Employee Health Care Plan

TABLE OF CONTENTS

Drury University
EMPLOYEE HEALTH CARE PLAN
PLAN DESCRIPTION

This booklet is the Plan Document which defines your benefits provided by Drury University Healthcare Plan. It is written so that it can be used by you, the Plan Administrator and Claims Supervisor in administering the Plan. Any definitions or policies not detailed in this document are referenced in the "Trilogy Claims Administrative Handbook", which is available for your review at Benefit Management, Inc. All claims to be filed or inquiries regarding such claims should be directed to Benefit Management, Inc., P.O. Box 3001, Joplin, Missouri 64803, (417) 782-1515 or (888) 294-1515.

MEDICAL PLAN

MEDICAL PLAN CONCEPTS

Preferred Provider Networks
In an effort to better control costs and promote quality service, the Plan is participating in a managed care program. Employees and their Dependents are given the opportunity to utilize Physicians and Hospitals who have contracted with the Plan, also called Preferred Providers. The Plan member may choose to use a Preferred Provider or a Non-Preferred Provider. However, if the Plan member utilizes a Preferred Provider, the Plan will pay at a higher benefit percentage than if the member were to see a Non-Preferred Provider.

Pre-Certification
Pre-Certification is required for all inpatient Hospital stays, except as provided for under the Newborn's Act; see page 10. Upon learning that he/she will be hospitalized, the covered Plan member must notify the Pre-Certification service prior to, or at the time of his/her hospitalization. He/she will be required to give the Physician's name and telephone number and the Plan group number, which is 2202. The number to call is 1-888-294-1515 and is also displayed on your personal ID card. The Physician or Hospital may provide notification, but the responsibility of contacting the Pre-Certification service rests with the Plan member. Pre-Certification does not guarantee payment of benefits. All inpatient Hospital days which are not certified as Medically Necessary will not be covered. *Failure to Pre-Certify will result in a $500.00 reduction in benefits. This $500.00 penalty is NOT included in the Maximum Out-of-Pocket.* In case of an emergency, a Pre-Certification penalty will not be applied if the patient or Physician notifies the Pre-Certification service within forty-eight (48)

hours, or the next business day following hospitalization to provide the necessary review information. Longer stays than were originally Pre-Certified will require follow-up review by the Pre-Certification Service. If the Pre-Certification Service disagrees with the additional days requested by the Physician, the patient, Hospital and Physician will be advised.

Pre-Certification Procedures
Pre-certification is required prior to incurring expenses for certain services. The member is responsible for assuring Pre-certification has been obtained by the Provider before services are rendered. Services that require Pre-certification include: Applied Behavior Analysis, out-patient surgery, durable medical equipment (prosthetics, orthotics, insulin pumps, electric wheelchairs and mobility assisted equipment), genetic testing, home healthcare, hospice care, hospital inpatient stays, inpatient mental health stays, outpatient speech therapy, rehabilitation and therapy benefits (in excess of Plan limitations), scheduled ambulance services, skilled nursing services and inpatient substance abuse stays. Failure to Pre-certify may result in denial of benefits.

Case Management
Case Management helps Physicians and patients to identify ways in which patients with serious Illnesses or special needs can be treated in a cost-effective manner in a Hospital setting or at home, including assistance in negotiating preferred rates with Providers. A Case Management specialist is available through the Utilization Management Department. As defined in the Plan, services will be paid if recommended by the Physician and where Case Management and a Physician are in agreement.

MEDICAL PLAN BENEFITS

Calendar Year Deductible, Individual & Family
Each Plan member is responsible for payment of eligible charges up to the amount of his/her deductible. The amount of deductible, you are required to meet each year, is based on the Plan you have chosen. The deductible applies only once in any Calendar Year.

Co-Insurance
After any deductible amounts have been satisfied, the Plan member is required to pay a percentage of charges called co-insurance, also referred to as out-of-pocket.

Out-of-Pocket Maximum
Your Out-of-Pocket Maximum begins with, and includes, your deductible. After your deductible is satisfied, the Plan will pay the designated percentage of covered charges until the deductible and co-insurance total reaches the designated Plan maximum. At which time the Plan will pay 100% of the remainder of covered charges for the rest

of the Calendar Year, unless stated otherwise. The following charges do not apply toward the out-of-pocket maximum and are never paid at 100%:

- Non-covered charges
- Cost containment penalties

CALENDAR YEAR DEDUCTIBLE

	In-Network	Out-of-Network
Individual	$500	$2,000
Family	$1,000	$4000

SCHEDULE OF BENEFITS

Service or Care Provided	In-Network	Out-of-Network
Primary Care Office Visit **Telehealth** **Specialist Office Visit**	$20 co-pay $20 co-pay $40 co-pay	50% after deductible
Lab One, LabCorp & Quest Lab **Lab Services-Non Hospital**	100% no deductible 80% after deductible	N/A 50% after deductible
Urgent Care	$30 co-pay 80% after deductible	50% after deductible
Emergency Room **Co-pay waived if admitted*	$200 co-pay 80% after deductible	$200 co-pay 80% after deductible
ER Physician	80% after deductible	80% after deductible
Walk-In Retail Health Clinic	$20 co-pay 100% no deductible	50% after deductible
Ambulance Transportation	80% after deductible	80% after deductible
Imaging (CT/PET/MRI)	80% after deductible	50% after deductible
Preventive Care	100% no deductible	50% after deductible
Routine Mammogram, Pelvic Exam, Pap, PSA Test, Prostate Exam, Colonoscopy, and Routine screenings at CDC recommended ages and frequencies – 1 Routine exam per Calendar Year.		
Routine Immunizations *Subject to CDC recommended ages and frequencies.*	100% no deductible	50% after deductible

Service or Care Provided	In-Network	Out-of-Network
Temporomandibular Joint Disorder	80% after deductible	50% after deductible
Urinary Drug Screenings **Medical Necessity will be reviewed*	80% after deductible	50% after deductible
Chiropractic/Spinal Manipulation	80% after deductible	50% after deductible
Durable Medical Equipment	80% after deductible	50% after deductible
Hospital Services		
Pre-Admission Testing	80% after deductible	50% after deductible
Inpatient Hospital Services	$200 co-pay, 80% after deductible	$600 co-pay, 50% after deductible
Inpatient Physician Charges	80% after deductible	50% after deductible
Outpatient Services Only	$100 co-pay per day, 80% after deductible	$300 co-pay per day, 50% after deductible
Outpatient Physician Charges	80% after deductible	50% after deductible
Outpatient Advanced Imaging	80% after deductible	50% after deductible
Outpatient Lab & X-Ray	$100 co-pay, 80% after deductible	$300 co-pay, 50% after deductible
Outpatient Surgery/Surgeon Charges	80% after deductible	50% after deductible
Ambulatory Surgical Facility	$100 co-pay, 80% after deductible	$300 co-pay, 50% after deductible
Mental Health & Substance Abuse		
Office Visit	$20 co-pay	50% after deductible
Inpatient Services Only	$200 co-pay, 80% after deductible	$600 co-pay, 50% after deductible
Inpatient Physician Charges	80% after deductible	50% after deductible

Service or Care Provided	In-Network	Out-of-Network
Residential Services	$200 co-pay, 80% after deductible	$600 co-pay, 50% after deductible
Residential Physician Charges	80% after deductible	50% after deductible
Outpatient Mental Health & Substance Abuse Facility/Profession Fees	80% after deductible	50% after deductible
Mental Health & Substance Abuse Office Visits	$20 co-pay	50% after deductible
Outpatient or Partial Hospitalization Services Only	$100 co-pay per day, 80% after deductible	$300 co-pay per day, 50% after deductible
Outpatient or Partial Hospitalization Physician Charges	80% after deductible	50% after deductible
Additional Services		
Home Health Care 50 visits per Calendar Year maximum, $50,000 lifetime max	80% after deductible	50% after deductible
Hospice Care - Inpatient **Hospice Care - Outpatient**	$200 co-pay, 80% no deductible 80% no deductible	$200 co-pay, 50% no deductible 50% no deductible
Respite Care - Inpatient **Respite Care - Outpatient**	$200 co-pay, 80% no deductible 80% no deductible	$200 co-pay, 50% no deductible 50% no deductible
Extended Care Facility Benefits – Skilled Nursing, Convalescent, or Subacute *0-day combined maximum per calendar year.*	$200 co-pay 80% after deductible	$600 co-pay 50% after deductible
Private Duty Nursing *50 visit max per Calendar Year*	80% after deductible	50% after deductible
Therapy Services **Medical Necessity will be reviewed after 12 visits per type.*	80% after deductible	50% after deductible
Allergy Serum, Injections, & Sublingual Drops	80% no deductible	50% after deductible

Service or Care Provided	In-Network	Out-of-Network
Acupuncture Treatment • Maximum Benefit Per Calendar Year Including Tobacco Addiction • Maximum Benefit per Lifetime • Paid by Plan	$500 2 Treatments 100% no deductible	Not Covered
Breast Pumps	100% no deductible	50% after deductible
Bereavement Counseling *15 visit max per Calendar Year*	50% after deductible	50% after deductible
Cranial Prostheses related to Cancer Treatment & Alopecia Areata *Maximum $250 Lifetime*	80% after deductible	50% after deductible
Contraceptive Methods and Contraceptive Counseling Approved by the FDA • For Men • For Women	80% after deductible 100% no deductible	50% after deductible 50% after deductible
Sterilizations: • For Men • For Women	80% after deductible 100% no deductible	50% after deductible 50% after deductible
Maternity - Routine Prenatal Services *2 Ultrasounds per pregnancy*	100% no deductible	50% after deductible
Maternity – Non-Routine Prenatal Services, Delivery, Postnatal Care	80% after deductible	50% after deductible
Outpatient Birthing Center	$200 co-pay, 80% after deductible	$600 Co-pay, 50% after deductible
Gender Transition *One Gender Reassignment Surgery per lifetime.*	80% after deductible	50% after deductible
Dental Services • Primary Care	$20 Co-pay	Not Covered

Service or Care Provided	In-Network	Out-of-Network
• Specialist All Other Services	$40 Co-pay 80% after deductible	Not Covered 50% after deductible
Oral Surgery Primary Care Specialist All other covered services	 $20 Co-pay $40 Co-pay 80% after deductible	 Not Available Not Available 50% after deductible
Orthognathic, Prognathic & Maxillofacial Surgery *$5000 Max Benefit Lifetime*	80% after deductible	50% after deductible
Transplant Services - Optum *Maximum Benefit per Transplant $300,000* **Transplant Housing & Travel**	80% after deductible 100% no deductible	Not Covered Not Covered
Preventive/Routine Counseling for Alcohol or Substance Use Disorder, Tobacco/Nicotine Use, Obesity, Diet and Nutrition	100% no deductible	50% after deductible
Preventive/Routine Hearing Exam	100% no deductible	50% after deductible
Preventive/Routine Eye Exams and Glaucoma Testing *1 Exam per Calendar Year*	100% no deductible	50% after deductible
All Other Covered Services	80% after deductible	50% after deductible

Deductible, Coinsurance, Office Visit Copays and Prescription Copays are included in the Maximum Out-of-Pocket.

Maximum Out-of-Pocket per Plan Year (Includes Deductible)

	In-Network	Out-of-Network
Individual	$7,900	Unlimited
Family	$15,800	Unlimited

EXPLANATION OF MEDICAL BENEFITS

Medical Necessity
The Plan will pay for eligible charges submitted when determined to be Medically Necessary for the diagnosis or treatment of an Injury or Illness for which symptoms are present. If the requested charges are not determined to be Medically Necessary or if the charges are not identified as an established effective medical procedure, the charges will be excluded from coverage.

Out-of-Area Services
Charges for services and supplies not available In-Network, or charges incurred while traveling outside of the network (such as vacation or business travel), will be covered at the In-Network level of benefits. Charges are subject to the In-Network deductible and co-insurance maximums.

Inpatient Services
The following are covered benefits for inpatient Hospital services, where the patient is admitted for an overnight stay (more than 23 hours):

- Intensive and cardiac care;
- Semi-private room;
- Private room charges where semi-private rooms are not available;
- Private room charges considered at the semi-private room rate in the Hospital where the patient is confined, unless a private room is deemed Medically Necessary by the Physician or the Utilization Management department;
- Operating room and delivery room;
- Skilled Nursing facility services;
- Surgical preparatory room;
- Oxygen and its administration;
- Anesthesia and recovery;
- Dressings, splints, medical supplies and casts;
- Radiation therapy;
- Hospital ancillary charges other than room and board and deemed Medically Necessary; and
- Inpatient palliative care.

Outpatient Services
The following are covered services for outpatient procedures which may occur at a Hospital, Physician's office, or other medical setting.

- Physician's fees for diagnosis, treatment and surgery;
- Charges made by a licensed physical therapist if prescribed by a Physician;
- Diagnostic x-ray and laboratory services;
- Charges for pregnancy, childbirth or miscarriage;
- Emergency room charges;
- Radiation therapy, chemotherapy and radioactive isotopes;
- Hemodialysis;
- Ambulatory Surgical Center services;
- Outpatient surgery charges, anesthesia and anesthesia recovery room;
- Hospice and Home Health services;
- Oral surgery, including removal of impacted wisdom teeth;
- Chiropractic care and
- Second Surgical Opinions.

Physician Office Visits
Benefits for Physician Office Visits are payable as shown in the Schedule of Benefits. The office visit co-pay applies to the Office Visit, including laboratory and x-ray performed on the same day in the office. Any other services performed in the Physician's office are covered as shown in the Schedule of Benefits.

Abortions - Elective

Routine Wellness – Adult & Child
Coverage for Routine Wellness Care is covered as shown in the Schedule of Benefits. Benefits include physical exam, routine mammogram including 3-D, pap smear, immunizations and colonoscopies. Well Child exams are covered as shown in the Schedule of Benefits. Immunization coverage for children and adults is subject to CDC recommended ages and frequencies.

Emergency Room Benefits
Emergency Room services are payable as shown in the Schedule of Benefits. Services must be received on an outpatient basis at a Hospital or alternate facility.

Cardiac Pulmonary Rehabilitation when medically necessary when needed as a result of an illness or injury.

Cardiac Rehabilitation programs are covered when medically necessary, if referred by a Physician, for patients who have certain cardiac conditions.

Chiropractic Care/Spinal Manipulation
Charges for Chiropractic Care and Spinal Manipulation are covered as shown in the Schedule of Benefits.

ABA/IBI Autism Spectrum Disorder Therapy
Means intensive behavioral therapy programs used to treat Autism Spectrum Disorder. These programs are often referred to as Intensive Behavioral Analysis (ABA). These interventions aim to reduce problem behaviors and develop alternative behaviors and skills in those with Autism Spectrum Disorder.

Foot Care (Podiatry) that is recommended by a Physician as a result of infection. The following charges for foot care will also be covered:

- Treatment of any condition resulting from weak, strained, flat, unstable, or unbalanced feet when surgery is performed.
- Treatment of corns, calluses, and toenails when at least part of the nail root is removed or when needed to treat a metabolic or peripheral vascular disease.
- Physician office visit for diagnosis of bunions. The Plan also covers treatment of bunions when an open cutting operation or arthroscopy is performed.

Ambulance Services
Emergency transportation by a local professional ground ambulance service is covered if taken to the nearest Hospital facility equipped to treat the emergency. Emergency air transportation will only be approved if documentation supports that the medical condition was life or limb threatening and could not safely be done by a ground ambulance and are taken to the nearest Hospital facility equipped to treat the emergency. Services are covered as shown in the Schedule of Benefits.

Skilled Nursing Facility & Inpatient Rehabilitation Services
Charges incurred for Inpatient Skilled Nursing and Rehabilitation services are payable as shown in the Schedule of Benefits. Benefits are only available for the care and treatment of a Sickness or Injury that would have otherwise required an Inpatient stay in a Hospital.

Home Health Care
Payment for these services is subject to review by Case Management to identify medical criteria and cost-effective alternatives. Services must be provided in accordance with a Home Health Care Plan established by a Physician and recommended by Case Management. The Plan will cover the following:

Charges for Home Health Care visits made by a Registered Graduate Nurse (R.N.), a Licensed Practical Nurse (L.P.N.), a home health aide, a physical therapist, an occupational therapist or a speech therapist. Services must be provided in accordance with a Home Health Care Plan established by a Physician and recommended by Case Management.

Hospice Care
Charges must be Medically Necessary for the treatment of a Plan member who is totally disabled as a result of a terminal Illness, to include:

- Medications and drugs requiring a Physician's written prescription;
- Psychological counseling and therapy rendered solely to the Plan member or their immediate family by an M.D., Ph.D. or licensed social worker (M.S.W.); and
- Rental, up to purchase price, of Hospital-type equipment such as a Hospital bed, oxygen, or wheelchair.

Durable Medical Equipment and Supplies
The following are covered under the Plan, provided they are prescribed by a Physician as a result of Illness or Injury and are deemed Medically Necessary:

- Oxygen and the rental or purchase of equipment for its administration.
- Rental (up to the purchase price) of a Hospital-type bed, wheelchair, or similar durable medical equipment required for medical care or treatment which has no personal use in the absence of the condition for which prescribed.
- Orthotic appliances and prosthetic devices when prescribed by a Physician and custom-made. No coverage is provided for repair or replacement except when necessitated by normal wear or a change in medical condition. Coverage is not available for replacement due to member negligence or changes due to obesity.
- Diabetic supplies.
- First pair of eyeglasses or contact lenses following cataract surgery.
- One breast prosthesis per breast following a mastectomy.
- One wig following radiation therapy to the head or following chemotherapy; and
- Two mastectomy bras per Calendar Year.

Organ Transplants
All charges associated with tissue and organ transplants must be reviewed by Case Management prior to service; however, the review may be waived in the case of an emergency. The following procedures are included in this benefit:

- Charges for human organ and tissue transplants, including heart, heart/lung, lung, kidney, kidney/pancreas, liver, liver/small bowel, pancreas, and small bowel.
- Corneal transplants provided by a Physician at a Hospital.
- Immunosuppressants used in connection with covered human organ and tissue transplants.

Organ or tissue transplants or multiple organ transplants other than those listed above are excluded from coverage, unless prior approved.

Donor related expenses are covered only if benefits are unavailable to the donor from another source. Donor benefits include procurement and complications from the donor procedure up to six weeks after procurement. All experimental transplants are excluded from coverage, including experimental bone marrow transplants. In the event of a dispute or appeal as to whether a transplant or related charges are considered experimental in nature, the final decision will be rendered by the Plan Administrator.

Diabetes Treatment
Charges incurred for the treatment of diabetes and diabetic self-management education programs, diabetic shoes and nutritional counseling.

Dialysis Services
The Plan will cover Dialysis services subject to Calendar Year out-of-pocket maximums. All professional charges, equipment charges, facility charges and laboratory services associated with Dialysis therapy will be considered by the Plan at 110% of the Medicare allowable charge. All medications related to Dialysis therapy will be considered by the Plan at 110% of Average Wholesale Price (AWP).

Mental Health & Substance Abuse Treatment
Outpatient Services: The Plan provides coverage for outpatient Mental Health and Substance Abuse services received in a Physician's office or outpatient Hospital setting. Benefits are payable as shown in the Schedule of Benefits.

Inpatient Services: The Plan provides coverage for Inpatient Mental Health and Substance Abuse services received in a Hospital setting. Benefits are payable as shown in the Schedule of Benefits.

Maternity Care
Prenatal and postnatal physician office services for Maternity Care will be covered as shown in the Schedule of Benefits. Maternity care for eligible Dependent daughters is not a covered benefit.

Newborn's Act
Benefits for Hospital stays in connection with childbirth cannot be restricted to less than the following lengths of stay as mandated by Federal law: 1) 48 hours for both the mother and the newborn following a normal vaginal delivery, and 2) 96 hours for both the mother and the newborn following a Caesarean section. A shorter stay may be agreed to by the mother and the attending Physician. The Plan's Pre-Certification

penalties will not apply to Hospital stays that do not exceed these 48 or 96 hour periods.

Newborn Requirements
Newborns must be enrolled in the Plan within 30 days from birth to be considered eligible for benefits (see page 30). Once the newborn is considered an eligible Dependent, charges in relation to newborn care are payable as shown in the Schedule of Benefits. Routine circumcision is covered for newborn males in conjunction with the initial Hospital stay.

Nutritional Supplements, Enteral Feedings, Vitamins, and Electrolytes that are prescribed by a Physician and administered through a tube, provided they are the sole source of nutrition or are part of a chemotherapy regimen. This includes supplies related to enteral feedings (for example, feeding tubes, pumps, and other materials used to administer enteral feedings).

Ostomy Education

Radiology and Interpretation

Respiratory Therapy

Sleep Studies

Breastfeeding Support, Supplies, And Counseling

Circumcision

Cleft Palate and Cleft Lip

Cataract or Aphakia Surgery as well as surgically implanted conventional intraocular cataract lenses following such a procedure. Multifocal intraocular lenses are not allowable. Eye refractions and one set of contact lenses or glasses (frames and lenses) after cataract surgery are also covered.

Women's Health and Cancer Rights Act
Benefits will be provided by the Plan in accordance with the Women's Health and Cancer Rights Act for breast reconstruction as follows: 1) reconstruction of the breast for which a mastectomy has been performed, 2) surgery and reconstruction of the other breast to produce a symmetrical appearance, 3) prosthesis, and 4) treatment of the physical complications in all stages of mastectomy including lymphedemas. This benefit is subject to deductible and co-insurance maximums.

Prescription Drug Benefits

All Prescription Drugs covered under the Plan require the written approval of a Physician and must be approved by the Federal Food and Drug Administration. Medication may be purchased through a retail pharmacy. Prescription Drug benefits are limited to FDA & PDR-approved quantities and uses. Any Prescription Drug purchased outside of the United States that is not FDA approved will not be covered.

Retail Option – 30-day supply

Generic Drugs:	$ 5 copay
Formulary Name Brands:	$40 copay
Non-Formulary Name Brands:	$60 copay
Specialty Drugs:	15% copay (Prior Authorization is Required)

A Mail Order Option is available only on maintenance medications for a 90-day supply. Mail Order co-pays are 2.5 times the Retail co-pay amount.

Retail Option – 90-day supply

Generic Drugs:	$10 copay
Formulary Name Brands:	$80 copay
Non-Formulary Name Brands:	$120 copay

All specialty medications require prior authorization before coverage is available. Additionally, they are limited to a 30-day supply. Specialty medications include high-cost medications, medications requiring special handling, injectables, oral medications requiring intense clinical supervision, medications with a significant risk of adverse effects and medications that must be closely monitored for patient compliance. Specialty medications may also include medications costing more than $1,000 per month.

All opioids and medications in excess of $500 per month require prior authorization before benefits are available.

Excluded from coverage are: anabolic steroids, anorexiants (diet aids), anti-smoking aids, emergency contraceptives, contraceptive implants, transdermal contraceptives, cosmetic drugs, acetone or ketone testing strips, blood glucose monitoring units, fertility agents (oral or injectable), topical fluoride, growth hormone, impotency drugs, over-the-counter medications and vitamins that require a prescription (other than prenatal vitamins for pregnancy women and prescription potassium supplements).

MEDICAL EXCLUSIONS AND LIMITATIONS

Coverage under the Plan is limited to services incurred during the Plan year. The following are exclusions and limitations for which the Plan does not pay benefits, and shall apply to services described herein:

1. **Appointments Missed**: An appointment the Covered Person did not attend.
2. **Armed Forces**: any Injuries occurring while engaged in the services of any branch of Armed Forces, or in any act of war whether declared or undeclared.
3. **Biofeedback**: any charges related to electronic training techniques teaching therapeutic self-regulation skills.
4. **Breast Implant Removals**: except for post-mastectomy patients.
5. **Charges for Which Payment is Not Required**: or charges which the Covered Person is not legally obliged to pay.
6. **Chelation Therapy**: charges for chelation therapy, except for the treatment of heavy metal poisoning.
7. **Chiropractic Manipulation**: when performed under anesthesia.
8. **Complications of Non-Covered Treatment**: care, services or treatment required as a result of complications from a treatment not covered under the Plan.
9. **Cosmetic Treatment**: any procedure directed at improving the patient's appearance and does not meaningfully promote proper function of the body or prevent or treat Illness or disease, unless the surgery or procedure is necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, a personal Injury resulting from an accident or other trauma, or a disfiguring disease.
10. **Court Ordered Treatment**: charges for any care ordered by the court or the Police or Sheriff's Department.
11. **Custodial Care**: such as sitter's or homemaker's services providing care in a place that serves the patient primarily as a residence and where Skilled Nursing or Physician supervision is not required.
12. **Dental Services:** Dental services are excluded with the following exceptions: 1)emergency repair due to Injury to sound natural teeth, if repair is made within 12 months of the Injury date (unless delay is Medically Necessary); 2) Medically Necessary surgery to correct accidental Injury to the jaw, cheek, lips, tongue, floor and roof of the mouth; 3) removal of tumors, legions or cysts; 4) excision of impacted wisdom teeth, benign bony growths of the jaw and hard palate; 5) surgical treatment of sinuses, salivary glands, ducts and tongue; 6) surgical removal of impacted teeth; 7) outpatient oral surgical procedures when systemic disease or other physical

condition is present that requires services to be performed outside the dental office; 8) treatment to correct a non-odontogenic congenital defect that results in a functional defect in a covered Dependent child.

13. **Drugs or Medicine**: not requiring a Physician's prescription, or drugs or medications that have not been approved by the Food & Drug Administration for general marketing. Medication must be FDA approved for the Illness or Injury it is prescribed for, and benefits are limited to FDA and PDR-approved quantities and uses. Drugs or medications purchased outside of the United States that are not FDA approved are also excluded.
14. **Educational and/or Institutional**: charges for consultation, training or education whether inpatient or outpatient, to include, but not limited to, developmental delay and learning disorders, unless deemed Medically Necessary. Except that one Diabetes Education session will be covered, per lifetime.
15. **Exercise or Wellness Programs**: unless provided for by the Plan.
16. **Experimental or Investigational Treatment**: to include charges for care, treatment, services or supplies that are experimental or investigational in nature other than approved qualifying clinical trials.
17. **Foreign Travel**: care, treatment or supplies outside of the United States if travel is for the sole purpose of obtaining medical services.
18. **Genetic Testing**: including paternity testing, antigen testing or any type of genetic counseling.
19. **Growth Hormones**: charges incurred for testing or diagnosis, and any related lab charges or medications for members over the age of 18.
20. **Hair Loss**: care and treatment for hair loss including wigs, hair transplants or any drug that promises hair growth, whether prescribed by a Physician. One wig for hair loss due to chemotherapy or radiation therapy to the head will be covered.
21. **Hazardous Hobby or Activity**: care and treatment of an Injury or Sickness that results from engaging in additional interests or hobbies of a hazardous nature, specifically skydiving, hang gliding, bungee cord jumping or aeronautical device, or from competition involving pay, profit or gain, including but not limited to, organized motor vehicle racing, boat racing or participating in a rodeo.
22. **Hearing Aids**: including devices, implants, exams, fittings, and repair.
23. **Homeopathic or Alternative Medicine**: any form of alternative medicine used in place of conventional medicine.
24. **Hospital Employees**: professional services billed by a Physician or nurse who is an Employee of a Hospital or Skilled Nursing Facility and paid by the Hospital or facility for the service.
27. **Illegal Acts**: expenses incurred for Injuries and/or Illnesses sustained during the commission or attempted commission of any criminal or illegal act involving, but not limited to 1) the use of drugs or alcohol, including but not limited to, driving under the influence of an illegal substance or alcohol.

Medical laboratory test results or the arresting officer's determination of inebriation or being under the influence of an illegal substance will be sufficient for this exclusion; 2) any act involving violence or the threat of violence to another person including, but not limited to, assault or other felonious behavior, or by participating in a riot or public disturbance. This exclusion does not include domestic violence; 3) driving without a license or driving without auto insurance; and 4) the use of a firearm, explosive or other weapon likely to cause physical harm or death if used by a Covered Person. Services provided because of a medical condition, either physical or mental, are not included in this exclusion.

28. **Immediate Family**: charges from a Provider who usually resides in the same household as the Covered Person, or who is a member of his/her immediate family or the family of his/her spouse.
29. **Infant Formula**: not administered through a tube as the sole source of nutrition for the Covered Person.
30. **Infertility Services**: charges for in-vitro fertilization procedures or drugs, GIFT (Gamete Intra-Fallopian Transfer) procedures, artificial insemination, surrogate parenting, or any other studies or drugs related to the treatment of infertility. The Plan will cover sterilizations but will not cover sterilization reversal.
31. **Maintenance Therapy**: charges for ongoing maintenance therapy for a given condition after the maximum therapeutic benefit has been achieved.
32. **Marital Counseling**: including marital, pre-marital or family counseling.
33. **Massage Therapy**.
34. **Maternity Care for Dependent Daughters**: including charges incurred by the Dependent daughter's newborn.
35. **Medically Unnecessary Services**: services which are not Medically Necessary for the diagnosis or treatment of a condition with which symptoms are not present, except as described under Adult Wellness. Family history does not meet medical criteria for Medical Necessity. One routine sonogram per pregnancy will be covered.
36. **Medical Records**: to include payment for any records or documents associated with a request for enrollment in the Plan, determination of eligible charges, or any appeal by a Plan member.
37. **Mental Health**: There is no coverage for group therapy, family therapy, marriage counseling and conference/evaluations.
38. **No Obligation to Pay**: charges incurred for which the Plan has no legal obligation to pay.
39. **No Physician Recommendation**: care, treatment, services or supplies not recommended and approved by a Physician; or treatment, services or supplies when the Covered Person is not under the regular care of a Physician. Regular care means ongoing medical supervision or treatment which is appropriate care for the Injury or Sickness.

40. **Non-Compliance**: services related to a specific condition when a member has terminated scheduled services or treatment or has refused to comply with medical advice of the provider or mental health/substance abuse professional.
41. **Non-Implantable Communication-Assist Devices**: including, but not limited to, communication boards and computers.
37. **Non-Physician Care**: or charges for care or services not provided by a licensed, covered Provider.
38. **Non-Reasonable and Customary Charges**: which are in excess of the Reasonable and Customary charges for services and materials as determined by Reasonable and Customary guidelines or Benefit Management, Inc.
39. **Not Specified as Covered**: services, treatments and supplies which are not specified as covered under this Plan.
40. **Nutrition**: any nutrition, or special diets, including nutritional and electrolyte supplements, unless rendered during a Covered Person's hospitalization or Parenteral Nutrition.
41. **Over-the-Counter Medication and Supplies**: any medications or supplies which can be purchased without a Physician's written prescription including, but not limited to, finger and arm splints, cervical collars, back braces, and arch supports.
42. **Personal Comfort Items**: such as TV, telephone, air conditioning, humidifiers, physical fitness equipment and items generally useful outside the Hospital.
43. **Physician Care**: which is not within the scope of his/her license.
44. **Plan Design Excludes**: charges excluded by the Plan design as mentioned in this document.
45. **Prosthetic Repairs and Replacement**: repairs or replacement due to member negligence or changes due to obesity.
46. **Remicade Infusions**: if more frequently than every 8 weeks past the initial therapy.
47. **Routine Examinations**: in excess of the amount specified by the Plan.
49. **Self-Inflicted Injury or Illness**: charges for intentionally self-inflicted Injury or Illness unless it is a result of a medical condition, either physical or mental.
50. **Self-Injectable Medication**: which can be purchased in, and/or billed by the Physician's office.
51. **Services Before or After Coverage**: care, treatment or supplies for which a charge was incurred before a person was covered under this Plan or after coverage ceased under this Plan.
52. **Service Covered by Other Insurance Policies**: this Plan will pay secondary or excess benefits only to any other third-party policy, to include, but not limited to, no fault or personal Injury protection, catastrophic funds mandated by motor vehicle or other state law, uninsured motorist, motor vehicle medical reimbursement, (regardless of whether it is purchased by the

Plan member or Dependent), Homeowner's Insurance, Premises Policy, or any monies collected for pain and suffering.

53. Sex Therapy.

54. **Sexual Function:** Diagnostic service, non-surgical and surgical procedures and Prescription drugs (unless covered under the Prescription Drug Benefits section of this SPD) in connection with treatment for male or female impotence.

55. **Sleep Disorders**: care and treatment for sleep disorders unless deemed Medically Necessary.

56. **Social Counseling**: including marital counseling, religious counseling, vocational/employment counseling, and sexual disorder therapy. Counseling in connection with Hospice Care is covered as shown in the Explanation of Benefits.

57. **Sports-Related Expenses**: including services or devices used as safety items or used primarily for performance in sports-related activities, physical conditioning programs or related braces and orthotics.

58. **Travel or Accommodations**: charges for travel or accommodations, whether or not recommended by a Physician, except for ambulance charges as defined as a covered expense. Immunizations for the purpose of travel are also excluded.

59. **U. S. Government**: charges for services or supplies furnished by an agency of the federal, state, or local government, or a foreign government agency, unless required by law.

60. **Vitamins or Minerals**: except prenatal vitamins for pregnant women and prescription Potassium supplement.

61. **Vocational Rehabilitation**: by any name called.

62. **War**: any loss that is due to a declared or undeclared act of war.

63. **Weight Management**: charges for the treatment of obesity, including but not limited to gastric bypass, gastric balloon, stomach stapling, jejunal bypass, wiring of the jaw, removal of excess skin (including pannus) and services of a similar nature. Weight loss programs, nutritional supplements and appetite suppressants are also excluded.

64. **Work Related**: any Injury or Illness which arises out of the course of any employment, including but not limited to, self-employment, ranching, farming, roofing, mechanics, etc.

DEFINED TERMS

The following terms have special meanings and when used in this Plan will be capitalized.

Active Employee is an Employee who is on the regular payroll of the Employer and who is scheduled to perform the duties of his or her job with the Employer on a full-time basis.

Acute Care is a pattern of health care in which a patient is treated for an acute episode of Illness, for the sequelae of an accident or other trauma, or during recovery from surgery. Acute care is usually given in a Hospital by specialized personnel using complex and sophisticated technical equipment and materials, and it may involve intensive care or emergency care. This pattern of care is often necessary for only a short time, unlike chronic care.

Allowable Charge is based on amounts accepted by other Providers in the area for like treatment, care, services, or supplies. For charges rendered by any In-Network or Preferred Provider (including, but not limited to, a Designated Transplant Facility), the Allowable Charge is the amount based on the fee schedule negotiated with the In-Network or Preferred Provider. Our determination of what is an Allowable Charge is final for the purpose of determining benefits payable under the Plan.

Ambulatory Surgical Center is a licensed facility that is used mainly for performing outpatient surgery, has a staff of Physicians, has continuous Physician and nursing care by registered nurses (R.N.s) and does not provide for overnight stays.

Amendment means any written description of additional or alternative provisions to the health care Plan. Amendments are effective only when signed by the Plan Administrator. Amendments are subject to all conditions, limitations, and exclusions of the Plan, except for those that are specifically amended.

Baseline shall mean the initial test results to which the results in future years will be compared to detect abnormalities.

Benefits means the coverage your program provides. The benefits we provide for covered services are calculated starting with the billed charge or our allowed amount, whichever is less. We then subtract any deductible, co-payment and/or coinsurance amounts. These amounts are your share of the cost. The remaining portion of the charges are your benefits.

Birthing Center means any freestanding health facility, place, professional office, or institution which is not a Hospital or in a Hospital, where births occur in a home-like atmosphere. This facility must be licensed and operated in accordance with the laws pertaining to Birthing Centers in the jurisdiction where the facility is located.

The Birthing Center must provide facilities for obstetrical delivery and short-term recovery after delivery; provide care under the full-time supervision of a Physician and either a registered nurse (R.N.) or a licensed nurse-midwife; and have a written

agreement with a Hospital in the same locality for immediate acceptance of patients who develop complications or require pre- or post-delivery confinement.

Breast Reduction Criteria

1) Must provide documentation of pain in upper back, pain in neck, pain in shoulders, headaches or pain/ulceration from bra straps cutting into shoulders; and
2) Photographic documentation of severe breast hypertrophy; and
3) At least 500 grams of breast tissue per breast must be removed for coverage. Body Surface Area (BSA) criteria will be considered when determining coverage.

Calendar Year means January 1st through December 31st of the same year.

Case Management is a system of health care delivery designed to facilitate achievement of expected outcomes within an appropriate length of stay. The goals of Case Management are the provision of quality health along a continuum, decreased fragmentation of care across settings, enhancement of the client's quality of life, efficient utilization of patient care resources, and cost containment.

Certification - see Pre-Certification or Certification, Page 27.

COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Co-insurance or Out-of-Pocket is the percentage of covered charges not paid by the Plan. Refer to page 6 for member maximum out-of-pocket. Charges not covered by the Plan do not accumulate to the out-of-pocket.

Complication of Pregnancy means non-elective Caesarean section, non-elective abortion, ectopic pregnancy, which is terminated, spontaneous termination of pregnancy which occurs during a period of pregnancy in which a viable birth is not possible, or a grave condition (one usually requiring Hospital confinement) where the diagnosis is distinct from pregnancy, but the condition is caused by or adversely affected by pregnancy.

Such conditions include acute nephritis, nephrosis, cardiac decompensation, missed abortion, severe hyperemesis gravidarum, eclampsia, and similar conditions of like severity.

Such conditions do not include false labor, occasional spotting, rest prescribed by a Qualified Provider during the period of pregnancy, morning sickness, mild preeclampsia, and similar conditions of like severity associated with the management of a difficult pregnancy.

Co-payment or Co-pay is a specified dollar amount that must be paid by an Employee or a Dependent each time certain or specified services are rendered.

Cosmetic Dentistry means dentally unnecessary procedures.

Cosmetic Treatment is a procedure directed at improving the patient's appearance which does not meaningfully promote the proper function of the body or prevent or treat Illness or disease, unless the surgery is necessary to ameliorate a deformity arising from, or directly related to:

- A congenital abnormality.
- A personal Injury resulting from an accident or trauma; or
- A disfiguring disease.

Covered Charge is the actual charge for Medically Necessary and Appropriate treatment of Injury or Illness, not to exceed the Allowable Charge.

Covered Person is an Employee or Dependent who is covered under this Plan.

Creditable Coverage includes most health coverage, such as coverage under a group health Plan (including COBRA continuation coverage), HMO membership, an individual health insurance policy, Medicaid, or Medicare.
Creditable Coverage does not include coverage consisting solely of dental or vision benefits.

Custodial Care is care (including room and board needed to provide that care) that is given principally for personal hygiene or for assistance in daily activities and can, according to generally accepted medical standards, be performed by persons who have no medical training. Examples of Custodial Care are help in walking and supervision over medication which could normally be self-administered.

Deductible is the dollar amount of eligible expenses that you are responsible for paying before you are eligible for benefits for most care. You must meet your deductible once each Calendar Year.

Dentist is a person who is properly trained and licensed to practice dentistry and who is practicing within the scope of such license.

Dependent means any of the following persons:

- An Employee's spouse, unless legally separated or divorced.
- An Employee's domestic partner.
- An Employee's children from birth up to age 26, including natural children, legally adopted children, stepchildren, and children placed in the

Employee's physical custody for the purpose of adoption. Coverage terminates on the last day of the month in which the Dependent child attains age 26.

- Children the Employee must cover under a Qualified Medical Child Support Order.

These persons are excluded as Dependents:

- The legally separated or divorced former spouse of the Employee.
- Any person who is on active duty in any military service or any country; or
- Any person who is eligible for coverage under the Plan as an Employee.

If husband and wife are both covered as Employees under the Plan, their children will be covered as Dependents of the husband or the wife, but not both.

Drug Abuse - see Substance Abuse.

Durable Medical Equipment means equipment which (a) can withstand repeated use, (b) is primarily and customarily used to serve a medical purpose, (c) generally is not useful to a person in the absence of an Illness or Injury and (d) is appropriate for use in the home.

Eligible Employee is any person that is classified as a full-time Employee of Drury University regularly scheduled to work at least 30 hours per week. For those Employees not actively working at least 30 hours per week, an Eligible Employee also includes any eligible Retiree, any Employee on vacation, sick leave, extended sick leave, FMLA leave, short-term or long-term disability leave (with or without pay), COBRA, and any other person designated as an eligible Employee by the Employer's Human Resources department.

Employer is Drury University

Enrollment Date is the first day of coverage or, if there is a Waiting Period, the first day of the Waiting Period.

ERISA is the Employee Retirement Income Security Act of 1974, as amended.

Experimental and/or Investigational means services, supplies, care and treatment which does not constitute accepted medical practice properly within the range of appropriate medical practice under the standards of care of a reasonably substantial, qualified, responsible, relevant segment of the medical and dental community or government oversight agencies at the time services were rendered.

The Plan Administrator must make an independent evaluation of the experimental/non-experimental standings of specific technologies. The Plan

Administrator shall be guided by a reasonable interpretation of Plan provisions. The decisions shall be made in good faith and rendered following a detailed factual background investigation of the claim and the proposed treatment. The decision of the Plan Administrator will be guided by the following principles:

(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 the drug, device, medical treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval.

(3) If Reliable Evidence shows that the drug, device, medical treatment or procedure is the subject of on-going phase I or phase II clinical trials, is the research, experimental study or Investigational arm of on-going phase III clinical trials, or is otherwise 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: or

(4) 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.

Drugs are considered Experimental if they are not commercially available for purchase and/or they are not approved by the Food and Drug Administration for general use.

FMLA shall mean the Family Medical Leave Act of 1993, as amended. FMLA leave shall mean a leave of absence which the Employer is required to extend to an Employee under the provisions of FMLA.

Generally Accepted means that the treatment or service:

- has been accepted as the standard of practice according to the prevailing opinion among experts as shown by (or in) articles published in authoritative, peer-reviewed medical and scientific literature.
- is in general use in the medical community; and

- is not under continued scientific testing or research as a therapy for the Injury or sickness which is the subject of the claim.

Generic Drug means a Prescription Drug which has the equivalency of the brand name drug with the same use and metabolic disintegration. This Plan will consider as a Generic Drug any Food and Drug Administration approved generic pharmaceutical dispensed according to the professional standards of a licensed pharmacist and clearly designated by the pharmacist as being generic.

Genetic Information means information about genes, gene products and inherited characteristics that may derive from an 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.

HIPAA shall mean the Health Insurance Portability and Accountability Act of 1996, as amended.

Home Health Care Agency is an organization that meets all these tests:
- its main function is to provide Home Health Care Services and Supplies.
- it is federally certified as a Home Health Care Agency; and
- it is licensed by the state in which it is located if licensing is required.

Home Health Care Plan must meet these tests:
- it must be a formal written Plan made by the patient's attending Physician which is reviewed at least every 30 days;
- it must state the diagnosis;
- it must certify that the Home Health care is in place of Hospital confinement;
- and it must specify the type and extent of Home Health Care required for the treatment of the patient.

Home Health Care Services and Supplies include: part-time or intermittent nursing care by or under the supervision of a registered nurse (R.N.); part-time or intermittent home health aide services provided through a Home Health Care Agency (this does not include general housekeeping services); physical, occupational and speech therapy; medical supplies; and laboratory services by or on behalf of the Hospital.

Hospice Agency is an organization where its main function is to provide Hospice Care Services and Supplies and it is licensed by the state in which it is located, if licensing is required.

Hospice Care Plan is a plan of terminal patient care that is established and conducted by a Hospice Agency and supervised by a Physician.

Hospice Care Services and Supplies are those provided through a Hospice Agency and under a Hospice Care Plan and include inpatient care in a Hospice Unit or other licensed facility, home care, and family counseling during the bereavement period.

Hospice Care Team means a group that provides coordinated Hospice Care Services and normally includes: A Physician; a patient care coordinator (Physician or nurse who serves as an intermediary between the program and the attending Physician); a nurse; a mental health specialist; a social worker; a chaplain; and lay volunteers.

Hospice Unit is a facility or separate Hospital unit that provides treatment under a Hospice Care Plan and admits at least two unrelated persons who are expected to die within six months.

Hospital is an institution which is engaged primarily in providing medical care and treatment of sick and Injured persons on an inpatient basis at the patient's expense and which fully meets these tests: it is accredited as a Hospital by the Joint Commission on Accreditation of Healthcare Organizations; it is approved by Medicare as a Hospital; it maintains diagnostic and therapeutic facilities on the premises for surgical and medical diagnosis and treatment of sick and Injured persons by or under the supervision of a staff of Physicians; it continuously provides on the premises 24-hour-a-day nursing services by or under the supervision of registered nurses (R.N.'s); and it is operated continuously with organized facilities for operative surgery on the premises.

The definition of "Hospital" shall be expanded to include the following:

- A facility operating legally as a psychiatric Hospital or residential treatment facility for mental health and licensed as such by the state in which the facility operates.

- A facility operating primarily for the treatment of Substance Abuse if it meets these tests: maintains permanent and full-time facilities for bed care and full-time confinement of at least 15 resident patients; has a Physician in regular attendance; continuously provides 24-hour a day nursing service by a registered nurse (R.N.); has a full-time psychiatrist or psychologist on the staff; and is primarily engaged in providing diagnostic and therapeutic services and facilities for treatment of Substance Abuse.

Illness means a bodily disorder, disease, physical sickness, or Mental Disorder. Illness includes pregnancy, childbirth, miscarriage, or complications of pregnancy.

Injury means an accidental physical Injury to the body caused by unexpected external means.

Inpatient means treatment in an approved facility during the period when charges are made for room and board or the length of stay exceeds 23 hours.

Intensive Care Unit is defined as a separate, clearly designated service area which is maintained within a Hospital solely for the care and treatment of patients who are critically ill. This also includes what is referred to as a "coronary care unit" or an "acute care unit." It has facilities for special nursing care not available in regular rooms and wards of the Hospital; special life saving equipment which is immediately available at all time; at least two beds for the accommodation of the critically ill; and at least one registered nurse (R.N.) in continuous and constant attendance 24 hours a day.

Investigational is care that has not been proven conclusively to be beneficial, based on available medical information. The Plan does not cover Investigational care.
Legal Guardian is a person recognized by a court of law as having the duty of taking care of and managing the property and rights of a minor child.

Lifetime is a word that appears in this Plan in reference to benefit maximums and limitations. Lifetime is understood to mean while covered under this Plan. Under no circumstances does Lifetime mean during the lifetime of the Covered Person.

Managed-Care Provisions is the part of your program that is designed to encourage appropriate use of benefits. Managed-Care examples include Case Management, Pre-Certification and Re-Certification.

Medical Care Facility means a Hospital or facility that treats one or more specific ailments or any type of Skilled Nursing Facility.

Medical Emergency means a sudden onset of a condition with acute symptoms requiring immediate medical care and includes such conditions as heart attacks, cardiovascular accidents, poisonings, loss of consciousness or respiration, convulsions or other such acute life or limb threatening medical conditions.

Medically Necessary and Appropriate care and treatment is recommended or approved by a Physician; is consistent with the patient's condition (symptoms must be present) and accepted standards of good medical practice; is medically proven to be effective treatment of the condition; is not performed mainly for the convenience of the patient or Provider of medical services; is not conducted for research purposes; and is the most appropriate level of service which can be safely provided to the patient.

All of these criteria must be met; merely because a Physician recommends or approves certain care does not mean that it is Medically Necessary and Appropriate.

The Plan Administrator has the discretionary authority to decide whether care or treatment is Medically Necessary.

Medicare is the Health Insurance for the Aged and Disabled program under Title XVIII of the Social Security Act, as amended.

Mental Disorder means any disease or condition, regardless of whether the cause is organic, that is classified as a Mental Disorder in the current edition of International Classification of Diseases**,** published by the US. Department of Health and Human Services or is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association.

Morbid Obesity is a diagnosed condition in which the body weight exceeds the recommended weight by either 100 pounds or is twice the medically recommended weight for a person of the same height, age, bone structure and mobility as the Covered Person and conventional weight reduction measures have failed and the excess weight is causing or has caused a medical condition such as physical trauma, pulmonary and circulatory insufficiency, diabetes, or heart disease.

Multiple Surgical Procedure means the appropriateness of a bill for multiple surgical procedures must be clearly documented before a payment allowance is determined. The allowance for documented multiple surgical procedures, whether related or not, is 100% of the prevailing fee for the greater procedure and 50% of Allowable/UCR will be allowed for each secondary surgical procedure.

Exceptions to the Multiple Procedure Rule: The following lists situations where exceptions to the multiple procedure rule would be appropriate.

- Fractures: When reduction (or treatment) of one or more separate and distinct fractures takes place (such as an arm or leg), 100% of the prevailing fee is allowable for each fracture; and
- More than One Surgeon: When the skills of two or more Physicians are required and each surgeon performs a separate operation (e.g., a procedure is performed by a thoracic surgeon and fracture care is provided by an orthopedic surgeon), the allowance is 100% of the prevailing fee for each procedure, provided each of the doctor's bills separately for the procedure he performed. This applies even though both procedures were performed at the same operative session.

This is a partial guideline. The complete guideline as established by Trilogy and Benefit Management, Inc. will be taken into account when determining benefits.

Network Provider is any Provider having a contractual relationship with the Plan, at the time treatment, care, services, or supplies are provided. This will include any Provider that negotiates with Benefit Management, Inc. before or after services are rendered. BMI negotiations will always be paid at the PPO level of benefits. A Network Provider may also include any Provider who is contracted with one of BMI's national wrap-around PPO's if allowed by the Plan.

No-Fault Auto Insurance is the basic reparations provision of a law providing for payments without determining fault in connection with automobile accidents.

Out-of-Network Provider is any Provider not meeting the Plan definition of an In-Network Provider at the time treatment, care, services, or supplies are provided.

Nurse is a licensed registered nurse or a licensed practical nurse.

Office Visit means the evaluation and management of a new or established patient to acquire past medical history, examination and medical decision making for treatment of Sickness or Injury.

Outpatient Care and/or Services is treatment including services, supplies and medicines provided and used at a Hospital under the direction of a Physician by a person not admitted as a registered bed patient; or services rendered in a Physician's office, laboratory or X-ray facility, an Ambulatory Surgical Center, or the patient's home.

Pharmacy means a licensed establishment where covered Prescription Drugs are filled and dispensed by a pharmacist licensed under the laws of the state where he or she practices.

Physician means a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Dental Surgery (D.D.S.), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), Audiologist, Certified Nurse Anesthetist, Licensed Professional Counselor, Licensed Professional Physical Therapist, Midwife, Occupational therapist, Optometrist (O.D.), Physiotherapist, Psychiatrist, Psychologist (Ph.D.), Speech Language Pathologist and any other practitioner of the healing arts who is licensed and regulated by a state or federal agency and is acting within the scope of his or her license.

Plan means the Employer's Employee Healthcare Plan, which is a benefits Plan for certain Employees and is described in this document.
Plan Administrator is the person in your group who is primarily responsible for handling your benefits program.

Plan Participant is any Employee or Dependent who is covered under this Plan.

Plan Year is the 12-month period beginning on either the effective date of the Plan or on the day following the end of the first Plan Year which is a short Plan Year.

Pre-Certification or Re-Certification is a term for obtaining authorization to receive care. If you do not obtain certification when required, your benefits will be reduced.

Pregnancy is childbirth and conditions associated with being pregnant, including complications.

Prescription Drug means any of the following: a Food and Drug Administration-approved drug or medicine which, under federal law, is required to bear the legend: "Caution: federal law prohibits dispensing without prescription", injectable insulin, and hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed Physician. Such drug must be Medically Necessary in the treatment of a Sickness or Injury.

Reasonable and Customary Charge (also referred to as Usual and Reasonable Charge), pertains to the amount that the health Plan will recognize for payment. Benefit Management, Inc. will take into consideration amounts charged by health care Providers for similar services and supplies when provided in the same general area. Benefit Management, Inc. will also consider Provider cost of goods. Reasonable and Customary is not to be interpreted as the fee schedule or PPO allowable. Reasonable and Customary limits may be applied to In-Network or PPO Providers. Benefit Management, Inc. has the discretionary authority to decide whether a charge is Reasonable and Customary.

Second Surgical Opinion is the written opinion of a Qualified Provider, based on his or her physical examination of a patient, for the purpose of determining that patient's need for surgery or another treatment, but only if the Provider:

- is a board-certified specialist in the condition for which the procedure is proposed or has been referred to you (or your Dependent) by a local medical society;
- does not perform or assist with the procedure if it is performed; and
- does not have any business or financial association with the Qualified Provider performing the procedure if it is performed.

Sickness is:

(1) For a covered Employee and covered Spouse: Illness, disease or Pregnancy; or

(2) For a covered Dependent other than Spouse: Illness or disease, not including Pregnancy or its complications.

Skilled Nursing Facility is a facility that fully meets all of these tests:

(1) It is licensed to provide professional nursing services on an inpatient basis to persons convalescing from Injury or Sickness. The service must be rendered by a registered nurse (R.N.) or by a licensed practical nurse (L.P.N.) under the direction of a registered nurse. Services to help restore patients to self-care in essential daily living activities must be provided.

(2) Its services are provided for compensation and under the full-time supervision of a Physician;

(3) It provides 24-hour-per-day nursing services by licensed nurses, under the direction of a full-time registered nurse.

(4) It maintains a complete medical record on each patient.

(5) It has an effective utilization review plan.

(6) It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, mental retardates, custodial or educational care or care of Mental Disorders; and

(7) It is approved and licensed by Medicare.

This term also applies to charges incurred in a facility referring to itself as an extended care facility, rehabilitation Hospital or any other similar facility.

Covered Persons must meet ALL of the following criteria before Skilled Nursing Facility benefits are considered:

1) A Physician's order for skilled services with documentation of Medical Necessity for the treatment of Illness or Injury. This includes the treatment being consistent with the nature and severity of the Illness or Injury, and consistent with accepted standards of medical practice.
2) Expectation for significant reportable improvement within a predictable amount of time.
3) Services must not be possible on an outpatient basis. Examples include, but are not limited to the following:
    a) Intramuscular or intravenous injections, infusions, initiation of and training for the care of newly placed tracheostomies, complex wound care involving medication application and sterile technique of Grade 3 or higher decubitus ulcers or widespread skin disorders and complex respiratory care, including frequent suctioning.
4) Restorative Therapy: when the patient's condition prohibits outpatient therapy, the Plan will cover services designed to restore levels of function that had previously existed but that have been lost as a result of Injury or Sickness. Restorative Therapy services do not include therapy designed to acquire levels of function that had not been previously achieved prior to the Injury or Sickness.

Speech Therapy is therapy administered by a licensed speech therapist. Therapy must be ordered by a Physician and follow either; (i) surgery for correction of a congenital condition of the oral cavity, throat or nasal complex (other than a frenectomy) of a Covered Person; (ii) an Injury; or (iii) a Sickness that is other than a Mental Disorder, for example, cerebral vascular accident (stroke), cerebral tumor, laryngectomy or any other condition deemed Medically Necessary by the Plan Administrator.

Spinal Manipulation/Chiropractic Care means skeletal adjustments, manipulation or other treatment in connection with the detection and correction by manual or mechanical means of structural imbalance or subluxation in the human body. Such treatment is done by a Physician to remove nerve interference resulting from, or related to, distortion, misalignment, or subluxation of, or in, the vertebral column.

Standard of Care is how similarly qualified practitioners, in the same geographical area, would have managed the patient's care under the same or similar circumstances.

Substance Abuse is regular excessive compulsive drinking of alcohol and/or physical habitual dependence on drugs. This does not include dependence on tobacco and ordinary caffeine-containing drinks.

Temporomandibular Joint (TMJ) Syndrome is the treatment of jaw joint disorders including conditions of structures linking the jawbone and skull and the complex of muscles, nerves and other tissues related to the temporomandibular joint. Care and treatment shall include, but are not limited to orthodontics, crowns, inlays, physical therapy, and any appliance that is attached to or rests on the teeth.

Total Disability (Totally Disabled) means: In the case of an Active Employee, the complete inability to perform, because of Injury or Sickness, any and every duty of his occupation or employment. In the case of a Dependent or Retired Employee, it means the complete inability to perform the normal activities of a person of like age and sex in good health.

Urgent Services are Medically Necessary services which are required for Illnesses or Injuries that would *not* result in further disability or death if not treated immediately but require professional attention.

Utilization Review (UR) is the process of evaluating the use of professional medical care, services, procedures, and facilities against established criteria in order to prevent over-utilization and/or inappropriate utilization of health care resources.

ADMINISTRATION

PLAN ENROLLMENT AND MEMBERSHIP

Eligibility for Plan Membership
An eligible Employee is a person who is classified by the employer on both payroll and personnel records as an Employee who regularly works full-time 30 or more hours per week, but for purposes of this Plan, it does not include the following classifications of workers except as determined by the employer in its sole discretion:

- Leased Employees
- Independent Contractors as defined in this Plan
- Consultants who are paid on other than a regular wage of salary basis by the employer.
- Members of the employer's Board of Directors, owners, partners, or officers, unless engaged in the conduct of business on a full-time, regular basis.

For purposes of this Plan, eligibility requirements are used only to determine a person's initial eligibility for overage under this Plan. An Employee may retain eligibility for coverage under this Plan if the Employee is temporarily absent on an approved leave of absences, which may be combined with the employer's short-term disability policy, with the expectation of returning to work following the approved leave as determined by the employer's leave policy, provided that contributions continue to be paid on a timely basis. COBRA is not applicable until short-term disability is exhausted. Employees who meet eligibility requirements during a measurement period as required by the Affordable Care Act (ACA) regulations will have been deemed to have met the eligibility requirements for the resulting stability period as required by the ACA regulations. The employer's classification of an individual is conclusive and binding for purposes of determining eligibility under the Plan. No reclassification of a person's status, for any reason, by a third party, whether by a court, governmental agency, or otherwise, without regard to whether or not the employer agrees to such reclassification, will change a person's eligibility for benefits.

An eligible Employee who is covered under the Plan and who retires under the employer's formal retirement plan will be eligible to continue participating in the Plan upon retirement, provided the individual continues to make the required contribution. See the Coordination of Benefits section for more information on how this Plan coordinates with Medicare coverage.

Note: Eligible Employees and Dependents who decline to enroll in this Plan must state so in writing. In order to preserve potential special enrollment rights, eligible individuals declining coverage must state in writing that enrollment is declined due to coverage under another group health plan or health insurance policy. Proof of such plan or policy may be required upon application for special enrollment. See the Special Enrollment Provision section of this Plan.

An Eligible Dependent includes:

- Your legal spouse, provided he or she is not covered as an Employee under this Plan. For purposes of eligibility under this Plan, a legal spouse does not include a Common-Law Marriage spouse, even if such partnership is recognized as a legal marriage in the state in which the couple resides. An eligible Dependent does not include an individual from whom You have obtained a legal separation or divorce. Documentation on a Covered Person's marital status my be required by the Plan Administrator. Coverage under this Plan is not available to the spouse of an eligible Employee if the spouse works full-time and is eligible for health coverage through his or her own employer.
- A Dependent Child until the Child reaches his or her 26th birthday. The term "Child" includes the following Dependents:
    - A natural biological Child;
    - A stepchild;
    - A legally adopted Child or a Child legally Placed for Adoption as granted by action of a federal, state or local governmental agency responsible for adoption administration or a court of law if the Child has not attained age 26 as of the date of such placement;
    - A Child under Your (or Your spouse's) Legal Guardianship as ordered by a court;
    - A Child who is considered an alternate recipient under a Qualified Medical Child Support Order (QMCSO).
- A Dependent does not include the following:
    - A foster Child;
    - A Child of a Domestic Partner or a Child under Your Domestic Partner's Legal Guardianship;
    - A grandchild;
    - A Domestic Partner;
    - A Dependent Child if the Child is covered as a Dependent of another Employee at this company;
    - Any other relative or individual unless explicitly covered by this Plan.

Note: An Employee must be covered under this Plan in order for Dependents to qualify for and obtain coverage.

Eligibility for Retiree Coverage

A person is eligible for Retiree coverage provided he or she:

- Is a Retired Employee of the Employer with 10 or more years of service, and is at least 55 years of age; or
- Is a Retired Employee of the Employer whose years of service plus age totals 76 or more year; and
- He or she was hired prior to June 1, 2013.

Employees who were hired on or after June 1, 2013 will not be eligible for Retiree coverage under the Plan.

Eligibility Criteria: To be an eligible Totally Disabled Dependent Child, a Totally Disabled Dependent Child age 26 or over must be dependent upon the Employee for more than 50 percent of his or her support and maintenance. This financial requirement does not apply to Children who are enrolled in accordance with a Qualified Medical Child Support Order because of the Employee's divorce or separation decree.

Non-Duplication of Coverage: Any person who is covered as an eligible Employee will not also be considered an eligible Dependent under this Plan.

Right to Check a Dependent's Eligibility Status: The Plan reserves the right to check the eligibility status of a Dependent at any time throughout the year. You and Your Dependent have an obligation to notify the Plan should the Dependent's eligibility status change during the Plan Year. Please notify Your Human Resources Department regarding status changes.

Extended Coverage for Dependent Children: A Dependent Child may be eligible for extended Dependent coverage under this Plan under the following circumstances:

- The Dependent Child was covered by this Plan on the day before the Child's 26th birthday; or
- The Dependent Child is a Dependent of an Employee newly eligible for the Plan; or
- The Dependent Child is eligible due to a special enrollment event of a Qualifying Status Change even, as outlined in the Plan.

The Dependent Child must also fit the following category:

If You have a Dependent Child covered under this Plan who is under the age of 26 and Totally Disabled, either mentally or physically, that Child's health coverage may continue beyond the day the Child would otherwise cease to be a Dependent under the terms of this Plan. You must submit written proof that the Child is Totally Disabled within 30 calendar days after the day coverage for the Dependent would normally end. The Plan may, for three years, ask for additional proof at any time, after which the Plan may ask for proof not more than once per year. Coverage may continue subject to the following minimum requirements:

- The Dependent must not be able to hold a self-sustaining job due to the disability; and
- Proof of the disability must be submitted as required (Notice of Award of Social Security Income is acceptable), and
- The Employee must still be covered under this Plan

A Totally Disabled Dependent Child older than 26 who loses coverage under this Plan may not re-enroll in the Plan under any circumstances.

IMPORTANT: It is Your responsibility to notify the Plan Sponsor within 60 days if Your Dependent no longer meets the criteria listed in this section. If, at any time, the Dependent fails to meet the qualifications of a Totally Disabled Dependent, the Plan has the right to be reimbursed from the Dependent of Employee for any medical claims paid by the Plan during the period that the Dependent did not qualify for extended coverage. Please refer to the COBRA Continuation of Coverage section in this document.

Employees have the right to choose which eligible Dependents are covered under the Plan.

Effective Date of Employee's Coverage

Your coverage will begin on the later of the following dates;

- If You apply within 30 days of hire, Your coverage will become effective the first day of the month following Your date of hire; or
- If You are eligible to enroll under the Special Enrollment Provision, Your coverage will become effective on the date set forth under the Special Enrollment Provision if application is made within 31 calendar days of the event.

Effective Date of Coverage or Your Dependents

Your Dependent's coverage will be effective on the later of the following dates:

- The date Your coverage under the Plan begins if You enroll the Dependent at that time; or
- The date You acquire Your Dependent if application is made withing 31 calendar days following the event; or
- The date specified in a Qualified Medical Child Support Order or the date the Plan Administrator determines that the order is a QMCSO.

A contribution will be charged from the first day of coverage for the Dependent if an additional contribution is required. In no event will Your Dependent be covered prior to the day Your coverage begins.

Annual Open Enrollment Period

During the annual open enrollment period, eligible Employees will be able to enroll themselves and their eligible Dependents for coverage under this Plan. Covered Employees will be able to make changes in coverage for themselves and their eligible Dependents.

The annual open enrollment does not apply to Retirees or their Dependents.
If You and/or Your Dependent becomes covered under this Plan as a result of electing coverage during the annual open enrollment period, the following will apply:

- The employer will give eligible Employees written notice prior to the start of an annual open enrollment period; and
- This Plan does not apply to charges for services performed or treatment received prior to the Effective Date of the Covered Person's coverage; and
- The Effective Date of coverage will be June 1 following the annual open enrollment period.

Special Enrollment Provision – Under the Health Insurance Portability and Accountability Act.

This Plan gives and eligible person special enrolment rights if the person experiences a loss of other health coverage or a change in family status as explained below. The coverage choices that will be offered to You will be the same choice offered to other, similarly situated Employees.

Note: Retirees are not eligible for special enrollment due to loss of other coverage. Similarly Retirees who are not currently participating in the Plan will not be eligible to enroll upon acquisition of new Dependents.

Loss of Health Coverage
You and Your Dependents may have a special opportunity to enroll for coverage under this Plan if You experience loss of other coverage.

In order for You to be eligible for special enrollment rights, You must meet the following conditions;

- You and /or Your Dependents were covered under a group health plan or health insurance policy at the time coverage under this Plan was offered; and
- You and/or Your Dependents stated in writing that You declined coverage due to coverage under another group health plan or health insurance policy; and
- The coverage under the other group health h plan or health insurance policy was:
    - COBRA continuation coverage and that coverage was exhausted; or
    - Terminated and no substitute coverage was offered; or
    - No longer receiving any monetary contribution toward the premium from the employer.

You or Your Dependent must request and apply for coverage under this Plan no later than 31 calendar days after the date the other coverage ended.

You and/or Your Dependents were covered under a Medicaid plan or state child health plan and coverage for You or Your Dependents was terminated due to loss of eligibility. You must request coverage under this Plan within 60 days after the date of termination of such coverage.

You or Your Dependents may not enroll for health coverage under this Plan due to loss of health coverage under the following conditions:

- Coverage was terminated due to failure to pay timely premiums or for cause, such as making a fraudulent claim or an intentional misrepresentation of material fact, or
- You or Your Dependent voluntarily canceled the other coverage, unless the current or former employer no longer contributed any money toward the premium for that coverage.

Newly Eligible for Premium Assistance Under Medicaid or Children's Health Insurance Program

A current Employee and his or her Dependents may be eligible for a special enrollment period if the Employee and/or Dependents are determined eligible, under a state's Medicaid plan or state child health plan, for premium assistance with respect to coverage under this Plan. The Employee must request coverage under this Plan within 60 days after the date the Employee and/or Dependents are determined to be eligible for such assistance.

Change in Family Status

Current Employees and their Dependents, COBRA Qualified Beneficiaries, and other eligible persons have special opportunities to enroll for coverage under this Plan if they experience changes in family status.

If a person becomes an eligible Dependent through marriage, birth, adoption or Placement for Adoption, the Employee, spouse, and newly acquired Dependents(s) who are not already enrolled may enroll for health coverage under this Plan during a special enrollment period. The Employee must request and apply for coverage within 31 calendar days of the marriage, birth, adoption, or Placement for Adoption.

Effective Date of Coverage Under Special Enrollment Provision

If an eligible person properly applies for coverage during this special enrollment period, the coverage will become effective as follows:

- In the case of marriage, on the first day of the month following the date the completed enrollment form is received by the Plan (note that the eligible individuals must submit their enrollment forms prior to the Effective Dates of coverage in order for salary reductions to have preferred tax treatment from the date coverage begins); or
- In the case of a Dependent's birth, on the date of such birth; or

- In the case of a Dependent's adoption, the date of such adoption or Placement for Adoption; or
- In the case of eligibility for premium assistance under a state's Medicaid plan or state child health plan, on the first day of the month following an approved request for coverage; or
- In the case of loss of coverage, the first day of the month following the date the completed enrollment form is received by the Plan.

TERMINATION

For information about continuing coverage, refer to the COBRA Continuation of Coverage section of this SPD.

Employees Coverage

Your coverage under this Plan will end on the earliest of:

- The end of the period for which Your last contribution is made if You fail to make any required contributions toward the cost of coverage when due; or
- The date this Plan is canceled; or
- The date coverage for Your benefit class is canceled; or
- The last day of the month in which You tell the Plan to cancel Your coverage if You are voluntarily canceling it while remaining eligible because of a change in status, because of special enrollment or at annual open enrollment periods; or
- The end of the stability period in which You became a member of a non-covered class, as determined by the employer except as follows:
    - If You are temporarily absent from work due to an approved leave of absence for medical or other reasons, Your coverage under this Plan will continue during that leave for up to six months, provided the applicable Employee contribution is paid when due.
    - If you are temporarily absent from work due to active military duty, refer to USERRA under the Uniformed Services Employment and Reemployment Rights Act of 1994 section; or
- The last day of the month in which Your employment ends; or
- The date You submit a false claim or are involved in any other fraudulent act related to this Plan or any other group plan.

Your Dependent's Coverage

Coverage for Your Dependent will end on the earliest of the following:

- The end of the period for which Your last contribution is made if You fail to make any required contribution toward the cost of Your Dependent's coverage when due; or
- The day of the month in which Your coverage ends; or

- The last day of the month in which Your Dependent is no longer Your legal spouse due to legal separation or divorce, as determined by the law of the state in which You reside.
- The last day of the month in which Your Dependent Child attains the limiting age listed under the Eligibility and Enrollment section; or
- If Your Dependent Child qualifies for extended Dependent coverage because he or she is Totally Disabled, the last day of the month in which your Dependent Child is no longer deemed Totally Disabled under the terms of the Plan; or
- The last day of the month in which Your Dependent Child no longer satisfies a required eligibility criterion listed in the Eligibility and Enrollment section; or
- The date Dependent coverage is no longer offered under this Plan; or
- The last day of the month in which You tell the Plan to cancel Your Dependent's coverage if You are voluntarily canceling it while remaining eligible because of a change in status, because of special enrollment, or at annual open enrollment periods; or
- The last day of the month in which the Dependent becomes covered as an Employee under this Plan; or
- The date You or Your Dependent submits a false claim or is involved in any other fraudulent act related to this Plan or any other group plan.

Termination Dates of Retiree Coverage

The coverage of any Retiree who is covered under the Plan will terminate on the earliest to occur of the following dates:

- The last day of the month following termination of the Plan; or
- The last day of the month in, or with respect to which, he or she requests that such coverage be terminated, provided such request is made on or before such date. This provision shall be administered in compliance with Section 125 of the Internal Revenue Code, when applicable; or
- The date of the death of the covered Retiree; or
- The date of the expiration of the last period for which the Retiree has made a contribution, in the event of his or her failure to make, when due, any contribution for coverage for himself or herself to which he or she has agreed in writing.

Rescission of Coverage

As permitted by the Patient Protection and Affordable Care Act, the Plan reserves the right to rescind coverage. A rescission of coverage is a retroactive cancellation or discontinuance of coverage due to fraud or intentional misrepresentation of material fact.

A cancellation/discontinuance of coverage is not a rescission if:

- It has only a prospective effect; or

- It is attributable to non-payment of premiums or contributions; or
- It is initiated by You or Your personal representative.

Reinstatement of Coverage
If Your coverage ends due to termination of employment, leave of absence, reduction of hours, or layoff and You qualify for eligibility under this Plan again (are rehired or considered to be rehired for purposes of the Affordable Care Act) within 26 weeks from the date Your coverage ended, Your coverage will be reinstated. If Your coverage ends due to termination of employment, leave of absence, reduction of hours, or layoff and you do not qualify for eligibility under this Plan again (are not rehired or considered to be rehired for purposes of the Affordable Care Act) within 26 weeks from the date Your coverage ended, and You did not perform any hours of service that were credited within the 26-week period, You will be treated as a new hire and will be required to meet all the requirements of a new Employee. Refer to the information on the Family and Medical Leave Act and the Uniformed Services Employment and Reemployment Rights Act for possible exceptions, or contact your Human Resources for Personnel office.

COBRA Rights - Continuation of Coverage
If an Employee or Dependent would lose coverage under the Plan as a result of a qualifying event, the individual losing coverage may elect to continue their coverage under the provisions of COBRA.

The COBRA qualifying events are:
(a) The death of an Employee;
(b) The Employee's termination of employment (for reasons other than gross misconduct).
(c) A reduction in the Employee's hours of employment below 30 per week on a regular basis.
(d) The Employee's entitlement to Medicare.
(e) A divorce or legal separation from an Employee; or
(f) A child's ceasing to be eligible under the terms of the Plan.

It is the obligation of the Employee to notify the Employer within 60 days of any divorce, legal separation or child's ceasing to be eligible under the Plan. It is also the responsibility of the Employee to notify the Plan Administrator of any changes in marital status or address. If notice is not received within 60 days of a qualifying event, the provisions of COBRA do not apply.

Maximum Coverage Periods
If the Employee does choose continuation coverage, the Employer is required to give the Employee coverage which, as of the time coverage is being provided, is identical to the coverage provided under the plan to similarly situated Employees or family members. The law requires that the Employee be afforded the opportunity to

maintain continuation coverage for a period of 18 months. The 18 months may be extended to 36 months if other events (such as death, divorce, legal separation, or Medicare entitlement) occur during that 18-month period.

Multiple Qualifying Events
If COBRA coverage is elected following an Employee's termination of employment or reduction in work hours, and then another qualifying event occurs during the 18-month continuation period, that Employee's Dependents may continue their coverage for up to 36 months, rather than 18 by adding an additional 18 months to the original 18-month period.

Social Security Disability
Special rules for disabled individuals may extend the maximum periods of coverage. If a qualified beneficiary is determined under Title II or XVI of the Social Security Act to have been disabled at the time of termination of employment or reduction in employment hours and the qualified beneficiary notifies the Plan Administrator of the disability determination, the 18-month period is expanded to 29 months. Notification must occur within 60 days of the COBRA coverage effective date.

If the beneficiary is deemed disabled during the 18-month COBRA period, the entitlement date for Social Security disability benefits must occur within the first 60 days of COBRA coverage. Disabled beneficiaries must notify the Plan Administrator of Social Security disability determinations within 60 days of the date listed on the determination letter, and notification must occur prior to expiration of the 18-month period of COBRA coverage. These beneficiaries must also notify the Plan Administrator within 30 days of a final determination that they are no longer disabled.

Termination of COBRA Coverage
COBRA coverage for any individual will be automatically terminated upon the occurrence of any of the following events:
(a) The premium for continuation coverage is not paid on time.
(b) The COBRA member becomes covered by another group Plan that contains no exclusion or limitation of benefits for any Pre-Existing condition or whose Pre-Existing condition limitation or exclusion does not apply to the member due to the requirements of the Health Insurance Portability and Accountability Act of 1996.
(c) The COBRA member becomes entitled to Medicare; or
(d) The Employer no longer provides group health coverage to any of its Employees.

Coverage of Newborn or Newly Adopted Children
A child who is born to, adopted by or placed with a COBRA member is also eligible for coverage. That subsequent qualifying event provides the child with independent

coverage eligibility up to 36 months beginning on the date of the Employee's original qualifying event.

Cost and Coverage
The monthly charge for COBRA coverage will be determined by the Plan Administrator. For disabled beneficiaries receiving an additional 11 months of coverage after the initial 18 months, the premium for those additional months may be increased. Premiums due may be increased if the costs to the Plan increases.

The initial premium payment must be made within 45 days after the date of the COBRA election by the qualified beneficiary. Payment generally must cover the period of coverage from the date of COBRA election retroactive to the date of the qualifying event. Premiums for successive periods of coverage are due on the date stated in the Plan with a minimum 30-day grace period for payments.

Specific Notice
A qualified beneficiary must notify the Plan Administrator within 60 days after events such as divorce or legal separation or a child's ceasing to be a covered as a Dependent under Plan rules.

Certificate of Group Health Plan Coverage
Under 1996 HIPAA regulations, the Plan will provide the terminating member a certificate of group health Plan coverage. This certificate may be necessary for enrolling in a new Plan or in buying insurance. Ask your Plan Administrator for details.

Continuation of Coverage Under FMLA
If you take a period of leave authorized by the Family and Medical Leave Act (FMLA Leave), you may continue coverage for yourself and your covered Dependents under the Plan during your period of FMLA Leave by making the same contributions you would have made had you continued your employment and participation in the Plan.

If you are entitled to a period of FMLA Leave or are on such Leave, and you inform your Employer that you do not intend to return to active employment, you will have no right to continue coverage under the FMLA provisions. You may have a right to continue coverage under the COBRA provisions described above.

Payment for Coverage
(a) Paid Leave: If you are on a period of leave that is paid leave, your contributions will be made in the same manner that they would have been made had you continued your employment and participation in the Plan.
(b) Unpaid FMLA Leave: If your FMLA Leave is unpaid, you must make your contributions no later than the time they would have been made had you not taken FMLA Leave but had instead continued your employment and participation in

the Plan.

(c) Termination of Coverage: If you are entitled to a period of FMLA Leave, you may elect not to continue your coverage. In that case, all coverage will terminate on the last day of the month for which you pay contributions. However, if you elect to continue coverage during a period of FMLA Leave, your Employee and Dependent coverage will continue until the earliest of:

(1) The date you fail to return to work for your Employer after your period of FMLA Leave, and after your employment is thereby terminated.

(2) The date you exhaust your entire FMLA Leave.

(3) The 30th day following the date your contribution was due and unpaid; or

(4) The date the Plan terminates.

Restoration of Coverage. If you are on FMLA Leave and do not continue or fail to pay for your coverage, you and your Dependents are entitled to reinstatement of coverage under the Plan upon your return from FMLA Leave.

Need to Repay Employer Contributions. If you began a period of FMLA Leave and continued coverage under this Plan, and you fail to return to work for at least 30 calendar days, your Employer will have the right to recover the contributions made by the Employer during your leave.

Exception to Repayment Rule. The Employer has no right to recover if you fail to return from FMLA Leave due to a condition that would entitle you to a period of FMLA Leave or other circumstances beyond your control.

Special Rules for Key Employees. If you meet the definition of a Key Employee under the government regulations, special rules apply. If you are entitled to FMLA Leave and the Employer informs you that it does not intend to restore you to your job at the end of your leave because doing so would cause grievous economic injury to the Employer's operations, and if you do not, within 30 days after receiving that notice, return to work for the Employer, your coverage will continue until the earliest of:

(1) The date you give notice to your Employer that you no longer wish to return to work.
(2) The date the Employer denies your reinstatement to employment at the end of your FMLA Leave.
(3) The 30th day following the date your contribution was due and unpaid on the 30th day; or
(4) The date the Plan terminates.

Need to Repay Employer Contributions. This provision does not apply to Key

Employees and their Dependents if the Employer denies employment reinstatement.

Rescission of Coverage
Coverage may be rescinded if an Employee or Dependent provides fraudulent information or intentionally misrepresents facts. Coverage may also be rescinded for failure to pay required premium contributions required by the Plan. The Plan reserves the right to recover benefits paid because of the fraud or misrepresentation.

Reinstatement of Medical Coverage After Military Leave
In accordance with the Uniformed Services Employment and Re-Employment Rights Act of 1994 (USERRA), when your coverage ends because you enter into active service in the United States Armed Forces, you may again be covered if:

1) You return to active full-time employment with your Employer; and
2) You make a written request for reinstatement to the Plan Administrator within:
    a) 90 days of your discharge from active service; or
    b) One year following hospitalization which continues after your discharge from active service.

The coverage provided will be the same coverage provided by your Employer to other Employees and Dependents at the time of application. Your coverage will start on the date the Plan receives your request for reinstatement. If you had completed all or part of an exclusionary or Waiting Period under the Plan before your entry into active military service, you will not be required to complete that period a second time.

Each Dependent who was covered under this Plan immediately prior to your entry into active military service will also be reinstated for coverage the date your coverage begins again, if otherwise eligible. Eligible Dependents born during the period of active military service will have the same rights as other Dependents under this Plan. No payment will be made for any care or treatment given for an Injury, Illness, or physical or mental condition arising during, and occurring as a direct result of, your active service in the United States Armed Forces, as determined by the Secretary of Veterans Affairs.

CLAIMS PROCESSING

Filing a Claim
All Participants are required to submit at least one signed claim form each Plan year to receive benefits. All claims to be filed or inquiries regarding such claims should be directed to Benefit Management, Inc., P.O. Box 3001, Joplin, Missouri 64803.

All claims must be received in the office of Benefit Management, Inc. within one year from the date incurred to be eligible for coverage under the Plan.

All claims for terminated Participants must be received within 90 days from the date of termination.

Appeal Procedure
If a claim dispute cannot be resolved with the claim's office, a disputed claim review and appeal procedure can be requested.

First Appeal - The first review will begin by a request from the Plan member in writing. The requests for a review must be submitted to the Plan within 180 days from receipt of a notification of adverse benefit determination. The request, addressed to the Claims Manager at Benefit Management, Inc., should include the patient's name and the name of the covered Employee. Only the covered Plan member or Dependent can file an appeal. Please include all the reasons for requesting a review, stating as specifically as possible why it is believed the denial is incorrect. Any supplemental materials, including additional medical information, should also be submitted. Benefit Management, Inc.'s determination will be rendered as follows:

Urgent Claim - within 72 hours from receipt of the appeal.
Pre-Service Claim - within 15 days from receipt of the appeal.
Post-Service Claim - within 30 days from receipt of the appeal.

The determination will be sent directly to the Plan member. The determination will reference the Plan provision(s) and facts upon which it is based.

Final Appeal - If the decision of Benefit Management, Inc. is unsatisfactory, a written request for a final appeal may be submitted by the Plan member to the office of the Plan Administrator or at the office of Benefit Management, Inc. The written request must be received within 60 days after receipt of the first appeal decision. If there is any supplemental material which has not been previously submitted, it must be submitted along with the notice of appeal. A list of External Appeal Organizations will be provided to the Plan Member, who may choose the Organization to provide the Final Appeal determination. The Plan will abide by that determination.

Pre-Service Claim - within 15 days from receipt of second appeal.
Post-Service Claim - within 90 days from receipt of second appeal.

STATEMENT OF ERISA RIGHTS

Under the Employee Retirement Income Security Act of 1974 (ERISA), all Covered Persons will have the right to:
RECEIVE INFORMATION ABOUT PLAN AND BENEFITS

- Examine, without charge, at the Plan Administrator's office and at other specified locations (such as worksites and union halls), all documents governing the Plan, including insurance contracts, collective bargaining agreements if applicable, 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. No charge will be made for examining the documents at the Plan Administrator's principal office.

- Obtain, upon written request to the Plan Administrator, copies of documents that govern the operation of the Plan, including insurance contracts and collective bargaining agreements if applicable, and copies of the latest annual report and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

CONTINUE GROUP HEALTH COVERAGE

Covered Persons have the right to continue health care coverage if they experience a loss of coverage under the Plan as a result of a COBRA qualifying event. You or Your Dependents may have to pay for such coverage. Review this SPD and the documents governing the Plan on the rules governing COBRA continuation coverage rights.

PRUDENT ACTIONS BY PLAN FIDUCIARIES

In addition to creating rights for Covered Persons, ERISA imposes duties upon the people who are responsible for the operation of this Plan. The people who operate this Plan, called "fiduciaries" of this Plan, have a duty to do so prudently and in the interest of all Plan participants.

NO DISCRIMINATION

No one may terminate Your employment or otherwise discriminate against You or Your covered Dependents in any way to prevent You or Your Dependents from obtaining a benefit or exercising rights provided to Covered Persons under ERISA.

ENFORCING COVERED PERSONS' RIGHTS

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

Under ERISA, there are steps an Employee can take to enforce the above rights. For instance, if a Covered Person requests a copy of the Plan documents or the latest annual report from the Plan and does not receive them within 30 days, the Covered

Person may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay the Covered Person up to $110 per day until the materials are received, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If a claim for benefits is denied or ignored, in whole or in part, the 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 status of a medical Child support order, the Covered Person may file suit in federal court. If it should happen that the Plan fiduciaries misuse the Plan's money, or if a Covered Person is discriminated against for asserting his or her rights, the Covered Person may seek assistance from the U.S. Department of Labor, or 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 sued to pay these costs and fees. If the Covered Person loses, the court may order the Covered Person to pay these costs and fees (for example, if it finds the claim to be frivolous).

ASSISTANCE WITH QUESTIONS

If You have any questions about this Plan, contact the Plan Administrator. If You have any questions about this statement or about a Covered Person's rights under ERISA, or if You need assistance in obtaining documents from the Plan Administrator, 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. Covered Persons may also obtain certain publications about their rights and responsibilities under ERISA by calling the publication hotline of the Employee Benefits Security Administration.

COORDINATION OF BENEFITS & SUBROGATION

Definitions. For purposes of this section, the following definitions shall apply:

"Plan" refers to any entity that provides benefits or services for those items which are listed as covered Medical Benefits under this Plan and not otherwise excluded from coverage, including but not limited to:

(a) group, blanket or franchise insurance coverage.
(b) group Blue Cross/Blue Shield, service plan contracts, group practice, individual practice and other prepayment coverage;
(c) any coverage under labor-management trusteed plans, union welfare plans, Employer organization plans, Employee benefit organization plans or any other

arrangement of benefits for individuals of a group.

(d) any coverage under governmental programs and any coverage required or provided by any federal or state statute; and

(e) any individual or family insurance policy or contract or arrangement, excluding only one which provides solely medical benefits, including but not limited to automobile accident, no fault or liability insurance.

The term "Plan" shall be construed separately with respect to each policy, contract or other arrangement for benefits or services, and separately with respect to that portion of any such policy, contract or other arrangement that reserves the right to take the benefits or services of other Plans into consideration in determining benefits and that portion which does not.

"Primary Plan" refers to a Plan whose benefits are to be determined before the benefits of another Plan, in accordance with the provisions of this section.
"Secondary Plan" refers to a Plan whose benefits are to be determined after benefits of another Plan, in accordance with the provisions of this section.

Coordination of Benefits
Coordination of Benefits (COB) means that the benefits provided by this Plan will be coordinated with the benefits provided by any other Plans covering the person for whom a claim is made. If this Plan is a secondary Plan, the benefits payable under the Plan may be reduced, so that a Covered Person's total payment from all Plans will not exceed 100% of the amount this Plan would have paid in the absence of the other Plan. Benefits payable under another Plan include benefits that would have been payable had claim been duly made, therefore. Benefits will not be coordinated within the Plan for Employees and Dependents who both work for the company.

Order of Benefit Determination. For purposes of Coordination of Benefits, the rules establishing the order of benefit determination are as follows:

(a) A Plan that covers a person other than as a Dependent will be primary to a Plan that covers such person as a Dependent.

(b) A Plan that covers a person as a Dependent of an Employee whose date of birth occurs earlier in a Calendar Year will be primary to a Plan that covers such person as a Dependent of an Employee whose date of birth occurs later in a Calendar Year.

(c) In the case of Dependent child whose parents are separated or divorced:
   (1) when the parent with custody of the child has not remarried, the Plan that covers the child as a Dependent of the parent with custody will be primary to the Plan that covers the child as a Dependent of the parent without custody; and
   (2) when the parent with custody of the child has remarried, the Plan that covers the child as a Dependent of the parent with custody will be primary to the

Plan that covers the child as a stepparent, and the Plan that covers the child as a Dependent of the stepparent will be primary to the Plan that covers the child as a Dependent of the parent without custody.

Notwithstanding the above, if there is a court decree which establishes financial responsibility for the medical expenses of the child, the Plan that covers the child as a Dependent of the parent with such responsibility will be primary to any other Plan that covers the child as a Dependent.

When the rules stated above do not determine an order of benefit determination, the Plan that has covered a person for the longer period will be primary, provided that the Plan that covers the person as a laid-off or retired Employee, or as a Dependent of such an Employee will be secondary to any Plan that covers such person as an active Employee or as a Dependent of such an Employee.

Payment to Other Organizations. Whenever payments that should have been made under this Plan in accordance with this coordination of benefits provisions have been made under any other Plans, this Plan may pay to any entity making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of these provisions. Amounts so paid shall be deemed to be benefits paid under this Plan, and to the extent of such payments, this Plan shall be fully discharged from liability.

Reimbursement. If at any time the amount of benefits provided by this Plan exceed the maximum payment necessary to satisfy the intent of the coordination of benefits provisions, this Plan may recover any excess payments from any one or more of the following: (a) you; (b) if you are a Dependent, the Employee or retiree whose Dependent you are; (c) any other Plan or person that has received payment; (d) any other Plan that should have made payment.

Automobile Limitations. When medical payments are available under vehicle insurance, the Plan shall pay excess benefits only, without reimbursement for vehicle Plan deductibles. This Plan shall always be considered the secondary carrier regardless of the individual's election under PIP (personal Injury Protection) coverage with the auto carrier.

Limitation. Benefit Payment for Covered Services will be reduced by Benefits that could be paid by Part A and Part B of Medicare. This will apply even if a Covered Person is eligible for Medicare but failed to enroll or maintain eligibility.

Right to Receive and Release Necessary Information. To decide if this COB section (or any other Plan's COB section) applies to a claim, the Administrator (without the consent of or notice to any person) has the right to:

a. Release to any person, insurance company or organization, the necessary claim information.
b. Receive from any person, insurance company or organization the necessary claim information.

Any person claiming benefits under contract must give information needed to coordinate those benefits.

Subrogation. The Plan will have the right to recover any benefits paid to you or for a Covered Person under this Plan on any loss for which a Third Party is liable. Such recovery will be available from any liable Third Party, including but not limited to:

1. The persons and entities, either individually or collectively, causing an Injury, Illness or other loss for which this Plan had or may provide benefits.
2. Third Party Insurance.
3. No-fault or personal Injury protection ("PIP") insurance.
4. Financial responsibility or catastrophe funds mandated by motor vehicle or other state law.
5. Uninsured or motorist underinsured insurance.
6. Motor vehicle reimbursement insurance, regardless of whether it is purchased by you or a Dependent; or
7. Homeowner's insurance and other premises insurance, including reimbursement coverage.

This Plan is not intended to provide the member with benefits greater than his or her medical expenses. If the Plan member is entitled to payment of his or her medical expenses by another person, Plan, or entity, whether they request payment or not, this Plan has the right to reduce its payments accordingly so that the Plan Member is not paid more than they owe for medical expenses. If the Plan Member has a right against any other person, firm, or organization for an Injury or Illness, the Plan has the right to subrogate all benefits paid, or that will be paid, by the Plan because of the Illness or Injury. If the Plan pays for benefits which are the responsibility or liability of a third party, the Plan has the right to recover any benefits paid.

Once the Plan Supervisor determines that third party liability may be involved with a claim, the Plan Member will be asked to sign a subrogation and reimbursement agreement, protecting the Plan against any loss where other parties may be responsible. The Plan Supervisor must have received the signed subrogation agreement before any claims may be considered for payment. If a signed subrogation agreement is not received within 90 days after being provided by the Plan Supervisor, the claims will be denied, and the Plan will have no future responsibility for consideration of payment.

If the Covered Person, or the legal representative, fails to cooperate in fulfilling the

responsibilities set forth in this section, no further benefits will be payable under this Plan for charges incurred in connection with or resulting from the condition for which such loss is undergoing recovery proceedings.

The amount of this Plan's subrogation interest will be deducted first and in full from a Covered Person's recovery arising out of the Injury.

This Plan or the Plan Administrator will not be required to pay attorney fees or other costs incurred in connection with its recovery unless it consents in writing to make such payment.

For purposes of this provision, any recovery from a third party paid to the Plan Member by way of judgment, settlement, or otherwise to compensate for any losses will be deemed to be a recovery for medical, dental, vision and/or prescription drug expenses incurred to the extent of any actual loss due to Injury, Illness or disability involved.

Clerical Error

Any clerical error by the Plan Administrator or an agent of the Plan Administrator in keeping pertinent records or a delay in making any changes will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered.

If, due to a clerical error, an overpayment occurs in a Plan reimbursement amount, the Plan retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money. In the case of a Plan Participant, if it is requested, the amount of overpayment will be deducted from future benefits payable.

Notice of Privacy Policy

Your privacy is important to us. BMI and our clients strongly believe in ensuring the confidentiality of the personal information you entrust in us. This notice describes our policies and practices concerning our handling of your personal information.

Purpose: *The following privacy policy is adopted to ensure that Benefit Management, Inc. (also referred to as BMI) and its clients comply fully with all federal and state privacy protection laws and regulations. Protection of patient privacy is of paramount importance to this organization. Violations of any of these provisions will result in severe disciplinary action including termination of employment and possible referral for criminal prosecution.*

Effective Date:
This policy is in effect as of June 01, 2023.

Expiration Date:
This policy remains in effect until superseded or cancelled.

Policy Owner:
Benefit Management, Inc.
P.O. Box 3001
Joplin, MO 64803
(417) 782-1515

And its clients who have adopted this policy.

Assigning Privacy and Security Responsibilities
It is the policy of BMI and its clients that specific individuals within our workforce are assigned the responsibility of implementing and maintaining the HIPAA Privacy and Security Rule's requirements. Furthermore, it is the policy of BMI and its clients that these individuals will be provided sufficient resources and authority to fulfill their responsibilities. At a minimum it is the policy of BMI and its clients that there will be one individual or job description designated as the Privacy Official.

Collecting Information
Benefit Management, Inc. collects nonpublic personal financial and health information about our customers to conduct business, such as to provide customer service, to process claims, to fulfill legal and regulatory requirements and for other lawful purposes. We collect this information directly from you as well as from other sources.

Information we need to collect varies according to the products and services you request, but may include information from:

- your insurance applications and other forms (such as information about other insurance policies).
- other transactions you've had with BMI (such as information about other insurance policies).
- your medical providers and health records (such as information concerning your health status).
- Other sources.

Uses and Disclosures of Protected Health Information
It is the policy of BMI and its clients that protected health information may not be used or disclosed except when at least one of the following conditions is true:

1. The individual who is the subject of the information has authorized the use or disclosure.

2. The individual who is the subject of the information has received our Notice of Privacy Practices and acknowledged receipt of the Notice, thus allowing the use or disclosure and the use or disclosure is for treatment, payment or health care operations.

3. The individual who is the subject of the information agrees or does not object to the disclosure and the disclosure is to persons involved in the health care of the individual.

4. The disclosure is to the individual who is the subject of the information or to HHS for compliance-related purposes.

5. The use or disclosure is for one of the HIPAA 'public purposes" (i.e. required by law, etc.).

Deceased Individuals
It is the policy of BMI and its clients that privacy protections extend to information concerning deceased individuals.

Notice of Privacy Practices
It is the policy of BMI and its clients that a notice of privacy practices must be published, that this notice and any revisions to it be provided to all individuals at the earliest practicable time, and that all uses, and disclosures of protected health information be done in accord with this organization's notice of privacy practices. We will attempt to gain written acknowledgement of the receipt of the notice from all individuals to whom we provide the notice of privacy practices and, if we fail, will document our attempts to gain such acknowledgement.

Access to Protected Health Information
It is the policy of BMI and its clients that access to protected health information must be granted to each employee or contractor based on the assigned job functions of the employee or contractor. It is also the policy of this organization that such access privileges should not exceed those necessary to accomplish the assigned job function.

De-Identified Data and Limited Data Sets
It is the policy of BMI and its clients to disclose de-identified data only if it has been properly de-identified by a qualified statistician or by removing all the relevant identifying data. We will make use of limited data sets, but only after the relevant

identifying data have been removed and then only to organizations with whom we have adequate data use agreements and only for research, public health, or health care operations purposes.

Retention of Records
It is the policy of BMI and its clients that the HIPAA Privacy Rule record retention requirement of six years will be strictly adhered to. All records designated by HIPAA in this retention requirement will be maintained in a manner that allows for access within a reasonable period. This records retention time requirement may be extended at this organization's discretion to meet with other governmental regulations or those requirements imposed by our professional liability carrier.

Cooperation with Privacy Oversight Authorities
It is the policy of BMI and its clients that oversight agencies such as the Office for Civil Rights of the Department of Health and Human Services be given full support and cooperation in their efforts to ensure the protection of health information within this organization. It is also the policy of this organization that all personnel must cooperate fully with all privacy compliance reviews and investigations

PLAN INFORMATION

Name of Plan:	Drury University Group Health Benefit Plan
Type of Plan:	Self-funded Health & Welfare Plan providing group health benefits
Sponsor:	Drury University EIN: 20-1152045
Group Code:	501
Group #:	2302
Plan Administrator:	Drury University
Plan Cost:	Contributions to this Plan are made by the Employer and Employees and are based on the amount necessary to

provide the Plan's benefits.

Agent for Service of Process: Drury University
900 N Benton Ave
Springfield, MO. 65802
417-873-7854

Plan Benefit Year: January 1st through December 31st

Plan Fiscal Year: June 1st through May 31st

Plan Supervisor: Benefit Management, Inc.
P.O. Box 3001
Joplin, MO 64803
Phone: (417) 782-1515
Toll Free: (888) 294-1515

Loss of Benefits: Participant must continue to be an eligible member of the class to which the Plan pertains to qualify for benefits.

Fiduciary Name: Drury University

Plan Amendment or Termination: The Drury University Employee Healthcare Plan has the right to amend, modify, or terminate the Plan benefits in any way at any time by written notification to Plan members from the Plan Administrator.

Plan Interpretations: All interpretations of the Plan and all questions concerning its administration and application, including eligibility determination, shall be determined by the Plan Supervisor and the Plan Administrator in its sole and absolute discretion. Such determination shall be final and binding on all persons.

Accepted by:

Effective Date: June 1, 2023