON-PPO PROVIDERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office visits (visit charge only) 2</td>
<td>$20 copay, then 100%</td>
<td>60%</td>
</tr>
<tr>
<td>Primary Care Physician</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specialist Physician</td>
<td>$40 copay, then 100%</td>
<td></td>
</tr>
<tr>
<td>Outpatient LabOne Services 3</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Inpatient Visits</td>
<td>90%</td>
<td>60%</td>
</tr>
<tr>
<td>Surgery</td>
<td>90%</td>
<td>60%</td>
</tr>
<tr>
<td>Urgent Care Clinic</td>
<td>$30 copay, then deductible, then 90%</td>
<td>60%</td>
</tr>
</tbody>
</table>

Second Surgical Opinion Same as any Sickness

**Home Health Care**

(50 visits per calendar year maximum) $50,000 lifetime maximum

<table>
<thead>
<tr>
<th>Service Description</th>
<th>PPO PROVIDERS</th>
<th>NON-PPO PROVIDERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>90%</td>
<td>60%</td>
<td></td>
</tr>
</tbody>
</table>

**Private Duty Nursing**

(50 visits per calendar year maximum)

<table>
<thead>
<tr>
<th>Service Description</th>
<th>PPO PROVIDERS</th>
<th>NON-PPO PROVIDERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>90%</td>
<td>60%</td>
<td></td>
</tr>
</tbody>
</table>

**Allergy Injections**

<table>
<thead>
<tr>
<th>Service Description</th>
<th>PPO PROVIDERS</th>
<th>NON-PPO PROVIDERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>90%</td>
<td>60%</td>
<td></td>
</tr>
</tbody>
</table>

**Hospice Care**

<table>
<thead>
<tr>
<th>Service Description</th>
<th>PPO PROVIDERS</th>
<th>NON-PPO PROVIDERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>90%</td>
<td>60%</td>
<td></td>
</tr>
</tbody>
</table>

**Bereavement (15 visits per family)**

<table>
<thead>
<tr>
<th>Service Description</th>
<th>PPO PROVIDERS</th>
<th>NON-PPO PROVIDERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>50%</td>
<td>50%</td>
<td></td>
</tr>
</tbody>
</table>

**Ambulance Service**

<table>
<thead>
<tr>
<th>Service Description</th>
<th>PPO PROVIDERS</th>
<th>NON-PPO PROVIDERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>80%</td>
<td>80%</td>
<td></td>
</tr>
</tbody>
</table>

**Occupational Therapy**

<table>
<thead>
<tr>
<th>Service Description</th>
<th>PPO PROVIDERS</th>
<th>NON-PPO PROVIDERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>90%</td>
<td>60%</td>
<td></td>
</tr>
</tbody>
</table>

**Speech Therapy**

<table>
<thead>
<tr>
<th>Service Description</th>
<th>PPO PROVIDERS</th>
<th>NON-PPO PROVIDERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>90%</td>
<td>60%</td>
<td></td>
</tr>
</tbody>
</table>

**Physical Therapy**

<table>
<thead>
<tr>
<th>Service Description</th>
<th>PPO PROVIDERS</th>
<th>NON-PPO PROVIDERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>90%</td>
<td>60%</td>
<td></td>
</tr>
</tbody>
</table>

**Respiratory Therapy**

<table>
<thead>
<tr>
<th>Service Description</th>
<th>PPO PROVIDERS</th>
<th>NON-PPO PROVIDERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>90%</td>
<td>60%</td>
<td></td>
</tr>
</tbody>
</table>

**Durable Medical Equipment**

<table>
<thead>
<tr>
<th>Service Description</th>
<th>PPO PROVIDERS</th>
<th>NON-PPO PROVIDERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>90%</td>
<td>60%</td>
<td></td>
</tr>
</tbody>
</table>

**Prosthetics**

<table>
<thead>
<tr>
<th>Service Description</th>
<th>PPO PROVIDERS</th>
<th>NON-PPO PROVIDERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>90%</td>
<td>60%</td>
<td></td>
</tr>
</tbody>
</table>

**Orthotics**

<table>
<thead>
<tr>
<th>Service Description</th>
<th>PPO PROVIDERS</th>
<th>NON-PPO PROVIDERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>90%</td>
<td>60%</td>
<td></td>
</tr>
</tbody>
</table>

**Medical Supplies**

<table>
<thead>
<tr>
<th>Service Description</th>
<th>PPO PROVIDERS</th>
<th>NON-PPO PROVIDERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>90%</td>
<td>60%</td>
<td></td>
</tr>
</tbody>
</table>

**Maternity**

Same as any Sickness

---

1 The Emergency Room copay will be waived if admitted as an inpatient.

2 All other services and supplies provided during an office visit which include, but are not limited to: examinations, x-ray, laboratory tests, supplies, injections, cast application, and minor surgery will be payable subject to the Deductible and Co-insurance.

3 The use of the LabOne program is strictly voluntary. If a covered person or covered dependent uses the services of LabOne, the Plan will pay 100% of the eligible charges the person incurs for outpatient laboratory services, and will waive any of this Plan’s deductible and co-insurance requirements which would otherwise have applied to such charges.

4 One amniocentesis per pregnancy, up to 2 ultrasounds per pregnancy, unless deemed medically necessary.
<table>
<thead>
<tr>
<th>Service</th>
<th>PPO PROVIDERS</th>
<th>NON-PPO PROVIDERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine Well Newborn Care⁵</td>
<td>Same as any Sickness</td>
<td></td>
</tr>
<tr>
<td>Birthing Center</td>
<td>90%</td>
<td>60%</td>
</tr>
<tr>
<td>Voluntary Sterilizations</td>
<td>90%</td>
<td>60%</td>
</tr>
<tr>
<td>Mental Illness/Substance Abuse</td>
<td>Same as any Sickness</td>
<td></td>
</tr>
<tr>
<td>Chiropractic Treatment/Spinal Manipulation⁶</td>
<td>90%</td>
<td>60%</td>
</tr>
<tr>
<td>TMJ and Selected Jaw Joint Treatment ($5,000 calendar year maximum)</td>
<td>Same as any Sickness</td>
<td></td>
</tr>
<tr>
<td>Organ Transplants</td>
<td>Same as any Sickness</td>
<td></td>
</tr>
<tr>
<td>Smoking Cessation ($500 per calendar year maximum) (2 treatments per lifetime maximum)</td>
<td>100%</td>
<td>Not Covered</td>
</tr>
<tr>
<td>All Other Covered Services</td>
<td>90%</td>
<td>60%</td>
</tr>
</tbody>
</table>

⁵ Routine Newborn care inpatient covered under Maternity.
⁶ Benefits for services received from a chiropractor are limited to $500 per calendar year. The calendar year maximum benefit does not apply to services received from a D.O.

**PRESCRIPTION DRUG PROGRAM BENEFITS**

<table>
<thead>
<tr>
<th>Pharmacy (30 day supply)</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Generic Drugs</td>
<td>$0</td>
<td></td>
</tr>
<tr>
<td>Brand Name Formulary Drugs</td>
<td>Greater of $30 copay or 15%</td>
<td></td>
</tr>
<tr>
<td>Brand Name Non-Formulary Drugs</td>
<td>Greater of $50 copay or 15%</td>
<td></td>
</tr>
<tr>
<td>Specialty Drugs</td>
<td>Greater of 10% or $250 max per script</td>
<td></td>
</tr>
<tr>
<td>Mail Order or Pharmacy (90 day supply)</td>
<td>$0</td>
<td></td>
</tr>
<tr>
<td>Generic Drugs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brand Name Formulary Drugs</td>
<td>Greater of $60 copay or 15%</td>
<td></td>
</tr>
<tr>
<td>Brand Name Non-Formulary Drugs</td>
<td>Greater of $100 copay or 15%</td>
<td></td>
</tr>
</tbody>
</table>

Copayments - Copay expenses do not apply to the Deductible Out-of-Pocket maximum.
**UTILIZATION REVIEW**

The Utilization Review Administrator must be notified prior to any of the following treatment:

- All inpatient surgeries/procedures and admissions (acute and subacute* care)
- Emergency Admissions (within 48 hours)
- Cholecystectomy (Laparoscopic)
- Hysterectomy (patient younger than 30)
- Nasal Septoplasty
- Rhinoplasty
- MRA of the head and/or neck
- MRI of the brain and/or spine
- PET Scans
- CAT Scans
- Durable Medical Equipment > $1000

Failure to do so will result in a penalty in the form of a reduction in benefits otherwise computed. The reduction shall be 50% of the actual benefits available under the Plan.

* Subacute care is care provided by a facility that has nursing staff on-site at all times and a Physician on call at all times.

**NOTICES**

Group health plan generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than forty-eight (48) hours following a vaginal delivery, or less than ninety-six (96) hours following a Caesarean section, or require that a provider obtain authorization from the plan for prescribing a length of stay not in excess of the above periods. However, federal law generally does not prohibit the mother’s or newborn’s attending provider, after consultation with the mother, from discharging the mother or her newborn earlier than forty-eight (48) hours (or ninety-six (96) hours, as applicable).

Federal law requires this Plan to provide the following benefits for elective breast reconstruction in connection with a mastectomy:

1. reconstruction of the breast on which the mastectomy has been performed;
2. surgery and reconstruction of the other breast to produce a symmetrical appearance; and
3. prosthesis and physical complications in all stages of mastectomy, including lymphedemas;

in a manner determined in consultation with the attending Physician and the patient. Such coverage is subject to all other Plan terms and limitations.
It is the Covered Person’s or Covered Dependent’s responsibility to notify the Employer or Plan Administrator within thirty-one (31) days of any event which would cause such person or a family member to (i) gain or lose eligibility for coverage under the Plan, (ii) become eligible for or entitled to any Plan benefit, or (iii) lose eligibility for or entitlement to any Plan benefit; unless the Plan elsewhere specifically provides for a longer notice provision.

This Summary is a summary of Plan benefits. Please read the remainder of this booklet carefully for a detailed explanation of Plan benefits and limitations.
EMPLOYEE ELIGIBILITY

Eligibility Requirements

Each Employee and that Employee’s Eligible Dependents shall be eligible to participate in the Plan on the first Eligibility Date following attainment of status as Full-Time Employee. An Employee must make written application for coverage and sign a payroll deduction order, if necessary, prior to coverage becoming effective.

An Employee must enroll in the Plan within thirty-one (31) days of his initial Eligibility Date, during the annual open enrollment period in May of each year, or during an Employee Special Enrollment Period or Medicaid and CHIP Enrollment Period in order to obtain coverage under the Plan. An Employee is not eligible to enroll in the Plan at any other time.

Eligibility Date

An Employee shall be eligible for coverage under the Plan on the first day of the month following the date he satisfies the Eligibility Requirements outlined above, provided he is properly enrolled in the Plan within thirty-one (31) days of that date. An Employee who applies for coverage during the open enrollment period shall be eligible for coverage on the next following June 1. An Employee who applies for coverage during an Employee Special Enrollment Period (other than due to a birth, adoption, or placement for adoption of a child) or Medicaid and CHIP Enrollment Period shall be eligible for coverage on the first of the month following the date of the event precipitating the Employee Special Enrollment Period or Medicaid and CHIP Enrollment Period. An Employee who applies for coverage during an Employee Special Enrollment Period due to a birth, adoption, or placement for adoption of a child, shall be eligible for coverage on the date of the event precipitating the Employee Special Enrollment Period.

Employee Special Enrollment Periods

An Employee who did not enroll in the Plan on his initial Eligibility Date may also enroll in the Plan during an Employee Special Enrollment Period. An “Employee Special Enrollment Period” shall be the thirty-one (31) day period immediately following one of the events described below:

(a) Loss of Other Coverage

The date the Employee exhausted coverage under a COBRA continuation provision of a group health plan, or the termination of coverage under another group health plan as a result of loss of eligibility for such coverage or the termination of employer contributions toward such coverage; provided the Employee was covered under a group health plan or had health insurance coverage at the time coverage under the Plan was previously offered to the Employee.
(b) Dependent Special Enrollment Period

(1) The date of marriage of the Employee;

(2) The birth of a child of the Employee; or

(3) The adoption of a child by the Employee or the placement of a child in the home of the Employee while adoption proceedings are pending with respect to that child.

The Employee may only enroll for coverage during a Dependent Special Enrollment Period if the dependent described in subsections (1), (2), or (3) is also enrolled in the Plan during the thirty-one (31) day period described above.

Medicaid and CHIP Enrollment Periods

An Employee who did not enroll in the Plan on his initial Eligibility Date may also enroll in the Plan during a Medicaid and CHIP Enrollment Period. A “Medicaid and CHIP Enrollment Period” shall be the sixty (60) day period immediately following one of the events described below:

(a) The Employee is covered under a Medicaid plan under title XIX of the Social Security Act or under a State child health plan under title XXI of such Act and coverage of the Employee under such plan is terminated as a result of loss of eligibility for such coverage; or

(b) The Employee becomes eligible for assistance, with respect to coverage under the Plan, under such Medicaid plan or State child health plan (including under any waiver or demonstration project conducted under or in relation to such a plan).

DEPENDENT ELIGIBILITY

Eligibility for Dependent’s Coverage

A Covered Person may obtain benefits for his Eligible Dependents under the Plan on:

(a) The date the Covered Person is eligible for coverage under the Plan, if on that date he has such Eligible Dependents; or

(b) The date the Covered Person gains an Eligible Dependent, if on that date he is covered by the Plan.
An Employee must make written application for coverage and sign a payroll deduction order, if necessary, prior to coverage for an Eligible Dependent becoming effective.

In the event two parents are both eligible to be covered by the Plan as Covered Persons, only one parent will be eligible to cover any Eligible Dependent children they might have.

**Eligibility Date of Dependent’s Coverage**

(a) The Eligibility Date of coverage for each Eligible Dependent will be the later of (i) the date on which the Covered Person who is the source of a dependent's eligibility becomes eligible for dependent coverage or (ii) the date the dependent becomes an Eligible Dependent, subject to the following:

1. A newborn child of a Covered Person will be considered an Eligible Dependent from the moment of birth and will be eligible for benefits for Sickness or Injury, including the necessary care or treatment of medically diagnosed congenital defects, birth abnormalities or prematurity, provided the child is properly enrolled as a dependent of the Covered Person within thirty-one (31) days of the child’s date of birth;

2. A spouse will be considered an Eligible Dependent the 1st of the month following the date of marriage, provided the spouse is properly enrolled as a dependent of the Covered Person within thirty-one (31) days of the date of marriage; and

3. A dependent acquired other than at the time of birth due to court order, decree, marriage, or placement in the home of the Covered Person while adoption proceedings are pending will be considered an Eligible Dependent from the date of such court order, decree, marriage, or placement, provided that the dependent is properly enrolled as a dependent of the Covered Person within thirty-one (31) days of the date of the court order, decree, marriage, or placement.

No claims will be processed under the Plan until the dependent is properly enrolled.

(b) An Eligible Dependent must enroll in the Plan within thirty-one (31) days of his initial Eligibility Date, during the annual open enrollment period in May of each year, or during a Special Enrollment Period or Medicaid and CHIP Enrollment Period in order to obtain coverage under the Plan. An Eligible Dependent is not eligible to enroll in the Plan at any other time.
An Eligible Dependent who applies for coverage during the open enrollment period shall be eligible for coverage on the next following June 1. An Eligible Dependent who applies for coverage during a Special Enrollment Period (other than due to a birth, adoption, or placement for adoption of a child) or Medicaid and CHIP Enrollment Period shall be eligible for coverage from the date of the event precipitating the Special Enrollment Period or Medicaid and CHIP Enrollment Period. An Eligible Dependent who applies for coverage during a Special Enrollment Period due to a birth, adoption, or placement for adoption of a child, shall be eligible for coverage on the date of the event precipitating the Special Enrollment Period.

In no event will the Eligibility Date for a dependent precede the Eligibility Date for the Covered Person who determines the dependent’s eligibility for benefits under the Plan.

**Special Enrollment Periods**

An Eligible Dependent may also enroll in the Plan during a Special Enrollment Period. A “Special Enrollment Period” shall be the thirty-one (31) day period immediately following one of the events described below:

(a) Loss of Other Coverage

The date the Eligible Dependent exhausted coverage under a COBRA continuation provision of a group health plan, or the termination of coverage under another group health plan as a result of loss of eligibility for such coverage or the termination of employer contributions toward such coverage; provided the Eligible Dependent was covered under a group health plan or had health insurance coverage at the time coverage under the Plan was previously offered to him.

(b) Dependent Special Enrollment Period

(1) The date of marriage to the Employee;

(2) The birth of the Eligible Dependent; or

(3) The adoption of the Eligible Dependent by the Employee or the placement of the Eligible Dependent in the home of the Employee while adoption proceedings are pending with respect to that dependent.

An Eligible Dependent spouse shall also be entitled to enroll for coverage along with the Eligible Dependent described in Subsections (2) and (3) above.
The Eligible Dependent may only enroll for coverage during a Special Enrollment Period if the Employee is also enrolled in the Plan on or before the thirty-one (31) day period described above.

**Medicaid and CHIP Enrollment Periods**

An Eligible Dependent who did not enroll in the Plan on his initial Eligibility Date may also enroll in the Plan during a Medicaid and CHIP Enrollment Period. A “Medicaid and CHIP Enrollment Period” shall be the sixty (60) day period immediately following one of the events described below:

(a) The Eligible Dependent is covered under a Medicaid plan under title XIX of the Social Security Act or under a State child health plan under title XXI of such Act and coverage of the Eligible Dependent under such plan is terminated as a result of loss of eligibility for such coverage; or

(b) The Eligible Dependent becomes eligible for assistance, with respect to coverage under the Plan, under such Medicaid plan or State child health plan (including under any waiver or demonstration project conducted under or in relation to such a plan).

The Eligible Dependent may only enroll for coverage during a Medicaid and CHIP Enrollment Period if the Employee is also enrolled in the Plan on or before the sixty (60) day period described above.

**BENEFITS**

**Limitations**

(a) Shared Expenses

During each calendar year, except where specifically indicated to the contrary, each Covered Person or Covered Dependent shall be responsible for the deductible, copayment, and coinsurance requirements listed in the Summary of Benefits. Expenses Incurred in October, November, and December which were applied to the deductible during the previous calendar year will also be applied to satisfy the deductible for the current calendar year. Expenses Incurred during the first nine (9) months of the previous calendar year will not be applied to satisfy the deductible during the current year. The deductible shall be paid only once during a calendar year by each Covered Person or Covered Dependent, and shall be paid only once if (i) a Covered Person and one (1) or more of his Covered Dependents, or (ii) two (2) or more Covered Dependents of a Covered Person incur Injuries in the same accident.
(b) Maximum Lifetime Benefits While Covered Under This Plan

The maximum benefit while covered under this Plan for any Covered Person or Covered Dependent shall not exceed the amount listed in the Summary of Benefits.

(c) Pre-Existing Conditions

No benefits will be paid with respect to Expenses Incurred for a Pre-Existing Condition until the Covered Person or Covered Dependent completes twelve (12) months from the date coverage commenced under the Plan, or, if earlier, from the first day of any required waiting period, reduced by any period of Creditable Coverage. A waiting period means the period that must pass with respect to the initial eligibility of an individual before an otherwise qualified individual may be covered under the Plan.

The above limitation shall not apply to a Covered Person or a Covered Dependent under the following circumstances:

1. A Covered Person or Covered Dependent who has been continuously covered under the Plan since the Effective Date of the Plan and who was, on the day prior to such Effective Date, covered under the group plan sponsored by the Employer immediately prior to the Effective Date, to the extent he had satisfied a similar provision under such prior plan;

2. An Eligible Dependent under age eighteen (18) who was either adopted by a Covered Person or placed in the home of a Covered Person while adoption proceedings with respect to that dependent are pending, provided such child is covered by the Plan, or otherwise covered by Creditable Coverage, within thirty-one (31) days of becoming an Eligible Dependent. However, if such Eligible Dependent incurs a sixty-three (63) day period during which he is not covered by Creditable Coverage, this exclusion from the Pre-Existing Condition limitation shall no longer apply;

3. A newborn, provided such child is covered by the Plan, or otherwise covered by Creditable Coverage, within thirty-one (31) days of becoming an Eligible Dependent. However, if such Eligible Dependent incurs a sixty-three (63) day period during which he is not covered by Creditable Coverage, this exclusion from the Pre-Existing Condition shall no longer apply;

4. A Covered Person or Covered Dependent with respect to the pregnancy of such individual; or

5. Benefits obtained pursuant to the Prescription Drug Card Plan.
Any period of Creditable Coverage shall be applied to reduce the Pre-Existing Condition limitation described in the Plan, except that no Creditable Coverage shall be considered if, after such Creditable Coverage, there occurs a continuous sixty-three (63) day period during all of which the individual was not covered under Creditable Coverage. However, any waiting period that must pass under this Plan or any other plan before the individual is initially entitled to benefits shall not be considered for the purpose of determining such sixty-three (63) day period. In addition, for an individual who elects COBRA continuation coverage during the second election period provided under the Trade Act of 2002, the days between the date the individual lost group health plan coverage and the first day of the second COBRA election period are not taken into account in determining whether such sixty-three (63) day period has occurred.

Periods of Creditable Coverage shall be established through presentation of certificates prepared by an individual’s prior group health plan or health insurance issuer. The certificate will describe an individual’s period of Creditable Coverage and any applicable waiting period that had to pass under the plan before the individual was initially entitled to benefits. A Covered Person or Covered Dependent has a right to request a Certificate of Creditable Coverage from the prior group health plan or health insurance issuer if necessary to properly establish the period of Creditable Coverage. The Employer will assist the Covered Person or Covered Dependent in obtaining this certificate if requested.

A Covered Person or Covered Dependent may request a certificate of Creditable Coverage from the Plan by requesting such certificate in writing from the Contract Administrator. No certificate shall be issued by the Plan if requested more than twenty-four (24) months from the date coverage under the Plan terminated.

(d) Maternity Benefits

Expenses Incurred as a result of the pregnancy will be eligible for benefits the same as any other Sickness under the Plan, except that the following provisions shall be applicable:

(1) a minimum of forty-eight (48) hours of inpatient Hospital care for the mother and newborn child shall be provided following a vaginal delivery; and

(2) a minimum of ninety-six (96) hours of inpatient Hospital care for the mother and newborn child shall be provided following a delivery by Caesarean section.

A shorter inpatient Hospital stay may be provided if a Physician licensed to practice medicine in all of its branches determines, in accordance with the protocols and guidelines developed by the American College of Obstetricians and Gynecologists or the American Academy of Pediatrics, that the mother and the newborn child meet the appropriate guidelines for a shorter stay, based upon an evaluation of the mother and
newborn child and taking into consideration the availability of a post-discharge visit within forty-eight (48) hours following the discharge, with either a Physician in his office or with an R.N., or L.P.N. supervised by an R.N., in the child's home.

A mother and newborn child are considered separate persons for all purposes under the Plan, except that the following services are available for the child even if the mother is covered under the Plan and there is no dependent coverage in effect at the time of birth to provide benefits under the Plan for the child:

(A) routine inpatient Hospital nursery charges and inpatient pediatric care; and

(B) routine inpatient examinations by a Physician other than the Physician who delivered the child or administered anesthesia during delivery; and

(C) Expenses Incurred for circumcision.

(e) Benefits Obtained from Preferred Provider

The Employer may enter into one or more Preferred Provider Agreements with certain health care service providers from time to time. Those participating providers are designated as Preferred Providers or PPO Providers. As a result, covered services obtained from Preferred Providers are subject to a reduced Shared Expense limitation as described in the Summary of Benefits. A complete listing of all Preferred Providers is available free of charge from the Employer and is subject to change at any time.

In addition, the following benefits will be paid at the Preferred Provider level if obtained from a Non-Preferred Provider:

(1) Expenses Incurred for Emergency Treatment;

(2) Professional services which are not available within fifty (50) miles from the Employer;

(3) Medical supplies for which there is no Preferred Provider available;

(4) Covered Persons or Covered Dependents who are referred outside the Preferred Provider Network by a Physician for those services not available in the PPO Network;

(5) X-ray and laboratory services of a Non-Preferred Provider when referred by a Preferred Provider Physician or facility; and

(6) Professional services which are provided by a Non-Preferred Provider but rendered at a Preferred Provider facility.
Medical Benefits

Reasonable and Customary Expenses Incurred on behalf of each Covered Person or Covered Dependent for:

Routine Care Services

(a) Routine well care services not necessary to treat an active Sickness or Injury.

(b) Routine eye examinations.

(c) Routine hearing examinations.

Inpatient Hospital Services

(d) Hospital Services:

(1) regular Room and Board (semi-private room rate);
(2) confinement in an Intensive Care Unit; and
(3) Necessary Services and Supplies.

(e) Skilled Nursing Facility Confinement:

(1) Room and Board, including any charges made by the facility as a condition of occupancy or on a regular daily or weekly basis such as general nursing services. If private room accommodations are used, benefits available for Room and Board will not exceed the average semi-private rate charged by the facility or a representative cross section of similar institutions in the area;

(2) Medical services customarily provided by the Skilled Nursing Facility, with the exception of private duty or special nursing services and Physician's fees; and

(3) Drugs, biologicals, solutions, dressings, and casts furnished for use during the convalescent period, but no other supplies.

A Covered Person or Covered Dependent shall be eligible for benefits under this Subsection only to the extent confinement in a Skilled Nursing Facility:

(1) is certified by a Physician as essential for recuperation from Sickness or Injury that caused such Hospital Confinement;
(2) is not incurred for custodial care; and

(3) commences within fourteen (14) days after a confinement of at least three (3) days duration in a Hospital for which benefits were payable under the Plan.

(f) Partial Hospitalization Treatment Program: Treatment in a planned therapeutic treatment program of a Hospital or Substance Abuse Treatment Facility in which patients with Mental Illness or Substance Abuse spend days or nights, provided that admission to the program occurs within seventy-two (72) hours of discharge from Hospital Confinement/Admission for which benefits were available under Plan.

Out-Patient Services

(g) Out-Patient Treatment: Reasonable and Customary Expenses Incurred for the following Out-Patient Treatment:

(1) Surgery and related diagnostic service received on the same day as the Surgery, whether as Out-Patient Treatment or in a Physician’s office, including Physician’s surgical charges;

(2) Diagnostic testing related to Surgery or medical care; and

(3) Services provided in an Ambulatory Surgical Facility.

(h) Emergency Room Treatment: Reasonable and Customary Expenses Incurred for initial Emergency Treatment of a Sickness or Injury in a Hospital emergency room or by a Physician.

(i) Pre-Admission Testing: Reasonable and Customary Expenses Incurred for pre-admission testing which is performed either:

(1) at a Hospital on an out-patient basis; or

(2) at an out-patient facility if the test results are accepted by the Hospital to which the patient is admitted;

provided that such testing is performed within seven (7) days prior to admission to that Hospital on an in-patient basis for treatment in connection with the Sickness or Injury to which the pre-admission testing relates. No benefits are available pursuant to this subsection if the treatment to which the testing relates is postponed, unless such postponement is Medically Necessary.
Physician Services

(j) Physician's services for surgical procedures, diagnostic services, Mental Illness, and Substance Abuse treatment.

(k) Office visits, house calls, or visits to a Hospital or facility by a Physician.

(l) Second surgical opinions and, if the second surgical opinion does not confirm the first opinion, a third opinion is also covered.

(m) Oral Surgery, as defined herein, including anesthesia and related charges.

(n) Anesthetics and their administration by a professional anesthetist or anesthesiologist.

(o) Special treatments, on an inpatient or outpatient basis, if rendered by a Physician or Hospital:

(1) X-ray and radiation therapy treatments;

(2) Chemotherapy;

(3) Shock therapy treatments;

(4) Renal dialysis treatments; or

(5) Allergy testing and treatment.

Other Covered Services

(p) Private duty professional nursing services by a Registered Nurse or Licensed Practical Nurse, but only:

(1) on an inpatient basis, if the Employer determines that services provided are of such a nature or degree of complexity or quantity that they cannot be or are not usually provided by the regular nursing staff of the Hospital or other facility; or

(2) in the home, if the services provided are of such a nature that they cannot be provided by non-professional personnel.

(q) Physical therapy (whether rendered by a Physician or licensed physical therapist).
(r) Services of a qualified Physician or qualified speech therapist for restoratory or rehabilitory speech therapy for speech loss or impairment due to Sickness or Injury, or due to a congenital anomaly.

(s) Services of a Physician or registered occupational therapist for constructive therapeutic activity designed and adapted to promote the restoration of useful physical function.

(t) Phase I and Phase II cardiac rehabilitation services.

(u) Local ground transportation provided by a professional ambulance service, to the nearest Hospital, between Hospitals, or between a Hospital and a Skilled Nursing Facility, including air ambulance service, when Medically Necessary.

(v) Processing and administration of blood or blood components, including the cost of the actual blood or blood components, unless replaced.

(w) The following medical supplies:

1. prosthetic appliances required to replace all or part of an organ or tissue or the function of an organ or tissue, including adjustment, repair or replacement of such devices where required due to wear or a change in the patient’s condition, but specifically excluding dental appliances or vision appliances other than cataract lenses or standard glasses required promptly after, and because of, cataract surgery;

2. durable medical equipment, including such things as internal cardiac valves, internal pacemakers, paraffin baths, bone screws, bolts, nails, plates, wheelchairs, hospital beds, artificial limbs, and other similar devices (rental or purchase, at the option of the Contract Administrator);

3. dressings, sutures, casts, splints, trusses, crutches, braces or other necessary medical supplies with the exception of dental braces or corrective shoes;

4. oxygen and rental equipment for its administration;

5. leg, back, arm and neck braces required due to Sickness or Injury; and

6. charges for drugs which can be obtained only with the written prescription of a Physician, insulin and disposable needles, pursuant to the terms of the drug card program maintained by the
Employer with Pharmacy Benefit Manager and more fully described in Addendum A. Deductible and copayment expenses paid by a Covered Person or Covered Dependent in accordance with the Summary of Benefits shall not apply toward satisfaction of any other limitation herein.

(x) Chiropractic services performed by a chiropractor or Physician.

(y) Services obtained at a Birthing Center.

(z) Services for voluntary sterilization for Covered Persons or their spouses.

(aa) Elective abortions.

(bb) One (1) amniocentesis test per pregnancy, and up to two (2) ultrasounds per pregnancy (more than two (2) only when it is determined to be Medically Necessary).

(cc) Diagnosis, testing and treatment of Attention Deficit Disorder and Attention Deficit Hyperactivity Disorder.

(dd) Contraceptive procedures and medications, including but not limited to, oral, patches, injections diaphragms, intrauterine devices (IUD), Norplant, Depo Provera and any related office visit. Contraceptives available under the Prescription Drug Card program are not otherwise available under the Plan. The Plan does not cover contraceptive supplies or devices available without a Physician’s prescription or contraceptives provided over the counter.

(ee) Treatment for the following foot conditions: (i) weak, unstable or flat feet; (ii) bunions, when an open cutting operation is performed; (iii) non-routine treatment of corns or calluses; (iv) toenails when at least part of the nail root is removed; (v) any Medically Necessary surgical procedure required for a foot condition; or (vi) orthotics, including orthopedic shoes when an integral part of a leg brace or when deemed Medically Necessary.

(ff) Diabetic education and self-management programs, and supplies that are not covered under the Prescription Drug Card Plan for treatment of gestational, Type I and Type II diabetes for all Physician prescribed Medically Necessary equipment and supplies used in the management and treatment of diabetes; and diabetes outpatient self-management training and education, including medical nutrition therapy that is provided by a certified, registered, or licensed health care professional working in a program consistent with the national standards of diabetes self-management education as established by the American Diabetes Association.
(gg) Special dietary treatment for phenylketonuria (PKU) when recommended by a Physician.

(hh) Diagnosis, testing and treatment of autism.

(ii) Treatment of temporomandibular joint (TMJ) syndrome with intraoral prosthetic devices.

(jj) Scalp hair prosthesis due to hair loss as a result of alopecia areata, radiation or chemotherapy for diagnosed cancer.

(kk) Services related to smoking cessation, including but not limited to office visits, acupuncture, hypnotherapy, and other smoking cessation programs. Smoking deterrents are available under the Prescription Drug Card Program.

(ll) Services and supplies provided by an Urgent Care Facility.

(mm) Expenses Incurred, up to a maximum of $100, for obtaining medical records.

(nn) Treatment of Mental Illness and Substance Abuse.

(oo) Hospice care for terminally ill persons certified by a Physician as having a life expectancy of less than six (6) months, limited as follows:

1) Room and Board;

2) necessary services and supplies at a facility or in the home;

3) part-time nursing care;

4) consultation and case management services by a Physician;

5) physical therapy and speech therapy;

6) medical supplies and prescription drugs otherwise covered by the Plan; and

7) bereavement counseling, limited to fifty percent (50%) of Expenses Incurred and further limited to fifteen (15) sessions per family.
Home Health Care Expense Benefits, as follows:

(1) Benefits

Reasonable and Customary Expenses Incurred for services and supplies furnished in the home of the Covered Person or Covered Dependent in accordance with a Home Health Care Plan for care which begins within three (3) days of a Hospital Confinement/Admission or discharge from a Skilled Nursing Facility.

Expenses covered under this Section include:

(A) part-time or intermittent nursing care by or under the supervision of a Registered Nurse;

(B) part-time or intermittent home health aid services, when provided by a person specifically trained to provide such services, which consist primarily of caring for the patient;

(C) physical therapy, occupational therapy, respiratory therapy and speech therapy provided by the Home Health Care Agency; and

(D) medical supplies, drugs and medications prescribed by a Physician, and laboratory services, to the extent such items would have been paid by the Plan if the Covered Person or Covered Dependent had remained in the Hospital or Skilled Nursing Facility.

(2) Limitations

Each visit of four (4) hours or less by a Home Health Care Agency team, other than a home health aide, shall be considered as one (1) Home Health Care Visit and four (4) hours of health aide services shall be considered as one (1) Home Health Care Visit. Home Health Care Visits are limited as described in the Summary of Benefits. No benefits are payable under this Section for:

(A) services or supplies not covered by the Home Health Care Plan;

(B) Services performed by an individual who ordinarily resides in the Covered Person's or Covered Dependent's home or is a member of the Covered Person's or Covered Dependent's Immediate Family;
(C) Services of any social worker;

(D) Expenses Incurred for transportation; or

(E) Services or supplies rendered during any period in which the Covered Person or Covered Dependent is not under the continuing care of a Physician.

(qq) The following benefits for elective breast reconstruction in connection with a mastectomy:

(1) reconstruction of the breast on which the mastectomy has been performed;

(2) Surgery and reconstruction of the other breast to produce a symmetrical appearance; and

(3) prostheses and physical complications in all stages of mastectomy, including lymphedemas;

in a manner determined in consultation with the attending Physician and the patient.

(rr) Reasonable and Customary Expenses Incurred for the following named human organ transplants: cornea, kidney, heart, heart/lung, lung, kidney/pancreas, bone marrow, liver, human organ or tissue transplants, subject to the following:

(1) If both the donor and the recipient are covered by the Plan, each shall have their benefits computed in accordance with the provisions of their own coverage.

(2) If the recipient is covered by the Plan and the donor has no other source of benefits, benefits for both the donor and the recipient shall be computed in accordance with the provisions governing the recipient's eligibility for benefits under the Plan.

(3) If the donor is covered by the Plan and no benefits are available to the donor from any other source, benefits shall be provided to the donor under the provisions of the Plan, but no benefits shall be provided to the recipient.

(ss) Clinical Trials: Health care services for the treatment of cancer for an individual enrolled in a Qualified Clinical Trial (see Definitions), which is consistent with the usual and customary standard of care for someone with the patient's diagnosis, is consistent with the study protocol for the
clinical trial, and would be covered if the patient did not participate in the Qualified Clinical Trial.

Health care services do not include any of the following:

(1) an FDA approved drug or device shall be considered eligible only to the extent that the drug or device is not paid by the manufacturer, the distributor or the provider of the drug or device; or

(2) non-health care services that a patient may be required to receive to receive as a result of being health care services that a patient may be required to receive as a result of being enrolled in the Qualified Clinical Trial; or

(3) costs associated with managing the research associated with the Qualified Clinical Trial;

(4) costs that would not be covered for non-investigational treatments;

(5) any item, service or cost that is reimbursed or otherwise furnished by the sponsor of the Qualified Clinical Trial; or

(6) the costs of services, which are not provided as part of of the Qualified Clinical Trial’s stated protocol or other similarly, intended guidelines.

CLAIM PROVISIONS

Benefit Claims

(a) Discretion of Plan Administrator

All claims must be filed with the Contract Administrator or other appropriate entity as directed by the Plan Administrator. The Plan Administrator shall be ultimately and finally responsible for adjudicating such claims and for providing full and fair review of the decision on such claims in accordance with the following provisions and with applicable law. Benefits under the Plan will be paid only if the Plan Administrator decides in its discretion that the claimant is entitled to them. The responsibility to process claims in accordance with the Plan is delegated to the Contract Administrator or other appropriate entity as directed by the Plan Administrator, provided, however, that the Contract Administrator or other appropriate entity, is not a fiduciary of the Plan and does not have the authority to make decisions involving the use of discretion.

Each claimant claiming benefits under the Plan shall be responsible for supplying, at such times and in such manner as the Plan Administrator in its sole discretion may require, written proof that the expenses were incurred or that the benefit
is covered under the Plan. If the Plan Administrator in its sole discretion shall determine that the claimant has not incurred a covered expense or that the benefit is not covered under the Plan, or if the claimant shall fail to furnish such proof as is requested, no benefits shall be payable under the Plan.

(b) When Claims Must Be Filed

Claims must be filed with the Contract Administrator within one (1) year of the date charges for the service were incurred. Benefits are based upon the Plan's provisions at the time the charges were incurred. Charges are considered incurred when treatment or care is given or supplies are provided. Claims filed later than that date will be denied.

A Pre-Service Claim is considered to be filed when the request for approval of treatment or services is made and received by the Contract Administrator in accordance with the Plan’s procedures. However, a Post-Service Claim is considered to be filed when the following information is received by the Contract Administrator, together with a Form HCFA or Form UB92 or other approved standardized method:

(1) The date of service;

(2) The name, address, telephone number, and tax identification number of the provider of the services or supplies;

(3) The place where the services were rendered;

(4) The diagnosis and procedure codes;

(5) The amount of charges;

(6) The name of the Covered Person; and

(7) The name of the patient.

Upon receipt of this information, the claim will be deemed to be filed with the Plan. The Contract Administrator will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested as provided herein. This additional information must be received by the Contract Administrator within forty-five (45) days from receipt by the claimant of the request for additional information. Failure to do so may result in claims being denied or reduced.

(c) Timing of Claim Decisions

The Contract Administrator or Plan Administrator shall notify the claimant, in accordance with the provisions set forth below, of any adverse benefit determination.
(and, in the case of Pre-Service Claims, of decisions that a claim is payable in full) within the following timeframes:

(1) Pre-Service Claims

(A) If the claimant has provided all of the information needed to process the claim, in a reasonable period of time appropriate to the medical circumstances, but not later than fifteen (15) days after receipt of the claim, unless an extension has been requested, then prior to the end of the fifteen (15) day extension period.

(B) If the claimant has not provided all of the information needed to process the claim, then the claimant will be notified as to what specific information is needed as soon as possible, but not later than five (5) days after receipt of the claim. The claimant will be notified of a determination of benefits in a reasonable period of time appropriate to the medical circumstances, either prior to the end of the extension period (if additional information was requested during the initial processing period), or by the date agreed to by the Contract Administrator or Plan Administrator and the claimant (if additional information was requested during the extension period).

(2) Post-Service Claims

(A) If the claimant has provided all of the information needed to process the claim, in a reasonable period of time, but not later than thirty (30) days after receipt of the claim, unless an extension has been requested, then prior to the end of the fifteen (15) day extension period.

(B) If the claimant has not provided all of the information needed to process the claim and additional information is requested during the initial processing period, then the claimant will be notified of a determination of benefits prior to the end of the extension period, unless additional information is requested during the extension period, then the claimant will be notified of the determination by a date agreed to by the Contract Administrator or Plan Administrator and the claimant.

(3) Extensions – Pre-Service Claims

This period may be extended by the Plan for up to fifteen (15) days, provided that the Plan Administrator both determines that such an
extension is necessary due to matters beyond the control of the Plan and notifies the claimant, prior to the expiration of the initial fifteen (15) day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

(4) Extensions – Post-Service Claims

This period may be extended by the Plan for up to fifteen (15) days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the claimant, prior to the expiration of the initial thirty (30) day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

(5) Calculating Time Periods

The period of time within which a benefit determination is required to be made shall begin at the time a claim is deemed to be filed in accordance with the procedures of the Plan.

(d) Notification of an Adverse Benefit Determination

The Contract Administrator or Plan Administrator shall provide a claimant with a notice, either in writing or electronically, containing the following information:

(1) A reference to the specific portion(s) of the Plan upon which a denial is based;

(2) Specific reason(s) for a denial;

(3) A description of any additional information necessary for the claimant to perfect the claim and an explanation of why such information is necessary;

(4) A description of the Plan’s review procedures and the time limits applicable to the procedures, including a statement of the claimant’s right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on final review;

(5) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claimant’s claim for benefits;

(6) The identity of any medical or vocational experts consulted in connection with a claim, even if the Plan did not rely upon their
advice (or a statement that the identity of the expert will be provided, upon request);

(7) Any rule, guideline, protocol, or similar criterion that was relied upon in making the determination (or a statement that it was relied upon and that a copy will be provided to the claimant, free of charge, upon request); and

(8) In the case of denials based upon a medical judgment (such as whether the treatment is Medically Necessary or experimental treatment), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant’s medical circumstances, or a statement that such explanation will be provided to the claimant, free of charge, upon request.

**Appeal of Adverse Benefit Determinations**

In cases where a claim for benefits is denied, in whole or in part, and the claimant believes the claim has been denied wrongly, the claimant may appeal the denial and review pertinent documents. The claims procedures of this Plan provide a claimant with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination. More specifically, the Plan provides:

(a) Claimants have at least one hundred eighty (180) days following receipt of a notification of an initial adverse benefit determination within which to appeal the determination and sixty (60) days to appeal a second adverse benefit determination;

(b) Claimants have the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;

(c) For a review that does not afford deference to the previous adverse benefit determination and that is conducted by an appropriate named fiduciary of the Plan, who shall be neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;

(d) For a review that takes into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in any prior benefit determination;

(e) That, in deciding an appeal of any adverse benefit determination that is based in whole or in part upon a medical judgment, the Plan fiduciary shall consult with a health care professional who has appropriate training and
experience in the field of medicine involved in the medical judgment, who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual;

(f) For the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claim, even if the Plan did not rely upon their advice; and

(g) That a claimant will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant’s claim for benefits in possession of the Plan Administrator or the Contract Administrator; information regarding any voluntary appeals procedures offered by the Plan; any internal rule, guideline, protocol or other similar criterion relied upon in making the adverse determination; and an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant’s medical circumstances.

First Appeal Level

(a) Requirements for First Appeal

The claimant must file the first appeal in writing within one hundred eighty (180) days following receipt of the notice of an adverse benefit determination. To file an appeal in writing, the claimant's appeal must be addressed as follows and mailed to: Appeals, P. O. Box 284, Peoria, IL 61650-0284.

It shall be the responsibility of the claimant to submit proof that the claim for benefits is covered and payable under the provisions of the Plan. Any appeal must include:

(1) The name of the Employee/claimant;

(2) The Employee/claimant's social security number;

(3) The group name or identification number;

(4) All facts and theories supporting the claim for benefits. **Failure to include any theories or facts in the appeal will result in their being deemed waived. In other words, the claimant will lose the right to raise factual arguments and theories which support this claim if the claimant fails to include them in the appeal;**
(5) A statement in clear and concise terms of the reason or reasons for disagreement with the handling of the claim; and

(6) Any material or information that the claimant has which indicates that the claimant is entitled to benefits under the Plan.

If the claimant provides all of the required information, it may be that the expenses will be eligible for payment under the Plan.

(b) Timing of Notification of Benefit Determination on First Appeal

The Plan Administrator shall notify the claimant of the Plan’s benefit determination on review within the following timeframes:

(1) For Pre-Service Claims, within a reasonable period of time appropriate to the medical circumstances, but not later than fifteen (15) days after receipt of the appeal.

(2) For Post-Service Claims, within a reasonable period of time, but not later than thirty (30) days after receipt of the appeal.

(3) The period of time within which the Plan's determination is required to be made shall begin at the time an appeal is filed in accordance with the procedures of this Plan, without regard to whether all information necessary to make the determination accompanies the filing.

(c) Manner and Content of Notification of Adverse Benefit Determination on First Appeal

The Plan Administrator shall provide a claimant with notification, in writing or electronically, of a Plan's adverse benefit determination on review, setting forth:

(1) The specific reason or reasons for the denial;

(2) Reference to the specific portion(s) of the Plan on which the denial(s) is based;

(3) The identity of any medical or vocational experts consulted in connection with the claim, even if the Plan did not rely upon their advice;

(4) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits;
(5) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the claimant upon request;

(6) If the adverse benefit determination is based upon a medical judgment, a statement that an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant’s medical circumstances, will be provided free of charge upon request;

(7) A description of any additional information necessary for the claimant to perfect the claim and an explanation of why such information is necessary;

(8) A description of the Plan's review procedures and the time limits applicable to the procedures;

(9) A statement of the claimant’s right to bring an action under section 502(a) of ERISA, following an adverse benefit determination on final review; and

(10) The following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency."

(d) Furnishing Documents in the Event of an Adverse Determination

In the case of an adverse benefit determination on review, the Plan Administrator shall provide such access to, and copies of, documents, records, and other information described in subsections (3) through (6) of section (c) relating to "Manner and Content of Notification of Adverse Benefit Determination on First Appeal" as appropriate.

Second Appeal Level

(a) Adverse Decision on First Appeal; Requirements for Second Appeal

Upon receipt of notice of the Plan’s adverse decision regarding the first appeal, the claimant has sixty (60) days to file a second appeal of the denial of benefits. The claimant again is entitled to a "full and fair review" of any denial made at the first appeal, which means the claimant has the same rights during the second appeal as he or she had during the first appeal. As with the first appeal, the claimant's second appeal must
be in writing and must include all of the items set forth in the section entitled "Requirements for First Appeal."

(b) Timing of Notification of Benefit Determination on Second Appeal

The Plan Administrator shall notify the claimant of the Plan’s benefit determination on review within the following timeframes:

(1) For Pre-Service Claims within a reasonable period of time appropriate to the medical circumstances, but not later than fifteen (15) days after receipt of the second appeal.

(2) For Post-Service Claims within a reasonable period of time, but not later than thirty (30) days after receipt of the second appeal.

(3) The period of time within which the Plan’s determination is required to be made shall begin at the time the second appeal is filed in accordance with the procedures of this Plan, without regard to whether all information necessary to make the determination accompanies the filing.

(c) Manner and Content of Notification of Adverse Benefit Determination on Second Appeal

The same information must be included in the Plan’s response to a second appeal as a first appeal, except for (i) a description of any additional information necessary for the claimant to perfect the claim and an explanation of why such information is needed; and (ii) a description of the Plan’s review procedures and the time limits applicable to the procedures. See the section entitled "Manner and Content of Notification of Adverse Benefit Determination on First Appeal."

(d) Furnishing Documents in the Event of an Adverse Determination

In the case of an adverse benefit determination on the second appeal, the Plan Administrator shall provide such access to, and copies of, documents, records, and other information described in subsections (3) through (6) of the section relating to "Manner and Content of Notification of Adverse Benefit Determination on First Appeal" as is appropriate.

(e) Decision on Second Appeal to be Final

If, for any reason, the claimant does not receive a written response to the appeal within the appropriate time period set forth above, the claimant may assume that the appeal has been denied. The decision by the Plan Administrator or other appropriate named fiduciary of the Plan on review will be final, binding and conclusive and will be afforded the maximum deference permitted by law. All claim review procedures
provided for in the Plan must be exhausted before any legal action is brought. Any legal action for the recovery of any benefits must be commenced within one (1) year after the Plan’s claim review procedures have been exhausted.

Appointment of Authorized Representative

A claimant is permitted to appoint an authorized representative to act on his behalf with respect to a benefit claim or appeal of a denial. An assignment of benefits by a claimant to a provider will not constitute appointment of that provider as an authorized representative. To appoint such a representative, the claimant must complete a form which can be obtained from the Plan Administrator or the Contract Administrator. In the event a claimant designates an authorized representative, all future communications from the Plan will be with the representative, rather than the claimant, unless the claimant directs the Plan Administrator, in writing, to the contrary.

Facility of Payment

If a Covered Person or Covered Dependent dies while benefits provided for Hospital, nursing, medical or surgical services remain unpaid, the Contract Administrator may, at its option, make direct payments to the individual or institution on whose charges claim is based or to the surviving spouse of the Covered Person, or if none, to his surviving child or children (including legally adopted child or children) share and share alike, or if none, to the executors or administrators of the Covered Person's or Covered Dependent's estate.

Minor or Incompetency

If a Covered Person or Covered Dependent is a minor or, in the opinion of the Contract Administrator, not competent to give a valid receipt for payment of any benefit due him under the Plan and if no request for payment has been received by the Contract Administrator from a duly appointed guardian or other legally appointed representative of that person, the Contract Administrator may, at its option, make direct payment to the individual or institution appearing to the Contract Administrator to have assumed the custody or the principal support of that person.

Discharge

Any payment by the Contract Administrator in accordance with these provisions will discharge the Employer and the Contract Administrator from all further liability to the extent of the payment made.

Time Limitations

If any time limitations provided in the Plan for giving notice of claims, furnishing proof of loss, or for bringing any action at law or in equity is less than that permitted by
the applicable law, then the time limitation provided in the Plan is hereby extended to agree with the minimum permitted by the applicable law.

**Claims Mistakenly Paid**

The Contract Administrator shall have the right to recover any payment of claims which have been mistakenly paid on behalf of a claimant. This includes the right to recover benefits paid on the basis of claims filed which were fraudulently or intentionally misstated by the claimant. The claimant will be notified in writing and given an opportunity for review in accordance with the claims procedures herein. A payment by the Contract Administrator in accordance with the Plan is not an admission by the Employer or Contract Administrator that the Expenses Incurred with respect to which a claim for benefits is filed are eligible for benefits under this Plan.

**ADMINISTRATION**

**Assignment**

Benefits under this Plan may be assigned to a provider upon written authorization of the Covered Person or Covered Dependent.

**Withholding of Benefit Payments**

In the event any question or dispute shall arise as to the proper person or persons to whom any payments shall be made hereunder, the Employer may direct the Contract Administrator to withhold such payment until there shall have been made an adjudication of such question or dispute which in the Employer's sole judgment is satisfactory to it, or until the Employer and Contract Administrator shall have been fully protected against loss by means of such indemnification agreement or bond as it determines to be adequate.

**Medical Examination**

The Contract Administrator shall have the right, through a Physician of its choice, to examine a Covered Person or Covered Dependent as often as may be reasonable during the pendency of a claim hereunder, and the right and opportunity to make an autopsy in case of death where it is not forbidden by law.

The Contract Administrator shall be entitled to receive any and all reports regarding such examinations or autopsies.

**Right to Receive and Release Information**

The Contract Administrator, pursuant to the reasonable exercise of its discretion or incident thereto, may release to, or obtain from any other company, organization or person, without consent of or notice to any person, any information regarding any
person which the Plan Administrator or Contract Administrator deems necessary to carry out the provisions of the Plan, or to determine how, or if, they apply. To the extent that this information is protected health information as described in 45 C.F.R. 164.500, et seq., or other applicable law, the Plan Administrator or Contract Administrator may only use or disclose such information for treatment, payment or health care operations as allowed by such applicable law. Any claimant under the Plan shall furnish to the Contract Administrator such information as may be necessary to carry out this provision.

The only employees or other persons under the direct control of the Plan Sponsor who are allowed access to the protected health information of other individuals are those employees or persons with direct responsibility for the control and operation of the Plan and only to the extent necessary to perform the duties as Plan Administrator as determined pursuant to the reasonable exercise of discretion of the Plan Administrator.

In addition, the Plan Sponsor hereby certifies and agrees that it will:

(a) Not use or further disclose the information other than as permitted or required by the Plan or as required by law;

(b) Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information that it creates, receives, maintains, or transmits on behalf of the Plan;

(c) Ensure that any agents, including a subcontractor, to whom it provides protected health information received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information;

(d) Not use or disclose the information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor;

(e) Report to the appropriate representative of the Plan Administrator any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware;

(f) Make available protected health information in accordance with 45 C.F.R. 164.524;

(g) Make health information for amendment and incorporate any amendments to protected health information in accordance with 45 C.F.R. 164.526;

(h) Make available the information required to provide an accounting of disclosures in accordance with 45 C.F.R. 164.528;
(i) Make its internal practices, books, and records relating to the use and disclosure of protected health information received from the Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with the privacy requirements of 45 C.F.R. 164.500, et seq.;

(j) If feasible, return or destroy all protected health information received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and

(k) Ensure that the adequate separation between the Plan and the Plan Sponsor is established and maintained pursuant to 45 C.F.R. 164.504(f)(2)(iii) and is supported by reasonable and appropriate security measures.

The use of protected health information by the Plan shall be in accordance with the privacy rules established by 45 C.F.R. 164.500, et seq. Any issues of noncompliance with the provisions of this Section shall be resolved by the privacy officer of the Plan Administrator.

**Facility of Reimbursement**

If payments which should have been made under this Plan have been made under any other plan or plans, the Contract Administrator may, at its sole discretion, pay to any organization making such other payments any amounts which it determines will satisfy the intent of the Plan. Amounts so paid shall be deemed benefits paid under this Plan and, to the extent of such payments, the Employer and Contract Administrator shall be fully discharged from liability under this Plan.

**Right to Recovery**

If the total payments made by the Contract Administrator as to any expenses at any time are more than the maximum payment then necessary to satisfy the intent of the Plan, the Contract Administrator shall have the right to recover the extra amount of such payments from one or more of the following, as the Contract Administrator will determine: any person to, or for, or with respect to whom such payments were made, any other insurance companies, and any other organizations.

**Subrogation and Reimbursement**

(a) Payment Conditions

(1) The Plan, in its sole discretion, may elect, but is not required, to
conditionally advance payment or extended credit of medical benefits in those situations where a Sickness, Injury, or disability is caused in whole or in part by, or results from, the acts or omissions of a third party, or from the acts or omissions of a Covered Person or Covered Dependent (including such Covered Person or Covered Dependent’s beneficiaries, heirs, or assigns) where any other insurance is available, including but not limited to, no-fault, uninsured motorist, underinsured motorist, medical payment provisions or other insurance policies or funds (“Coverage”).

(2) The Covered Person or Covered Dependent, his or her attorney and/or legal guardian of a minor or incapacitated individual agrees that acceptance of the Plan’s payment of medical benefits is constructive notice of this provision in its entirety and agrees to maintain one hundred percent (100%) of the Plan’s payment of benefits or the full extent of payment from any one or combination of first and third party sources in trust and without dissipation except for reimbursement to the Plan or its assignee. By accepting benefits under the Plan, the Covered Person or Covered Dependent agrees that the Plan shall have an equitable lien on any funds received by the Covered Person or Covered Dependent or such person’s attorney, if any, from any source and shall be held in trust until such time as the obligation under this provision is fully satisfied.

(3) In the event a Covered Person or Covered Dependent settles, recovers or is reimbursed by any third party or Coverage, the Covered Person or Covered Dependent agrees to reimburse the Plan for all benefits paid or that will be paid as a result of said Sickness, Injury, or disability. If the Covered Person or Covered Dependent fails to reimburse the Plan out of any judgment or settlement received, the Covered Person or Covered Dependent will be liable for any and all expenses (whether fees or costs) associated with the Plan’s attempt to recover such money.

(b) Subrogation

(1) As a condition to participating in and receiving benefits under this Plan, the Covered Person or Covered Dependent agrees to subrogate the Plan to any and all claims, causes of action or rights that may arise against any person, corporation and/or entity and to any Coverage to which the Covered Person or Covered Dependent is entitled, regardless of how classified or characterized.

(2) If a Covered Person or Covered Dependent receives or becomes entitled to receive benefits, an automatic equitable subrogation lien
attaches in favor of the Plan to any claim, which any Covered Person or Covered Dependent may have against any party causing the Sickness, Injury, or disability to the extent of such payment by the Plan plus reasonable costs of collection.

(3) The Plan may in its own name or in the name of the Covered Person or Covered Dependent or their personal representative commence a proceeding or pursue a claim against any third party or Coverage for the recovery of all damages to the full extent of the value of any such benefits or payments advanced by the Plan.

(4) If the Covered Person or Covered Dependent fails to make a claim against or pursue damages against:

(A) the responsible party, its insurer or any other source on behalf of that party;

(B) any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;

(C) any policy or contract of insurance from any insurance company or guarantor of a third party;

(D) workers’ compensation or other liability insurance company; or

(E) any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments and no-fault or school insurance coverages;

then the Covered Person or Covered Dependent authorizes the Plan to pursue, sue, compromise or settle any such claims in their name and/or the Plan’s name and agrees to fully cooperate with the Plan in the prosecution of such claims. The Covered Person or Covered Dependent, or his or her guardian or the estate of a Covered Person or Covered Dependent, assigns all rights to the Plan or its assignee to pursue a claim and the recovery of all expenses from any sources listed above.

(c) Right of Reimbursement

(1) The Plan shall be entitled to recover one hundred percent (100%) of the benefits paid, without deduction for attorneys’ fees and costs, or application of the common fund doctrine, make whole doctrine, or any other similar legal theory, and without regard to whether the
Covered Person or Covered Dependent is fully compensated by his/her recovery from all sources. The obligation exists whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability or other expenses. The obligation exists regardless of how classified or characterized. If the Covered Person or Covered Dependent’s recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved.

(2) The Plan’s equitable subrogation lien specifically supersedes all common law or statutory rules and doctrines such as the “make whole doctrine,” the “common fund doctrine,” and the law of any state prohibiting any assignment of rights, which interfered with or compromises in any way the Plan’s equitable subrogation lien.

(3) The Plan will not pay or be responsible, for any expenses, attorney’s fees, costs or other monies incurred by the attorney for the Covered Person or Covered Dependent or his/her beneficiaries, commonly known as the common fund doctrine. No court costs, expert’s fees, attorney’s fees, filing fees or other costs or expenses of a litigation nature may be deducted from the Plan’s recovery without the prior written consent of the Plan.

(4) The Plan’s right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of the Covered Person or Covered Dependent, whether under the doctrines of causation, comparative fault or contributory negligence, or any other similar doctrine in law. Accordingly, any lien reduction statutes, which attempt to apply such laws and reduce a subrogating Plan’s recovery for any reason, will not be applicable to the Plan and will not reduce the Plan’s subrogation recovery.

(5) These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgment of these rights is required by the Plan and signed by the Covered Person or Covered Dependent.

(6) This provision shall not limit any other remedies of the Plan provided by law. These rights of subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable Sickness, Injury, or disability.

(d) Excess Insurance

(1) If at the time of Sickness, Injury, or disability, there is available, or potentially available (based on information known or provided to the
Plan, to the Covered Person or Covered Dependent) any other Coverage (including but not limited to Coverage resulting from a judgment at law or settlements) the benefits under this Plan shall apply only as excess insurance over such other sources of Coverage. The Plan’s benefits shall be excess to:

(A) the responsible party, its insurer, or any other source on behalf of that party;

(B) any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;

(C) any policy of insurance from any insurance company or guarantor of a third party;

(D) workers’ compensation or other liability insurance company; or

(E) any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverages.

(e) Wrongful Death Claims

In the event that the Covered Person or Covered Dependent dies as a result of his or her injuries and a wrongful death or survivor claim is asserted against a third party or any Coverage, the Plan’s subrogation and reimbursement rights still apply.

(f) Obligations

(1) It is the Covered Person’s or Covered Dependent’s obligation to:

(A) to cooperate with the Plan, or any representatives of the Plan, in protecting its rights of subrogation and reimbursement, including completing discovery, attending depositions, and/or attending or cooperating in trial in order to preserve the Plan’s subrogation rights;

(B) to provide the Plan with pertinent information regarding the Sickness, Injury, or disability, including accident reports, settlement information and any other requested additional information;
(C) to take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights;

(D) to do nothing to prejudice the Plan’s rights of subrogation and reimbursement;

(E) to promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received; and

(F) to not settle, without the prior consent of the Plan, any claim that the Covered Person or Covered Dependent may have against any legally responsible party or Coverage to the extent the Plan is or may be entitled to any part of such settlement proceeds.

(2) Failure to comply with any of these requirements by the Covered Person or Covered Dependent, his or her attorney or guardian may, at the Plan’s discretion, result in a forfeiture of payment by the Plan of medical benefits and any funds or payments due under this Plan may be withheld until the Covered Person or Covered Dependent satisfies his or her obligation. If the Covered Person or Covered Dependent fails to reimburse the Plan for all benefits paid or to be paid, as a result of said Sickness, Injury, or disability, out of any proceeds, judgment or settlement received, the Covered Person or Covered Dependent will be responsible for any and all expenses (whether fees or costs) associated with the Plan’s attempt to recover such money from the Covered Person or Covered Dependent.

(g) Minor Status

(1) In the event the Covered Person or Covered Dependent is a minor as that term is defined by applicable law, the minor’s parents or court-appointed guardian, shall cooperate in any and all actions requested by the Plan to seek and obtain any requisite court approval in order to bind the minor and his or her estate insofar as the subrogation and reimbursement provisions are concerned.

(2) If the minor’s parents or court-appointed guardian fail or refuse to take such action, the Plan shall have no obligation to advance payment of medical benefits on behalf of the minor. Any court costs or legal fees associated with obtaining such approval shall be paid by the minor’s parents or court-appointed guardian.
(h) Language Interpretation

The Plan Administrator retains sole, full and final discretionary authority to construe and interpret the language of this provision, to determine all questions of fact and law arising under this provision and to administer the Plan’s subrogation/reimbursement rights.

(i) Severability

In the event that any subsection of this provision is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining subsections of this provision and Plan. The subsection shall be fully severable. The Plan shall be construed and enforced as if such invalid or illegal subsections had never been inserted in the Plan.

Coordination of Benefits

In addition to benefits payable under this Plan, a Covered Person or Covered Dependent may be entitled to benefits from other plans, payable on account of the same Sickness or Injury. The other plans are those which provide benefits or services for or by reason of medical or dental care or treatment, when such benefits or services are provided on a group basis, whether insured or not, by any government or tax-supported program (including Medicare) or any similar plan or program.

This provision is applicable when the total benefits that would be payable in the absence of any coordination of benefits provision under this Plan and under all plans covering an individual exceed the total Expenses Incurred.

One of the two or more plans involved is the Primary Plan and the other plans are Secondary Plans. The Primary Plan pays benefits first and without consideration of the other plans. The Secondary Plans then make up the difference up to the total allowable Expenses Incurred. No plan will pay more than it would have paid without this special provision.

The following rules apply to determine which plan is Primary and which plan is Secondary:

(a) If one plan has no coordination of benefits provision, it is automatically Primary.

(b) A plan will be Primary if it covers the individual as an Employee and Secondary if it covers the individual as a Dependent.

(c) If an individual is covered as a Dependent under two or more plans, the plan which covers the individual as a Dependent of the person whose birthday falls earlier in the year is Primary. If both individuals share the
same date of birth, the plan covering the individual for the longer period of time is Primary.

(d) In the case of children of divorced parents, in the absence of court-determined responsibility, the plan covering the parent with custody is Primary. If the parent without custody has court-determined responsibility, but does not have health benefits available for children, then the plan covering the parent with custody is Primary.

(e) A plan will be Primary if it covers the individual as an Employee and Secondary if it covers the individual (i) as a former Employee, (ii) as a retiree, or (iii) as an individual who has elected to continue benefits under the Plan pursuant to the Continuation of Benefits Sections herein.

(f) If none of the above rules apply, a plan will be Primary if it has covered the individual for the longer period of time and Secondary if it has covered the individual for the shorter period of time.

Notwithstanding any provision herein to the contrary, if a Covered Person or Covered Dependent is eligible for Medicare, benefits otherwise payable on behalf of that Covered Person or Covered Dependent shall be reduced by the amount of benefits available from Medicare, regardless of whether such benefits are actually received from Medicare.

Information necessary to the administration of this Section will be required at the time a claim is submitted.

Coordination with Medicare and Medicaid

(a) Medicare

This Plan will be considered the Primary Plan for Covered Persons who are current Employees and their Covered Dependents who are nevertheless eligible for Medicare benefits if (i) such Covered Persons or Covered Dependents are age sixty-five (65) or older and their Employer employs twenty (20) or more Employees, or (ii) such Covered Persons or Covered Dependents are disabled and any Employer under this Plan employs one hundred (100) or more Employees. Except to the extent required by law for end stage renal disease, Medicare shall be considered the Primary Plan for all other Covered Persons who become eligible for Medicare and their Covered Dependents, unless the Covered Person on behalf of himself and his Covered Dependents reject coverage under this Plan. In the event of an election to terminate coverage, benefits will no longer be available under this Plan as either a Primary Plan or a Secondary Plan.
(b) Medicaid

Payment for Expenses Incurred with respect to a Covered Person or Covered Dependent under the Plan will be made in accordance with any assignment of rights made by or on behalf of such Covered Person or Covered Dependent as required by a State plan for medical assistance approved under Title XIX of the Social Security Act pursuant to Section 1912(a)(1)(A) of such Act. In enrolling or in determining or making any payments for Expenses Incurred of a Covered Person or Covered Dependent, the fact that the Covered Person or Covered Dependent is eligible for or is provided medical assistance under a State plan for medical assistance approved under Title XIX of the Social Security Act will not be taken into account. To the extent that payment has been made under a State plan for medical assistance approved under Title XIX of the Social Security Act when the Plan has a legal liability to make payment for the Expenses Incurred constituting such assistance, payment for the Expenses Incurred under this Plan will be made in accordance with any State law which provides that the State has acquired the rights with respect to a Covered Person or Covered Dependent to such payment for such Expenses Incurred.

**Qualified Medical Child Support Order**

The Plan shall comply with the terms of a Qualified Medical Child Support Order ("QMCSO"), directing the Plan to provide benefits to one or more alternate recipients, pursuant to the procedure set forth below:

(a) An order which purports to be a QMCSO must be served on the Contract Administrator.

(b) The Contract Administrator shall, within twenty (20) days of its receipt of the order, make a preliminary determination as to whether or not the order satisfies the requirements to be a QMCSO. In order to satisfy those requirements, an order must contain at least the following information:

1. a clause which creates or recognizes the existence of a dependent’s right to receive benefits under the Plan;

2. the name and last known mailing address of the Covered Person with respect to whom the order is issued and each dependent covered by the order;

3. a reasonable description of the type of coverage to be provided by the Plan to each dependent;

4. the time period to which the order applies; and

5. the order does not require the Plan to provide any type or form of benefit not otherwise provided under the Plan.
(c) An order which, in the judgment of the Contract Administrator, does not meet the requirements of a QMCSO shall be returned to legal counsel who prepared the order for revision. Revised orders which are resubmitted shall be considered new orders and shall be reviewed in accordance with the procedures set forth in this Section.

(d) When the Contract Administrator makes a preliminary determination that an order satisfies the requirements of a QMCSO, it shall forward the order to the Employer for review. The Employer shall make the final determination of the status of the order.

(e) The Contract Administrator shall notify all parties involved, including a designated representative of the Covered Dependent, of the Employer's decision and of the respective parties' entitlement to benefits.

Reimbursement of benefit payments under the Plan pursuant to a QMCSO may be made to the Covered Dependent or the Covered Dependent's custodial parent.

**Termination of Coverage**

(a) Termination of Covered Person Coverage:

The coverage of any Covered Person with respect to himself shall automatically cease, except as provided in any extension of benefits or continuation of benefits provision, upon the earliest of:

1. The date the Plan is terminated, or with respect to a specific benefit, the date the specific benefit is terminated;

2. The last day of the month the Covered Person ceased to be in a class of employees eligible for coverage;

3. The date beginning the period for which the Covered Person has failed to make any required contribution for coverage;

4. The last day of the month during which the Covered Person's employment with the Employer terminates; or

5. The date of the Covered Person's death.

(b) Termination of Covered Dependent Coverage:

The coverage of any Covered Dependent shall automatically cease, except as provided in any extension of benefits or continuation of benefits provision, upon the earliest of:
(1) The date coverage terminates for the Employee upon whom Covered Dependents depends for eligibility;

(2) The last day of the month such dependent ceased to be an Eligible Dependent as defined herein;

(3) The date the Plan is modified to terminate dependent coverage;

(4) The date beginning the period for which the Covered Person or Covered Dependent has failed to make any required contribution for dependent coverage, if contributions are required;

(5) The date the dependent child becomes eligible for coverage under the Plan as an Employee;

(6) The date the Plan is terminated or, with respect to a specific benefit, the date the specific benefit is terminated; or

(7) The date of the Covered Dependent’s death.

**Extension of Benefits**

If coverage under the Plan would otherwise terminate with respect to a Covered Person or Covered Dependent, without regard to the continuation of benefits provisions of the Plan, benefits under the Plan can nevertheless be extended under the specific circumstances enumerated below. Any extension of benefits period provided pursuant to this Section shall postpone the starting date for measurement of the maximum period available for continuation of benefits pursuant to the Continuation of Benefits Section.

(a) Sickness or Injury

If coverage under the Plan would otherwise terminate with respect to a Covered Person who is absent from work due to a Sickness or Injury, benefits will continue to be provided for the Covered Person and his Covered Dependents until the earlier of (i) the date the Sickness or Injury ceases, or (ii) the date the Employer stops making any Employer contribution required for coverage.

(b) Layoff or Leave of Absence

If coverage under the Plan would terminate with respect to a Covered Person who is on a layoff or leave of absence approved by the Employer, benefits will continue to be provided for that person and his Covered Dependents until the earlier of (i) the date the layoff is terminated or the leave of absence expires, (ii) the date the Covered Person fails to pay any contribution required for coverage, or (iii) twelve (12) months following the beginning of the layoff or leave of absence.
(c) Retiree Coverage

If coverage under the Plan would terminate with respect to a Covered Person who retires from the Employer as a Retiree, benefits will continue to be provided for that Retiree and his Covered Dependents until the earlier of (i) the date the Retiree again commences employment with the Employer, or (ii) the date the Retiree fails to pay any contribution required for coverage as stated in Drury policy.

(d) Death of Covered Person

If coverage under the Plan would otherwise terminate due to the death of the Covered Person, benefits will continue to be provided for those Covered Dependents until the earlier of (i) the date the Covered Dependents fail to pay any contribution required for coverage, or (ii) with respect to a dependent child, the date the child is no longer an Eligible Dependent for a reason other than the death of the Covered Person.

General Limitations

In addition to any limitations or exclusions stated elsewhere in the Plan, no benefits are payable under this Plan for Expenses Incurred:

(a) for charges which exceed the Reasonable and Customary charge for the service rendered or charges for which payment is not legally required;

(b) for treatment paid for by any agency of the United States Government or any state or political subdivision, or provided by or in a Hospital operated by any agency of the United States Government or any state or political subdivision, unless the Covered Person or Covered Dependent is legally required to pay such charges;

(c) for or in connection with:

(1) Sickness or Injury for which the Covered Person or Covered Dependent is entitled to benefits under any workers’ compensation law, employers’ liability law, or similar laws;

(2) Hospital, surgical, and medical services or supplies unless such expense is incurred upon the recommendation of a Physician for diagnosis or treatment of an Injury or Sickness;

(3) Injury or Sickness arising out of war, declared or undeclared, or service in any military forces or civilian non-combatant unit serving with such forces;

(4) Injury or Sickness sustained (i) during the voluntary participation in a felony, or (ii) while engaged in an illegal occupation;
The limitations of this section shall not apply unless there is a direct causal relationship between the activity described in (i) or (ii) and the Sickness or Injuries sustained;

(5) services or supplies which constitute personal comfort or beautification items, television or telephone use, education or training, or expenses actually incurred by persons who are not Covered Persons or Covered Dependents;

(6) cosmetic surgery, except for treatment necessitated by accidental Injury or for correction of a congenital malformation of a dependent child;

(7) services performed by any person who is a member of the Covered Person's or Covered Dependent's Immediate Family, or who normally resides in the Covered Person's or Covered Dependent's home;

(8) services, supplies or treatments not Medically Necessary for the diagnosis and/or treatment of an active Sickness or Injury; or charges for procedures, surgical or otherwise, which are specifically listed by the American Medical Association as having no medical value; or drugs not approved for use by the U.S. Food and Drug Administration;

(9) charges incurred outside the United States if the Covered Person or Covered Dependent traveled to such a location for the sole purpose of obtaining medical services, drugs, or supplies;

(10) hospitalization when such confinement occurs primarily for physiotherapy, hydrotherapy, or convalescent or rest care;

(11) the purchase or fitting of eyeglasses, contact lenses, hearing aids, or such similar aid devices except as otherwise specified herein. This exclusion shall not apply to the initial purchase of eyeglasses or contact lenses following cataract surgery;

(12) replacement of cataract lenses when a prescription change is not required;

(13) professional nursing services if rendered by other than a Registered Nurse or Licensed Practical Nurse, unless such care was vital as a safeguard of the Covered Person's or Covered Dependent's life, and unless such care is specifically listed as a benefit elsewhere in the Plan;
(14) treatment of obesity, including morbid obesity;

(15) diagnosis and treatment of infertility or restoration or enhancement of fertility, including but not limited to, therapeutic injections, fertility and other drugs, Surgery, artificial insemination, in-vitro fertilization, or surgical reversal of elective sterilization;

(16) religious, marital, family or relationship counseling;

(17) IQ testing or educational testing;

(18) vitamins or dietary supplements;

(19) services and supplies for naturopathic and homeopathic treatment;

(20) housekeeping or custodial care;

(21) weak, unstable or flat feet, or bunions, unless an open cutting operation is performed or for treatment of corns, calluses or toenails, unless at least part of the nail root is removed, or purchase of orthopedic shoes or other devices for support of the feet;

(22) acupuncture, except when used for smoking cessation;

(23) biofeedback;

(24) hypnotherapy, except when used for smoking cessation;

(25) Expenses Incurred as the result of radioactive contamination or the hazardous properties of nuclear material;

(26) services, supplies therapy, or drugs related to sexual dysfunction not related to organic disease;

(27) court ordered treatment;

(28) Expenses Incurred for treatment of gynecomastia;

(29) cognitive and kinetic therapy, unless related to the diagnosis, testing and treatment of Attention Deficit Disorder or Attention Deficit Hyperactive Disorder;

(30) services related to gambling addiction;

(31) genetic testing or counseling, except amniocentesis testing;
(32) treatment and appliances for correction of a malocclusion, protrusion, or recession of the mandible, maxillary or mandibular hyperplasia or hypoplasia;

(33) enrollment in a health, athletic, or similar club or weight loss, except as otherwise specifically provided herein;

(34) purchase or rental of supplies of common use such as: exercise cycles, air purifiers, air conditioners, water purifiers, hypoallergenic pillows or mattress or waterbeds;

(35) purchase or rental of: motorized transportation equipment, escalators, or elevators, saunas, steambaths, swimming pools, or blood pressure kits;

(36) sex transformation and hormones related to such treatment;

(37) chelation therapy, unless for heavy metal poisoning;

(38) developmental testing or exams, unless related to Attention Deficit Disorder or Attention Deficit Hyperactive Disorder;

(39) radial keratotomy, keratoplasty, or other eye Surgery to correct near or far sightedness;

(40) Expenses Incurred for behavioral, social maladjustment, lack of discipline, or other antisocial actions which are not specifically the result of Mental Illness;

(41) any taxes or other assessments owing with respect to Expense Incurred for medical services other than sales tax;

(42) care, services, or treatment required as a result of complications from treatment not covered by the Plan;

(43) Any limitations on benefits contained in the Summary of Benefits;

(44) services and supplies not specifically mentioned in the Plan; or

(d) Experimental/Investigational: Expenses for services or supplies which are not medically recognized or are Experimental Treatment, except for the Clinical Trials as set forth herein.
CONTINUATION OF BENEFITS

In accordance with the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), continuation coverage under the Plan is available to Qualified Beneficiaries under certain specified conditions.

For the purpose of this Section, "Qualified Beneficiary" means any beneficiary defined as such pursuant to Section 607(3) of ERISA, and generally includes any Covered Person or Covered Dependent whose coverage under the Plan would otherwise terminate upon occurrence of any of the events specified in this Section. A Qualified Beneficiary also includes a child who is born to or placed for adoption with the Covered Person during the continuation coverage elected under this Section, provided such child qualifies as an Eligible Dependent.

Eligibility to Make Election

A Qualified Beneficiary may elect to continue coverage under the Plan if coverage would otherwise cease under the Plan due to:

(a) the Covered Person’s death;
(b) termination of the Covered Person's employment or reduction of the Covered Person's hours (whether voluntarily or involuntarily);
(c) divorce or legal separation of the Covered Person and his spouse;
(d) the Covered Person becoming entitled to Medicare benefits;
(e) a Covered Person's child ceasing to be an Eligible Dependent; or
(f) a proceeding in bankruptcy under Title 11, United States Code, commencing on or after July 1, 1986, with respect to the Employer if the Covered Person is a retiree.

Notwithstanding the above, a Qualified Beneficiary is not entitled to elect continuation coverage if the Covered Person's termination of employment is for gross misconduct as determined by the Employer. In the case of bankruptcy proceedings as described in (f) above, a loss of coverage includes a substantial elimination of coverage with respect to a Qualified Beneficiary within one (1) year before or after the date of commencement of the proceedings.

Election Period and Procedure

The election to continue coverage must be made during the period beginning on the day when coverage would otherwise cease under the Plan and ending sixty (60) days after the later of (i) such date, or, (ii) if applicable under the Administrative Section,
the date when the Qualified Beneficiary is notified of the right to make such election. A Qualified Beneficiary's failure to comply with the procedures and requirements established by the Employer for making the election, as described herein or in the Employer's notice of election, shall constitute the failure to make an election to continue coverage as provided herein. The written waiver by a Qualified Beneficiary (or by the Covered Person or his spouse on behalf of a Qualified Beneficiary) of the election to continue coverage shall terminate the Qualified Beneficiary's right to later make an election, unless the Qualified Beneficiary revokes the waiver within the sixty (60) day election period described above. However, if a waiver is revoked, continuation coverage will be effective on the date the revocation is made and will not be retroactive to the date of the event described in the Eligibility to Make Election Section.

**Benefits**

A Qualified Beneficiary who elects continuation coverage as provided herein shall be eligible to receive the same benefits to which a Covered Person or Covered Dependent under similar circumstances is otherwise entitled. If benefits under the Plan are increased, decreased or otherwise amended or changed either prior to or subsequent to the Qualified Beneficiary's election of continuation coverage, each Qualified Beneficiary will be entitled to benefits comparable to those available to a Covered Person or Covered Dependent under similar circumstances.

**Payment for Benefits**

A Qualified Beneficiary is required to contribute toward the cost of continuing the benefits as provided herein ("Continuation Premium"). The amount of the Continuation Premium or schedule of Continuation Premiums for different classes of Qualified Beneficiaries shall be determined from time to time by the Employer. The Employer shall also establish procedures for the billing and payment of the Continuation Premium which shall be described in the Employer's notice of election form. A Qualified Beneficiary's failure to pay the Continuation Premium by the due date (including any grace period if the Employer establishes such a period) shall result in the Qualified Beneficiary's termination of continuation coverage as of the date covered by the last paid Continuation Premium and such Qualified Beneficiary shall be precluded from extending, renewing, or reelecting such continuation coverage.

**Duration of Continuation Coverage**

A Qualified Beneficiary electing to purchase continuation coverage under the Plan shall be eligible to continue coverage until the earliest of the following events:

(a) the date eighteen (18) months after the date of a Covered Person's termination of employment or reduction in hours;

(b) the date thirty-six (36) months after the date of any other event described in the Eligibility to Make Election Section other than a Covered Person's
termination of employment or reduction in hours (except that if a Covered Person who is an Employee has a termination of employment or reduction in hours entitling him to continuation coverage within eighteen (18) months of the date of his entitlement to Medicare then the period of Continuation Coverage for the Qualified Beneficiaries other than the Covered Person shall not terminate prior to the close of the thirty-six (36) month period beginning on the date the Covered Person became entitled to Medicare);

(c) the date the Employer ceases to provide any health benefit plan for any of its employees;

(d) the date the Qualified Beneficiary first becomes covered after the date of his election of continuation coverage (as an employee or otherwise) by another group health plan which does not contain any applicable exclusion or limitation with respect to any pre-existing condition of such Qualified Beneficiary, or the date the Qualified Beneficiary becomes entitled to benefits under Medicare;

(e) the date which is the last day of the period for which the Qualified Beneficiary's Continuation Premium payments have been paid (regardless of any grace period if the Employer establishes such a period) as determined by the Employer; or

(f) in the case of a Qualified Beneficiary who is determined, under Title II or XVI of the Social Security Act (“Act”), to have been disabled at any time during the first sixty (60) days of continuation coverage, the earlier of (i) the date twenty-nine (29) months after the date of the commencement of such continuation coverage, but only if the Qualified Beneficiary has provided notice of such determination under ERISA Section 606(3) within sixty (60) days of the receipt of the determination notice under the Act and before the expiration of eighteen (18) months from the date of occurrence of the qualifying event, or (ii) the end of the month next following the date of final determination under Title II or XVI of the Social Security Act that the Qualified Beneficiary is no longer disabled.

If more than one event that would entitle the Qualified Beneficiary to elect continuation coverage occurs (as described in the Eligibility to Make Election Section herein), the first occurring of such events shall be the measuring date for purposes of the maximum possible length of continuation coverage under this Section. In addition, the maximum period available for continuation coverage pursuant to the Continuation of Benefits Section is measured from the date of occurrence of the qualifying event specified in the Eligibility to Make Election Section, except where specifically indicated to the contrary.
Administration

(a) Notice on Death, Termination, Reduction of Hours, or Entitlement to Medicare

Within thirty (30) days of a Covered Person's death, termination of service, reduction of hours, or entitlement to Medicare, the Employer shall inform the Plan Administrator of:

(1) the Qualified Beneficiaries eligible to elect continuation coverage;

(2) the event precipitating such notice; and

(3) the date of the event.

The COBRA Notice Coordinator, at the direction of the Employer, shall then notify the Qualified Beneficiaries of their rights to elect pursuant to procedures established by the Employer and applicable law.

(b) Notice of Change in Marital Status or Dependent Status

If a Covered Dependent ceases to be eligible for coverage under the Plan because that person becomes divorced or legally separated from the Covered Person, or if a child of a Covered Person ceases to be eligible for coverage under the Plan because he is no longer an Eligible Dependent, either the Covered Person, the Covered Person's former spouse or the Covered Person's child must notify the COBRA Notice Coordinator of these events within sixty (60) days of their occurrence in order for the respective Qualified Beneficiary to be eligible to elect continuation coverage. The notice may be provided to the COBRA Notice Coordinator orally or in writing and must disclose:

(1) the name and Plan identification numbers of the Covered Person and the individuals affected by the event;

(2) the individual’s divorce, separation, or loss of status as an Eligible Dependent; and

(3) the date of such event.

Notice by a Qualified Beneficiary of the occurrence of an event giving rise to an election does not act as an election to receive continuation coverage under the Plan. In the event of divorce, legal separation, or change in dependent status, the COBRA Notice Coordinator, if notified within the time period specified in this Subsection (b), shall notify the Qualified Beneficiaries of their eligibility to elect continuation coverage.
(c) Notice of Disability

If a Covered Person or Covered Dependent is determined, under Title II or XVI of the Act to have been disabled at any time during the first sixty (60) days of continuation coverage, the Covered Person or Covered Dependent as the case may be must notify the COBRA Notice Coordinator of the determination under the Act within sixty (60) days of the latest to occur of the following:

1. The date of the Social Security Administration disability determination (sometimes referred to as the “award letter”);
2. The date of the termination of employment or reduction in hours entitling the Qualified Beneficiary to COBRA continuation coverage;
3. The date the Qualified Beneficiary otherwise loses coverage under the Plan as a result of the termination of employment or reduction in hours; or
4. The date the Qualified Beneficiary is informed of the obligation to provide notice of disability as provided herein.

Notwithstanding the above, the notice of determination must be provided the COBRA Notice Coordinator before the expiration of eighteen (18) months from the date of occurrence of the termination of employment or reduction in hours. The notice must be provided to the COBRA Notice Coordinator in writing and must disclose (i) the name and Plan identification number of the disabled Covered Person or Covered Dependent, and (ii) the determination notice provided pursuant to the Act to the disabled Covered Person or Covered Dependent.

The Qualified Beneficiaries must also notify the COBRA Notice Coordinator in writing within thirty (30) days of the date of any final determination under the Act that the Covered Person or Covered Dependent is no longer disabled. The notice shall disclose (i) the name and Plan identification number of the disabled Covered Person or Covered Dependent, and (ii) the final determination Notice provided pursuant to the Act that the person is no longer disabled.

(d) Notice of Coverage Under Group Health Plan or Entitlement to Medicare

If a Qualified Beneficiary (i) becomes covered (as an employee or otherwise) by another group health plan which does not contain any applicable exclusion or limitation with respect to any pre-existing condition of such Qualified Beneficiary, or (ii) becomes entitled to benefits under Medicare, the Qualified Beneficiary must notify the COBRA Notice Coordinator of such event in writing within thirty (30) days of such coverage date.

(e) General

1. Multiple Events. If more than one event described in the Eligibility to Make Election Section occurs, the first such event occurring will
determine which one of either Subsection (a) or (b) of this Section is applicable.

(2) Notices to Employer. Notices to the COBRA Notice Coordinator shall be provided to the COBRA Notice Coordinator listed on the General Information Section. If no COBRA Notice Coordinator is listed on the General Information Section then the Employer shall be considered the COBRA Notice Coordinator and notices shall be provided to the person or organizational unit of the Employer that customarily handles employee benefits matters of the Employer.

(3) Current Addresses. The notification of election rights under COBRA will generally be made by U.S. Mail to the Qualified Beneficiary’s last known address. As a result, it is important for each Covered Person and Covered Dependent to timely provide the Employer with his current mailing address.

(4) Interpretation. In the event of any inconsistency or omission, this Section and the applicable provisions of the Plan shall be construed, interpreted, and administered in a manner which meets the minimum requirements of COBRA.

MILITARY LEAVE

In accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"), continuation coverage under the Plan is available to Covered Persons and their Covered Dependents under certain specified conditions. Any extension of benefits period provided pursuant to this Section shall not postpone the starting date for measurement of the maximum period available for continuation of benefits pursuant to the Continuation of Benefits Section described above.

Election and Duration of Coverage

A Covered Person may elect to continue coverage under the Plan for himself and his Covered Dependents if coverage would otherwise cease under the Plan due to that person's absence from employment with the Employer by reason of his service in the uniformed services. The maximum period of coverage available to all Covered Persons and Covered Dependents under the provisions of this Section shall be the lesser of:

(a) the twenty-four (24) month period beginning on the date on which the Covered Person's military leave began; or

(b) the day after the date on which the Covered Person fails to apply for or return to a position of employment with the Employer following the expiration of the leave as set forth in Section 4312(e) of USERRA.
Benefits

Benefits under the Plan for Covered Persons and Covered Dependents under an election for military leave continuation coverage shall be the same coverage as provided to all other Covered Persons and Covered Dependents. If Benefits under the Plan are increased, decreased or otherwise amended or changed either prior to or subsequent to the election of continuation coverage, the benefits provided pursuant to this continuation coverage will be the same as those available to all other Covered Persons and Covered Dependents.

Payment for Benefits

A Covered Person is required to contribute toward the cost of continuing the benefits as provided herein (“Continuation Premium”). The amount of the Continuation Premium or schedule of Continuation Premiums for different classes of coverage shall be determined from time to time by the Employer. The Employer shall also establish procedures for the billing and payment of the Continuation Premium. A Covered Person's failure to pay the Continuation Premium by the due date (including any grace period if the Employer establishes such a period) shall result in the termination of continuation coverage as of the date covered by the last paid Continuation Premium and such Covered Person shall be precluded from extending, renewing, or reelecting such continuation coverage.

Employee Returning from Military Leave

In the case of a Covered Person whose coverage under the Plan was terminated by reason of service in the uniformed services, the Covered Person and his Eligible Dependents shall again be eligible for coverage under the Plan immediately upon return to active work. In addition, no other Plan limitation or exclusion shall apply to such returning Employee and his Eligible Dependents to the extent that such limitation or exclusion would not have applied had the Employee remained on the Plan during the military leave period. However, the preceding sentence shall not apply to the coverage of any Sickness or Injury determined by the Secretary of Veteran Affairs to have been incurred in, or aggravated during, the performance of service in the uniformed services.

FAMILY AND MEDICAL LEAVE

In accordance with the Family and Medical Leave Act of 1993 ("FMLA"), continuation coverage under the Plan is available to Covered Persons and their Covered Dependents under certain specified conditions.

A Covered Person who takes a leave of absence under applicable provisions of FMLA is entitled to continued coverage under the Plan for himself and his Covered Dependents. Benefits under the Plan are available to the same extent as if the Covered Person had been actively at work during the entire leave period, subject to the following terms and conditions:
(a) Coverage shall cease for a Covered Person (and his Covered Dependents) for the duration of the leave if at any time the Covered Person is more than thirty (30) days late in paying any required contribution.

(b) A Covered Person who declines coverage during the leave or whose coverage is terminated as a result of his failure to pay any required contributions shall, upon return from the leave, be entitled to be reinstated to the Plan on the same terms as prior to taking the leave, without any qualifying period, physical examination, or exclusion of pre-existing conditions.

(c) If a Covered Person who is a Key Employee does not return from leave when notified by the Employer that substantial or grievous economic injury will result from his reinstatement, the Key Employee's entitlement to Plan benefits continues unless and until the Covered Person advises the Employer that he does not desire restoration to employment at the end of the leave period, or the leave entitlement is exhausted, or reinstatement is actually denied.

(d) Any portion of the cost of coverage which had been paid by the Covered Person prior to the leave, must continue to be paid by the Covered Person during the leave. If the cost is raised or lowered during the leave, the Covered Person shall pay the new rates. If the leave is unpaid, the Covered Person and the Employer shall negotiate a reasonable means for paying the Covered Person's portion of the cost.

(e) If the Employer provides a new health plan or benefits or changes the health benefits or Plan while the Covered Person is on leave, the Covered Person is entitled to the new or changed plan and benefits to the same extent as if the Covered Person were not on leave.

(f) The Employer may recover its share of the cost of benefits paid during a period of unpaid leave if the Covered Person fails to return to work after the Covered Person's leave entitlement has been exhausted or expires, unless the reason the Covered Person does not return to work is due to (i) the continuation, recurrence, or onset of a serious health condition which would entitle the Covered Person to additional leave under the FMLA; or (ii) other circumstances beyond the Covered Person's control. If a Covered Person fails to return to work because of the continuation, recurrence, or onset of a serious health condition, thereby precluding the Employer from recovering its share of the cost of benefits paid on the Covered Person's behalf during a period of unpaid leave, the Employer may require medical certification of the Covered Person's or the Covered Dependent's serious health condition. The Covered Person is required to provide medical certification within thirty (30) days from the date of the
Employer’s request. If the Employer requests medical certification and the Covered Person does not provide such certification in a timely manner, the Employer may recover the costs of benefits paid during the period of unpaid leave.

MISCELLANEOUS

Nonalienation of Benefits

Benefits payable under this Plan, shall not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, charge, garnishment, execution, or levy of any kind, either voluntary or involuntary, including any such liability which is for alimony or other payments for the support of a spouse or former spouse or for any other relative of a Covered Person or Covered Dependent, prior to actually being received by the person entitled to the benefit under the terms of the Plan; and any attempt to anticipate, alienate, sell, transfer, assign, pledge, encumber, charge or otherwise dispose of any right to benefit payable hereunder, shall be void. The Plan shall not in any manner be liable for, or subject to, the debts, contracts, liabilities, engagements or torts of any person entitled to benefits hereunder.

Invalid Provision

If any term or provision of this Plan or the application thereof to any person or circumstance shall to any extent be invalid or unenforceable, the remainder of this Plan, or the application of such term or provision to such persons or circumstances other than those as to which it is invalid or unenforceable, shall not be affected thereby, and each term and provision of this Plan shall be valid and shall be enforced to the fullest extent permitted by law.

Governing Law

The interpretation of the terms and provisions of this Plan shall be governed by the Laws of the State of Illinois where it has been executed, except where preempted by federal law.

Amendment/Termination

It is the intention of the Employer to maintain the Plan indefinitely. However, the Employer may amend or terminate the Plan at any time, provided that no such amendment or termination shall diminish or eliminate any claim for any benefit to which a Covered Person or Covered Dependent shall have become entitled prior to such amendment or termination of the Plan. The Plan may be amended or terminated by written authorization and signed by one of the following officers of the University: President, Vice President for Administrative Services, or by any other officer to whom the University’s Board of Trustees delegates the authority to amend the Plan.
Exclusive Benefit/Legal Enforceability

The Plan has been established, and is being maintained, for the exclusive benefit of the Employees of the Employers. The Plan terms as provided herein are legally enforceable by the Employees.

INTERPRETATION OF THE PLAN

Final authority for interpretation of the terms and provisions of the Plan is vested in the Employer. Any interpretation so required by the Employer shall be made in good faith, subject to reasonable care and prudence, and all such interpretations are final. The Employer shall have discretionary authority to determine eligibility for benefits and to construe the terms of the Plan.

DEFINITIONS

Ambulatory Surgical Facility: Means any public or private establishment, which is either independent or part of a Hospital, with:

(a) an organized medical staff of Physicians;

(b) permanent facilities that are equipped and operated primarily for the purpose of performing surgical procedures;

(c) continuous Physician and Registered Nursing services whenever a patient is in the facility; and

(d) which does not provide services or other accommodations for patients to stay overnight.

Ambulatory Surgical Facility does not include an office maintained by a Physician for the practice of medicine or dentistry, or for the primary purpose of performing terminations of pregnancy.

Birthing Center: Means an entity licensed, approved or authorized to provide treatment for persons during uncomplicated pregnancy, routine full-term delivery, and the immediate post-partum period. Such entity must:

(a) provide skilled nursing care by or under the supervision of Registered Nurses;

(b) be staffed and equipped to provide Emergency Treatment; and

(c) have written back-up arrangements with a local Hospital to provide follow-up Emergency Treatment.
Covered Dependent: Means an Eligible Dependent of any Covered Person for whom coverage became effective and has not terminated.

Covered Person: Means an Employee or former Employee whose coverage under the Plan became effective and has not terminated.

Creditable Coverage: Means coverage of the Covered Person or Covered Dependent under any of the following:

(a) a group health plan;
(b) health insurance coverage;
(c) part A or B of Medicare;
(d) title XIX of the Social Security Act, other than coverage consisting solely of benefits under Section 1928;
(e) chapter 55 of title 10, United States Code;
(f) a medical care program of the Indian Health Service or of a tribal organization;
(g) a health plan offered under chapter 89 of title 5 of the United States Code;
(h) a state health benefits risk pool;
(i) a public health plan;
(j) a health benefit plan under section 5(e) of the Peace Corps Act; or
(k) title XXI of the Social Security Act.

Creditable Coverage shall not include coverage consisting solely of excepted benefits under the Health Insurance Portability and Accountability Act of 1996, including coverage solely for limited-scope dental or vision benefits.

Eligible Dependent: Means an Employee's:

(a) spouse;
(b) unmarried child less than nineteen (19) years of age who is chiefly dependent upon the Employee for support and maintenance;
(c) Full-Time Student less than (26) years of age who is chiefly dependent upon the Employee for support and maintenance; or
(d) any unmarried child nineteen (19) years of age or over who is incapable of self-sustaining employment by reason of mental retardation or physical handicap, and who is chiefly dependent upon the Employee for support and maintenance, provided the child is suffering from such disability on the date he attained age nineteen (19);

but excludes the following:

1. any person who is not a resident of the United States of America;
2. any person who is covered under this Plan as an Employee; and
3. any person who is on active duty in any military, naval, or air force of any country.

A “child” of the Employee includes a step-child residing in the Employee’s household in a normal parent-child relationship, adopted child, child in the custody of an Employee while adoption proceedings with respect to that child by the Employee are pending, or child for whom the Employee is the legal guardian, but specifically excluding a foster child or grandchild (unless legally adopted).

At any time, the Employer or Contract Administrator may require proof that a child continues to qualify as an Eligible Dependent herein.

**Emergency Treatment**: Means treatment required for accidental Injury or treatment of a sudden and unexpected Sickness which is life threatening or has such severe symptoms that the absence of immediate medical attention could result in serious and permanent medical consequences.

It shall not include treatment of symptoms of a chronic condition unless such symptoms are sudden, unexpected and severe.

**Employee**: Means a person employed by the Employer.

**Employer**: Means Drury University.

**Expenses Incurred**: Means charges for purchases or services rendered. An expense will be deemed to be incurred on the day the purchase is made or on the day the service is rendered for which the charge is made.

**Experimental Treatment**: Means drugs, medical supplies, medical devices, medical equipment, medical or surgical procedures, treatments or services which do not meet accepted standards of medical practice. A drug, device, treatment, or procedure is considered to be Experimental and/or investigational:
(a) if the device, drug, treatment, or procedure has not received the approval or endorsement of the American Medical Association (AMA), U.S. Food and Drug Administration (FDA) or the National Institute of Health (NIH) at the time the device, drug, or procedure was furnished; or

(b) if reliable evidence demonstrated that the device, drug, treatment, or procedure is the subject of ongoing Phase I, II, or III Clinical Trials or is under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy as compared with standard means of treatment or diagnosis; or

(c) if reliable evidence demonstrates that a consensus of opinion among medical experts regarding the device, drug, treatment or procedure is that further studies or Clinical Trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with the standard of treatment or diagnosis.

Reliable evidence means only published reports and articles in authoritative medical and scientific literature, the written protocol(s) used by the treating facility, the protocol(s) of another facility studying substantially the same device, drug, treatment or procedure, or the written informed consent used by the treating facility or another facility studying substantially the same device, drug, treatment or procedure.

**Full-Time Employee**: Means a person who is scheduled to work at least forty (40) hours per week, works for the Employer for at least nine (9) months each calendar year, and who is on the regular payroll of the Employer, and specifically excludes temporary, seasonal or part-time employees.

**Full-Time Student**: Means an unmarried child under the age of twenty-six (26) who is a registered student for full-time attendance at an accredited high school, college or similar institution of learning. A class schedule indicating full-time status or a letter from the institution(s) being attended which indicates full-time status. Coverage shall continue in effect until the conclusion of the semester or quarter, except in the following situations:

(a) In the case of a full-time student who turns age twenty-six (26) while covered under the Plan, coverage will end as of the last day of the month the student reaches the age of twenty-six (26).

(b) In the event that a student marries, coverage will end as of the date of marriage.

(c) In the event a student drops below the minimum number of hours to be considered full-time by the institution the child is attending or if the child ceases to be a student altogether (voluntarily or involuntarily), coverage will cease as of the last day of the month the child is considered a full-time student by the institution the child was attending, or, if on a Medically
Necessary Leave of Absence, the date the Medically Necessary Leave of Absence terminates.

(d) If the Employer obtains information regarding cessation of eligibility and benefits have been provided for the period of ineligibility, the Employer may terminate coverage retroactive to the first date of ineligibility and pursue recovery of benefits paid for that period.

Documentation of continued eligibility must be provided by the student or parent/guardian on behalf of the student for each period of attendance that coverage is requested.

**Home Health Care Agency:** Means an organization, or its distinct part, which:

(a) is primarily engaged in providing skilled nursing care and other therapeutic services for, and in the private residences of, persons recovering from Sickness or Injury;

(b) qualifies as a home health care agency under Medicare and is licensed or approved according to any applicable state or local standards and is operated pursuant to policies established by a professional staff, including at least one (1) Physician and one (1) Registered Nurse;

(c) provides full-time supervision of its services by a Physician or Registered Nurse, and maintains clinical records on all of its patients;

(d) has a full-time administrator; and

(e) is not, other than incidentally, engaged in providing care or treatment of the mentally ill, or in providing custodial type care.

**Home Health Care Plan:** Means a program of continued care and treatment for a Covered Person or Covered Dependent, established and approved in writing by the Physician of the Covered Person or Covered Dependent. The program must be accompanied by the Physician's certification that the proper treatment of the Sickness or Injury would require confinement as a Hospital inpatient in the absence of the services and supplies provided as part of the Home Health Care Plan.

**Hospice:** Means an entity licensed, approved or authorized to provide inpatient and at home medical relief of pain and supportive care to terminally ill persons. An inpatient facility must have on its premises:

(a) organized facilities to care for and treat terminally ill persons; and

(b) a paid staff of medical professionals to supervise such care and treatment.
Hospital: Means an institution constituted and operated in accordance with the laws pertaining to Hospitals, equipped with permanent facilities for diagnosis, Surgery, twenty-four (24) hour continuous nursing service by Registered Nurses, and a staff of one or more Physicians licensed to practice medicine available at all times for compensation, and provides for medical and surgical treatment for Injury and Sickness on an inpatient basis. The term Hospital does not include a facility specializing in dentistry or an institution which is, other than incidentally, a place for rest, a place for the aged, a place for drug addicts, a place for alcoholics, a convalescent home or a nursing home.

Hospital Confinement/Admission: Means being registered as a bed patient in a Hospital upon the recommendation of a Physician, or as a patient in a Hospital because of a surgical operation, or as a patient receiving emergency care in a Hospital for an Injury.

Immediate Family: Means a person's spouse, parent, step-parent, sibling, child, grandparent, or in-law.

Injury: Means accidental bodily injury of a Covered Person or Covered Dependent. All Injuries sustained by a Covered Person or Covered Dependent in connection with a single accident shall be considered one Injury.

Intensive Care Unit: Means a section, ward or wing within the Hospital which is separated from other Hospital facilities and:

(a) is operated exclusively for the purpose of providing professional care and treatment for critically ill patients;

(b) has special supplies and equipment, necessary for such care and treatment, available on a standby basis for immediate use; and

(c) provides Room and Board and constant observation and care by Registered Nurses or other specially trained Hospital personnel.

Key Employee: Means a salaried Employee eligible for leave under the Family and Medical Leave Act of 1993 who is among the highest paid ten percent (10%) of all the Employees employed by the Employer within seventy-five (75) miles of the Employee's worksite.

Licensed Practical Nurse: Means an individual who has received specialized nursing training and practical nursing experience and who is licensed to perform nursing service by the state in which he performs such service, other than one who ordinarily resides in the patient's home or who is a member of the patient's Immediate Family.

Medically Necessary: Means health care services, supplies or treatment which are appropriate and consistent with the diagnosis and which, in accordance with generally
accepted medical standards, could not have been omitted without adversely affecting the patient's condition or the quality of medical care rendered.

Medically Necessary Leave of Absence: Means a leave of absence of a Covered Dependent child age nineteen (19) or over from a postsecondary educational institution or institution of higher education that (i) commences while such child is suffering from a serious Sickness or Injury, (ii) is certified in writing by treating Physician as suffering from a serious Sickness or Injury and that the leave of absence from the postsecondary educational institution or institution of higher education is medically necessary, and (iii) terminates upon the earlier of (a) the date the leave of absence no longer meets the requirements of (i) or (ii) above, (b) the date the child is no longer an Eligible Dependent for a reason other than the leave of absence described in this paragraph, or (c) the date one (1) year from the commencement of the leave of absence.

Mental Illness: Means those illnesses classified as mental disorders in Section II of the edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association which is current as of the date services are rendered to a patient.

Necessary Services and Supplies: Means any charges made by a Hospital on its own behalf for necessary medical services and supplies actually administered during any Hospital Confinement/Admission other than charges for Room and Board, Intensive Care Unit, private duty nursing or Physician's services.

Oral Surgery: Means:

(a) surgical removal of impacted teeth;

(b) excision of tumors or cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth;

(c) surgical procedures to correct accidental Injuries of the jaws, cheeks, lips, tongue, roof and floor of the mouth, provided that the procedures are completed within twelve (12) months of the accident; and

(d) excision of exostoses of the jaws and hard palate (provided that this procedure is not done in preparation for dentures or other prostheses); treatment of fractures of facial bone; external incision and drainage of cellulitis; incision of accessory sinuses, salivary glands or ducts.

Out-Patient Treatment: Means treatment at a Hospital not requiring confinement and not involving a charge for Room and Board.

Physician: Means a practitioner of the healing arts who is duly licensed in the state where he is practicing and who is treating within the scope and limitation of that license. The term Physician includes, but is not limited to, Doctor of Medicine (M.D.), Doctor of
Osteopathy (D.O.), Chiropractor, Licensed Consulting Psychologist, Licensed Psychologist, Licensed Clinical Social Worker, Occupational Therapist, Optometrist, Ophthalmologist, Physical Therapist, Podiatrist, Registered Nurse (R.N.), Licensed Practical Nurse (L.P.N.), Speech Therapist, Speech Pathologist, and Licensed Midwife. An employee of a Physician who provides services under the direction and supervision of such Physician will also be deemed to be an eligible provider under the Plan. The term Physician will not include the Covered Person, nor his spouse, children, brothers, sisters, or parents; nor any person residing in his household.

**Post-Service Claim:** Means any claim for a benefit under the Plan that is not a Pre-Service Claim.

**Pre-Existing Condition:** Means a condition for which a medical expense was incurred or for which such person received medical care, treatment, consultation, diagnosis, diagnostic testing, advice, services, supplies or took prescribed drugs or medications, during the six (6) month period ending on the Eligibility Date of such person’s coverage under the Plan, or on the first day of a waiting period for coverage, if earlier. A waiting period shall mean the period that must pass with respect to an individual before the individual is eligible for benefits under the Plan. Birth defects in an Eligible Dependent who is a child shall not be considered a Pre-Existing Condition.

**Pre-Service Claim:** Means any claim for a benefit under the Plan with respect to which the terms of the Plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of receiving medical care.

**Qualified Clinical Trials:** A Qualified Clinical Trial is defined as a clinical that meets all of the following:

(a) The clinical trial is intended to treat cancer in a patient who has been so diagnosed;

(b) The clinical trial has been peer reviewed and is approved by at least one of the following;

(1) One of the United States National Institutes of Health;

(2) A cooperative group or center of the National Institutes of Health;

(3) A qualified non-governmental research entity identified in guidelines issued by the National institutes of Health for center support grants;

(4) The United States Food and Drug Administration pursuant to an investigational new drug exemption;

(5) The United States Departments of Defense or Veterans Affairs;
(6) Or, with respect to Phase II, III and IV clinical trials only, a qualified institutional review board.

(c) The facility and personnel conducting the clinical trial are capable of doing so by virtue of their experience and training and treat a sufficient volume of patients to maintain that expertise;

(d) The patient meets the patient selection criteria enunciated in the study protocol for expertise;

(e) The patient has provided informed consent for participation in the clinical trial in a manner that is consistent with current legal and ethical standards;

(f) The available clinical or pre-clinical data provide a reasonable expectation that the patient's participation in the clinical trial will provide a medical benefit that is commensurate with the risks of participation in the clinical trial;

(g) The clinical trial does not unjustifiably duplicate existing studies; and

(h) The clinical trial must have a therapeutic intent and must, to some extent, assess the effect of the intervention on the patient.

**Reasonable and Customary:** Means charges made for medical services or supplies essential to the care of an individual which are the amount normally charged by the provider for similar services and supplies and do not exceed the amount ordinarily charged by most providers of comparable services and supplies in the locality where the services or supplies are received for Sickness or Injury comparable in severity to the Sickness or Injury being treated.

**Registered Nurse:** Means a professional nurse who has the right to use the title Registered Nurse (R.N.) other than one who ordinarily resides in the patient's home or who is a member of the patient's Immediate Family.

**Retired Employee:** Means a retiree of the Employer who on the date of such person's retirement (i) has attained age fifty-five (55) and (ii) has completed at least ten (10) consecutive years of service with the Employer immediately preceding his retirement or sum of employees years of service and age totals seventy-six (76).

**Room and Board:** Means all charges commonly made by a Hospital or other facility on its own behalf for room and meals and for all general services and activities essential to the care of registered bed patients.

**Sickness:** Means disease, mental, emotional or nervous disorders of a Covered Person or Covered Dependent. It also includes the pregnancy of a Covered Person or Covered Dependent.
Skilled Nursing Facility: Means an institution, or a distinct part thereof, which is licensed pursuant to state and local laws and is operated primarily for the purpose of providing skilled nursing care and treatment for individuals convalescing from Injury or Sickness, and:

(a) is approved by and is a participating Skilled Nursing Facility of Medicare;

(b) has organized facilities for medical treatment and provides twenty-four (24) hour nursing service under the full-time supervision of a Physician or Registered Nurse;

(c) maintains daily clinical records on each patient and has available the services of a Physician under an established agreement; and

(d) has transfer arrangements with one or more Hospitals, a utilization review plan in effect and operational policies developed with the advice of, and reviewed by, a professional group including at least one Physician.

This definition does not include an institution operated primarily for care of the aged, or for treatment of mental disease, drug addiction, alcoholism or custodial care.

Substance Abuse: Means uncontrollable or excessive abuse of any addictive substance and the resultant physiological or psychological dependence which develops with continued use, requiring medical treatment as determined by a Physician.

Substance Abuse Treatment Facility: Means a facility (other than a Hospital) whose primary function is the treatment of alcohol and Substance Abuse and which is duly licensed by the appropriate state and local authority to provide such services.

Surgery: Means operative or cutting procedures including specialized instrumentations and the correction of fractures or complete dislocations.

**YOUR RIGHTS UNDER ERISA**

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:

(a) Receive Information About Your Plan and Benefits

Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.
Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, 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 plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

(b) Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the 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 plan on the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the 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 twenty-four (24) months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for twelve (12) months (18 months for late enrollees) after your enrollment date in your coverage.

(c) Prudent Actions by Plan Fiduciaries

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 benefit or exercising your rights under ERISA.

(d) Enforce Your Rights

If your claim for a 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 plan documents or the latest annual report 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 $110 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. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in 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 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, for example, if it finds your claim is frivolous.

(e) Assistance with Your Questions

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, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits 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 Pension and Welfare Benefits Administration.

DRURY UNIVERSITY

By: _______________________

Its: _______________________

Dated: _______________________

510-171.d4
ADDENDUM A

PRESCRIPTION DRUG CARD PLAN

BENEFITS

For

EMPLOYEES OF

DRURY UNIVERSITY
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I. **INTRODUCTION:**

The purpose of the Plan is to enable Eligible Persons to purchase Covered Drugs from a Pharmacy or through the Mail Order Program by paying only a portion (the Copayment Amount) of the full price of the particular drug. Covered Drugs are purchased from a Pharmacy by presenting to the Pharmacy both a Prescription Order (unless a refill) for the Covered Drugs and an Identification Card. Covered Drugs are obtained from the Mail Order Program by completing the Registration & Prescription Order Form available from the Contract Administrator and mailing the Form to Pharmacy Benefit Manager. The Plan will be responsible for payment of all amounts in excess of the Copayment Amount. Without the Plan, Covered Drugs could only be purchased by paying full price, which in most cases would be more than the Copayment Amount.

II. **ELIGIBILITY AND PLAN PARTICIPATION:**

1. **Eligibility Requirements.**

You and your Dependents will be eligible to participate in the Plan when you and your Dependents have satisfied the eligibility requirements for benefits under the terms of the Health Plan.

2. **Participation.**

You and your Dependents will begin participation on the first day which you and your Dependents have met the eligibility requirements. When you become a Participant in the Plan, the Employer will issue you an Identification Card. You must present your Identification Card at the time you purchase Covered Drugs from a Pharmacy in order to take advantage of the Plan's benefits.

III. **DEFINITIONS:**

**CODE** - Means the Internal Revenue Code of 1986, as amended from time to time.

**COPAYMENT AMOUNT** - Means the amount which an Eligible Person is required to pay for a Covered Drug in accordance with the Health Plan.

**COVERED DRUG** - Means any Prescription Legend Drug and such other drugs as may be set forth from time to time on the listing maintained by Pharmacy Benefit Manager and made a part of the Plan, when ordered by a Physician by means of a Prescription Order.

**DEPENDENT** - Means an individual who meets the definition of a Covered Dependent as set forth in the Health Plan.
**ELIGIBLE PERSON** - Means an individual described in an Identification Card who is entitled to Covered Drug expense benefits in accordance with and under the terms of the Plan, and his/her Dependents.

**EMPLOYEE** - Means a person employed by the Employer.

**EMPLOYER** - Means Drury University.

**HEALTH PLAN** - Means the Drury University Employee Healthcare Plan.

**IDENTIFICATION CARD** - Means a card or cards issued as proof of eligibility for Covered Drug expense benefits in accordance with and under the terms of the Plan.

**PARTICIPANT** - Means an Employee who has satisfied the Eligibility Requirements and has elected to participate in the Plan.

**PHARMACY** - Means a pharmacy doing business as a licensed pharmacy under an applicable state license or registration number and which has entered into a Prescription Drug Agreement with Pharmacy Benefit Manager.

**PRESCRIPTION LEGEND DRUG** - Means any medicinal substance the label of which is required by the Federal Food, Drug and Cosmetic Act to bear the legend--"Caution: Federal Law prohibits dispensing without prescription."

**PRESCRIPTION ORDER** - Means a request for medication by a Physician.

**PHYSICIAN** - Means a doctor of medicine, a doctor of osteopathy, a doctor of dental surgery, a doctor of dental medicine or a podiatrist, who is legally licensed to prescribe medications within the scope of that license.

**IV. BENEFITS**

Each Eligible Person may purchase Covered Drugs from a Pharmacy by presenting their Identification Card and paying the applicable Copayment Amount. Covered Drugs may be purchased from those Pharmacies listed on the Participating Pharmacy Listing, a copy of which may be reviewed at the location of the Contract Administrator, or at such other sites as the Contract Administrator deems necessary. Pharmacies may be added to or deleted from the Participating Pharmacy Listing from time to time.

Covered Drugs are obtained from the Mail Order Program by completing the Registration & Prescription Order Form available from the Contract Administrator and mailing the Form to Pharmacy Benefit Manager.
The Pharmacy Program has three parts:

- **Retail Pharmacy Benefit** – Choose from thousands of participating pharmacies nationwide to obtain up to a 30 day supply.
- **90-Day Retail Medication Program** – Get a 90-day supply of your maintenance medications from select retail locations.
- **Mail Service Pharmacy Benefit** – Order your 90-day supply prescriptions and have them delivered right to your door.

If you have questions, please contact the Pharmacy Benefit Manager at the number listed on the back of your identification card and a Member Services professional can assist you 24 hours a day and seven days a week.

**Preferred Drug List (PDL)**

The Preferred Drug List (also referred to as a formulary) is a list of preferred drugs. Show the PDL to your doctor, when your doctor prescribes a drug from the list, it can help you make the most out of your pharmacy plan benefits and control your prescription medication costs. You can use the PDL to learn about medication alternatives, such as generics that may reduce your copayments. All of the specially selected medications listed on the PDL have received the U.S. Food and Drug Administration (FDA) approval as safe and effective. The PDL does not imply drug coverage. To verify if a specific drug is covered under the Plan, please contact the Pharmacy Benefit Manager Customer Care Center toll free 24 hours a day, 7 days a week at the number listed on the back of your identification card.

**Your Cost**

When your covered prescriptions are filled under this program, you share a portion of the cost; the plan pays for the rest as outlined in the summary of benefits.

**CLINICAL PRIOR AUTHORIZATION PROGRAM**

Certain prescriptions require “clinical prior authorization” (CPA) or approval, before they will be covered. The categories/medications that required CPA may include, but are not limited to, Acne Topical, ADHD/Narcolepsy (Attention Deficit Disorder), Anabolic Steroids (Injectable), Anabolic Steroids (Oral), Anabolic Steroids (Topical); Synthetic Male Hormones, Antimetics Oral (Anti-Nausea), Botulinum Toxins (Injectables (Botox), Crinone 8% (Infertility), Gleevac™ (Leukemia) GnRH Analog (Prostate/Breast Cancer and Infertility), Lamisil/Sporanox Oral (Antifungal), Migraine (Headaches when exceeding quantity limits), and Wellbutrin SR (Antidepressant).

To confirm whether you need a clinical prior authorization and/or to request approval, call 1-800-997-3784. Please have available the name of your medication, physician's name, phone (and fax, if available), your member ID number, and your group number (from your ID card).
STEP CARE THERAPY

The Step Care program encourages appropriate utilization by requiring the use of prerequisite drugs that meet specific conditions prior to the coverage of other drugs. Your plan requires this program to be in place for the following categories, but are not limited to: COX 2 Inhibitors, which are anti-arthritic medications such as Celebrex, this program may require you first use lower cost Non-Steroidal Anti-Inflammatory Drug Syndrome (NSAIDS), medications such as ibuprofen, Prilosec OTC and generic omeprazole and other proton-pump inhibitors, used to treat gastrointestinal disorders (the program requires that you first use the lower cost over-the-counter products), Leukotreine Antagonists (Singulair, Accolate, and Zyflo) are FDA approved for the treatment of asthma, Singulair is the only agent of this class, to date, to receive an indication for the treatment of allergic rhinitis, and Claritin OTC, because of the comparable efficacy the use of the OTC Claritin/Claritin-D, this program will encourage the use of OTC Non-Sedating Antihistamines (NSA) products as the first line therapy. If you have any questions regarding step care therapy, please contact the Pharmacy Benefit Manager Customer Care Center at the number listed on the back of your identification card.

SPECIALTY PHARMACY
HEALTH MANAGEMENT PROGRAM

The Specialty Pharmacy Program offers extensive, patient-focused services that promote compliance to drug therapy and the prevention of costly health complications. Pharmacy Benefit Manager Specialty Pharmacy currently offers its Health Management Program for Ankylosing Spondylitis, Cystic Fibrosis, Growth Hormone Deficiency, HIV/AIDS, Multiple Sclerosis, Psoriasis, Rheumatoid Arthritis and Viral Hepatitis. The program provides enrolled patients with confidential counseling, education materials, side-effect management, refill assistance, and compliance monitoring.

The specialty pharmacy clinical call center is staffed by registered and certified pharmacy technicians. Pharmacists are available 24 hours a day, 7 days a week to respond to questions about medications and health conditions. You may contact them at 1-888-782-8443.

V. PENALTIES FOR IMPROPER USE:

Eligible Persons may not use their Identification Cards to obtain Covered Drugs after having received notification of the cancellation of their benefits or for persons other than Eligible Persons. Any Eligible Person who makes an improper use of his Identification Card may be guilty of a Class C misdemeanor in accordance with the provisions of Section 512-8(c) of the Illinois Insurance Code and may be liable to the Administrator or Employer for amounts the Contract Administrator or Employer has paid as a result of any improper use of his Identification Card.
The Contract Administrator may request such amounts be paid immediately, and, if not paid when due, may take appropriate action to recover such amounts.

VI. CLAIMS:

1. Filing of a Claim.

There may be certain instances in which an Eligible Person cannot use the Identification Card to receive prescription drug benefits from a Pharmacy. At those times, a claim may be submitted in accordance with the Claim Provisions Section set forth in the Health Plan for consideration of expenses incurred that exceed the Copayment Amount. The claim for prescription drug benefits must have the following information:

   (a) the name of the patient;
   (b) the Employee’s name and social security number;
   (c) the name of the Pharmacy dispensing the drug;
   (d) the name, strength, and quantity of the drug dispensed;
   (e) the date the drug was dispensed; and
   (f) the price of the drug.

2. Denial of Claims.

If your claim for benefits is denied, the Claim Section Provisions of the Health Plan sets forth your rights regarding claims review procedures.

VII. GENERAL:

1. Questions/Forms/Information.

Any questions, requests for forms, or other inquiries should be directed to the Contract Administrator or the Employer.

2. Nondiscrimination.

It is the intent of the Employer that the Plan not discriminate in favor of any Employee or group of Employees. If the Employer determines that the Plan is discriminatory, the Employer shall select and exclude from coverage under the Plan such Participants, or reduce the contributions and/or benefits of such Participants, as shall be necessary to comply with the nondiscrimination provisions of the Code.
ADDENDUM B
(Effective Prior to September 1, 2011)
COBRA PREMIUM REDUCTION PROVISIONS UNDER ARRA

The American Recovery and Reinvestment Act of 2008 ("ARRA") modifies COBRA rights and responsibilities otherwise set forth in the Plan in the manner described below. The ARRA gives "Assistance Eligible Individuals" the right to pay reduced COBRA premiums for periods of coverage beginning on or after February 17, 2009 and can last up to fifteen (15) months. If you qualify for reduced premiums, you need only pay thirty-five percent (35%) of the COBRA premium otherwise due under the Plan.

To be considered an "Assistance Eligible Individual" and get reduced premiums you:

(a) MUST be eligible for continuation coverage at any time during the period from September 1, 2008 through May 31, 2010 and elect the coverage;

(b) MUST have a continuation coverage election opportunity related to an involuntary termination of employment that occurred at some time from September 1, 2008 through May 31, 2010;

(c) MUST NOT be eligible for Medicare; and

(d) MUST NOT be eligible for coverage under any other group health plan, such as a plan sponsored by a successor employer or a spouse's employer.*

Individuals who experienced a qualifying event as the result of an involuntary termination of employment at any time from September 1, 2008 through February 16, 2009 and were offered, but did not elect, continuation coverage OR who elected continuation coverage and subsequently discontinued it may have the right to an additional sixty (60) day election period.

IMPORTANT

If, after you elect COBRA and while you are paying the reduced premium, you become eligible for other group health plan coverage or Medicare you MUST notify the COBRA Administrator in writing. If you do not, you may be subject to a tax penalty.

* Generally, this does not include coverage for only dental, vision, counseling, or referral services; coverage under a health flexible spending arrangement; or treatment that is furnished in an on-site medical facility maintained by the employer.
ELECTING THE PREMIUM REDUCTION DISQUALIFIES YOU FOR THE HEALTH COVERAGE TAX CREDIT. IF YOU ARE ELIGIBLE FOR THE HEALTH COVERAGE TAX CREDIT, WHICH COULD BE MORE VALUABLE THAN THE PREMIUM REDUCTION, YOU WILL HAVE RECEIVED A NOTIFICATION FROM THE IRS.

THE AMOUNT OF THE PREMIUM REDUCTION IS RECAPTURED FOR CERTAIN HIGH INCOME INDIVIDUALS. IF THE AMOUNT YOU EARN FOR THE YEAR IS MORE THAN $125,000 (OR $250,000 FOR MARRIED COUPLES FILING A JOINT FEDERAL INCOME TAX RETURN) ALL OR PART OF THE PREMIUM REDUCTION MAY BE RECAPTURED BY AN INCREASE IN YOUR INCOME TAX LIABILITY FOR THE YEAR. IF YOU THINK THAT YOUR INCOME MAY EXCEED THE AMOUNTS ABOVE, YOU MAY WISH TO CONSIDER WAIVING YOUR RIGHT TO THE PREMIUM DEDUCTION. FOR MORE INFORMATION, CONSULT YOUR TAX PREPARER OR VISIT THE IRS WEBPAGE ON ARRA AT [www.irs.gov](http://www.irs.gov).

IF YOU HAD EXHAUSTED THE NINE (9) MONTH REDUCED PREMIUM PERIOD OF PRIOR LAW BEFORE DECEMBER 19, 2009, YOU WILL HAVE A GRACE PERIOD TO PAY THE PREMIUM REDUCTION AMOUNTS FOR TIME PERIODS AFTER THAT DATE UNTIL THE LATER OF FEBRUARY 17, 2010 OR, IF LATER, THIRTY (30) DAYS AFTER NOTICE OF THE EXTENSION TO FIFTEEN (15) MONTHS IS PROVIDED BY THE PLAN ADMINISTRATOR.

FOR GENERAL INFORMATION REGARDING THE PLAN’S COBRA COVERAGE YOU CAN CONTACT THE COBRA ADMINISTRATOR.

FOR SPECIFIC INFORMATION RELATED TO THE PLAN’S ADMINISTRATION OF THE ARRA PREMIUM REDUCTION OR TO NOTIFY THE PLAN OF YOUR INELIGIBILITY TO CONTINUE PAYING REDUCED PREMIUMS, CONTACT THE COBRA ADMINISTRATOR.

IF YOU ARE DENIED TREATMENT AS AN “ASSISTANCE ELIGIBLE INDIVIDUAL” YOU MAY HAVE THE RIGHT TO HAVE THE DENIAL REVIEWED. FOR MORE INFORMATION REGARDING REVIEWS OR FOR GENERAL INFORMATION ABOUT THE ARRA PREMIUM REDUCTION GO TO:

[www.dol.gov/COBRA](http://www.dol.gov/COBRA) OR CALL 1-866-444-EBSA (3272)