DRURY UNIVERSITY

EMPLOYEE HEALTHCARE PLAN

This Plan is written, adopted and operative under the provisions of the Employee Retirement Income Security Act of 1974, as may be amended, and for the sole and exclusive purpose of providing to the Eligible Employees and their Eligible Dependents employee welfare benefits as described herein.

The Plan agrees to provide the Benefits set forth in the Schedule of Benefits to all Covered Persons in accordance with the provisions and conditions of the Plan.

The Plan is subject to all the conditions and provisions set forth in this document and subsequent amendments which are made a part of this Plan.

Drury University has caused this REVISED Plan to take effect as of 12:01 a.m., local time on June 1, 2006 at Springfield, MO.

___________________________________________ _____________________________
Authorized Signature    Date  Title

___________________________________________ _____________________________
Witness       Date   Title
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</tr>
</thead>
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</tbody>
</table>
### GENERAL INFORMATION

| **Name of Plan:** | Drury University  
|                  | Employee Healthcare Plan |
| **Type of Plan:** | Self-funded Welfare Plan |
| **Plan Number:** | 501 |
| **Plan Administrator:** | Drury University  
|                  | 900 North Benton Avenue  
|                  | Springfield, MO  65802 |
| **Group Number:** | 10845 |
| **Employer Tax ID Number:** | 20-1152045 |
| **Plan Effective Date:** | June 1, 2003  
| **Plan Revised Date:** | June 1, 2006 |
| **Plan Renewal Date:** | June 1 |
| **Plan Year Ends:** | May 31 |
| **Agent for Legal Service:** | Drury University  
|                  | 900 North Benton Avenue  
|                  | Springfield, MO  65802 |
| **Contract Administrator:** | Corporate Benefit Services of America, Inc.  
|                  | P.O. Box 27267  
|                  | Minneapolis, MN 55427-0267  
|                  | (952) 546-0062  
|                  | (800) 925-2272 |
| **Contributions:** | Employer pays the cost of employee coverage. Employer and employee share in the cost of dependent coverage. |
| **Funding:** | Coverage for employees and their eligible dependents are paid in part by the Employer out if its general assets and in part by employees’ payroll deductions (contributions). |
| **Effective Date of Coverage:** | First of the month following full-time employment. |
| **Termination Date of Coverage:** | The last day of the month in which the employee terminated. |
**IMPORTANT:** Guided2Health℠ must pre-certify all Inpatient stays (including acute Inpatient rehabilitation and subacute care provided in a facility that has nursing staff on-site 24 hours a day, 7 days a week, and a Physician on call 24 hours a day, 7 days a week), Inpatient Rehabilitation Facility and Chemical Dependency confinements. Pre-certification is also required for the following outpatient procedures if they are performed in a Hospital or Ambulatory Surgical Facility and/or there is an operating room charge: Cholecystectomy (Laparoscopic), Hysterectomy (patient younger than 30), Nasal Septoplasty, Rhinoplasty, MRA of the head and/or neck, MRI of the brain and/or spine, and PET scans. See Cost Management Services section of the Plan for details on Pre-Certification. If these procedures are not followed, eligible expenses will be reduced by 50% per individual.

---

### SCHEDULE OF BENEFITS

**HEALTH LINK OPEN ACCESS PLAN**

<table>
<thead>
<tr>
<th>CALENDAR YEAR</th>
<th>HMO PROVIDERS</th>
<th>PPO PROVIDERS</th>
<th>NON-PPO PROVIDERS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DEDUCTIBLE</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>$250</td>
<td>$500</td>
<td>$1,000</td>
</tr>
<tr>
<td>Family</td>
<td>$500</td>
<td>$1,000</td>
<td>$2,000</td>
</tr>
</tbody>
</table>

### MEDICAL BENEFITS AFTER THE DEDUCTIBLE

**Routine Care**

- **Primary Care Physician**
  - $15 Co-pay, then 80%; Deductible waived
- **Specialist**
  - $30 Co-pay, then 80%; Deductible waived

**Routine Eye Exams**

(includes refractions)

- $15 Co-pay, then 80%; Deductible waived

**Routine Hearing Exams**

- $15 Co-pay, then 80%; Deductible waived
<table>
<thead>
<tr>
<th>Service</th>
<th>HMO PROVIDERS</th>
<th>PPO PROVIDERS</th>
<th>NON-PPO PROVIDERS (Subject to Usual and Customary Charges)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Physician Office Visits</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(office visit charge only)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary Care Physician</td>
<td>$15 Co-pay, 80% then 100% Deductible waived</td>
<td>60%</td>
<td></td>
</tr>
<tr>
<td>Specialist</td>
<td>$30 Co-pay, 80% then 100% Deductible waived</td>
<td>60%</td>
<td></td>
</tr>
<tr>
<td><strong>Outpatient LabOne Services</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>100%; Deductible waived</td>
<td>100%; Deductible waived</td>
<td>100%; Deductible waived</td>
</tr>
<tr>
<td><strong>NOTE:</strong> The use of the LabOne program is strictly voluntary. If a Covered Person uses the services of LabOne, the Plan will pay 100% of the eligible charges a Covered Person incurs for outpatient laboratory services, and will waive any of this Plan’s Deductible and Co-insurance requirements which otherwise would have applied to such charges. See the Diagnostic Testing, X-ray and Laboratory Services benefit under <strong>Eligible Expenses</strong> for further details of this program.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Urgent Care Facility</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary Care Physician</td>
<td>$15 Co-pay, 80% then 100% Deductible waived</td>
<td>60%</td>
<td></td>
</tr>
<tr>
<td>Specialist</td>
<td>$30 Co-pay, 80% then 100% Deductible waived</td>
<td>60%</td>
<td></td>
</tr>
<tr>
<td><strong>Emergency Room Services</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>$100 Co-pay, then Deductible, then 90%</td>
<td>$100 Co-pay, then Deductible, then 80%</td>
<td>$100 Co-pay, then Deductible, then 60%</td>
</tr>
<tr>
<td><strong>NOTE:</strong> The Emergency Room Co-pay will be waived if admitted as an Inpatient.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Hospital Services
(facility charges only)

<table>
<thead>
<tr>
<th></th>
<th>HMO PROVIDERS</th>
<th>PPO PROVIDERS</th>
<th>NON-PPO PROVIDERS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Inpatient</strong></td>
<td>$200 Co-pay per admission, then Deductible, then 90%</td>
<td>$400 Co-pay per admission, then Deductible, then 80%</td>
<td>$600 Co-pay per admission, then Deductible, then 60%</td>
</tr>
<tr>
<td><strong>Outpatient</strong></td>
<td>$100 Co-pay* per occurrence, then Deductible, then 90%</td>
<td>$200 Co-pay* per occurrence, then Deductible, then 80%</td>
<td>$300 Co-pay* per occurrence, then Deductible, then 60%</td>
</tr>
</tbody>
</table>

* Co-pay does not apply to outpatient therapies.

### Ambulatory Surgical Facility
(includes all related charges)

<table>
<thead>
<tr>
<th></th>
<th>HMO PROVIDERS</th>
<th>PPO PROVIDERS</th>
<th>NON-PPO PROVIDERS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Inpatient</strong></td>
<td>$100 Co-pay per occurrence, then Deductible, then 90%</td>
<td>$200 Co-pay per occurrence, then Deductible, then 80%</td>
<td>$300 Co-pay per occurrence, then Deductible, then 60%</td>
</tr>
<tr>
<td><strong>Ambulance Services</strong></td>
<td>80%</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td><strong>Allergy Injections</strong></td>
<td>90%; Deductible waived</td>
<td>80%; Deductible waived</td>
<td>60%; Deductible waived</td>
</tr>
<tr>
<td><strong>Chiropractic Care</strong></td>
<td>90%</td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td><strong>Calendar Year Maximum Benefit</strong></td>
<td>$500</td>
<td>$500</td>
<td>$500</td>
</tr>
</tbody>
</table>

### Outpatient Therapies
(e.g. physical, speech and occupational therapy)

<table>
<thead>
<tr>
<th></th>
<th>HMO PROVIDERS</th>
<th>PPO PROVIDERS</th>
<th>NON-PPO PROVIDERS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Inpatient</strong></td>
<td>$25 Co-pay, then 100%; Deductible waived</td>
<td>$25 Co-pay, then 100%; Deductible waived</td>
<td>No Coverage</td>
</tr>
<tr>
<td><strong>Calendar Year Maximum Benefit</strong></td>
<td>$200</td>
<td>$200</td>
<td></td>
</tr>
</tbody>
</table>
Mental/Nervous Disorders
and Chemical Dependency
Treatment

**Inpatient**

<table>
<thead>
<tr>
<th>HMO PROVIDERS</th>
<th>PPO PROVIDERS</th>
<th>NON-PPO PROVIDERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>$200 Co-pay per admission, then Deductible, then 90%</td>
<td>$400 Co-pay per admission, then Deductible, then 80%</td>
<td>$600 Co-pay per admission, then Deductible, then 60%</td>
</tr>
</tbody>
</table>

**Outpatient**

<table>
<thead>
<tr>
<th>HMO PROVIDERS</th>
<th>PPO PROVIDERS</th>
<th>NON-PPO PROVIDERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>80%; Deductible waived</td>
<td>80%; Deductible waived</td>
<td>80%; Deductible waived</td>
</tr>
</tbody>
</table>

All Other Eligible Expenses

<table>
<thead>
<tr>
<th>HMO PROVIDERS</th>
<th>PPO PROVIDERS</th>
<th>NON-PPO PROVIDERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>90%</td>
<td>80%</td>
<td>60%</td>
</tr>
</tbody>
</table>

**CALENDAR YEAR OUT-OF-POCKET LIMIT**

(does not include Deductibles)

<table>
<thead>
<tr>
<th>HMO PROVIDERS</th>
<th>PPO PROVIDERS</th>
<th>NON-PPO PROVIDERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual $1,000</td>
<td>$2,000</td>
<td>$4,000</td>
</tr>
<tr>
<td>Family $2,000</td>
<td>$4,000</td>
<td>$8,000</td>
</tr>
</tbody>
</table>

NOTE: Expenses incurred for the following cannot be applied toward the Out-of-Pocket Limit: (1) Co-pays; (2) Deductibles; (3) any penalty amounts; and (4) any charges as defined in the Exclusions and Limitations section.

**BENEFIT ALLOWANCES - ALL PROVIDERS COMBINED**

**Hospital Expense Benefit**

<table>
<thead>
<tr>
<th>HMO PROVIDERS</th>
<th>PPO PROVIDERS</th>
<th>NON-PPO PROVIDERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Room and Board........................................................................</td>
<td>Semi-private room rate (private room when Medically Necessary)</td>
<td></td>
</tr>
<tr>
<td>Intensive Care Unit ...................................................................</td>
<td>Actual Charge</td>
<td></td>
</tr>
<tr>
<td>Miscellaneous Services and Supplies (does not include incremental nursing)</td>
<td>Usual and Customary Charge</td>
<td></td>
</tr>
</tbody>
</table>

**Extended Care Facility/Rehabilitation Facility**

<table>
<thead>
<tr>
<th>HMO PROVIDERS</th>
<th>PPO PROVIDERS</th>
<th>NON-PPO PROVIDERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calendar Year Maximum Benefit........................................</td>
<td>120 days</td>
<td></td>
</tr>
</tbody>
</table>

**Home Health Care**

<table>
<thead>
<tr>
<th>HMO PROVIDERS</th>
<th>PPO PROVIDERS</th>
<th>NON-PPO PROVIDERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calendar Year Maximum Benefit........................................</td>
<td>50 visits</td>
<td></td>
</tr>
<tr>
<td>Lifetime Maximum Benefit...............................................</td>
<td>$50,000</td>
<td></td>
</tr>
</tbody>
</table>
Private Duty Nursing
Calendar Year Maximum Benefit ................................................. 50 visits

Treatment of TMJ
Lifetime Maximum Benefit .......................................................... $5,000

Scalp Hair Prosthesis
 Lifetime Maximum Benefit .......................................................... $250

Transplants
Lifetime Maximum Benefit .......................................................... $300,000

Mental/Nervous Disorders and Chemical Dependency Treatment
Inpatient**
Combined Calendar Year Maximum Benefit ........................... 30 days***

Outpatient
Combined Calendar Year Maximum Benefit ........................... 20 visits

Chemical Dependency Treatment
Inpatient and Outpatient
Combined Lifetime Maximum Benefit .......................................... $50,000

** A program of Inpatient Chemical Dependency Treatment must be completed before Inpatient Chemical Dependency benefits will be payable under this Plan.

*** Two (2) days of partial hospitalization (minimum 6 hours to a maximum of 12 hours) will count as one day of confinement.

OVERALL LIFETIME MAXIMUM BENEFIT .......................................... $2,000,000
BENEFIT PROVISIONS

The Deductibles, Out-of-Pocket Limits and Maximums are combined for the HMO Providers, PPO Providers and the Non-PPO Providers.

A separate document may be obtained from the Plan Administrator showing the providers available within the Preferred Provider Network at no cost to the Covered Person.

PPO Providers are not subject to Usual and Customary Charges. Non-PPO Physician’s services are subject to Usual and Customary Charges and any charges in excess of Usual and Customary will not be considered eligible for payment.

It is recommended that those Covered Persons who are traveling outside their normal state of residence and need medical care or those Full-Time Students who reside outside the PPO Network and need medical care may call PHCS as shown on their ID card to receive benefits at their PPO Provider level.

Expenses which are incurred due to a Medical Emergency by a Non-PPO Provider will be paid at the PPO Provider level of benefits.

Professional services which are not available within the PPO Network will be paid at the PPO Provider level of benefits.

Medical supplies for which there is no network provider available will be paid at the PPO Provider level of benefits.

Individuals who are referred outside the PPO Network by a PPO Physician will have benefits paid at the Non-PPO Provider level of benefits, unless those services are not available in the PPO Network.

If a PPO Physician or PPO facility refers x-ray and laboratory services to a Non-PPO Provider, those services will be paid at the PPO Provider level of benefits.

Professional services which are provided by a Non-PPO Provider but rendered at a PPO facility will be paid at the PPO Provider level of benefits.

Expenses for obtaining medical records will be paid in full to a maximum benefit of $50 per provider.
IMPORTANT: Guided2Health℠ must pre-certify all Inpatient stays (including acute Inpatient rehabilitation and subacute care provided in a facility that has nursing staff on-site 24 hours a day, 7 days a week, and a Physician on call 24 hours a day, 7 days a week), Inpatient Rehabilitation Facility and Chemical Dependency confinements. Pre-certification is also required for the following outpatient procedures if they are performed in a Hospital or Ambulatory Surgical Facility and/or there is an operating room charge: Cholecystectomy (Laparoscopic), Hysterectomy (patient younger than 30), Nasal Septoplasty, Rhinoplasty, MRA of the head and/or neck, MRI of the brain and/or spine, and PET scans. See Cost Management Services section of the Plan for details on Pre-Certification. If these procedures are not followed, eligible expenses will be reduced by 50% per individual.

SCHEDULE OF BENEFITS

PHCS PLAN

<table>
<thead>
<tr>
<th></th>
<th>PPO PROVIDERS</th>
<th>NON-PPO PROVIDERS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>(Subject to Usual and Customary Charges)</td>
</tr>
<tr>
<td>CALENDAR YEAR DEDUCTIBLE</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>$500</td>
<td>$1,000</td>
</tr>
<tr>
<td>Family</td>
<td>$1,000</td>
<td>$2,000</td>
</tr>
<tr>
<td>MEDICAL BENEFITS AFTER THE DEDUCTIBLE</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Routine Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary Care Physician</td>
<td>80%</td>
<td>No Coverage</td>
</tr>
<tr>
<td>Specialist</td>
<td>80%</td>
<td>No Coverage</td>
</tr>
<tr>
<td>Routine Eye Exams</td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td>(includes refractions)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hearing Exams</td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td>Physician Office Visits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(office visit charge only)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary Care Physician</td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td>Specialist</td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td>Service</td>
<td>PPO PROVIDERS</td>
<td>NON-PPO PROVIDERS</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>---------------</td>
<td>-------------------</td>
</tr>
<tr>
<td><strong>Outpatient LabOne Services</strong></td>
<td>100%; Deductible waived</td>
<td>100%; Deductible waived</td>
</tr>
</tbody>
</table>

NOTE: The use of the LabOne program is strictly voluntary. If a Covered Person uses the services of LabOne, the Plan will pay 100% of the eligible charges a Covered Person incurs for outpatient laboratory services, and will waive any of this Plan’s Deductible and Co-insurance requirements which otherwise would have applied to such charges. See the Diagnostic Testing, X-ray and Laboratory Services benefit under **Eligible Expenses** for further details of this program.

<table>
<thead>
<tr>
<th>Facility</th>
<th>PPO PROVIDERS</th>
<th>NON-PPO PROVIDERS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Urgent Care Facility</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary Care Physician</td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td>Specialist</td>
<td>80%</td>
<td>60%</td>
</tr>
</tbody>
</table>

**Emergency Room Services**

$100 Co-pay, then subject to Deductible, then 80%; $100 Co-pay, then subject to Deductible, then 60%

NOTE: The Emergency Room Co-pay will be waived if admitted as an Inpatient.

<table>
<thead>
<tr>
<th>Service</th>
<th>PPO PROVIDERS</th>
<th>NON-PPO PROVIDERS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hospital Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(facility charges only)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient</td>
<td>$400 Co-pay per admission, then subject to Deductible, then 80%</td>
<td>$600 Co-pay per admission, then subject to Deductible, then 60%</td>
</tr>
<tr>
<td>Outpatient</td>
<td>$200 Co-pay* per occurrence, then subject to Deductible, then 80%</td>
<td>$300 Co-pay* per occurrence, then subject to Deductible, then 60%</td>
</tr>
</tbody>
</table>

* Co-pay does not apply to outpatient therapies.

<table>
<thead>
<tr>
<th>Service</th>
<th>PPO PROVIDERS</th>
<th>NON-PPO PROVIDERS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Ambulatory Surgical Facility</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(includes all related charges)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>$200 Co-pay per occurrence, then subject to Deductible, then 80%</td>
<td>$300 Co-pay per occurrence, then subject to Deductible, then 60%</td>
</tr>
</tbody>
</table>

**Ambulance Services**

80% 80%
<table>
<thead>
<tr>
<th>Service</th>
<th>PPO PROVIDERS</th>
<th>NON-PPO PROVIDERS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Allergy Injections</strong></td>
<td>80%; Deductible waived</td>
<td>60%; Deductible waived</td>
</tr>
<tr>
<td><strong>Chiropractic Care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Calendar Year Maximum Benefit</td>
<td>$500</td>
<td>$500</td>
</tr>
<tr>
<td><strong>Outpatient Therapies</strong></td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td>(e.g. physical, speech and occupational therapy)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Smoking Cessation</strong></td>
<td>$25 Co-pay, then 100%; Deductible waived</td>
<td>No Coverage</td>
</tr>
<tr>
<td>Calendar Year Maximum Benefit</td>
<td>$200</td>
<td></td>
</tr>
<tr>
<td><strong>Mental/Nervous Disorders and Chemical Dependency Treatment</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient</td>
<td>$400 Co-pay per admission, then 80%</td>
<td>$600 Co-pay per admission, then 60%</td>
</tr>
<tr>
<td>Outpatient</td>
<td>80%; Deductible waived</td>
<td>80%; Deductible waived</td>
</tr>
<tr>
<td><strong>All Other Eligible Expenses</strong></td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td><strong>CALENDAR YEAR OUT-OF-POCKET LIMIT</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(does not include Deductibles)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>$2,000</td>
<td>$4,000</td>
</tr>
<tr>
<td>Family</td>
<td>$4,000</td>
<td>$8,000</td>
</tr>
</tbody>
</table>

NOTE: Expenses incurred for the following cannot be applied toward the Out-of-Pocket Limit: (1) Co-pays; (2) Deductibles; (3) any penalty amounts; and (4) any charges as defined in the Exclusions and Limitations section.
BENEFIT ALLOWANCES - ALL PROVIDERS COMBINED

Hospital Expense Benefit
- Room and Board................................................................. Semi-private room rate
  (private room when Medically Necessary)
- Intensive Care Unit ............................................................. Actual Charge
- Miscellaneous Services and Supplies (does not include incremental nursing)........................................ Usual and Customary Charge

Extended Care Facility/Rehabilitation Facility
- Calendar Year Maximum Benefit............................................ 120 days

Home Health Care
- Calendar Year Maximum Benefit............................................ 50 visits
- Lifetime Maximum Benefit.................................................... $50,000

Private Duty Nursing
- Calendar Year Maximum Benefit............................................ 50 visits

Treatment of TMJ
- Lifetime Maximum Benefit.................................................... $5,000

Scalp Hair Prosthesis
- Lifetime Maximum Benefit.................................................... $250

Transplants
- Lifetime Maximum Benefit.................................................... $300,000

Mental/Nervous Disorders and Chemical Dependency Treatment
- Inpatient**
  - Combined Calendar Year Maximum Benefit....................... 30 days***
- Outpatient
  - Combined Calendar Year Maximum Benefit....................... 20 visits

Chemical Dependency Treatment
- Inpatient and Outpatient
  - Combined Lifetime Maximum Benefit............................... $50,000

** A program of Inpatient Chemical Dependency Treatment must be completed before Inpatient Chemical Dependency benefits will be payable under this Plan.

*** Two (2) days of partial hospitalization (minimum 6 hours to a maximum of 12 hours) will count as one day of confinement.
OVERALL LIFETIME MAXIMUM BENEFIT

$2,000,000

BENEFIT PROVISIONS

The Deductibles, Out-of-Pocket Limits and Maximums are combined for both the PPO Providers and the Non-PPO Providers.

A separate document may be obtained from the Plan Administrator showing the providers available within the Preferred Provider Network at no cost to the Covered Person.

PPO Providers are not subject to Usual and Customary Charges. Non-PPO Physician’s services are subject to Usual and Customary Charges and any charges in excess of Usual and Customary will not be considered eligible for payment.

Expenses which are incurred due to a Medical Emergency by a Non-PPO Provider will be paid at the PPO Provider level of benefits.

Professional services which are not available within the PPO Network will be paid at the PPO Provider level of benefits.

Medical supplies for which there is no network provider available will be paid at the PPO Provider level of benefits.

Individuals who are referred outside the PPO Network by a PPO Physician will have benefits paid at the Non-PPO Provider level of benefits, unless those services are not available in the PPO Network.

If a PPO Physician or PPO facility refers x-ray and laboratory services to a Non-PPO Provider, those services will be paid at the PPO Provider level of benefits.

Professional services which are provided by a Non-PPO Provider but rendered at a PPO facility will be paid at the PPO Provider level of benefits.

Expenses for obtaining medical records will be paid in full to a maximum benefit of $50 per provider.
PRESCRIPTION DRUG CARD BENEFITS

<table>
<thead>
<tr>
<th>Network Pharmacy Benefits</th>
<th>Retail 30-Day Supply</th>
<th>Advantage90 Retail Stores or Mail Order 90-102 Day Supply</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generic (Tier 1)</td>
<td>$7 Co-pay</td>
<td>$14 Co-pay</td>
</tr>
<tr>
<td>Preferred Drugs (Tier 2)</td>
<td>$20 Co-pay or 10%, whichever is greater</td>
<td>$40 Co-pay or 10%, whichever is greater</td>
</tr>
<tr>
<td>Non-Preferred Drugs (Tier 3)</td>
<td>$40 or 10%, whichever is greater</td>
<td>$80 or 10%, whichever is greater</td>
</tr>
</tbody>
</table>

PRESCRIPTION DRUG CARD PROGRAM

Eligible drugs and medicines prescribed in writing by a Physician and dispensed by a licensed pharmacist, up to a thirty (30) day supply at retail locations (90-102 day supply at Advantage90 retail stores or mail order) which are deemed necessary for treatment of an Illness or Injury, including, but not limited to, insulin, diabetic supplies, smoking deterrents, and non-implantable contraceptives regardless of intended use).

Expenses for injectables not covered under the Prescription Drug Card program will be payable under this Plan subject to any applicable PPO Deductibles and Co-insurance.

NOTE: Coverage, limitations, and exclusions for prescription drugs will be determined through the Prescription Drug Card program elected by the Employer and will not be subject to any limitations and exclusions under the major medical plan. The Prescription Drug Card program is a separate benefit from the major medical plan. However, prescription drugs are subject to the Overall Lifetime Maximum Benefit shown in the Schedule of Benefits.

1st Tier - Generic - Most generic drugs are in the 1st tier. These drugs are generally the least expensive and are the most cost-effective for both the Covered Person and the Plan Administrator.

2nd Tier - Preferred Drugs - A 2nd tier drug is a brand name drug that either does not have a generic equivalent or may be less expensive, but equally effective, alternative to its 3rd tier counterpart. These drugs are also referred to as preferred brand drugs.

3rd Tier - Non-Preferred Drugs - A 3rd tier drug is a brand name drug that may have either a generic or 2nd tier alternative available. These drugs are generally the most expensive drugs for both the Covered Person and the Plan Administrator and are referred to as non-preferred brands.
ELIGIBILITY & ENROLLMENT

EMPLOYEES

Coverage provided under this Plan for employees and their dependents shall be in accordance with the Eligibility & Enrollment, Effective Date of Coverage, Termination of Benefits, and Continuation Coverage Rights Under COBRA provisions as stated in this Plan Document.

A - ELIGIBLE EMPLOYEES

A full-time employee of the Employer who regularly works forty (40) or more hours per week at least nine (9) months of the Calendar Year will be eligible to enroll for coverage under this Plan. Other employees such as part-time, temporary or seasonal will not be eligible to enroll for coverage under this Plan.

Also eligible is a retiree of the Employer who has attained the age of fifty-five (55) and has ten (10) or more years of service.

B - WAITING PERIOD

An employee's Eligibility Date is the first of the month following full-time employment.

C - PLAN ENROLLMENT

An Eligible Employee who elects to participate in the Plan, must complete, sign and return the provided "enrollment form" to the Employer within thirty-one (31) days of the Eligibility Date. Failure to enroll within this time limit will be deemed waiver of participation and the employee will be considered a Late Enrollee or Special Enrollee.

Special Enrollee: If an Eligible Employee declined single or family coverage hereunder at the time of initial eligibility (and stated in writing at that time that coverage was declined because of alternative health coverage) but subsequently loses coverage under the other health plan and makes application for coverage under this Plan within thirty-one (31) days of the loss, such individual shall be a Special Enrollee provided such person: (a) was under a COBRA continuation provision and the coverage under such provision was exhausted; or (b) was not under such a provision and either the coverage was terminated as a result of loss of eligibility for the coverage (see below), or employer contributions toward such coverage were terminated. Individuals who lose other coverage due to non-payment of premium or for cause (e.g., filing fraudulent claims) shall not be Special Enrollees hereunder. Coverage for a Special Enrollee who had other coverage and then lost it shall begin as of the first day of the calendar month following the enrollment request.

Loss of eligibility includes, but is not limited to: (a) legal separation, divorce, cessation of dependent status (such as attaining the maximum age to be considered an Eligible Dependent under the plan), death of an employee, termination of employment, reduction in the number of hours of employment; (b) coverage is offered through an HMO or other arrangement, in the
individual market that does not provide benefits to individuals who no longer reside, live or work in a service area (whether or not within the choice of the individual); (c) coverage is offered through an HMO or other arrangement, in the group market that does not provide benefits to individuals who no longer reside, live or work in a service area (whether or not within the choice of the individual), and no other benefit package is available to the individual; (d) when a Covered Person incurs a claim that would meet or exceed a lifetime limit on all benefits (this right continues until at least 31 days after the earliest date that a claim is denied due to the operation of the lifetime limit); (e) when a plan no longer offers any benefits to a class of similarly situated individuals, i.e. terminated coverage for part-time employees, etc.

An Eligible Employee, Spouse, or newly acquired Dependent who seeks to enroll in the Plan as a result of the acquisition of a new dependent through marriage, birth, adoption or placement for adoption shall be a Special Enrollee hereunder if the Eligible Employee, Spouse, or newly acquired Dependent enrolls within thirty-one (31) days of the acquisition of the new Dependent. Coverage for such Special Enrollee shall begin as stated in the Effective Date of Coverage section.

**Late Enrollee**: A Late Enrollee will not be eligible to enroll for coverage under this Plan in the future.

**D - RETURN TO WORK – USERRA**

Employees who are covered under the Uniformed Services Employment and Reemployment Rights Act (USERRA) will be eligible for coverage on the date they return to work, provided the employee returns to work with the Employer within the specified time period in the Uniformed Services Employment and Reemployment Rights Act (USERRA). Coverage for a reservist will be on the same basis it is for active employees and dependents. Eligibility waiting periods and the Pre-Existing Condition Limitation will be imposed only to the extent they were applicable prior to the period of uniformed services.
A - ELIGIBLE DEPENDENTS

An Eligible Dependent will be a Covered Employee's legally married Spouse and each unmarried child who is not yet age nineteen (19), provided such child is dependent on the employee for support and maintenance.

The term "child", as used herein, shall be defined as: (a) a natural born child; (b) a stepchild; (c) an adopted child (from the date of placement with the employee for the purpose of legal adoption); (d) a child for whom the employee is the legal guardian, until the date the child no longer qualifies as an Eligible Dependent as defined under this Plan; or (e) a child for whom the employee is required to provide health coverage due to a Qualified Medical Child Support Order (QMCSO). Procedures for determining a QMCSO may be obtained from the Contract Administrator at no cost.

The Plan Administrator shall have the right to require documentation necessary, in its sole discretion, to establish an individual’s status as an Eligible Dependent.

No individual may be covered under this Plan as both an employee and a dependent. Also, no individual will be considered an Eligible Dependent of more than one employee.

Full-Time Student: The term “Full-Time Student,” as used herein, shall be defined as an unmarried dependent child who is enrolled in and regularly attending an educational institution such as high school, an accredited post-secondary school, an accredited college or university for the minimum number of credit hours required by that institution in order to maintain Full-Time Student status.

Other examples of post-secondary education institutions include an accredited business school, trade school, nursing school, business college, mortuary school, cosmetology school, community or junior college, or other similar accredited educational institution which offers a full-time curriculum. The institution must be accredited in order to qualify the dependent for Full-Time Student status.

If an unmarried child is or becomes a Full-Time Student while between the ages of nineteen (19) and twenty-six (26) and is dependent upon the employee for support and maintenance, then such child will be considered an Eligible Dependent until the date the child attains age twenty-six (26). Coverage for a Full-Time Student will be effective as follows:

1. A dependent child covered by this Plan who graduates from high school will remain covered provided the child enrolls and begins attending classes full-time in an accredited post-secondary school, college, or university within four (4) months of the child’s high school graduation date; or
2. A dependent child who is not covered by this Plan and who subsequently enrolls and begins attending classes as a Full-Time Student will also be eligible for coverage. In this instance, the date the child begins attending full-time classes will be considered the date the employee acquires an Eligible Dependent for plan enrollment purposes. The Plan may require a completed application for the dependent’s coverage within a specified time frame (see section B - Plan Enrollment); and

3. A Full-Time Student will remain covered during any regular scheduled break in the educational institution’s full-time curriculum (such as spring or summer break), as long as the dependent was a Full-Time Student the quarter/semester before the break and is a Full-Time Student again the quarter/semester following the break.

If a dependent child ceases to maintain Full-Time Student status, the dependent child’s coverage will cease on the last day of the month following the dependent’s last day in attendance as a Full-Time Student. For purposes of offering Continuation of Benefits (COBRA) to such dependent child, the sixty (60) day period during which the Plan must be notified of the dependent’s ineligibility will begin the earlier of:

1. The start of classes in the next quarter/semester designated by the last school attended; or

2. In the case of withdrawal from enrollment or graduation, the day after withdrawal or graduation.

**Mentally or Physically Handicapped Child:** If an unmarried dependent child, upon reaching age nineteen (19), is incapacitated, unable to be self-supporting, and resides with the employee, then such child will continue to be an Eligible Dependent.

**B - PLAN ENROLLMENT**

An Eligible Dependent is able to participate in the Plan when the Covered Employee completes, signs and returns an enrollment form indicating dependent coverage to the Employer. The employee must enroll the dependent(s) within thirty-one (31) days of whichever of the following occurs first:

1. The employee's Eligibility Date if the employee has any Eligible Dependents at that time; or

2. The date the employee acquires an Eligible Dependent.

Children covered by Qualified Medical Child Support Orders (QMCSO) may be enrolled in this Plan if the employee would otherwise be eligible for coverage, regardless of whether the employee is currently enrolled. The Plan must enroll the child(ren) and the employee covered by the notice without any enrollment restrictions (i.e. they will not be considered Late Enrollees).
If dependent coverage is already in force, the employee is required to enroll additional dependent children acquired after dependent coverage is in force.

Newborn children and adopted children will be covered on the date of birth or adoption (or placement for adoption) if enrolled within thirty-one (31) days of the birth, adoption or placement for adoption.

Failure to enroll for dependent coverage within this time limit will be deemed waiver of participation and future coverage for dependents under the Plan will be subject to the Late Enrollee or Special Enrollee provisions.

**Special Enrollee**: If an Eligible Employee declined single or family coverage hereunder at the time of initial eligibility (and stated in writing at that time that coverage was declined because of alternative health coverage) but subsequently loses coverage under the other health plan and makes application for coverage under this Plan within thirty-one (31) days of the loss, such individual shall be a Special Enrollee provided such person: (a) was under a COBRA continuation provision and the coverage under such provision was exhausted; or (b) was not under such a provision and either the coverage was terminated as a result of loss of eligibility for the coverage (see below), or employer contributions toward such coverage were terminated. Individuals who lose other coverage due to non-payment of premium or for cause (e.g., filing fraudulent claims) shall not be Special Enrollees hereunder. Coverage for a Special Enrollee who had other coverage and then lost it shall begin as of the first day of the calendar month following the enrollment request.

Loss of eligibility includes, but is not limited to: (a) legal separation, divorce, cessation of dependent status (such as attaining the maximum age to be considered an Eligible Dependent under the plan), death of an employee, termination of employment, reduction in the number of hours of employment; (b) coverage is offered through an HMO or other arrangement, in the individual market that does not provide benefits to individuals who no longer reside, live or work in a service area (whether or not within the choice of the individual); (c) coverage is offered through an HMO or other arrangement, in the group market that does not provide benefits to individuals who no longer reside, live or work in a service area (whether or not within the choice of the individual), and no other benefit package is available to the individual; (d) when a Covered Person incurs a claim that would meet or exceed a lifetime limit on all benefits (this right continues until at least 31 days after the earliest date that a claim is denied due to the operation of the lifetime limit); (e) when a plan no longer offers any benefits to a class of similarly situated individuals, i.e. terminated coverage for part-time employees, etc.

An Eligible Employee, spouse, or newly acquired dependent who seeks to enroll in the Plan as a result of the acquisition of a new dependent through marriage, birth, adoption or placement for adoption shall be a Special Enrollee hereunder if the Eligible Employee, spouse, or newly acquired dependent enrols within thirty-one (31) days of the acquisition of the new dependent. Coverage for such Special Enrollee shall begin as stated in the Effective Date of Coverage section.

**Late Enrollee**: A Late Enrollee will not be eligible to enroll for coverage under this Plan in the future.
EFFECTIVE DATE OF COVERAGE

A – EMPLOYEES

Coverage for an Eligible Employee who enrolls in the Plan will be effective on whichever of the following occurs first:

1. The employee's Eligibility Date if the employee enrolls within thirty-one (31) days thereafter;

2. The first of the month following the date the employee's coverage terminated due to loss of eligibility under a Qualified Health Plan, or termination of employer contributions toward the cost of coverage through a Qualified Health Plan, provided enrollment is made within thirty-one (31) days in the case of a Special Enrollee;

3. The first of the month following the date of marriage, provided the employee enrolls within thirty-one (31) days of the marriage;

4. The date of birth or adoption (or placement for adoption) of a new dependent, provided the employee enrolls within thirty-one (31) days of the birth, adoption or placement for adoption; or

5. The day following the date in which COBRA coverage is exhausted if the employee had elected COBRA coverage under a Qualified Health Plan in the case of a Special Enrollee.

B – DEPENDENTS

When a Covered Employee enrolls an Eligible Dependent in the Plan, the dependent's coverage will be effective on whichever of the following occurs later:

1. The employee's effective date of coverage;

2. The first of the month following the date the dependent's coverage through terminated due to loss of eligibility under a Qualified Health Plan, or termination of employer contributions toward the cost of coverage through a Qualified Health Plan, provided enrollment is made within thirty-one (31) days in the case of a Special Enrollee;

3. The first of the month following the date of marriage, provided the dependent is enrolled within thirty-one (31) days following the marriage;

4. The date of birth or adoption (or placement for adoption) if enrolled within thirty-one (31) days of the birth, adoption or placement for adoption;
5. In the case of a newly eligible or returning Full-Time Student, the date the dependent child begins attending full-time classes; or

6. The day following the date in which COBRA coverage is exhausted if the dependent had elected COBRA coverage under a Qualified Health Plan in the case of a Special Enrollee.
ELIGIBLE EXPENSES

Eligible expenses shall be the charges actually made to the Covered Person and, unless otherwise shown, will be considered eligible only if the expenses are:

1. Due to Illness or Injury;
2. Ordered or performed by a Physician;
3. Medically Necessary; and
4. Usual and Customary Charges.

Reimbursement for eligible expenses will be made directly to the provider of the service, unless a receipt showing payment is submitted. All eligible expenses incurred at a Preferred Provider will be reimbursed to the provider.

1. **ALLERGY SERVICES:** Allergy testing, treatment, serum and injections. Allergy injections will be payable as shown in the Schedule of Benefits.

2. **AMBULANCE SERVICE:** Commercial ground or air ambulance service will be payable as shown in the Schedule of Benefits to transport the patient: (a) to a Hospital equipped to treat the specific Illness or Injury, in an emergency situation; or (b) when Medically Necessary.

3. **AMBULATORY SURGICAL FACILITY:** Services and supplies provided by an Ambulatory Surgical Facility will be payable as shown in the Schedule of Benefits.

4. **ANESTHETICS:** Anesthetics and their professional administration.

5. **ATTENTION DEFICIT DISORDER:** Diagnosis, testing and treatment of Attention Deficit Disorder (ADD) and Attention Deficit Hyperactivity Disorder (ADHD). This is considered a separate benefit from Mental/Nervous Disorders.

6. **BLOOD AND BLOOD DERIVATIVES:** Blood, blood plasma, or blood components not donated or replaced.

7. **CHEMICAL DEPENDENCY:** Inpatient and outpatient treatment of Chemical Dependency will be payable as shown in the Schedule of Benefits. A program of Inpatient treatment must be completed before Inpatient benefits will be payable under this Plan.

8. **CHIROPRACTIC CARE:** Chiropractic treatment when related to the spine, muscles or joints, including x-rays will be payable as shown in the Schedule of Benefits.
9. **CIRCUMCISION:** Services and supplies related to circumcision. Circumcision performed while Hospital confined following birth will be considered as part of the mother’s expense.

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

11. **COSMETIC SURGERY:** Charges for Cosmetic Surgery or reconstructive surgery will be considered eligible only under the following circumstances: (a) for the correction of congenital defects for a dependent child; and (b) any other Medically Necessary surgery related to an Illness or Injury.

12. **DENTAL CARE:** Dental services and x-rays rendered by Dentist or dental surgeon for: (a) the treatment of a fractured jaw, or accidental Injuries to sound natural teeth within one year of the accident, including the replacement of sound natural teeth; and (b) the surgical removal of impacted wisdom teeth.

   General anesthesia and Hospital expenses for covered dental care when there is a serious underlying medical condition which exists or is necessary due to accidental Injury to sound natural teeth.

13. **DIABETIC SUPPLIES:** Diabetic supplies for the treatment of diabetes that are not covered under the Prescription Drug Card program.

   The following diabetic education and self-management programs: (a) all Physician prescribed medically appropriate and necessary equipment and supplies used in the management and treatment of diabetes; and (b) 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. Coverage is provided for individuals with gestational, Type I or Type II diabetes.

14. **DIAGNOSTIC TESTING, X-RAY AND LABORATORY SERVICES:** Diagnostic testing, x-ray, and laboratory services, including services of a professional radiologist or pathologist. Dental x-rays are not eligible expenses, except as specified under Dental Care.

   The use of the LabOne program is strictly voluntary. If a Covered Person uses the services of LabOne, benefits will be payable as shown in the Schedule of Benefits. There are two (2) ways for a Covered Person to use the services of LabOne. One way is to take the lab work ordered by a Physician directly to a LabOne Patient Service Center. These LabOne Patient Service Centers will determine eligibility through the LabOne I.D. card, collect specimens, perform testing and deliver the results to the
Physician upon completion. The other way for a Covered Person to receive benefits from the LabOne program is to present their I.D. card to the Physician and request that the lab specimens, collected in the Physician’s office be sent to LabOne for processing. LabOne will pick up the specimen, perform the testing and upon completion of the tests, deliver the results to the Covered Person’s Physician. Collection fees imposed by the provider for the LabOne draw are subject to the Deductible and Co-insurance.

15. **DURABLE MEDICAL EQUIPMENT:** The rental of wheelchairs, walkers, special Hospital beds, iron lungs, and other Durable Medical Equipment which are prescribed by a Physician for the treatment of an Illness or Injury.

When the extended use of any eligible rental equipment is deemed necessary for the treatment of the patient, purchase of the equipment may be permitted. The total cost of rental and purchase will never exceed the purchase price of the equipment.

16. **EMERGENCY ROOM SERVICES:** Treatment in a Hospital emergency room, including professional services will be payable as shown in the Schedule of Benefits. The Co-pay will be waived if the person is admitted directly as an Inpatient to the Hospital.

17. **EXTENDED CARE FACILITY:** Extended convalescent care provided in an Extended Care Facility will be payable as shown in the Schedule of Benefits, provided such confinement: (a) is under the recommendation and general supervision of a Physician; (b) begins within fourteen (14) days after discharge from required Hospital or Rehabilitation Facility confinement of at least three (3) days in length for which room and board benefits are paid; (c) is for the purpose of receiving medical care necessary for convalescence from the conditions causing or contributing to the precedent Hospital or Rehabilitation Facility confinement; and (d) is not for Custodial Care.

See the Rehabilitation Facility benefit for services and supplies provided for confinements in a Rehabilitation Facility.

18. **HOME HEALTH CARE:** Services provided by a Home Health Care Agency to a Covered Person in the home will be payable as shown in the Schedule of Benefits. The following are considered eligible home health care services: (a) home nursing care; (b) services of a home health aide or licensed practical nurse (L.P.N.), under the supervision of a registered nurse (R. N.); (c) physical, occupational or speech therapy if provided by the Home Health Care Agency; (d) medical supplies, drugs and medications prescribed by a Physician; (e) laboratory services; and (f) nutritional counseling by a licensed dietician.

For the purpose of determining the benefits for home health care available to a Covered Person, each visit by a member of a Home Health Care Agency shall be considered as one home health care visit and each four (4) hours of home health aide services shall be considered as one home health care visit.

In no event will the services of a Close Relative, social worker, transportation services, housekeeping services, and meals, etc. be considered an eligible expense.
19. **HOSPICE CARE:** Hospice care on either an Inpatient or outpatient basis for a terminally ill person rendered under a Hospice treatment plan. The Hospice treatment plan must certify that the person is terminally ill with a life expectancy of six (6) months or less.

Covered services include: (a) room and board charges by the Hospice; (b) other Medically Necessary services and supplies; (c) nursing care by or under the supervision of a registered nurse (R.N.); (d) home health care services furnished in the patient's home by a Home Health Care Agency for the following: (i) health aide services consisting primarily of caring for the patient (excluding housekeeping, meals, etc.); and (ii) physical and speech therapy; (e) counseling services by a licensed social worker or a licensed pastoral counselor for the patient's immediate family; (f) bereavement counseling services by a licensed social worker or a licensed pastoral counselor for the patient's immediate family. (The bereavement services must be furnished within six [6] months after the patient's death and coverage is limited to 50% of the charges for the services and not more than a total of fifteen [15] visits per family.)

Counseling services received in connection with a terminal Illness as described above will not be considered to have been received due to a Mental/Nervous Disorder.

The term "Patient's Immediate Family" as used herein means the patient's spouse, parents, and/or dependent children who are covered under the Plan.

20. **HOSPITAL SERVICES:**

**Inpatient**
Hospital room and board, including all regular daily services will be payable as shown in the Schedule of Benefits. Charges made by a Hospital having only single or private rooms will be considered at the least expensive rate for a single or private room.

Care provided in an Intensive Care Unit will be payable as shown in the Schedule of Benefits.

Miscellaneous services and supplies, including any additional Medically Necessary nursing services furnished while being treated on an Inpatient basis. However, incremental nursing is not considered eligible.

**Outpatient**
Services and supplies furnished while being treated on an outpatient basis will be payable as shown in the Schedule of Benefits. Clinic charges on an outpatient Hospital bill using the words “clinic” or “office visit” will have all charges processed for that day as a clinic charge using appropriate Physician's services benefit codes.
21. **MATERNITY:** Expenses incurred by all Covered Persons for:
   
   (a) Pregnancy;
   
   (b) Services provided by a Birthing Center;
   
   (c) One amniocentesis test per pregnancy;
   
   (d) Up to two (2) ultrasounds per pregnancy (more than 2 only when it is determined to be Medically Necessary);
   
   (e) Elective induced abortions.

   Hospital stays in connection with childbirth for either the mother or newborn may not be less than forty-eight (48) hours following a vaginal delivery or ninety-six (96) hours following a cesarean section. These requirements can only be waived by the attending Physician in consultation with the mother. The Covered Person or provider is not required to pre-certify the maternity admission, unless the stay extends past the applicable forty-eight (48) or ninety-six (96) hour stay. A Hospital stay begins at the time of delivery or for deliveries outside the Hospital, the time the newborn or mother is admitted to a Hospital following birth, in connection with childbirth. **If a newborn remains hospitalized beyond the time frames specified above, the confinement must be pre-certified or a penalty may be applied.**

22. **MEDICAL AND SURGICAL SUPPLIES:** Casts, splints, trusses, braces, crutches, dressings and other Medically Necessary supplies ordered by a Physician.

23. **MENTAL/NERVOUS DISORDERS:** Inpatient and outpatient treatment of Mental/Nervous Disorders will be payable as shown in the **Schedule of Benefits.**

24. **OCCUPATIONAL THERAPY:** Occupational therapy rendered by an occupational therapist under the recommendation of a Physician. Outpatient occupational therapy will be payable as shown in the **Schedule of Benefits.**

25. **OUTPATIENT PRE-ADMISSION TESTING:** Outpatient pre-admission testing performed within seven (7) days of a scheduled Inpatient hospitalization or Surgery.

26. **OXYGEN:** Oxygen and rental of equipment for its administration.

27. **PHENYLKETONURIA:** Special dietary treatment for phenylketonuria (PKU) when recommended by a Physician.

28. **PHYSICAL THERAPY:** Physical therapy rendered by a physical therapist under the recommendation of a Physician. Outpatient physical therapy will be payable as shown in the **Schedule of Benefits.**
29. **Physician's Services**: Services of a Physician for medical care or Surgery.

Charges for an office visit will be payable as shown in the Schedule of Benefits. All other services and supplies provided during an office visit which include, but are not limited to: examinations, x-ray and laboratory tests (including the reading or processing of the tests), supplies, injections, cast application, and minor Surgery will be payable subject to the Deductible and Co-insurance.

Clinic charges on an outpatient Hospital bill using the words “clinic” or “office visit” will have all charges processed for that day as a clinic charge using appropriate Physician’s services benefit codes.

30. **Podiatry**: Treatment for the following foot conditions: (a) weak, unstable or flat feet; (b) bunions, when an open cutting operation is performed; (c) non-routine treatment of corns or calluses; (d) toenails when at least part of the nail root is removed; (e) any Medically Necessary surgical procedure required for a foot condition; or (f) orthotics, including orthopedic shoes when an integral part of a leg brace or when deemed Medically Necessary.

31. **Private Duty Nursing**: Service of a registered nurse (R.N.) or a licensed practical nurse (L.P.N.) for private duty nursing as follows:

   (a) Inpatient private duty nursing is covered only when care is Medically Necessary and not for Custodial Care, and the Hospital's Intensive Care Unit is filled or the Hospital has no Intensive Care Unit. Incremental nursing is not considered eligible.

   (b) Outpatient private duty nursing is covered only when Medically Necessary and will be payable under the Home Health Care benefit.

32. **Prosthetics**: Artificial limbs, eyes, or other prosthetic devices when necessary due to an Illness or Injury. Charges for the replacement will only be included as an eligible expense when required due to a pathological change and does not include charges for repair or maintenance.


34. **Reconstructive Breast Surgery**: Charges for reconstructive breast surgery following a mastectomy will be eligible as follows: (a) reconstruction of the breast on which the mastectomy has been performed; (b) surgery and reconstruction of the other breast to produce symmetrical appearance; and (c) coverage for prostheses and physical complications of all stages of mastectomy, including lymphedemas.

   The manner in which breast reconstruction is performed will be determined in consultation with the attending Physician and the patient.
35. **Rehabilitation Facility:** Inpatient care provided in a Rehabilitation Facility will be payable as shown in the **Schedule of Benefits**, provided such confinement: (a) is under the recommendation and general supervision of a Physician; (b) begins within fourteen (14) days after discharge from a required Hospital or Extended Care Facility confinement of at least three (3) days in length for which room and board benefits are paid; (c) is for the purpose of receiving medical care necessary for convalescence from the conditions causing or contributing to the precedent Hospital or Extended Care Facility confinement; and (d) is not for Custodial Care.

See the Extended Care Facility benefit for services and supplies provided for confinements in an Extended Care Facility.

36. **Routine Care (HMO or PPO Providers Only):** Routine care including, but not limited to, the office visit, lab tests, x-rays, routine testing, vaccinations or inoculations, well child care, pap smears, mammograms, and PSA testing will be payable as shown in the **Schedule of Benefits**. If a diagnosis is indicated after a routine exam, the exam will still be payable under the routine care benefit, however, all charges related to the diagnosis (except the initial exam) will be payable as any other Illness.

37. **Routine Eye Exams:** Routine eye exams and refractions including any related office visit will be payable as shown in the **Schedule of Benefits**.

38. **Routine Hearing Exams:** Routine hearing exams and any related office visit will be payable as shown in the **Schedule of Benefits**.

39. **Routine Newborn Care:** Routine newborn care, including Hospital nursery expenses and routine pediatric care while confined following birth will be considered as part of the mother’s expense.

If the newborn is ill, suffers an Injury, or requires care other than routine care, benefits will be provided on the same basis as any other eligible expense.

40. **Scalp Hair Prosthesis:** Purchase of a scalp hair prosthesis when necessitated by hair loss due to the medical condition known as alopecia areata, or as the result of hair loss due to radiation or chemotherapy for diagnosed cancer will be payable as shown in the **Schedule of Benefits**.

41. **Second Surgical Opinions:** Voluntary second surgical opinions for elective, non-emergency Surgery when recommended for a Covered Person.

Benefits for the second opinion will be payable only if the opinion is given by a specialist who: (a) is certified in the field related to the proposed Surgery; and (b) is not affiliated in any way with the Physician recommending the Surgery.
42. **SMOKING CESSATION (HMO AND PPO PROVIDERS ONLY):** The following services when related to smoking cessation: office visits related to smoking cessation, acupuncture, hypnotherapy, and other smoking cessation programs will be payable as shown in the **Schedule of Benefits.** Smoking deterrents are available under the Prescription Drug Card program.

43. **SPEECH THERAPY:** Restorative or rehabilitative speech therapy necessary because of loss or impairment due to an Illness or Surgery, or therapy to correct a congenital defect. Speech therapy for developmental delay will not be considered eligible. Outpatient speech therapy will be payable as shown in the **Schedule of Benefits.**

44. **STERILIZATION:** Elective sterilization procedures.

45. **TEMPOROMANDIBULAR JOINT DYSFUNCTION (TMJ):** Surgical and non-surgical treatment of Temporomandibular Joint Dysfunction (TMJ) will be payable as shown in the **Schedule of Benefits.**

46. **TRANSPLANTS:** Services and supplies in connection with Medically Necessary non-Experimental transplant procedures, subject to the following conditions:

   (a) A concurring opinion must be obtained prior to undergoing any transplant procedure. This mandatory opinion must concur with the attending Physician's findings regarding the Medical Necessity of such procedure. The Physician rendering this concurring opinion must be qualified to render such a service either through experience, specialist training, education, or such similar criteria, and must not be affiliated in any way with the Physician who will be performing the actual Surgery.

   (b) If the donor is covered under this Plan, eligible expenses incurred by the donor will be considered eligible. If the donor is not covered under this Plan, reference provision (e).

   (c) If the recipient is covered under this Plan, eligible expenses incurred by the recipient will be considered eligible.

   (d) If both the donor and the recipient are covered under this Plan, eligible expenses incurred by each person will be treated separately for each person.

   (e) The Usual and Customary fee of securing an organ from the designated live donor, a cadaver or tissue bank, including the surgeon's fees, anesthesiology, radiology, and pathology fees for the removal of the organ, and a Hospital's charge for storage or transportation of the organ will be considered eligible.
Transplant coverage is limited to those transplants that are medically recognized and are non-Experimental/Investigational in nature.

47. **URGENT CARE FACILITY**: Services and supplies provided by an Urgent Care Facility will be payable as shown in the **Schedule of Benefits**.

**ALTERNATIVE BENEFITS**

In addition to the benefits specified, the Plan may elect to offer benefits for services furnished by any provider pursuant to a Plan-approved alternative treatment plan, in which case those charges incurred for services provided to a Covered Person under an alternate treatment plan to its end, will be more cost effective than those charges to be incurred for services to be provided under the current treatment plan to its end.

The Plan shall provide such alternative benefits at its sole discretion and only when and for so long as it determines that alternative care services are Medically Necessary and cost effective. If the Plan elects to provide alternative benefits for a Covered Person in one instance, it shall not be obligated to provide the same or similar benefits for other Covered Persons under this Plan in any other instance, nor shall it be construed as a waiver of the Plan Administrator's rights to administer this Plan thereafter in strict accordance with its express terms.
PRE-EXISTING CONDITION LIMITATION

Expenses incurred in connection with a Pre-Existing Condition will not be considered eligible. A Pre-Existing Condition means a physical or mental condition, regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received during the six (6) consecutive month period prior to the individual's Enrollment Date of coverage under this Plan. Pre-Existing Conditions will be covered after the end of twelve (12) consecutive months after the individual's Enrollment Date.

The Pre-Existing Condition Limitation does not apply to:

1. Pregnancy and pregnancy-related conditions.

2. A newborn or newly adopted child (under age 19) who is enrolled in the Plan within thirty-one (31) days of birth, adoption, or placement for adoption and who begins dependent coverage does not have any Pre-Existing Conditions for purposes of this Plan. Also, any such child who has Creditable Coverage from birth, adoption, or placement for adoption under another plan and who is enrolled in this Plan prior to incurring a significant break in Coverage, does not have any Pre-Existing Conditions for the purposes of this Plan.

3. Genetic Information provided there has been no diagnosis of a condition related to the Genetic Information.

4. Prescription drugs purchased through the Prescription Drug Card program.

5. An employee and/or dependent who was covered under a Qualified Health Plan which is replaced by this Plan, unless they have not satisfied the Pre-Existing Condition Limitation of the Qualified Health Plan in effect prior to the effective date of this Plan.

If they have not satisfied the prior plan's Pre-Existing Conditions provision, credit will be given towards this Pre-Existing Condition Limitation for any time which has elapsed while they were covered by a Qualified Health Plan, provided there was not a break in coverage of sixty-three (63) or more days. A certification of Creditable Coverage may be required to accurately determine the Pre-Existing Condition Limitation.

The Plan must establish a procedure for Covered Persons to request and receive a certificate of Creditable Coverage. Any questions regarding obtaining a Certificate of Creditable Coverage or obtaining credit for additional past periods of coverage, please contact CBSA’s Service Center at (800) 925-2272, or fax the Certificate(s) of Creditable Coverage from the prior plan(s) to: (952) 593-3779.

If the Plan requests additional information to determine if a pre-existing condition exists or requests a Certificate of Creditable Coverage, and that information is not received as requested, all additional claims related to that condition will receive an Adverse Benefit Determination and will be denied until the necessary information is received. Please refer to the General Provisions - Right of Review and Appeal section for further details.
COST MANAGEMENT SERVICES

Guided2Health℠

The patient or family member or the patient’s representative must call to receive certification of Inpatient Hospital admissions and certain outpatient procedures.

GUIDED2HEALTH℠ UTILIZATION MANAGEMENT

Utilization Management is a program designed to help ensure that all Covered Persons receive necessary and appropriate health care while avoiding unnecessary expenses. The program consists of:

1. Pre-Certification of the Medical Necessity for hospitalization before medical services are provided. Pre-Certification is required for all Inpatient stays (including acute Inpatient rehabilitation and subacute care provided in a facility that has nursing staff on-site 24 hours a day, 7 days a week, and a Physician on call 24 hours a day, 7 days a week), and Inpatient Rehabilitation Facility and Chemical Dependency confinements.

2. Pre-Certification is also required for the following outpatient procedures if they are performed in a Hospital or Ambulatory Surgical Facility and/or there is an operating room charge:

   - 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

3. Concurrent Review for continued length of stay and assistance with discharge planning activities.

4. Retrospective review for Medical Necessity of non-pre-certified Inpatient confinements.

Utilization Management Does Not Guarantee Payment. All benefits/payments are subject to the Covered Person’s eligibility under the Plan. For benefit payment, services rendered must be considered an eligible expense under the Plan and are subject to all other provisions of the Plan.

This program is not designed to be the practice of medicine or to be a substitute for the medical judgment of the attending Physician or other health care provider.
DEFINITIONS

Concurrent Review: All Inpatient admissions or confinements that occur in a facility are subject to review by the Utilization Management Staff. The review is based on clinical information received in the utilization management department by the provider or facility.

Emergency Care: Medical services and supplies provided after the sudden onset of a medical condition (Injury or Illness) manifesting itself by acute symptoms, including intense pain, which are severe enough that the lack of immediate medical attention could reasonably be expected to result in any of the following: (1) the patient's health would be placed in serious jeopardy; (2) bodily function would be seriously impaired; or (3) there would be serious dysfunction of a bodily organ or part.

Non-Emergency Care: Any services which are not considered Emergency Care, or services that are scheduled in advance.

Pre-Certification: All Inpatient admissions or confinements that take place in a facility are subject to review by the Utilization Management Staff. The review is based on clinical information received in the utilization management department from the provider or facility.

HOW THE PROGRAM WORKS

PRE-CERTIFICATION

Before a Covered Person is admitted to a medical facility on a non-emergency basis or receives a listed outpatient procedure, the Utilization Management Staff will, based on clinical information from the provider or facility, certify the care according to Guided2Healthsm policy and procedures. A non-emergency stay in a medical facility is one that can be scheduled in advance.

The utilization management program is set in motion by a telephone call from the Covered Person, medical provider or a Covered Person’s family member.

To allow for adequate processing of the request, contact the Utilization Management Staff at Guided2Healthsm before the Hospital admission with the following information:

1. Name, identification number and date of birth of the patient;
2. The relationship of the patient to the Covered Employee;
3. Name, identification number, address and telephone number of the Covered Employee;
4. Name of Employer and group number;
5. Name, address, Tax ID #, and telephone number of the admitting Physician;
6. Name, address, Tax ID #, and telephone number of the medical facility with the proposed date of admission and proposed length of stay;
7. Proposed treatment plan; and
8. Admitting diagnosis.
If there is an emergency admission to the medical care facility, the patient or the patient’s designee, the facility or admitting Physician must contact Guided2Health within forty-eight (48) hours after the start of the confinement or on the next business day, whichever is later.

Hospital stays in connection with childbirth for either the mother or newborn may not be less than forty-eight (48) hours following a vaginal delivery, or ninety-six (96) hours following a cesarean section. These requirements can only be waived by the attending Physician in consultation with the mother.

The Covered Person or provider is NOT REQUIRED to pre-certify the maternity delivery admission, unless the stay extends past the applicable forty-eight (48) or ninety-six (96) hour stay. A Hospital stay begins at the time of delivery or for deliveries outside the Hospital, the time the newborn or mother is admitted to a Hospital following birth, in connection with childbirth. If a newborn remains hospitalized beyond the time frames specified above, the confinement must be pre-certified with Guided2Health or a penalty will be applied.

The Utilization Management Staff, in coordination with the facility and/or provider, will make a determination on the number of days certified based on Guided2Health policy, procedure and guidelines. If the confinement will last longer than the number of days certified, a representative of the Physician or the facility must call Guided2Health before those extra days begin and obtain certification for the additional time. If the additional days are not requested and certified, room and board expenses will not be payable for any days beyond those certified.

If the Covered Person does not receive Pre-Certification as explained in this section, eligible expenses will be reduced by 50% per individual.

**CONCURRENT REVIEW, DISCHARGE PLANNING**

Discharge planning needs is part of the utilization management program. The Utilization Management Staff will assist and coordinate the initial implementation of any services the patient will need post hospitalization with the attending Physician and the facility. If the attending Physician feels that it is Medically Necessary for a Covered Person to stay in the medical care facility for a greater length of time than has been pre-certified, the attending Physician or the medical facility must request the additional service or days.

**TO FILE A COMPLAINT OR REQUEST AN APPEAL TO A NON-CERTIFICATION**

Written appeal requests and documents should be submitted to:

Guided2Health
P.O. Box 6668
Brandon, FL 33505-6011
Attention: Appeals Department

Verbal appeal requests should be directed to 1-877-710-0278.
GUIDED2HEALTHsm CARE MANAGEMENT

When a catastrophic condition, such as a spinal cord injury, cancer, AIDS or a premature birth occurs, a person may require long-term, perhaps lifetime care. After the patient’s condition is diagnosed, the patient might need extensive services or might be able to be moved into another type of care setting, even to the patient’s home.

Care management is a program whereby a Care Manager contacts the patient to obtain consent for care management services. The Care Manager monitors the patient and explores, discusses and recommends coordinated and/or alternate types of appropriate medical care. The Care Manager consults with the patient, family and the attending Physician in order to develop a plan of care for approval by the patient’s attending Physician and the patient.

This plan of care may include some or all of the following:

1. Personal support to the patient;
2. Contacting the family to offer assistance and support;
3. Monitoring Hospital or Skilled Nursing Care or home health care;
4. Determine alternative care options; and
5. Assisting in obtaining any necessary equipment and services.

Care management occurs when this alternate benefit will be beneficial to both the patient and the Plan.

The Care Manager will coordinate and implement the care management program by providing guidance and information on available resources and suggesting the most appropriate treatment plan. The Plan Staff, attending Physician, patient and patient’s family must all agree to the alternate treatment plan.

NOTE: Care management is a voluntary service. There are no reductions of benefits or penalties if the patient and family choose not to participate.

Each treatment plan is individually tailored to a specific patient and should not be seen as appropriate or recommended for any other patient, even one with the same diagnosis.

ORGAN TRANSPLANT PROGRAM

Transplant care management is a process for attaining significant cost savings on transplants while ensuring high quality care is provided. It involves patient education regarding the risks and benefits of transplants, and helping the patient to choose a "Center of Excellence". The Transplant Care Manager coordinates contracting for the transplant, and forwards the patient evaluation to an independent Physician review team for Medical Necessity and Experimental/Investigational determination. The Transplant Care Manager is a patient advocate from diagnosis through the post-operative phase to ensure the best possible care for the patient, while effectively managing the pre- and post-transplant costs. See the Eligible Expenses section for further information on eligible transplants.
EXCLUSIONS AND LIMITATIONS

No payment will be eligible under any portion of this Plan for expenses incurred by a Covered Person for the expenses or circumstances listed below. If an expense is paid that is found to be excluded or limited as shown below, the Plan has the right to collect that amount from the payee, the Covered Person, or from future benefits, and any such payment does not waive the written exclusions, limitations or other terms of the Plan.

1. **Acupuncture:** Expenses for acupuncture will not be considered eligible, except when used for smoking cessation.

2. **Breast Surgery:** Expenses for treatment of gynecomastia will not be considered eligible.

3. **Cardiac Rehabilitation:** Expenses in connection with Phase III cardiac rehabilitation, including, but not limited to occupational therapy or work hardening programs will not be considered eligible. Phase III is defined as the general maintenance level of treatment, with no further medical improvements being made, and exercise therapy that no longer requires the supervision of medical professionals.

4. **Chelation Therapy:** Expenses for chelation therapy will not be considered eligible, unless due to heavy metal poisoning. Chelation therapy reduces the plaque deposits in the arteries and other parts of the body.

5. **Chemical Dependency Evaluations:** Expenses for Chemical Dependency evaluations will not be considered eligible, unless followed by an Inpatient stay in a Hospital or a residential Chemical Dependency treatment facility, or an outpatient treatment program within fourteen (14) days of the receipt of the evaluation.

6. **Close Relative:** Expenses for services, care or supplies provided by a Close Relative will not be considered eligible.

7. **Cognitive and Kinetic Therapy:** Expenses for cognitive therapy and kinetic therapy will not be considered eligible. Cognitive therapy is defined as therapy which embraces mental activities associated with thinking, learning, and memory. Kinetic therapy is defined as therapy related to motion or movement (i.e. the study of motion, acceleration or rate of change). This exclusion will not apply to expenses related to the diagnosis, testing and treatment of ADD or ADHD.

8. **Complications:** Expenses for care, services or treatment required as a result of complications from a treatment not covered under the Plan will not be considered eligible.

9. **Convenience Items:** Expenses for personal hygiene and convenience items will not be considered eligible.
10. **Cosmetic Surgery**: Expenses for Cosmetic Surgery will not be considered eligible, except as specified under **Eligible Expenses**.

11. **Counseling**: Expenses for religious, marital, family or relationship counseling will not be considered eligible, except as specified under Hospice Care.

12. **Coverage Under Other Plans**: Expenses for treatment for which the Covered Person is also eligible for benefits under any other group insurance or service plan through any employer (see **Coordination of Benefits** section); or the medical payment or personal Injury sections of automobile, casualty or liability insurance regardless of whether such policy is owned by the Covered Person or some other party (see **Subrogation** section) will not be considered eligible.

13. **Custodial Care**: Expenses for Custodial Care will not be considered eligible, except as specified under the Home Health Care and Hospice Care benefits.

14. **Dental Care**: Expenses incurred in connection with dental care, treatment, x-rays, general anesthesia or Hospital expenses will not be considered eligible, except as specified under **Eligible Expenses**.

15. **Detoxification**: Expenses for detoxification will not be considered eligible, unless followed by an Inpatient stay in a Hospital or a residential chemical dependency treatment facility or an outpatient treatment program within fourteen (14) days of the receipt of the detoxification services.

16. **Developmental Delays**: Expenses in connection with the treatment of developmental delays, including, but not limited to speech therapy, occupational therapy, physical therapy and any related diagnostic testing will not be considered eligible. This exclusion will not apply to expenses related to the diagnosis, testing and treatment of ADD or ADHD.

17. **Durable Medical Equipment**: Expenses for repair or maintenance of Durable Medical Equipment will not be considered eligible. Expenses for the rental or purchase of any type of air conditioner, air purifier, or any other device or appliance will not be considered eligible, except as specified under **Eligible Expenses**.

18. **Experimental/Investigational**: Expenses for services or supplies which are not medically recognized or are Experimental/Investigational in nature will not be considered eligible.

19. **Felony/Illegal Occupation**: Expenses for or in connection with an Injury or Illness arising out of the commission of a felony or an illegal occupation will not be considered eligible. This exclusion will not apply to injuries and/or illnesses sustained due to a medical condition (physical or mental) or domestic violence.
20. **Foot Care:** Expenses for routine foot care will not be considered eligible.

21. **Gambling Addiction:** Expenses for services related to gambling addiction will not be considered eligible.

22. **Genetic Testing:** Expenses for genetic testing or genetic counseling will not be considered eligible, except amniocentesis testing as specified under Eligible Expenses.

23. **Governmental Agency:** Expenses for services and supplies which are provided by any governmental agency for which the Covered Person is not liable for payment will not be considered eligible. In the case of a state-sponsored medical assistance program, benefits payable under this Plan will be primary. Benefits payable under this Plan will also be primary for any Covered Person eligible under TRICARE (the government sponsored program for military dependents).

24. **Hearing Aids:** Expenses for hearing aids, including the fitting thereof will not be considered eligible.

25. **Homeopathic Treatment:** Expenses for naturopathic and homeopathic treatments, services and supplies will not be considered eligible.

26. **Human Subject Study:** Expenses which are performed subject to the Covered Person’s informed consent under a treatment protocol that explains the treatment or procedure as being conducted under a human subject study experiment will not be considered eligible.

27. **Hypnotherapy:** Expenses for hypnotherapy will not be considered eligible, except when used for smoking cessation.

28. **Incremental Nursing:** Expenses for incremental nursing will not be considered eligible.

29. **Infertility:** Expenses for confinement, treatment, testing or service related to infertility (the inability to conceive) or the promotion of conception will not be considered eligible.

30. **Maintenance Therapy:** Expenses for maintenance therapy of any type when the individual has reached the maximum level of improvement will not be considered eligible.

31. **Mandible Treatment:** Expenses for appliances, medical or surgical treatment for correction of a malocclusion or protrusion or recession of the mandible; maxillary or mandibular hyperplasia, or maxillary or mandibular hypoplasia will not be considered eligible. (Malocclusion - teeth do not fit together properly, bite problem; mandible protrusion or recession: underbite, chin excessively large or overbite, chin abnormally small; maxillary/mandibular hyperplasia: overbite due to excess growth of upper/lower jaw; maxillary/mandibular hypoplasia: undergrowth of upper/lower jaw). This is
considered dental surgery, performed by dental surgeons. This is not considered a medical procedure.

32. **MASSAGE THERAPY:** Expenses for massage therapy will not be considered eligible, unless when part of an overall patient treatment plan.

33. **MEDICALLY NECESSARY:** Expenses which are determined not to be Medically Necessary will not be considered eligible.

34. **MISSED APPOINTMENTS:** Expenses for completion of claim forms, missed appointments or telephone consultations will not be considered eligible.

35. **NO LEGAL OBLIGATION:** Expenses for services which are furnished under conditions which the Covered Person has no legal obligation to pay will not be considered eligible. This exclusion will not apply to eligible expenses which may be covered by state Medicaid coverage where federal law requires this Employer's plan to be primary.

36. **NOT PERFORMED UNDER THE DIRECTION OF A PHYSICIAN:** Expenses for services and supplies which are not prescribed or performed by or under the direction of a Physician will not be considered eligible.

37. **NOT RECOMMENDED BY A PHYSICIAN:** Expenses by a Hospital or covered residential treatment center if hospitalization is not recommended or approved by a legally qualified Physician will not be considered eligible.

38. **NUTRITIONAL SUPPLEMENTS:** Expenses for nutritional supplements, special infant formulas, or other enteral supplementation will not be considered eligible, unless received in an Inpatient Hospital environment or as specified under Eligible Expenses. Equipment used to administer nutritional supplements or other enteral supplementation may be covered by the Plan.

39. **OBESITY:** Expenses for weight loss programs or treatment of obesity, including morbid obesity will not be considered eligible.

40. **OCCUPATIONAL THERAPY:** Expenses for occupational therapy primarily for recreational or social interaction will not be considered eligible.

41. **OPERATED BY THE GOVERNMENT:** Expenses for treatment at a facility owned or operated by the government will not be considered eligible, unless the Covered Person is legally obligated to pay. This does not apply to covered expenses rendered by a Hospital owned or operated by the United States Veteran's Administration when services are provided to a Covered Person for a non-service related Illness or Injury.
42. **OUTSIDE THE UNITED STATES**: Expenses for services or supplies if the Covered Person leaves the United States, the U.S. Territories, or Canada for the express purpose of receiving medical treatment will not be considered eligible.

Expenses for a patient who becomes sick or injured while out of the United States, the U.S. Territories, or Canada will not be considered eligible after one hundred twenty (120) consecutive days. This time limit will not be applied if the Covered Person is out of the country for business or as a Full-Time Student.

43. **OVER-THE-COUNTER MEDICATION**: Expenses for any over-the-counter medication will not be considered eligible. Expenses for drugs and medicines not requiring a prescription by a licensed Physician and not dispensed by a licensed pharmacist will not be considered eligible.

44. **PRIOR TO EFFECTIVE DATE**: Expenses which are incurred prior to the effective date of coverage, or after the termination date of coverage will not be considered eligible.

45. **RADIOACTIVE CONTAMINATION**: Expenses incurred as the result of radioactive contamination or the hazardous properties of nuclear material will not be considered eligible.

46. **RECREATIONAL AND EDUCATIONAL THERAPY**: Expenses for recreational and educational therapy; learning disabilities; behavior modification therapy; any form of non-medical self-care or self-help training, including any related diagnostic testing; music therapy; health club memberships; aquatic or pool therapies will not be considered eligible. Diabetic education is considered eligible as specified under Eligible Expenses. This exclusion will not apply to expenses related to the diagnosis, testing and treatment of ADD or ADHD.

47. **REFRACTIVE ERRORS**: Expenses for radial keratotomy, lasik surgery or any surgical procedure to correct refractive errors of the eye will not be considered eligible.

48. **REQUIRED BY LAW**: Expenses which would be eligible for payment under any plan or policy required by law, whether the Covered Person chose to be covered under such plan or not will not be considered eligible. Under required No-fault auto coverage, minimum coverage required by law will be treated as an additional deductible.

49. **ROUTINE CARE**: Expenses for well child care and routine care, including x-ray and laboratory tests, vaccinations and immunizations will not be considered eligible, except as specified under Eligible Expenses.

50. **SEX TRANSFORMATION**: Expenses in connection with sex transformation will not be considered eligible.
51. **SEXUAL DYSFUNCTION:** Expenses for services, supplies or drugs related to sexual dysfunction not related to organic disease; or sex therapy will not be considered eligible.

52. **STERILIZATION:** Expenses for the reversal of elective sterilization will not be considered eligible.

53. **TRAVEL:** Expenses for travel will not be considered eligible, except ambulance services as specified under **Eligible Expenses**.

54. **USUAL AND CUSTOMARY CHARGE:** Expenses in excess of the Usual or Customary Charge will not be considered eligible.

55. **VISION CARE:** Expenses for vision care, including professional services for the fitting and/or supply of lenses, frames, contact lenses and other fabricated optical devices will not be considered eligible, except routine eye exams as specified under **Eligible Expenses**. However, benefits will be provided for the necessary initial placement of a pair of eyeglasses, contact lenses or an intraocular lens following a surgical procedure to the eye. This exclusion does not apply to aphakic patient and soft lenses or sclera shells intended for use as corneal bandages.

56. **WAGE OR PROFIT:** Expenses for or in connection with any Injury or Illness which arises out of or in the course of any occupation for wage or profit (including self-employment) will not be considered eligible.

57. **WAR:** Expenses for the treatment of Illness or Injury resulting from war or any act of war, whether declared or undeclared, or while in the armed forces of any country or international organization will not be considered eligible.

58. **WORKER’S COMPENSATION:** Expenses for or in connection with any Injury or Illness which arises out of or in the course of any occupation for which the Covered Person would be entitled to compensation under any Worker's Compensation Law or occupational disease law or similar legislation will not be considered eligible.

Expenses for Injuries or Illness which were eligible for payment under Worker's Compensation or similar law and have reached the maximum reimbursement paid under Worker's Compensation or similar law will not be eligible for payment under this Plan.
DEFINITIONS

The following defined terms are capitalized and used throughout the document:

ADVERSE BENEFIT DETERMINATION: Means any of the following:

1. A denial in benefits;
2. A reduction in benefits;
3. A termination of benefits; or
4. A failure to provide or make payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Claimant’s eligibility to participate in the Plan.

AMBULATORY SURGICAL FACILITY: An ambulatory surgical center, free-standing surgical center, or outpatient surgical center, which is not part of a Hospital and which: (1) has an organized medical staff of Physicians; (2) has permanent facilities that are equipped and operated primarily for the purpose of performing surgical procedures; (3) has continuous Physician’s services and registered graduate nursing (R.N.) services whenever a patient is in the facility; (4) is licensed by the jurisdiction in which it is located; and (5) does not provide for overnight accommodations.

AUTHORIZED REPRESENTATIVE: A Claimant may authorize a representative to act on their behalf in pursuing a benefit claim or appeal of an Adverse Benefit Determination. The Claimant must authorize the representative in writing, and this written authorization must be provided to the Plan. The Plan will recognize this Authorized Representative when the Plan receives the written authorization. In the case of a claim involving urgent care, a Health Care Professional with knowledge of the Claimant's medical condition is also permitted to act as the Claimant's Authorized Representative.

BIRTHING CENTER: A place licensed as such by an agency of the state. If the state does not have any licensing requirements, it must meet all of the following tests: (1) is primarily engaged in providing birthing services for low risk pregnancies; (2) it is operated under the supervision of a Physician; (3) it has at least one registered nurse (R.N.) certified as a nurse midwife in attendance at all times; (4) it has a written agreement with a licensed ambulance for that service to provide immediate transportation of the Covered Person to a Hospital as defined herein if an emergency arises; and (5) it has a written agreement with a Hospital located in the immediate geographical area of the Birthing Center to provide emergency admission of the Covered Person.

CALENDAR YEAR: January 1 through December 31 each year.
CHEMICAL DEPENDENCY: A condition characterized by physiological or psychological dependence, or both, on alcohol or a controlled substance. It is further characterized by a frequent or intense pattern of pathological use, to the point that the user: (1) loses self-control over the amount and circumstances of use; or (2) develops symptoms of tolerance, or psychological and/or physiological withdrawal if use is reduced or stopped; or (3) substantially impairs or endangers their health or substantially disrupts their social or economic function. Chemical Dependency includes alcohol or drug psychoses and alcohol or drug dependence syndromes.

CLAIM FOR BENEFITS: A request for a plan benefit or benefits made by a claimant in accordance with a Plan’s reasonable procedure for filing benefit claims. A claim for benefits includes any Pre-Service and Post-Service Claims. A request for benefits includes a request for coverage determination, for pre-authorization or approval of a plan benefit, or for a utilization review determination in accordance with the terms of the Plan.

CLAIMANT: A person requesting benefits under the Plan. A Claimant may or may not be a Covered Person under the Plan.

CLOSE RELATIVE: A Covered Person’s spouse, parent (including step-parents), sibling, child, grandparent, or in-law.

CO-INSURANCE: The percentage of eligible expenses the Plan and the Covered Person are required to pay. The amount of Co-insurance a Covered Person is required to pay is the difference from what the Plan pays as shown in the Schedule of Benefits.

CO-PAY: The portion of the medical expense which is the responsibility of the Covered Person as shown in the Schedule of Benefits. A Co-pay is applied for each occurrence of such covered medical service and is not applied toward satisfaction of the Deductible, Co-insurance or Out-of-Pocket Limit.

CONCURRENT CARE: Ongoing care or course of treatment.

CONTRACT ADMINISTRATOR: The organization providing services to the Employer in connection with the operation of this Plan and performing such other functions, including processing of claims, as may be delegated to it.

COSMETIC SURGERY: Any procedure which is primarily directed at improving an individual’s appearance and does not meaningfully promote the proper function of the body or prevent or treat illness or disease.

COVERED EMPLOYEE: An Eligible Employee whose coverage has become effective and has not terminated.

COVERED PERSON: An Eligible Employee or Eligible Dependent whose coverage has become effective and has not terminated.
CREDITABLE COVERAGE: Coverage provided under any Qualified Health Plan.

CUSTODIAL CARE: Care or service which is designed primarily to assist a Covered Person, whether or not disabled, in the activities of daily living. Such activities include, but are not limited to: bathing, dressing, feeding, preparation of special diets, assistance in walking or in getting in and out of bed, and supervision over medication which can normally be self-administered.

DEDUCTIBLE: The total amount of eligible expenses, as shown in the Schedule of Benefits, which must be incurred by a Covered Person during any Calendar Year before covered expenses are payable under the Plan. The Family Deductible maximum, as shown in the Schedule of Benefits, is the maximum amount which must be incurred by the covered family members during a Calendar Year. However, each individual in a family is not required to contribute more than one individual Deductible amount to the family Deductible.

Carry-Over: If the medical Deductible is satisfied in whole or in part by eligible expenses incurred during October, November, or December, those expenses will apply to the Deductible applicable in the next Calendar Year.

Common Accident: If two (2) or more covered family members suffer Injuries from the same accident, only one Deductible will be applied to all charges incurred for the treatment of those Injuries during the same Calendar Year.

DURABLE MEDICAL EQUIPMENT: Equipment prescribed by the attending Physician which meets all of the following requirements: (1) it is Medically Necessary; (2) it can withstand repeated use; (3) it is not disposable; (4) it is not useful in the absence of an Illness or Injury; (5) it would have been covered if provided in a Hospital; and (6) it is appropriate for use in the home.

ELIGIBILITY DATE: The first date of coverage after the Eligible Employee has satisfied any applicable waiting period. See Eligibility & Enrollment section.

ENROLLMENT DATE: The earlier of: (1) the first date of coverage; or (2) the first day of any applicable waiting period.

EXPERIMENTAL/INVESTIGATIONAL: A drug, device, medical treatment or procedure is Experimental or Investigational: (1) if the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; (2) if Reliable Evidence shows that the drug, device, medical 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 or its efficacy as compared with a standard means of treatment or diagnosis; (3) if Reliable Evidence shows that the prevailing opinion among experts regarding the drug, device, medical 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 a standard means of treatment or diagnosis.
“Reliable Evidence” shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, medical treatment or procedure; or the written informed consent used by the treating facility or another facility studying substantially the same drug, device, medical treatment or procedure.

**Extended Care Facility:** An institution or that part of any institution which operates to provide convalescent or nursing care which: (1) is primarily engaged in providing to Inpatients skilled nursing care and related services for patients who require medical or nursing care; or rehabilitation services for the rehabilitation of injured, disabled, or sick persons; (2) has policies which are developed with the advice of (and with provision for review of such policies from time to time by) a group of professional personnel, including one or more Physicians and one or more registered nurses (R.N.) to govern the skilled nursing care and related medical or other services it provides; (3) has a Physician, a registered nurse (R.N.), or a medical staff responsible for the execution of such policies; (4) has a requirement that the health care of every patient be under the supervision of a Physician, and provides for having a Physician available to furnish necessary medical care in case of emergency; (5) maintains clinical records on all patients; (6) provides twenty-four (24) hour nursing service which is sufficient to meet nursing needs in accordance with the policies developed above, and has at least one registered nurse (R.N.) employed full-time; (7) provides appropriate methods and procedures for the dispensing and administering of drugs and injections; (8) in the case of an institution in any state in which state or applicable local law provides for the licensing of institutions of this nature, is licensed pursuant to such law, or is approved by the agency of the state or locality responsible for licensing institutions of this nature as meeting the standards established for such licensing; and (9) meets any other conditions relating to the health and safety of individuals who are furnished services in such institutions or relating to the physical facilities thereof.

**Genetic Information:** Information about genes, gene products, and inherited characteristics that may derive from the individual or a family member. This includes information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories, and direct analysis of genes or chromosomes.

**Health Care Professional:** A Physician or other Health Care Professional licensed, accredited, or certified to perform specified health services consistent with State law.

**Home Health Care Agency:** A public or private agency or organization that specializes in providing medical care and treatment in the home. Such a provider must meet all of the following conditions, it: (1) is duly licensed, if such licensing is required, by the appropriate licensing authority to provide skilled nursing services and other therapeutic services; (2) qualifies as a Home Health Care Agency under Medicare; (3) meets the standards of the area-wide health care planning agency; (4) provides skilled nursing services and other services on a visiting basis in the patient’s home; (5) is responsible for administering a home health care program; and (6) supervises the delivery of a home health care program where the services are prescribed and approved in writing by the patient’s attending Physician.
HOSPICE: An agency that provides counseling and incidental medical services and may provide room and board to terminally ill individuals and which meets all of the following requirements: (1) it has obtained any required state or governmental Certificate of Need approval; (2) it provides twenty-four (24) hour-a-day, seven (7) days-a-week service; (3) it is under the direct supervision of a duly qualified Physician; (4) it has a nurse coordinator who is a registered nurse (R.N.) with four (4) years of full-time clinical experience, at least two (2) of which involved caring for terminally ill patients; (5) it has a social-service coordinator who is licensed in the jurisdiction in which it is located; (6) it is an agency that has as its primary purpose the provision of hospice services; (7) it has a full-time administrator; (8) it maintains written records of services provided to the patient; (9) its employees are bonded, and it provides malpractice and malplacement insurance; (10) it is established and operated in accordance with the applicable laws in the jurisdiction in which it is located and, where licensing is required, has been licensed and approved by the regulatory authority having responsibility for licensing under the law; (11) it provides nursing care by a registered nurse (R.N.), a licensed practical nurse (L.P.N.), a licensed physical therapist, certified occupational therapist, American Speech Language and Hearing Association certified speech therapist, or a certified respiratory therapist; and (12) it provides a home health aide acting under the direct supervision of one of the above persons while performing services specifically ordered by a Physician.

HOSPITAL: A facility which: (1) is licensed as a Hospital where licensing is required; (2) is open at all times; (3) is operated mainly to diagnose and treat Illnesses or Injuries on an Inpatient basis; (4) has a staff of one or more Physicians on call at all times; (5) has twenty-four (24) hour a day nursing services by registered nurses (R.N.'s); and (6) has organized facilities for major Surgery.

However, an institution specializing in the care and treatment of Mental/Nervous Disorders or Chemical Dependency which would qualify as a Hospital, except that it lacks organized facilities on its premises for major Surgery, shall be deemed a Hospital.

In no event shall "Hospital" include an institution which is primarily a rest home, a nursing home, a clinic, an Extended Care Facility, a convalescent home or a similar institution.

ILLNESS: A disease, sickness, pregnancy or a condition involving bodily or mental disorder of any kind. All disorders which exist simultaneously and are due to the same or related causes shall be considered one Illness.

INJURY: A bodily Injury which results independently of Illness and is caused by accidental means. All bodily Injuries sustained in any one accident and all related conditions and recurrent symptoms will be considered one Injury.

INPATIENT: Admission as a bed patient to an eligible institution.

LATE ENROLLEE: An Eligible Employee or Eligible Dependent who does not elect coverage under this Plan within thirty-one (31) days of their Eligibility Date and who is not otherwise considered a Special Enrollee. An employee not enrolled or not eligible for coverage under the Employer's previous Employer-sponsored plan will be considered a Late Enrollee.
LIFETIME MAXIMUM: The maximum benefit payable during an individual's lifetime while covered under this Plan. Benefits are available only when an individual is eligible for coverage under this Plan. The Plan provides for a Lifetime Maximum Benefit for specific types of medical treatment as well as for the total benefits provided by the Plan as shown in the medical and prescription drug Schedule of Benefits.

MEDICAL EMERGENCY: Medical services and supplies provided after the sudden onset of a medical condition (Injury or Illness) manifesting itself by acute symptoms, including intense pain, which are severe enough that the lack of immediate medical attention could reasonably be expected to result in any of the following: (1) the patient's health would be placed in serious jeopardy; (2) bodily function would be seriously impaired; or (3) there would be serious dysfunction of a bodily organ or part.

MEDICALLY NECESSARY: The medical service a patient receives which is recommended by a Physician and is required to treat the medical symptoms of a certain Illness or Injury. Although the service may be prescribed by a Physician, that does not mean the service is Medically Necessary. The medical care or treatment must: (1) be consistent with the medical diagnosis and prescribed course of medical treatment for the Covered Person's medical condition; (2) be required for reasons other than the convenience of the Covered Person or the attending Physician; (3) generally be accepted as an appropriate form of care for the medical condition being treated; and (4) be likely to result in physical improvement of the patient's medical condition which is unlikely to ever occur if the medical treatment is not administered.

MENTAL/NERVOUS DISORDERS: Any condition classified as a mental disorder, except for mental retardation and Chemical Dependency, in the current edition of the International Classification of Diseases published by the U.S. Department of Health and Human Services. This includes, but is not limited to, eating disorders, bipolar disorders, psychotic disorders, neurotic disorders, adjustment disorders and personality disorders.

OUT-OF-POCKET LIMIT: An Out-of-Pocket Limit is the maximum amount of Co-insurance a Covered Person and/or all family members will pay for eligible expenses incurred during a Calendar Year before the covered percentage increases to 100%.

NOTE: Expenses incurred for the following cannot be applied toward the Out-of-Pocket Limit: (1) Co-pays; (2) Deductibles; (3) any penalty amounts; and (4) any charges as defined in the Exclusions and Limitations section.

PHYSICIAN: A legally licensed Physician who is acting within the scope of their license, and any other licensed practitioner required to be recognized for benefit payment purposes under the laws of the state in which they practice and who is acting within the scope of their license. The definition of 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.
PLAN ADMINISTRATOR: The Employer, which is sponsoring this Plan for its employees. The Plan Administrator may hire persons or firms to process claims and perform other Plan connected services.

POST-SERVICE CLAIM: Post-Service Claims are all claims that are not Pre-Service Claims.

PRE-SERVICE CLAIM: Pre-Service Claim is any request for approval of a benefit 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 obtaining medical care.

PREFERRED PROVIDER NETWORK: All participating providers, health professionals, Hospitals, or other organizations having an agreement with the Preferred Provider Organization (PPO).

PRIMARY CARE PHYSICIAN: A Physician responsible for managing and coordinating the full scope of a Covered Person’s medical care, including but not limited to performing routine evaluations and treatment, arranging for all necessary referrals to Specialists, ordering laboratory tests and x-ray examinations, prescribing necessary medications and arranging for a Covered Person’s hospitalization or other services when appropriate. Primary medical care includes these medical specialties: Internal Medicine (General), Pediatrics, and Family Practice.

QUALIFIED HEALTH PLAN: The following will be considered Qualified Health Plans: (1) a group health plan; (2) health insurance coverage; (3) Medicare; (4) Medicaid; (5) TRI-CARE; (6) Indian Health Service plan or tribal organization plan; (7) a state risk pool coverage; (8) federal employees health insurance coverage; (9) public health plan; and (10) Peace Corps plan.

REHABILITATION FACILITY: The facility must meet all of the following requirements: (1) must be for the treatment of acute Injury or Illness; (2) is licensed as an acute rehabilitation facility; (3) the care is under the direct supervision of a Physician; (4) services are Medically Necessary; (4) services are specific to an active written treatment plan; (5) the patient’s condition requires skilled nursing care and interventions which cannot be achieved or managed at a lower level of care; (6) twenty-four (24) hour nursing services are available; and (7) the confinement is not for Custodial Care or maintenance care.

SPECIAL ENROLLEE: If an Eligible Employee declined single or family coverage hereunder at the time of initial eligibility (and stated in writing at that time that coverage was declined because of alternative health coverage) but subsequently loses coverage under the other health plan and makes application for coverage under this Plan within thirty-one (31) days of the loss, such individual shall be a Special Enrollee provided such person: (a) was under a COBRA continuation provision and the coverage under such provision was exhausted; or (b) was not under such a provision and either the coverage was terminated as a result of loss of eligibility for the coverage (see below), or employer contributions toward such coverage were terminated. Individuals who lose other coverage due to non-payment of premium or for cause (e.g., filing fraudulent claims) shall not be Special Enrollees hereunder. Coverage for a Special Enrollee who had other coverage and then lost it shall begin as of the first day of the calendar month following the enrollment request.
Loss of eligibility includes, but is not limited to: (a) legal separation, divorce, cessation of dependent status (such as attaining the maximum age to be considered an Eligible Dependent under the plan), death of an employee, termination of employment, reduction in the number of hours of employment; (b) coverage is offered through an HMO or other arrangement, in the individual market that does not provide benefits to individuals who no longer reside, live or work in a service area (whether or not within the choice of the individual); (c) coverage is offered through an HMO or other arrangement, in the group market that does not provide benefits to individuals who no longer reside, live or work in a service area (whether or not within the choice of the individual), and no other benefit package is available to the individual; (d) when a Covered Person incurs a claim that would meet or exceed a lifetime limit on all benefits (this right continues until at least 31 days after the earliest date that a claim is denied due to the operation of the lifetime limit); (e) when a plan no longer offers any benefits to a class of similarly situated individuals, i.e. terminated coverage for part-time employees, etc.

An Eligible Employee, Spouse, or newly acquired Dependent who seeks to enroll in the Plan as a result of the acquisition of a new dependent through marriage, birth, adoption or placement for adoption shall be a Special Enrollee hereunder if the Eligible Employee, Spouse, or newly acquired Dependent enrolls within thirty-one (31) days of the acquisition of the new Dependent. Coverage for such Special Enrollee shall begin as stated in the Effective Date of Coverage section.

**SPECIALISTS:** A Physician who provides services to a Covered Person within the range of their specialty (i.e. Cardiologist, Neurologist, Obstetrics/Gynecology (OB/GYN), etc.).

**SURGERY:** Any operative or diagnostic procedure performed in the treatment of an Illness or Injury by an instrument or cutting procedure through any natural body opening or incision. The reduction of a fracture or dislocation will also be considered Surgery.

**TRUST:** Means the agreement and Declaration of Trust made as of June 1, 2004, by and among Drury University.

**URGENT CARE CLAIM:** Any Pre-Service Claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the Claimant or the ability of the Claimant to regain maximum function, or in the opinion of a Physician with knowledge of the Claimant’s medical condition, would subject the Claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. A Post-Service Claim is never an Urgent Care Claim.

**URGENT CARE FACILITY:** A facility which is engaged primarily in providing minor emergency and episodic medical care to a Covered Person. A board-certified Physician, a registered nurse, and a registered x-ray technician must be in attendance at all times that the facility is open. The facility must include x-ray and laboratory equipment and a life support system. For the purpose of this Plan, a facility meeting these requirements will be considered to be an Urgent Care Facility, by whatever actual name it may be called; however, an after-hours clinic shall be excluded from the terms of this definition.
**USUAL AND CUSTOMARY CHARGE:** Charges made for medical services or supplies essential to the care of the individual will be subject to a Usual and Customary determination. Usual and Customary allowances are based on what is usually and customarily accepted as payment for the same service within a geographical area. In determining whether charges are Usual and Customary, consideration will be given to the nature and severity of the condition and any medical complications or unusual circumstances which require additional time, skill or experience.
TERMINATION OF BENEFITS

An employee's or dependent's coverage shall terminate at the earliest time indicated below:

1. In the event the employee fails to make any required contributions when due, benefits shall automatically terminate at the end of the period for which the contribution was made.

2. Upon termination of employment or retirement, benefits will cease on the last day of the month in which the employee terminated. Cessation of active work by an employee shall be deemed termination of employment, except as follows:

   (a) In the event an employee is absent on account of Illness or Injury, employment shall be deemed to continue for the purpose of benefits hereunder until the date contributions received from the Employer for such employee's benefits are discontinued; or

   (b) An employee who retires prior to age sixty-five (65), is at least the age of fifty-five (55) and has ten (10) or more years of service with the Employer, may continue coverage under the Plan. Once the retiree becomes eligible for Medicare, this Plan will pay secondary to Medicare. (The retiree must enroll for both Parts A & B Medicare.) This extension also applies to the retiree's dependents; or

   (c) The benefits of an employee who is temporarily laid-off or granted leave of absence may be continued, but not beyond the end of the leave of absence or lay-off. The leave of absence or lay-off may not exceed twelve (12) months.

3. The end of the month the employee ceases to be eligible for coverage or ceases to be in a class eligible for coverage.

4. The date the dependent ceases to be eligible for coverage or ceases to be in a class eligible for coverage.

5. When maximum benefits of this Plan have been exhausted.

6. The date the dependent becomes an Eligible Employee.

7. When the employee or dependent enters the military service on a full-time active duty basis other than scheduled drills or other training not exceeding one month in any Calendar Year.

8. The date the Plan is terminated.
SUVIVOR BENEFIT

When a Covered Employee (or retiree) dies, the surviving dependents may continue coverage under the Plan. The dependent child may continue coverage until the date the child reaches the dependent age limit.

Once the surviving spouse becomes eligible for Medicare, this Plan will pay secondary to Medicare. (The spouse must enroll for both Parts A & B Medicare.)
FAMILY AND MEDICAL LEAVE ACT (FMLA)

An eligible employee is entitled to a maximum of twelve (12) weeks of unpaid leave in any twelve (12) month period for reasons that qualify under FMLA.

An employee may choose not to retain health coverage during the FMLA leave. However, when an employee returns from leave, the employee is entitled to have coverage reinstated on the same basis as it would have been if the leave had not been taken. (Coverage will be reinstated without any additional qualification requirements imposed by the Plan. The Plan’s provisions with respect to Pre-Existing Conditions, Deductibles and Co-insurance amounts will apply on the same basis as they did prior to the FMLA leave.)
If an individual was covered under this Plan immediately prior to being called to active duty by any of the uniformed services of the United States of America, coverage may continue for up to twenty-four (24) months or the period of uniformed service leave, whichever is shortest, if the individual pays any required contributions toward the cost of coverage during the leave. If the leave is less than thirty (30) days, the contribution rate will be the same as for active employees. If the leave is longer than thirty (30) days, the required contribution will not exceed 102% of the cost of coverage.

Whether or not the individual elects continuation coverage under the Uniformed Services Employment and Reemployment Rights Act (USERRA), coverage will be reinstated on the first day the individual returns to active employment with the Employer if released under honorable conditions and the individual returns to employment: (a) on the first full business day following completion of the military service for a leave of thirty (30) days or less; or (b) within fourteen (14) days of completing military service for a leave of thirty-one (31) to one hundred eighty (180) days; or (c) within ninety (90) days of completing military service for a leave of more than one hundred eighty (180) days (a reasonable amount of travel time or recovery time for an Illness or Injury determined by the VA to be service connected will be allowed).

When coverage under this Plan is reinstated, all provisions and limitations in this Plan will apply to the extent that they would have applied if the military leave had not been taken and coverage had been continuous under this Plan. The eligibility waiting period will be waived and the Pre-Existing Condition Limitation will be credited as if you had been continuously covered under this Plan from the original effective date. (This waiver of limitations does not provide coverage for any Illness or Injury caused or aggravated by the military service, as determined by the VA. For complete information regarding the rights under USERRA contact the Employer.)
CONTINUATION COVERAGE RIGHTS UNDER COBRA

INTRODUCTION

This section contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and to other members of your family who are covered under the Plan when you would otherwise lose your group health coverage. This section generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it. This section gives only a summary of your COBRA continuation coverage rights.

The Plan Administrator is responsible for administering COBRA continuation coverage. The Plan Administrator has contracted with Infinisource, COBRA Compliance Systems, Inc., to conduct the day-to-day COBRA continuation coverage operations of the Plan. Infinisource’s address and telephone number are the following: 15 East Washington Street, Coldwater, MI, 49036 and phone number is 800-594-6957.

COBRA CONTINUATION COVERAGE

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a “qualifying event.” Specific qualifying events are listed later in this section. COBRA continuation coverage must be offered to each person who is a “qualified beneficiary.” Only qualified beneficiaries may elect to continue their group health plan coverage. A qualified beneficiary is someone who will lose coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees, and dependent children of employees may be qualified beneficiaries. (Certain newborns, newly-adopted children and alternate recipients under Qualified Medical Child Support Orders (QMCSO) may also be qualified beneficiaries. This is discussed in more detail in separate paragraphs below.) Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

Continuation coverage is the same coverage that the Plan gives to other participants or beneficiaries under the Plan who are not receiving continuation coverage. Each qualified beneficiary who elects continuation coverage will have the same rights under the Plan as other participants or beneficiaries covered under the Plan, including special enrollment rights.

If you are an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because either one of the following qualifying events happens:

1. Your hours of employment are reduced, or
2. Your employment ends for any reason other than your gross misconduct.
If you are the spouse of an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because any of the following qualifying events happens:

1. Your spouse dies;
2. Your spouse’s hours of employment are reduced;
3. Your spouse’s employment ends for any reason other than his or her gross misconduct;
4. Your spouse becomes enrolled in Medicare (Part A, Part B, or both); or
5. You become divorced from your spouse. If an employee cancels coverage for his or her spouse in anticipation of a divorce and a divorce later occurs, then the divorce will be considered a qualifying event even though the ex-spouse lost coverage earlier. If the ex-spouse notifies the administrator within 60 days after the divorce and can establish that the employee canceled the coverage earlier in anticipation of the divorce, then COBRA coverage may be available for the period after the divorce.

Your dependent children will become qualified beneficiaries if they will lose coverage under the Plan because any of the following qualifying events happens:

1. The parent-employee dies;
2. The parent-employee’s hours of employment are reduced;
3. The parent-employee’s employment ends for any reason other than his or her gross misconduct;
4. The parent-employee becomes enrolled in Medicare (Part A, Part B, or both);
5. The parents become divorced or legally separated; or
6. The child stops being eligible for coverage under the plan as a “dependent child.”

Sometimes, filing a proceeding in bankruptcy under Title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to Drury University, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee is a qualified beneficiary with respect to the bankruptcy. The retired employee’s spouse, surviving spouse, and dependent children will also be qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

**NOTIFYING THE PLAN ADMINISTRATOR OF QUALIFYING EVENTS**

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been timely notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, commencement of a proceeding in bankruptcy with respect to the employer, or enrollment of the employee in Medicare (Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event within thirty (30) days of any of these events.

**Important:** For the other qualifying events (divorce of the employee and spouse or a dependent child’s losing eligibility for coverage as a dependent child), you must notify the Plan Administrator. The Plan requires you to notify the Plan Administrator in writing within sixty (60) days after the later of the qualifying event or the loss of coverage, using the procedures specified within this section. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator during the sixty (60) day notice
period, any spouse or dependent child who loses coverage will not be offered the option to elect continuation coverage.

**ELECTING COBRA CONTINUATION COVERAGE**

Once the Plan Administrator receives timely notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. For each qualified beneficiary who timely elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that Plan coverage would otherwise have been lost.

Each qualified beneficiary has an independent right to elect continuation coverage. For example, both the employee and the employee’s spouse may elect continuation coverage, or only one of them. Parents may elect to continue coverage on behalf of their dependent children only. **A qualified beneficiary must elect coverage in writing within sixty (60) days of being provided a COBRA election notice, using the Plan’s Election Form and following the procedures specified on the Election Form.** (A copy of the Plan’s Election Form may be obtained from the Plan Administrator.) Your written notice must be provided to the Plan Administrator at the address provided on the Plan’s Election Form. If you mail your election, it must be postmarked no later than the last day of the sixty (60) day election period. **If you or your spouse or dependent children do not elect continuation coverage within the sixty (60) day election period, YOU WILL LOSE YOUR RIGHT TO ELECT CONTINUATION COVERAGE.** A qualified beneficiary may change a prior rejection of continuation coverage any time until the end of the 60-day election period, in writing, by using the Election Form and following the procedures specified on the Election Form.

In considering whether to elect continuation coverage, you should take into account that a failure to continue your group health coverage will affect your future rights under federal law. First, you can lose the right to avoid having preexisting condition exclusions applied to you by other group health plans if you have more than a sixty-three (63) day gap in health coverage, and election of continuation coverage may help you not have such a gap. Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such preexisting condition exclusions if you do not get continuation coverage for the maximum time available to you. Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse’s employer) within thirty (30) days after your group health coverage ends because of the qualifying event listed above. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

**LENGTH OF COBRA CONTINUATION COVERAGE**

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, enrollment of the employee in Medicare (Part A, Part B, or both), your divorce or legal separation, or a dependent child losing eligibility as a dependent child, COBRA continuation coverage lasts for up to thirty-six (36) months.
When the qualifying event is the end of employment or reduction of the employee’s hours of employment, COBRA continuation coverage lasts for up to eighteen (18) months. There are three (3) ways in which this eighteen (18) month period of COBRA continuation coverage can be extended.

**DISABILITY EXTENSION OF EIGHTEEN (18) MONTH PERIOD OF CONTINUATION COVERAGE**

An eleven (11) month extension of coverage may be available if any of the qualified beneficiaries in your family is disabled. All of the qualified beneficiaries who have elected continuation coverage will be entitled to the eleven (11) month disability extension if one of them qualifies. The Social Security Administration (SSA) must determine that the qualified beneficiary was disabled at some time during the first sixty (60) days of continuation coverage, and you must notify Infinisource of that fact in writing within sixty (60) days of the SSA’s termination and before the end of the first eighteen (18) months of continuation coverage. If these procedures are not followed or if a written notice of a disability is not provided to the Plan Administrator within the required period, THEN THERE WILL BE NO DISABILITY EXTENSION OF COBRA CONTINUATION COVERAGE.

If the qualified beneficiary is determined by the SSA to no longer be disabled, you must notify Infinisource of that fact within thirty (30) days of the SSA’s determination. COBRA coverage for all qualified beneficiaries will terminate as of the first day of the month that is more than thirty (30) days after the SSA’s determination that the qualified beneficiary is no longer disabled. The plan reserves the right to retroactively cancel COBRA coverage and will require reimbursement of all benefits paid after the first day of the month that is more than thirty (30) days after the SSA’s determination that the qualified beneficiary is no longer disabled.

**SECOND QUALIFYING EVENT EXTENSION OF EIGHTEEN (18) MONTH PERIOD OF CONTINUATION COVERAGE**

An eighteen (18) month extension of coverage will be available to spouses and dependent children who elect continuation coverage if a second qualifying event occurs during the first eighteen (18) months of continuation coverage. The maximum amount of continuation coverage available when a second qualifying event occurs is thirty-six (36) months. Such second qualifying events include the death of a covered employee, divorce from the covered employee, or a dependent child’s ceasing to be eligible for coverage as a dependent under the Plan.

Upon the occurrence of a second qualifying event, you must notify Infinisource in writing within sixty (60) days after the second qualifying event occurs. If these procedures are not followed or if a written notice of a second qualifying event is not provided to the Plan Administrator within the required period, THEN THERE WILL BE NO EXTENSION OF COBRA CONTINUATION COVERAGE DUE TO A SECOND QUALIFYING EVENT.
MEDICARE EXTENSION FOR SPOUSE AND DEPENDENT CHILDREN

If a qualifying event that is a termination of employment or reduction of hours occurs within eighteen (18) months after the covered employee becomes entitled to Medicare, then the maximum coverage period for the spouse and dependent children will end three years from the date the employee became entitled to Medicare (but the covered employee’s maximum coverage period will be 18 months).

TERMINATION OF COBRA CONTINUATION COVERAGE BEFORE THE END OF THE MAXIMUM COVERAGE PERIOD

Continuation coverage will be terminated before the end of the maximum period if (1) any required premium is not paid on time; (2) after electing COBRA coverage, a qualified beneficiary becomes covered under another group health plan that does not impose any preexisting condition exclusion for a preexisting condition of the qualified beneficiary; (3) after electing COBRA coverage, a qualified beneficiary enrolls in Medicare; or (4) the employer ceases to provide any group health plan for its employees. Continuation coverage may also be terminated for any reason the Plan would terminate coverage of a participant or beneficiary not receiving continuation coverage (such as fraud).

You must notify the Plan Administrator in writing within thirty (30) days if, after electing COBRA coverage, a qualified beneficiary becomes covered under another group health plan or enrolls in Medicare Part A or B. The Plan reserves the right to retroactively cancel COBRA coverage and in that case will require reimbursement of all benefits paid after the date of commencement of other group health plan coverage or Medicare entitlement.

COST OF CONTINUATION COVERAGE

Generally, each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount a qualified beneficiary may be required to pay may not exceed 102% of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly-situated plan participant or beneficiary who is not receiving continuation coverage (or, in the case of an extension of continuation coverage due to a disability, 150%).

The Trade Act of 2002 created a new health coverage tax credit for certain individuals who become eligible for trade adjustment assistance (eligible individuals). Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. If you have questions about these new tax provisions, you may call the Health Care Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact/2002act_index.cfm.

Special COBRA rights apply to certain employees who are eligible for the health coverage tax credit. These employees are entitled to a second opportunity to elect COBRA coverage for themselves and certain family members (if they did not already elect COBRA coverage) during a special second election period. This special second election period lasts for sixty (60) days or less. It is the sixty (60) day period beginning on the first day of the month in which an eligible employee
becomes eligible for the health coverage tax credit, but only if the election is made within the six months immediately after the eligible employee’s group health plan coverage ended. If you qualify or may qualify for the health coverage tax credit, contact the Drury University Human Resources Director for additional information. **YOU MUST CONTACT THE HUMAN RESOURCES DIRECTOR PROMPTLY AFTER QUALIFYING FOR THE HEALTH COVERAGE TAX CREDIT OR YOU WILL LOSE YOUR SPECIAL COBRA RIGHTS.**

**PAYMENT FOR CONTINUATION COVERAGE**

**FIRST PAYMENT FOR CONTINUATION COVERAGE**

If you elect continuation coverage, you do not have to send any payment for continuation coverage with the Election Form. However, you must make your first payment for continuation coverage within forty-five (45) days after the date of your election. (This is the date the Election Notice is post-marked, if mailed.) If you do not make your first payment for continuation coverage within that forty-five (45) days, you will lose all continuation coverage rights under the Plan.

Your first payment must cover the cost of continuation coverage from the time your coverage under the Plan would have otherwise terminated. You are responsible for making sure that the amount of your first payment is enough to cover this entire period. You may contact Infinisource to confirm the correct amount of your first payment.

Your first payment for continuation coverage should be sent to the address indicated on the election notice provided at the time of your COBRA qualifying event.

**PERIODIC PAYMENTS FOR CONTINUATION COVERAGE**

After you make your first payment for continuation coverage, you will be required to pay for continuation coverage for each subsequent month of coverage. Under the Plan, these periodic payments for continuation coverage are due on the first day of the month. If you make a periodic payment on or before its due date, your coverage under the Plan will continue for that coverage period without any break. The Plan will not send periodic notices of payments due for these coverage periods. You must make your payment by the due date or within the grace period (discussed below) whether or not you receive a notice.

Periodic payments for continuation coverage should be sent to the address indicated on the election notice provided at the time of your COBRA qualifying event.

**GRACE PERIODS FOR PERIODIC PAYMENTS**

Although periodic payments are due on the date shown above, you will be given a grace period of thirty (30) days to make each periodic payment. Your continuation coverage will be provided for each coverage period so long as payment for that coverage period is made before the end of the grace period for that payment. Failure to pay any premium will cause your coverage to be retroactively terminated.
If you fail to make a periodic payment before the end of the grace period for that payment, you will lose all rights to continuation coverage under the Plan.

**MORE INFORMATION ABOUT INDIVIDUALS WHO MAY BE QUALIFIED BENEFICIARIES**

**CHILDREN BORN TO OR PLACED FOR ADOPTION WITH THE COVERED EMPLOYEE DURING COBRA PERIOD**

A child born to, adopted by or placed for adoption with a covered employee during a period of continuation coverage is considered to be a qualified beneficiary provided that, if the covered employee is a qualified beneficiary, the covered employee has elected continuation coverage for himself or herself. The child’s COBRA coverage begins when the child is enrolled in the Plan, whether through special enrollment or open enrollment, and it lasts for as long as COBRA coverage lasts for other family members of the employee. To be enrolled in the Plan, the child must satisfy the otherwise applicable Plan eligibility requirements (for example, regarding age).

**ALTERNATE RECIPIENTS UNDER QMCSOS**

A child of the covered employee who is receiving benefits under the Plan pursuant to a Qualified Medical Child Support Order (QMCSO) received by the Plan Administrator during the covered employee’s period of employment with the employer is entitled to the same rights under COBRA as a dependent child of the covered employee, regardless of whether that child would otherwise be considered a dependent.

**NOTICE PROCEDURES:**

**Notices Must be Mailed or Hand Delivered to:**

Plan Administrator: Drury University  
900 North Benton Avenue  
Springfield, MO  65802

**NOTICE PROCEDURES OF QUALIFYING EVENT**

**Deadline for Notice of Qualifying Event**

The deadline for providing this notice is sixty (60) days after the later of (1) the qualifying event (i.e., a divorce or legal separation or a child’s loss of dependent status); and (2) the date on which the covered spouse or dependent child would lose coverage under the terms of the Plan as a result of the qualifying event.
How to Provide Notice of Qualifying Event

Your notice must be in writing and must be mailed or hand delivered. Oral notice, including notice by telephone, is not acceptable. Electronic (including e-mailed or faxed) notices are not acceptable. If mailed, your notice must be postmarked no later than the deadline described above. If hand delivered, your notice must be received by the individual at the addresses specified above no later than the deadline described above.

Required Form and Information for Notice of Qualifying Event

You must use the Plan's form entitled "Notice of Qualifying Event" to notify Drury University of a qualifying event (i.e., a divorce or legal separation or a child's loss of dependent status) and all of the applicable items on the form must be completed. You may obtain a copy of the “Notice of Qualifying Event” from Drury University.

If you are notifying Drury University of a divorce or legal separation, your notice must include a copy of the decree of divorce or legal separation.

If your coverage is reduced or eliminated and later a divorce or legal separation occurs, and you are notifying Drury University that your Plan coverage was reduced or eliminated in anticipation of the divorce or legal separation, you must provide notice within sixty (60) days after the divorce or legal separation in accordance with these Notice Procedures for Notice of Qualifying Event and must, in addition, provide evidence satisfactory to Drury University that your coverage was reduced or eliminated in anticipation of the divorce or legal separation.

Incomplete Notice of Qualifying Event

If you provide a written notice that does not contain all of the information and documentation required by these NOTICE PROCEDURES for Notice of Qualifying Event, such a notice will nevertheless be considered timely if all of the following conditions are met:

(a) The notice is mailed or hand delivered to the individual and address specified above;
(b) The notice is provided by the deadline described above;
(c) From the written notice provided, Drury University is able to identify the covered employee and qualified beneficiary(ies), the qualifying event (the divorce, legal separation, or child's loss of dependent status), and the date on which the qualifying event occurred; and
(d) The notice is supplemented in writing with the additional information and documentation necessary to meet the Plan's requirements (as described in these Notice Procedures for Notice of Qualifying Event) within fifteen (15) business days after a written or oral request from Drury university for more information (or, if later, by the deadline for Notice of Qualifying Event described above).
If any of these conditions is not met, the incomplete notice will be rejected and COBRA will not be offered. If all of these conditions are met, the Plan will treat the notice as having been provided on the date that the Plan receives all of the required information and documentation but will accept the notice as timely.

**Additional evidence of the date of a child’s loss of dependent status may be required.**

If your notice was regarding a child’s loss of dependent status, you must, if Drury University requests it, provide documentation of the date of the qualifying event that is satisfactory to Drury University (for example, a birth certificate to establish the date that a child reached the limiting age, a marriage certificate to establish date that a child married, or a transcript showing the last date of enrollment in an educational institution). This will allow Drury University to determine if you gave timely notice of the qualifying event and were consequently entitled to elect COBRA. If you do not provide satisfactory evidence within fifteen (15) business days after a written or oral request from Drury University that the child ceased to be a dependent on the date specified in your Notice of Qualifying Event, his or her COBRA coverage may be terminated (retroactively if applicable) as of the date that COBRA coverage would have started. Drury University will require repayment to the Plan of all benefits paid after the termination date.

**IF YOU HAVE QUESTIONS**

If you have questions about your COBRA continuation coverage, you should contact Infinisource or you may contact the nearest Regional or District Office of the U.S. Department of Labor’s Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA’s website at [www.dol.gov/ebsa](http://www.dol.gov/ebsa).

**KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES**

In order to protect your family’s rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.
COORDINATION OF BENEFITS

If a Covered Person is covered under more than one group plan as defined below, including this Plan, benefits will be coordinated. The benefits payable under this Plan for any Claim Determination Period, will be either its regular benefits or reduced benefits which, when added to the benefits of the other plan, may equal 100% of the Allowable Expenses defined below.

DEFINITIONS

Allowable Expenses: Any Medically Necessary, Usual and Customary item of expense incurred by a Covered Person which is covered at least in part under this Plan.

Claim Determination Period: A Calendar or Plan Year or that portion of a Calendar or Plan Year during which the Covered Person for whom claim is made has been covered under this Plan.

Plan: Any plan under which benefits or services are provided by:

1. Group, blanket or franchise insurance coverage;
2. Any group Hospital service prepayment, group medical service prepayment, group practice or other group prepayment coverage;
3. Group coverage under labor-management trusteed plans, union welfare plans, Employer organization plans or employee benefits plans;
4. Coverage under Medicare and any other governmental program that the Covered Person is liable for payment, except state-sponsored medical assistance programs and TRICARE, in which case this Plan pays primary;
5. Coverage provided through a school or other educational institution; or

ORDER OF BENEFIT DETERMINATION

When a claim is made, the primary plan pays its benefits without regard to any other plans. The secondary plan adjusts its benefits so that the total benefits paid by both plans will not exceed 100% of the Allowable Expenses. Neither plan pays more than it would without the Coordination of Benefits provision.

A plan without a Coordination of Benefits provision is always the primary plan. The FIRST rule that applies determines primary carrier and supersedes the following rules. If all plans have a Coordination of Benefits provision:

1. The plan covering the person directly, rather than as an employee's dependent, is primary and the other plans are secondary.
2. Dependent children of parents not separated or divorced, or unmarried parents living together: the plan covering the parent whose birthday falls earlier in the year pays first. The plan covering the parent whose birthday falls later in the year pays second.

However, if the other plan does not have this rule but instead has a rule based upon the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.

3. Dependent children of separated or divorced parents, or unmarried parents not living together: When parents are separated or divorced or unmarried and not living together, neither the male/female nor the birthday rules apply. Instead:

(a) The plan of the parent with custody pays first;
(b) The plan of the spouse of the parent with custody (the step-parent) pays next;
(c) The plan of the parent without custody pays next; and
(d) The plan of the spouse of the non-custodial parent pays last.

However, if specific terms of a court decree state that one of the parents is responsible for the child's health care expenses, and the insurer or other entity obliged to pay or provide the benefits of that parent's plan has actual knowledge of those terms, that plan pays first.

4. Active/Laid-Off or Retired Employees: The plan which covers that person as an active employee (or as that employee’s dependent) determines its benefits before the Plan which covers that person as a laid-off or retired employee (or as that employee’s dependent). If the Plan which covers that person has not adopted this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule (4) will not apply.

5. If a person whose coverage is provided under a right of continuation pursuant to state or federal law (i.e. COBRA) is also covered under another plan, the plan covering the person as an employee, member, subscriber, or retiree (or as that person’s dependent) is primary and the continuation coverage is secondary. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule (5) is ignored.

6. If none of the above rules determines the order of benefits, the plan covering a person longer pays first. The plan covering that person for the shorter time pays second.

Coordination of Benefits may operate to reduce the total amount of benefits otherwise payable during any Claim Determination Period with respect to a Covered Person under this Plan. When the benefits of this Plan are reduced, each benefit is reduced proportionately. The reduced amount is then charged against any applicable benefit limit of this Plan.
When a Plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered will be considered to be both an Allowable Expense and a benefit paid.

**RECOVERY**

If the amount of the payment made by this Plan is more than it should have been, the Contract Administrator on behalf of the Plan, has the right to recover the excess from one or more of the following:

1. The person this Plan has paid or for whom it has paid;
2. Providers of care;
3. Insurance companies; or
4. Other organizations.

**PAYMENT TO OTHER CARRIERS**

Whenever payments, which should have been made under this Plan in accordance with the above provisions, have been made, this Plan will have the right to pay any organization making those payments any amounts it determines to be warranted in order to satisfy the intent of the above provisions. Amounts paid in this manner will be considered to be benefits paid under this Plan and, to the extent of these payments, this Plan will be fully discharged from liability.
EFFECT OF MEDICARE

In accordance with Federal Medicare regulations, the following is a brief explanation of the Medicare guidelines, not to be considered all inclusive.

1. **Working Aged Benefits**

   *Employers with 20 or more Employees:* This Plan will be primary when an active employee or spouse is age sixty-five (65) and over. The employee must decline coverage under this Plan in order to have Medicare pay primary.

2. **Disabled Employees/Spouses**

   *Employers with 100 or more Employees:* This Plan will be primary when an active employee or dependent is disabled and covered by Medicare.

3. **Disability Due to End Stage Renal Disease (ESRD)**

   For employees or dependents under age sixty-five (65), if Medicare eligibility is due solely to End Stage Renal Disease (ESRD), the Plan will be primary only during the first thirty (30) months of Medicare coverage. Thereafter, the Plan will be secondary with respect to Medicare coverage.

   If an employee or dependent is under age sixty-five (65) when Medicare eligibility is due solely to ESRD, and the individual attains age sixty-five (65), the Plan will be primary for a full thirty (30) months (or 33 months, depending upon whether a transplant or self-dialysis is involved) from the date of ESRD eligibility. Thereafter, Medicare will be primary and the Plan will be secondary.

   If an employee or dependent is age sixty-five (65) and over, working and develops or is undergoing treatment for ESRD, the Plan will be primary for a full thirty (30) months (or 33 months from the date of ESRD eligibility). Thereafter, Medicare will be primary and the Plan will be secondary.

4. **All Individuals Eligible for Medicare**

   Covered Persons should be certain to enroll in Medicare Part A & B coverage in a timely manner to assure maximum coverage. Contact the Social Security Administration office to enroll for Medicare. If this Plan is secondary, benefits under this Plan will be coordinated with the dollar amount that Medicare will pay, subject to the rules and regulations specified by federal law.

5. **Medicare and COBRA**

   For most COBRA beneficiaries, Medicare rules state that Medicare will be primary to COBRA continuation coverage, and this would apply to this Plan’s Continuation of Benefits (COBRA) coverage.
SUBROGATION

Benefits are payable only upon the Covered Person's acceptance of the terms of the Plan. As a condition to receiving benefits under this Plan, a Covered Person agrees:

1. To serve as a constructive trustee, and to hold in constructive trust such money or property resulting from any payments or settlement proceeds and agrees that they will not dissipate any such money or property without prior written consent of the Plan, regardless of how such money or property is classified or characterized, from any person, corporation, entity, no-fault carrier, uninsured motorist carrier, underinsured motorist carrier, other insurance policies for funds; and

2. To restore to the Plan any such benefits paid or payable to, or on behalf of, the Covered Person when said benefits are paid or established by any person, corporation, entity, no-fault carrier, uninsured motorist carrier, underinsured motorist carrier, other insurance policies for funds; and

3. To refrain from releasing any party, person, corporation, entity, insurance company, insurance policies or funds that may be liable for or obligated to the Covered Person for the Injury or condition without obtaining the Plan's written approval; and

4. Without limiting the preceding, to subrogate the Plan to any and all claims, causes of action or rights that they have or that may arise against any person, corporation and/or other entity and to any coverage, no-fault coverage, uninsured motorist coverage, underinsured motorist coverage, other insurance policies or funds ("Coverage") for which the Covered Person claims an entitlement to benefits under this Plan, regardless of how classified or characterized.

In the event a Covered Person settles, recovers, receives, or is reimbursed by any first or third party or Coverage, the Covered Person agrees that they are a constructive trustee, and shall hold any such funds received in constructive trust for the benefit of the Plan, and to transfer title to the Plan for all benefits paid or that will be paid as a result of said Injury or condition. The Covered Person acknowledges that the Plan has a property interest in the Covered Person's settlement, recovery, or reimbursement, and that the Plan's subrogation rights shall be considered a first priority claim and shall be paid before any other claims for the Covered Person as the result of the Illness or Injury, regardless of whether the Covered Person is made whole. If the Covered Person fails to reimburse the Plan for all benefits paid or to be paid, as a result of said Injury or condition, out of any recovery or reimbursement received, the Covered Person will be liable for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Covered Person.

The Covered Person shall execute and return a Subrogation Agreement to the Plan Administrator and shall supply other reasonable information and assistance as requested by the Plan Administrator regarding the claim or potential claim. If the Subrogation Agreement is not executed and returned or if information and assistance is not provided to the Plan Administrator upon request, no benefits will be payable under the Plan with respect to costs incurred in connection with such Illness or Injury.
If the Covered Person (or guardian or estate) decides to pursue a first or third party or any Coverage available to them as a result of the said Injury or condition, the Covered Person agrees to include the Plan's subrogation claim in that action and if there is failure to do so the Plan will be legally presumed to be included in such action or recovery. In the event the Covered Person decides not to pursue any and all first or third parties or Coverage, the Covered Person authorizes the Plan to pursue, sue, compromise or settle any such claims in their name, to execute any and all documents necessary to pursue said claims in their name, and agrees to fully cooperate with the Plan in the prosecution of any such claims. The Covered Person (or guardian or estate) agrees to take no prejudicial actions against the subrogation rights of the Plan or to in any way impede the action taken by the Plan to recover its subrogation claim. Such cooperation shall include a duty to provide information, execute and deliver any acknowledgment and other legal instruments documenting the Plan's subrogation rights and take such action as requested by the Plan to secure the subrogation rights of the Plan.

The Plan will not pay or be responsible, without its written consent, for any fees or costs associated with a Covered Person pursuing a claim against any Coverage or first or third party. The Plan Administrator retains sole and final discretion for interpreting the terms and conditions of the Plan document. The Plan Administrator may amend the Plan in its sole discretion at anytime without notice. This right of subrogation shall bind the Covered Person's guardian(s), estate, executor, personal representative, and heir(s).

**REIMBURSEMENT RIGHTS**

The Covered Person, by accepting benefits under this Plan, agrees to hold in constructive trust any money or property resulting from any recovery, insurance payments or settlement proceeds, first or third party payments, settlement proceeds or judgment for the Plan's benefits under this provision. If a Covered Person fails to reimburse the Plan for all benefits paid or to be paid, as a result of their Illness or Injury, out of any recovery or reimbursement received, the Covered Person will be liable for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Covered Person. This right of reimbursement shall bind the Covered Person's guardian(s), estate, executor, personal representative, and heir(s).
RIGHTS OF RECOVERY

In the event of any overpayment of benefits by this Plan, the Plan will have the right to recover the overpayment. If a Covered Person is paid a benefit greater than allowed in accordance with the provisions of this Plan, the Covered Person will be required to refund the overpayment. If payment is made on behalf of a Covered Person to a Hospital, Physician or other provider of health care, and the payment is found to be an overpayment, the Plan will request a refund of the overpayment from the provider. If the refund is not received from the provider, or from the Covered Person, the amount of the overpayment will be deducted from future benefits, if available. If future benefits are not available, the Covered Person will be required to refund the overpayment.

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION

For the purposes of implementing the terms of this Plan, the Contract Administrator retains the right to request any medical information from any insurance company or provider of service it deems necessary to properly process a claim. The Contract Administrator may, without consent of the Covered Person, release or obtain any information it deems necessary. Any person claiming benefits under this Plan shall furnish to the Contract Administrator such information as may be necessary to implement this provision.
RIGHTS OF COVERED EMPLOYEES (ERISA)

As a participant in this Plan, Covered Persons 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:

**RECEIVE INFORMATION ABOUT THE PLAN AND BENEFITS**

Examine, without charge, at the Plan Administrator’s office and at other specified locations, all documents governing the Plan, including insurance contracts, 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 Employee Benefits Security Administration.

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

Receive a summary of the Plan’s annual financial report (Form 5500 series). The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

**CONTINUE GROUP HEALTH PLAN COVERAGE**

Continue health care coverage for the employee, the employee’s spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. The employee or the employee’s dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for pre-existing conditions under the Plan, if the Covered Person has creditable coverage from another plan. A Covered Person should be provided a certificate of creditable coverage, free of charge, from the group health plan or health insurance issuer when the Covered Person loses coverage under the Plan, when the Covered Person becomes entitled to elect COBRA continuation coverage, when COBRA continuation coverage ceases, if the Covered Person requests it before losing coverage, or if the Covered Person requests it up to twenty-four (24) months after losing coverage. Without evidence of creditable coverage, a Covered Person may be subject to a pre-existing condition exclusion after the Covered Person’s enrollment date for coverage.
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 the Plan, called “fiduciaries” of the Plan, have a duty to do so prudently and in the interest of all plan participants and beneficiaries. No one, including the Employer or any other person, may fire the employee or otherwise discriminate against the employee in any way to prevent the employee from obtaining a welfare benefit or exercising a Covered Person’s rights under ERISA.

ENFORCEMENT OF RIGHTS

If a claim for a welfare benefit is denied or ignored, in whole or in part, a Covered Person has 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 the Plan’s claim procedures discussed in the section entitled “General Provisions”.

Under ERISA there are steps a Covered Person can take to enforce the above rights. For instance, if a Covered Person requests a copy of plan documents or the latest annual report from the Plan and does not receive them within thirty (30) days, a Covered Person may file suit in Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay up to $110 a day until the Covered Person receives the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If a Covered Person has a claim for which benefits are denied or ignored, in whole or in part, and the Covered Person has exhausted the claims procedures available under the Plan, a Covered Person may file suit in a state or Federal court. In addition, if a Covered Person disagrees with the Plan’s decision or lack thereof concerning the qualified medical child support order, a Covered Person may file suit in Federal court. If it should happen that plan fiduciaries misuse the Plan’s money, or if the Covered Person is discriminated against for asserting their rights, the Covered Person may seek assistance from the U.S. Department of Labor, or the Covered Person may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If the Covered Person is successful, the court may order the person the Covered Person sued to pay these costs and fees. If a Covered Person loses, the court may order the Covered Person to pay these costs and fees, for example, if it finds the claim is frivolous.

ASSISTANCE WITH QUESTIONS

If a Covered Person has any questions about the Plan, the Covered Person should contact the Plan Administrator. If a Covered Person has any questions about this statement or about the Covered Person’s rights under ERISA, or if the Covered Person needs assistance in obtaining documents from the Plan Administrator, the Covered Person should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in the telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210, or visit the EBSA website at www.dol.gov/ebsa. (Addressees and phone numbers of regional and District EBSA offices are available through EBSA’s website.)
GENERAL PROVISIONS

NOTICE OF CLAIM

Written notice of a claim and all information needed to process the claim must be given to the Contract Administrator as soon as reasonably possible and in no event, later than one year from the date such claim is incurred.

RECORDS

For the purposes of claims administration, each Covered Person authorizes and directs any provider that has attended, examined, or treated them to furnish to the Contract Administrator, at any time upon its request, any and all information, records or copies of records relating to the attendance, examination or treatment rendered to the Covered Person; and the Contract Administrator agrees that such information and records will be considered confidential. Further, any charges imposed relative to the acquisition of such information will be absorbed by the Covered Person, except as specified in the Schedule of Benefits.

CLAIM DETERMINATION

Urgent Care Claims: Determination for any pre-service Urgent Care Claims (whether adverse or not) must take place as soon as possible but not longer than seventy-two (72) hours, unless the Claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. In the case of such failure, the Contract Administrator shall notify the Claimant as soon as possible, but not later than twenty-four (24) hours after receipt of the claim by the Plan, of the specific information necessary to complete the claim. The Claimant will be afforded a reasonable amount of time, taking into account the circumstances, but not less than forty-eight (48) hours, to provide the specified information. The Contract Administrator shall notify the Claimant of the Plan’s benefit determination as soon as possible, but in no case later than forty-eight (48) hours after the earlier of:

1. The Plan’s receipt of the specified information; or
2. The end of the period afforded the Claimant to provide the additional information.

Urgent Care Claims must be decided within seventy-two (72) hours. There is no extension of time allowed for claims involving urgent care.

Pre-Service Claims: Pre-Service Claims must be decided within a maximum of fifteen (15) days at the initial level and up to thirty (30) days following an Adverse Benefit Determination. In the case of a failure by a Claimant or an Authorized Representative of a Claimant to follow the Plan’s procedures for filing a Pre-Service Claim, the Claimant or representative shall be notified of the failure and the proper procedures to be followed in filing a Claim for Benefits. This notification shall be provided to the Claimant or Authorized Representative, as appropriate, as soon as possible, but not later than five (5) days following the failure. Notification may be oral, unless written notification is requested by the Claimant or Authorized Representative.
Post-Service Claims: Post-Service Claims must be decided within thirty (30) days for the initial decision and a maximum of sixty (60) days on review.

Filing Extensions: The Plan may extend determination on both Pre-Service and Post-Service Claims for one additional period of fifteen (15) days after expiration of the relevant initial period, if the Contract Administrator determines that such an extension is necessary for reasons beyond the control of the Plan. Delays caused by cyclical or seasonal fluctuations in claims volume are not considered to be matters beyond the control of the Plan that would justify an extension.

If the reason for taking the extension is the failure of the Claimant to provide necessary information, the time period for making the determination is tolled from the date on which notice of the necessary information is sent to the Claimant until the date on which the Claimant responds to the notice. The time periods for making a decision are considered to commence when a claim is filed in accordance with the reasonable filing procedures of the Plan, without regard to whether all the information necessary to decide the claim accompanies the filing.

Concurrent Care Decisions: If a Plan has approved an ongoing course of treatment to be provided over a period of time, or number of treatments, any reduction or termination by the Plan (other than by plan amendments or termination) before the end of such period of time or number of treatments shall be considered an Adverse Benefit Determination. The Contract Administrator shall notify the Claimant of the Adverse Benefit Determination at a time sufficiently in advance of the reduction or termination to allow the Claimant to appeal and obtain a determination on review of that Adverse Benefit Determination before the benefit is reduced or terminated.

Any request by a Claimant to extend the course of treatment beyond the period of time or number of treatments for a claim involving urgent care, shall be decided as soon as possible, taking into account the medical exigencies, and the Contract Administrator shall notify the Claimant of the benefit determination, whether adverse or not, within twenty-four (24) hours after receipt of the claim by the Plan, provided that any such claim is made to the Plan at least twenty-four (24) hours prior to the expiration of the prescribed period of time or number of treatments.

Adverse Benefit Determination: The notice of an Adverse Benefit Determination will either include the protocol in which it was based upon or a statement that a protocol was relied upon and that a copy is available free of charge upon request by the Claimant.

Notification of an Adverse Benefit Determination (at both the initial level and on review) based on medical necessity, experimental treatment, or other similar exclusion or limit will be explained as to the scientific or clinical judgment of the Plan to the Claimant’s medical circumstances, or an explanation will be provided free of charge to the Claimant upon request.

Where the Plan utilizes a specific internal rule or protocol, it must furnish the protocol to the Claimant or their Authorized Representative upon request.
**Authorized Representative:** The Plan will recognize an Authorized Representative, including a health care provider, acting on behalf of a Claimant. The Plan will recognize a Health Care Professional with knowledge of a Claimant’s medical condition as the Claimant’s representative in connection with an Urgent Care Claim. Procedures will be established by the Plan for verifying that an individual has been authorized to act on behalf of a Claimant.

**RIGHT OF REVIEW AND APPEAL**

A Claimant has up to one hundred eighty (180) days to file an appeal of an Adverse Benefit Determination. As part of the appeal process, a Covered Person has the right to (a) review this Plan and other relevant documents, (b) argue against the denial in writing, and (c) have a representative act on behalf of the Covered Person in the appeal. All relevant documents will be provided free of charge, upon request by the Claimant, after receiving an Adverse Benefit Determination. A document, record or other information is considered relevant if it was relied upon in making the benefit determination, if it was considered or generated in the course of making the benefit determination, if it demonstrates compliance with the administrative processes, or if it constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for the Claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the determination.

If the Claimant or an Authorized Representative appeals an Adverse Benefit Determination, the Contract Administrator will respond to the appeal within seventy-two (72) hours for an Urgent Care Claim, thirty (30) days for a Pre-Service Claim, and sixty (60) days for a Post-Service Claim. The notice will specify the reason for the denial or describe the additional information required to process the claim. Written denial will include:

1. Specific reasons for denial with reference to the Plan Document section(s);
2. A description and need for any other material pertinent to the claim; and
3. An explanation of this Plan’s review procedure and the names of any medical professionals consulted as part of the claims process.

A full and fair review of an Adverse Benefit Determination will be performed by an appropriate named fiduciary, who is neither the party who made the initial adverse determination, nor the subordinate of such person. The review will not defer to the initial Adverse Benefit Determination. The review will take into account all comments, documents, records and other information submitted by the Claimant, without regard to whether such information was previously submitted or considered in the initial determination.

If the review results in another Adverse Benefit Determination, it shall include specific reasons for denial, written in a manner understandable to the Covered Person, and will contain specific reference to the pertinent Plan provisions upon which the decision was based.
A Covered Person must follow the Right of Review and Appeal procedures listed above before initiating any legal actions. These are the Covered Person's administrative remedies, which must be exhausted before legal action may be pursued.

If the Plan fails to provide procedures in compliance with the regulation, or the required procedures, the Claimant is deemed to have exhausted the administrative remedies and is free to pursue legal action on the basis that the Plan has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim.

**PLAN INTERPRETATION**

All decisions concerning the interpretation or the application of this Plan and its terms shall be at the discretion of the Plan Administrator.

**PERIODIC REPORT**

Within one month following the date of any change in the group of employees and dependents covered, the Employer shall furnish the Contract Administrator the names of all employees who have become covered or cease to be covered since the date of the previous reports.

Failure on the part of the Employer to report the name of any employees or dependents who are eligible for coverage, shall not deprive such persons of their benefits under the Plan; nor shall failure on the part of the Employer to report any termination of any employee or dependent, obligate the Plan to continue such benefits beyond the date of termination.

**CHOICE OF PHYSICIAN**

The Covered Person shall have the free choice of any legally qualified Physician and the Physician-patient relationship shall be maintained.

**AFFILIATED COMPANIES**

Any of the Employer's affiliates, subsidiaries or divisions may be deleted or added to the Plan upon written notice by the Employer on or before the date such deletion or addition is effective.

**EMPLOYEE CONTRIBUTION**

Participation in this Plan is entirely voluntary. The Employer reserves the right to modify the amount of any employee contributions.

**INSPECTION OF PLAN DOCUMENT**

Upon request, the Employer shall make this Plan Document available for inspection by any Covered Person at a reasonably accessible place.
AMENDMENT OR TERMINATION OF THE PLAN

The Plan may be amended or terminated at any time without prior notice and, except as otherwise provided, in any manner, 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.

It is the intent of this Plan to comply with all applicable Federal and State laws. Wherever this Plan is in conflict with either Federal or State law, the Federal or State law will prevail, unless exempt from either law.
INSTRUCTIONS FOR SUBMISSION OF CLAIMS

All claims submitted should include all of the following:

1. Employee's name, identification number and home address.
2. If claim is made for a dependent, the dependent's name, Employer and age.
3. Employer's name and group number.
4. Name and address of the Physician or Hospital.
5. Physician's diagnosis.
6. Itemization of charges.
7. Date the Injury or Illness began.
8. Drug bills (not cash register receipts) showing RX number, name of drug, date prescribed, and name of person for whom drug is prescribed.

Claims Processing Procedures:

Acceptable claims forms, bills and/or documents:

1. HCFA/UB or ADA Dental Claim Forms; or
2. Superbills - any submitted claim form with all of the following information:
   (a) Detail of procedure performed
   (b) Detailed breakdown of charges
   (c) Diagnosis
   (d) Date of service
   (e) Federal Tax Identification Number (TIN) and address of provider

A claim submitted with all of the above information included will be processed, unless additional information is required to complete the claim. Additional information that may be required to process a claim may include, but is not limited to the following:

1. Coordination of Benefits - Other Insurance Coverage
2. COBRA eligibility
3. Parental custody
4. Legal responsibility for dependent child health coverage
5. Divorce decree
6. Medicare eligibility
7. Full-Time Student status
8. Certificate of Creditable Coverage
9. Medical history information
10. Injury or accident information.
When the Contract Administrator receives a billing with the required information, the Contract Administrator will process it in accordance with the time frames for Post-Service Claims, Pre-Service Claims and Urgent Care Claims, and in accordance with all other Plan provisions, and in accordance with eligibility and claim information on file. The Contract Administrator will provide a notice of benefit determination or a notice of Adverse Benefit Determination to the Covered Person’s designated address.

Please direct all questions regarding claims to:

Corporate Benefit Services of America, Inc.
P.O. Box 27267
Minneapolis, MN 55427-0267
(952) 546-0062
(800) 925-2272

Please direct all claims to the address shown on the ID card.

Every attempt will be made to help Covered Persons understand their benefits; however, any statement made by an employee of the Employer or the Contract Administrator will be deemed a representation and not a warranty. Actual benefit payment can only be determined at the time the claim is submitted and all facts are presented in writing.

If a definite answer to a specific question is required, please submit a written request, including all pertinent information, and a statement from the attending Physician (if applicable), and a written reply (which will be kept on file) will be sent.
DRURY UNIVERSITY
Employee Healthcare Plan
Amendment #2
Group Number: 10845

Effective June 1, 2007 the document specified above shall be amended as shown below:

Section under “A – Eligible Dependents” under Eligibility & Enrollment – Dependents is hereby deleted and replaced with the following:

ELIGIBILITY & ENROLLMENT

DEPENDENTS

A - ELIGIBLE DEPENDENTS

Eligible Dependents will be a Covered Employee's legally married spouse, domestic partner (same sex) and each unmarried child who is not yet age nineteen (19), provided such dependent is dependent on the employee for support and maintenance. (Under certain circumstances the employee may be required to provide the Plan with proof of dependency).

The term "domestic partner" as used herein, shall mean a person who is approved by the Employer as a domestic partner and executes and provides the Employer with an Affidavit of Same-Sex Domestic Partnership, on a form provided by the Employer, which states and gives proof that the domestic partner:

1. Has had the same permanent residence as the employee for a minimum of six (6) consecutive months prior to the date of the Affidavit and has not signed an Affidavit of Same-Sex Domestic Partnership of any other person during the six (6) months prior to the date of the Affidavit;

2. Is at least eighteen (18) years old and is mentally competent to contract in the state in which they reside;

3. Are the sole domestic partner of the employee, and is not married or a domestic partner to anyone else;

4. Intends to reside together indefinitely as a life partner in a relationship of mutual support, caring and commitment;

5. Share basic living expenses and are jointly responsible for each other's common welfare and are financially interdependent, sharing financial responsibilities and expenses (see Affidavit for requirements);

6. Meets the qualifications and requirements for the particular benefit Plan(s) selected; and

7. Are not married to anyone or related to the other by adoption or blood to a degree of closeness that would otherwise bar marriage in the state in which they legally reside.

The employee or domestic partner must notify the University Benefits Office within thirty-one (31) days of the death of a domestic partner or of a change in any of the above circumstances resulting in termination of this relationship.
If an employee enrolls a domestic partner as a dependent under the Plan and the domestic partnership dissolves, terminating the coverage of the domestic partner, the employee may not enroll another person as a domestic partner until six (6) months after said termination of coverage.

The term "child", as used herein, shall also include an employee's or domestic partner's: (a) natural born child; (b) stepchild; (c) adopted child (from the date of placement with the employee for the purpose of legal adoption); (d) child for whom the employee is the legal guardian; or (e) child for whom the employee is required to provide health coverage due to a Qualified Medical Child Support Order (QMCSO).

The Plan Administrator shall have the right to require documentation necessary, in its sole discretion, to establish an individual’s status as an Eligible Dependent.

No individual may be covered under this Plan as both an employee and a dependent. Also, no individual will be considered an Eligible Dependent of more than one employee.

**Full-Time Student:** The term “Full-Time Student,” as used herein, shall be defined as an unmarried dependent child who is enrolled in and regularly attending an educational institution such as high school, an accredited post-secondary school, an accredited college or university for the minimum number of credit hours required by that institution in order to maintain Full-Time Student status.

Other examples of post-secondary education institutions include an accredited business school, trade school, nursing school, business college, mortuary school, cosmetology school, community or junior college, or other similar accredited educational institution which offers a full-time curriculum. The institution must be accredited in order to qualify the dependent for Full-Time Student status.

If an unmarried child is or becomes a Full-Time Student while between the ages of nineteen (19) and twenty-six (26) and is dependent upon the employee for support and maintenance, then such child will be considered an Eligible Dependent until the date the child attains age twenty-six (26). Coverage for a Full-Time Student will be effective as follows:

1. A dependent child covered by this Plan who graduates from high school will remain covered provided the child enrolls and begins attending classes full-time in an accredited post-secondary school, college, or university within four (4) months of the child’s high school graduation date; or

2. A dependent child who is not covered by this Plan and who subsequently enrolls and begins attending classes as a Full-Time Student will also be eligible for coverage. In this instance, the date the child begins attending full-time classes will be considered the date the employee acquires an Eligible Dependent for plan enrollment purposes. The Plan may require a completed application for the dependent’s coverage within a specified time frame (see section B - Plan Enrollment); and

3. A Full-Time Student will remain covered during any regular scheduled break in the educational institution’s full-time curriculum (such as spring or summer break), as long as the dependent was a Full-Time Student the quarter/semester before the break and is a Full-Time Student again the quarter/semester following the break.

If a dependent child ceases to maintain Full-Time Student status, the dependent child’s coverage will cease on the last day of the month following the dependent’s last day in attendance as a Full-Time Student. For purposes of offering Continuation of Benefits (COBRA) to such dependent child, the sixty (60) day period during which the Plan must be notified of the dependent’s ineligibility will begin the earlier of:
1. The start of classes in the next quarter/semester designated by the last school attended; or
2. In the case of withdrawal from enrollment or graduation, the day after withdrawal or graduation.

**Mentally or Physically Handicapped Child:** If an unmarried dependent child, upon reaching age nineteen (19), is incapacitated, unable to be self-supporting, and resides with the employee, then such child will continue to be an Eligible Dependent.

*The “Late Enrollee” section under C – Plan Enrollment under Eligibility & Enrollment – Employees is hereby deleted and replaced with the following:*

**ELIGIBILITY & ENROLLMENT**

**EMPLOYEES**

**C - PLAN ENROLLMENT**

**Open Enrollment/ Late Enrollee:** There will be a one time enrollment period during the month of May 2007, at which time Covered Employees and their eligible dependents and Late Enrollees may elect single or family coverage under the Plan to be effective on June 1, 2007. The waiting period will be waived; however, the Pre-Existing Condition Limitation and Creditable Coverage provisions will apply.

Thereafter, a Late Enrollee will not be eligible to enroll for coverage under this Plan.

*The “Late Enrollee” section under “B – Plan Enrollment” under Eligibility & Enrollment – Dependents is hereby deleted and replaced with the following:*

**ELIGIBILITY & ENROLLMENT**

**DEPENDENTS**

**B - PLAN ENROLLMENT**

**Open Enrollment/ Late Enrollee:** There will be a one time enrollment period during the month of May 2007, at which time Covered Employees and their eligible dependents and Late Enrollees may elect single or family coverage under the Plan to be effective on June 1, 2007. The waiting period will be waived; however, the Pre-Existing Condition Limitation and Creditable Coverage provisions will apply.

Thereafter, a Late Enrollee will not be eligible to enroll for coverage under this Plan.

In Witness Whereof, Drury University has caused this Amendment to take effect, be attached to, and form a part of their Employee Healthcare Plan.

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DRURY UNIVERSITY

Employee Healthcare Plan

Amendment #1

Group Number: 10845

Effective October 1, 2006 the document specified above shall be amended as shown below:

Section “A – Eligible Employees” under Eligibility & Enrollment – Employees is hereby deleted and replaced with the following:

ELIGIBILITY & ENROLLMENT

EMPLOYEES

A - ELIGIBLE EMPLOYEES

A full-time employee of the Employer who regularly works forty (40) or more hours per week at least nine (9) months of the Calendar Year will be eligible to enroll for coverage under this Plan. Other employees such as part-time, temporary or seasonal will not be eligible to enroll for coverage under this Plan.

Also eligible is a retiree of the Employer who has attained the age of fifty-five (55) and has ten (10) or more years of service; or when the sum of the employee’s years of service and age totals seventy-six (76).

Item (b) under number (2) under Termination of Benefits is hereby deleted and replaced with the following:

TERMINATION OF BENEFITS

2. Upon termination of employment or retirement, benefits will cease on the last day of the month in which the employee terminated. Cessation of active work by an employee shall be deemed termination of employment, except as follows:

   (b) An employee who retires prior to age sixty-five (65) and is at least the age of fifty-five (55) and has ten (10) or more years of service, or the sum of the employee’s years of service and age totals seventy-six (76), may continue coverage under the Plan. Once the retiree becomes eligible for Medicare, this Plan will pay secondary to Medicare. (The retiree must enroll for both Parts A & B Medicare.) This extension also applies to the retiree’s dependents; or

In Witness Whereof, Drury University has caused this Amendment to take effect, be attached to, and form a part of their Employee Healthcare Plan.

Authorized Signature ______________________ Date ______________________ Title ______________________

Witness ______________________ Date ______________________ Title ______________________