

UNIVERSITY OF DUBUQUE

EMPLOYEE HEALTH CARE PLAN

This booklet is your Summary Plan Description. Its purpose is to summarize the provisions of the Plan, which provide and/or affect payment or reimbursement. The Plan Document supersedes this booklet. The Summary Plan Description replaces and supersedes any and all Summary Plan Descriptions issued to you by University of Dubuque.

The Plan is funded by University of Dubuque and employee contributions. The benefits and principal provisions of the group Plan are described in this booklet. They are effective only if you are eligible for the coverage, become covered, and remain covered in accordance with the provisions of the group Plan.

The purpose of providing a comprehensive medical plan is to protect you and your family from serious financial loss resulting from necessary medical care. However, we must recognize and deal with escalating costs. Being fully informed about the specific provisions of your Plan will help both you and the Company maintain reasonable rates in the future. We have prepared the following few pages as a general guide for you to become a "good consumer" of your health care. It will take a joint effort between hospitals, physicians, you and us--the Company--to make our Plan work, both now and in future years.

All health benefits described herein are being provided and maintained for you and your covered dependents by University of Dubuque hereinafter referred to as the "Company." Self Insured Services Company will process all benefit payments.

Claims should be submitted to:

Self Insured Services Company
P. O. Box 389
Dubuque, Iowa 52004-0389
(563)583-7344
(800) 457-4726

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PLAN DESCRIPTION

Purpose

The Plan Document details the benefits, rights, and privileges of Covered Individuals (as later defined), in a fund established by University of Dubuque (the "Company") and referred to as the "Plan." The Plan Document explains the times when the Plan will pay or reimburse all or a portion of Eligible Expenses.

Effective Date of Plan	February 1, 1983; restated March 1, 1991 and August 1, 2012
Name of Plan	University of Dubuque Health Care Plan
Name and Address of Plan Sponsor	University of Dubuque 2000 University Ave Dubuque, IA 52001-5099
Name and Address of Claims Administrator	Self Insured Services Company (SISCO) P.O. Box 389 Dubuque, Iowa 52004-0389 (800) 457-4726
Name and Address of Review Organization	HealthCorp P.O. Box 1475 Dubuque, Iowa 52004-1475 (800) 457-4726
Employer I.D. Number	42-0680323
Plan Number	501
Type of Plan	A self-funded group health plan providing medical, prescription drug, dental, and vision expense coverage
Agent For Legal Service	University of Dubuque
Funding of the Plan	University of Dubuque and Employee Contributions
Medium For Providing Benefits	The benefits are administered in accordance with the Plan Document by the Claims Administrator.
Fiscal Year of the Plan	Beginning June 1 and ends May 31

Named Fiduciary and Plan Administrator

The Named Fiduciary and Plan Administrator is University of Dubuque, who has the authority to control and manage the operation and administration of the Plan. The Plan Administrator or its delegate has the sole authority and discretion to interpret and construe the terms of the Plan and to determine any and all questions in relation to the administration, interpretation or operation of the Plan, including, but not limited to, eligibility under the Plan, payment of benefits or claims under the Plan and any and all other matters arising under the Plan. The decision of the Plan Administrator will be final and binding on all interested parties.

Contributions to the Plan

The amount of contributions to the Plan are to be made on the following basis:

The Company will from time to time evaluate the costs of the Plan and determine the amount to be contributed by the Company and the amount to be contributed (if any) by each covered Employee. Notwithstanding any other provision of the Plan, the Company's obligation to pay claims otherwise allowable under the terms of the Plan will be limited to its obligation to make contributions to the Plan as set forth in the preceding sentence. Payment of said claims in accordance with these procedures will discharge completely the Company's obligation with respect to such payments. In the event that the Company terminates the Plan, then as of the effective date of termination, the Company and Covered Individuals will have no further obligation to make additional contributions to the Plan.

Plan Modification and Amendments

Subject to any negotiated agreements, the Company may modify, amend, or discontinue the Plan without the consent of or notice to Covered Individuals. Any changes made shall be binding on each Employee and on any other Covered Individuals. This right to make amendments shall extend to amending the coverage (if any) granted to retirees covered under the Plan, including the right to terminate such coverage (if any) entirely.

Termination of Plan

The Company reserves the right at any time to terminate the Plan by a written instrument to that effect. All previous contributions by the Company will continue to be issued for the purpose of paying benefits under the provisions of this Plan with respect to claims arising before such termination, or will be used for the purpose of providing similar health benefits to Covered Individuals, until all contributions are exhausted.

Plan Is Not a Contract

The Plan Document constitutes the entire Plan. The Plan will not be deemed to constitute a contract of employment or give any Employee of the Company the right to be retained in the service of the Company or to interfere with the right of the Company to discharge or otherwise terminate the employment of any Employee.

Claim Procedure

In accordance with Section 503 of ERISA, the Company will provide adequate notice in writing to any Covered Individuals whose claim for benefits under this Plan has been denied, setting forth the specific reasons for such denial and written in a manner calculated to be understood by the Covered Individuals. Further, the Company will afford a reasonable opportunity to any Covered Individuals, whose claim for benefits has been denied, for a full and fair review of the decision denying the claim by the person designated by the Company for that purpose.

Protection against Creditors

No benefit payment under this Plan will be subject in any way to alienation, sale, transfer, pledge, attachment, garnishment, execution, or encumbrance of any kind, and any attempt to accomplish the same will be void. If the Company finds that such an attempt has been made with respect to any payment due or to become due to any Covered Individual, the Company in its sole discretion may terminate the interest of such Covered Individual or former Covered Individual in such payment, and in such case will apply the amount of such payment to or for the benefit of such Covered Individual or former Covered Individual, his spouse, parent, adult child, guardian of a minor child, brother or sister, or other relative of a Dependent of such Covered Individual or former Covered Individual, as the Company may determine, and any such application will be a complete discharge of all liability with respect to such benefit payment. This Provision does not prohibit a Covered Individual from assigning his benefits to an Eligible Provider.

Indemnification of Employees

Except as otherwise provided in ERISA, no director, officer, or Employee of the Company or of the Claims Administrator will incur any personal liability for the breach of any responsibility, obligation, or duty in connection with any act done or omitted to be done in good faith in the administration or management of the Plan and will be indemnified and held harmless by the Company from and against any such personal liability, including all expenses reasonably incurred in his defense if the Company fails to provide such defense. The Company and the Plan may each purchase fiduciary liability insurance consistent with applicable law.

PLAN SUMMARY
FOR
UNIVERSITY OF DUBUQUE

Eligibility Provisions

Eligible Class

All Employees who work for the University of Dubuque for at least 30 hours per week on a regular basis, faculty and staff on approved leaves and Other Eligible Participants as defined by the Plan. Temporary or contracted employees are not eligible.

Required Period of Service

An Employee will be eligible for coverage on the first of the month coincident with or next following employment.

Contribution

The Plan may be evaluated from time to time to determine the amount of Employee contribution (if any) required.

Spousal Provision (applies to medical plan only)

If an Employee's spouse is working and eligible for their employer sponsored group health plan, the spouse must enroll for primary coverage in that plan in order to be eligible for secondary coverage under this Plan.

Changes in Eligibility

You should report any change in eligibility to your employer as soon as possible. Changes in eligibility include, but are not limited to:

- Marriage or divorce
- Death of a Dependent
- Birth or adoption of a child
- Dependent child reaching the limiting age

Managed Care

This Plan has a mandatory utilization review requirement called “pre-certification”. Pre-certification is required prior to all scheduled Hospital admissions, Skilled Nursing/Extended Care admissions, and Outpatient services as outlined below. **Pre-certification does not guarantee that proposed admissions or Outpatient procedures are covered under the Plan as Eligible Expenses.**

Review Organization

The Review Organization for this Plan is:

HealthCorp
P.O. Box 1475
Dubuque, Iowa 52004-1475
1-800-457-4726

Hospital Pre-Admission Certification

The Plan requires that all non-emergency inpatient hospitalizations and Skilled Nursing/Extended Care Facility admissions be pre-certified by the Review Organization prior to the admission; all emergency inpatient hospitalizations must be reported within two (2) business days of admission. If an individual fails to pre-certify an inpatient stay with the Review Organization, Eligible Expenses related to the admission will be subject to a penalty as listed in the Plan.

The Covered Individual must inform the provider that he participates in a program, which has pre-certification requirements. In order to obtain pre-certification:

1. Notify the appropriate Review Organization of the upcoming Hospital or Skilled Nursing/Extended Care Facility stay no later than 24 hours prior to the admission. Emergency admissions to the hospital must be reported to the Review Organization within two (2) business days of the admission.
2. Notice can be given by: (a) the Hospital/Skilled Nursing/Extended Care Facility; (b) admitting Physician; (c) Covered Individual; or (d) a Family member of the Covered Individual, but **it is ultimately the responsibility of the Covered Individual to make sure a Hospital admission or Skilled Nursing/Extended Care Facility admission has been pre-certified.**
3. The Review Organization must be provided with information necessary to make a decision as to the Medical Necessity of the admission.

In regard to maternity or Newborn infant admissions, the health Plan may not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or Newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section, or require that a provider obtain authorization from the Plan for prescribing a length of stay not in excess of the above periods. However, Federal law generally does not prohibit the mother’s or Newborn’s attending provider, after consulting with the mother, from discharging the mother or her Newborn earlier than 48 hours (or 96 hours as applicable).

A maternity or Newborn admission in excess of the 48/96 hour time frame requires calling the Review Organization for pre-certification of the additional stay.

Continued Stay Review

When the Review Organization provides pre-certification to the Covered Individual, the Review Organization will assign a certain number of inpatient Hospital days or inpatient Skilled Nursing/Extended Care Facility days for the stay. If any days are not Medically Necessary, and the Covered Individual remains beyond the Medically Necessary length of stay, the Covered Individual shall be liable for all Hospital/Skilled Nursing/Extended Care Facility charges beyond the Medically Necessary length of stay.

Outpatient Management Pre-Certification

The Plan requires that the following scheduled procedures/services be pre-certified by the Review Organization, subject to its' guidelines, prior to receiving treatment/service. Emergency outpatient services do not require pre-certification. If the service is not pre-certified, Eligible Expenses related to the service will be subject to a penalty as listed in the Plan.

- Chemotherapy
- CT Scans
- Home Health Services
- Medical Equipment – purchase, if price is above \$500 and all rentals
- MRA
- MRI
- PET Scan
- Radiation Therapy

Penalty for Non-Certification

If pre-certification is not obtained in connection with an Inpatient hospitalization, Inpatient Skilled Nursing/Extended Care Facility admission, or listed outpatient procedure/service, the Eligible Expenses will be reduced by 50% to a maximum penalty of \$250. The additional penalty will be figured before the Deductible and coinsurance are applied. The penalty is not considered an Eligible Expense.

Case Management

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

Case management is a program whereby a case manager monitors a patient and explores, discusses and recommends coordinated and/or alternate types of appropriate Medically Necessary Care. The case manager consults with the patient, the family and the attending Physician in order to develop a plan of care for approval by the patient's attending Physician and the patient.

Case management is a voluntary service. There are no reductions of benefits or penalties if a Covered Individual chooses not to participate.

Comprehensive Medical Expense Benefits

Your Plan utilizes a Preferred Provider Organization (PPO) which, through negotiation, offers discounts for using the preferred providers for your medical care. If you utilize the PPO providers for eligible services, you will receive the In-Network benefit listed below. To obtain a list of the preferred providers, contact your human resources department.

All services under the PPO Plan must be provided by participating providers to be covered at the In-Network benefit level. Services received elsewhere will be paid at the Out-of-Network level of benefits. However, if any of the following circumstances apply, benefits will be payable at the In-Network level of benefits:

- The service is not available through the PPO.
- The Covered Individual has a written referral from a PPO Physician for specific services; such referral must be obtained prior to the service being performed. A referral will remain in force through a course of treatment or twelve (12) consecutive months, whichever is less.
- Emergency care.
- Ancillary services when the primary service is rendered by a PPO provider.
- Services for Dependents who, because of a divorce or separation, live Out-of-Network.
- Services for college students who live Out-of-Network.

Plan A

Annual Individual Deductible	\$500
Annual Family Deductible	\$1,000 (all Family members combined)
Annual Out-of-Pocket Maximum Including the Deductible (Does not include the benefit reduction for failure to comply with the Managed Care measures of the Plan, ineligible charges, or any amount over the Usual, Customary and Reasonable procedure rate.)	In-Network: Individual: \$1,250 Family: \$2,500 (All Family members combined) Out-of-Network: Individual: \$1,500 Family: \$3,000 (All Family members combined)
Benefit Percentage for Well Care Including Women’s Preventive Services	In-Network: 100% no Deductible required Out-of-Network: 60% after the Annual Deductible
Benefit Percentage for Mental Health/ Substance Abuse Services	80% after the Annual Deductible
Benefit Percentage for Outpatient Therapy including in a Physician’s Office Occupational, Physical, and Speech Therapy are limited to 30 visits per Calendar Year combined; additional visits may be available with pre-approval from the Review Agent	In-Network: 80% after the Annual Deductible Out-of-Network: 60% after the Annual Deductible

Benefit Percentage for Second Surgical Opinion (includes exam and diagnostic tests)	100% no Deductible required
Benefit Percentage for Chiropractic Care Limited to 24 visits per Calendar Year	In-Network: 80% after the Annual Deductible Out-of-Network: 60% after the Annual Deductible
Benefit Percentage for All Other Eligible Medical Expenses	In-Network: 80% after the Annual Deductible Out-of-Network: 60% after the Annual Deductible

Prescription Drug Expense Benefit

Plan A

Benefit Percentage	100% after the Prescription Co-Pay up to an Annual Out-of-Pocket Maximum of \$500 per individual and \$1,000 per family.
Prescription Co-Pay (Per prescription and each refill of a prescription. Limited to a 100-day supply)	Generic: \$10 Name Brand: \$20

Generic contraceptives and name brand contraceptives with no generic equivalent are covered 100% as part of the Well Care benefit.

The Prescription drug coverage provided by this Plan is “creditable” to Medicare D. If you or one of your covered family members is eligible for Medicare, you may obtain a “creditable coverage” letter by contacting SISCO –800-457-4726.

Plan B

Annual Individual Deductible	\$0
Annual Family Deductible	\$0 (all Family members combined)
Annual Out-of-Pocket Maximum Including the Deductible (Does not include the benefit reduction for failure to comply with the Managed Care measures of the Plan, ineligible charges, or any amount over the Usual, Customary and Reasonable procedure rate.)	Individual: \$0 Family: \$0 (All Family members combined)
Benefit Percentage for Well Care Including Women’s Preventive Services	In-Network: 100% Out-of-Network: 100%
Benefit Percentage for Mental Health/ Substance Abuse Services	100%

Benefit Percentage for Outpatient Therapy including in a Physician’s Office Occupational, Physical, and Speech Therapy are limited to 30 visits per Calendar Year combined; additional visits may be available with pre-approval from the Review Agent	100%
Benefit Percentage for Second Surgical Opinion (includes exam and diagnostic tests)	100%
Benefit Percentage for Chiropractic Care Limited to 24 visits per Calendar Year	100%
Benefit Percentage for All Other Eligible Medical Expenses	100%

**Prescription Drug Expense Benefit
Plan B**

Benefit Percentage	100% after the Prescription Co-Pay up to an Annual Out-of-Pocket Maximum of \$500 per individual and \$1,000 per family.
Prescription Co-Pay (Per prescription and each refill of a prescription. Limited to a 100-day supply)	Generic: \$0 Name Brand: \$20

Generic contraceptives and name brand contraceptives with no generic equivalent are covered 100% as part of the Well Care benefit.

The Prescription drug coverage provided by this Plan is “creditable” to Medicare D. If you or one of your covered family members is eligible for Medicare, you may obtain a “creditable coverage” letter by contacting SISCO –800-457-4726.

Plan C

Annual Individual Deductible	\$2,600
Annual Family Deductible	\$5,200 (all Family members combined)
Annual Out-of-Pocket Maximum Including the Deductible (Does not include the benefit reduction for failure to comply with the Managed Care measures of the Plan, ineligible charges, or any amount over the Usual, Customary and Reasonable procedure rate.)	<p>In-Network: Individual: \$4,000 Family: \$8,000 (All Family members combined)</p> <p>Out-of-Network: Individual: \$8,000 Family: \$16,000 (All Family members combined)</p>
Benefit Percentage for Well Care Including Women’s Preventive Services	<p>In-Network: 100% no Deductible required Out-of-Network: 60% after the Annual Deductible</p>
Benefit Percentage for Mental Health/ Substance Abuse Services	70% after the Annual Deductible
Benefit Percentage for Outpatient Therapy including in a Physician’s Office Occupational, Physical, and Speech Therapy are limited to 30 visits per Calendar Year combined; additional visits may be available with pre-approval from the Review Agent	<p>In-Network: 70% after the Annual Deductible Out-of-Network: 60% after the Annual Deductible</p>
Benefit Percentage for Second Surgical Opinion (includes exam and diagnostic tests)	100% no Deductible required
Benefit Percentage for Chiropractic Care Limited to 24 visits per Calendar Year	<p>In-Network: 70% after the Annual Deductible Out-of-Network: 60% after the Annual Deductible</p>
Benefit Percentage for Prescription Drugs	70% after the In-Network Deductible, applies to In-Network Out-of-Pocket Maximum
Benefit Percentage for All Other Eligible Medical Expenses	<p>In-Network: 70% after the Annual Deductible Out-of-Network: 60% after the Annual Deductible</p>

Dental Expense Benefits

Annual Individual Deductible	\$50
Annual Family Deductible	\$100
Benefit Percentage for Dental Expenses	
Class I (Diagnostic and Preventive Services)	100% no Deductible required
Class II (Basic Restorative Services)	80% after the Annual Deductible
Class III (Major Restorative Services)	50% after the Annual Deductible
Class IV (Orthodontia; limited to Dependent children up to age 19)	50% after the Annual Deductible
Maximum Annual Benefit per Individual Classes I, II & III Combined	\$1,500 per Covered Individual per Calendar Year
Maximum Lifetime Benefit per Individual Class IV	\$1,000 per Covered Individual (limited to Dependent children up to age 19)

Enrollment for coverage is required within 31 days of the date an individual would otherwise be eligible. If enrollment is sought after that time, or after a previous termination of coverage, or because of failure to make a contribution when due, the individual will be considered a late enrollee. A late enrollee will only be eligible for \$150 in benefits during the first twelve (12) months of coverage. If enrollment is sought to replace comparable existing coverage under another plan, the total benefits limitation will not apply.

**Vision Care Expense Benefits
(Optional Benefit)**

Exam and lenses available once every 24 months for persons age 18 and over; once every 12 months for persons under age 18. Frames available once every 24 months.

Deductible	None
Benefit	100% of Scheduled Allowances
Scheduled Allowances	
Eye Examination	100% of Usual, Customary & Reasonable Allowance
Frames	\$60
Single Lens	\$40 per pair
Bifocal Lens	\$55 per pair
Trifocal Lens	\$70 per pair
Lenticular Lens	\$95 per pair
Contact Lens	\$100 per benefit period
Limitation	One set of frames and lenses OR one regimen of contacts (but not both) in a benefit period. (Does not cover sunglasses.)

Enrollment for coverage is required within 31 days of the date an individual would otherwise be eligible. If enrollment is not completed within that time, an Employee will be eligible to enroll during the Annual enrollment period established by the Company or under the Special Enrollment provisions. If coverage is subsequently terminated for either the Employee and/or any Dependent, they will not be eligible to re-enroll in the Plan unless the Special Enrollment provisions of the Plan apply.

COMPREHENSIVE MEDICAL EXPENSE BENEFITS

Upon receipt of proof of loss, the Plan will pay the Benefit Percentage listed in the Plan Summary for Medically Necessary Eligible Expenses incurred in each Benefit Period. The amount payable in no event shall exceed any Maximum Benefit stated in the Plan Summary.

The Deductible

The Deductible is the amount of Eligible Expenses which must be paid each Calendar Year before Comprehensive Medical Expense Benefits are payable. The amount of the Deductible is shown in the Plan Summary. Each Family member is subject to the Deductible up to the Family maximum as shown in the Plan Summary. A Newborn will be not be subject to the Annual Deductible during the initial Hospital confinement.

Family Deductible Feature

If the Family Deductible limit, as shown in the Plan Summary, is incurred by covered Family members during the Calendar Year, no further Deductibles will be required on any Family members for the rest of the Calendar Year; each Family member's responsibility will be limited to the individual deductible as specified in the Summary of Benefits.

Out-of-Pocket Maximum

After the Annual Deductible is met, the Plan will pay the applicable percentages of Eligible Expenses as shown in the Schedule of Benefits. When a Covered Individual meets the Annual Out-of-Pocket Maximum as stated in the Schedule of Benefits, the Plan will pay 100% of additional Eligible Expenses for the remainder of that Calendar Year.

Allocation and Apportionment of Benefits

The Company reserves the right to allocate the Deductible amount to any Eligible Expenses and to apportion the benefits to the Covered Individual and any assignees. Such allocation and apportionment shall be conclusive and shall be binding upon the Covered Individual and all assignees.

Medical Eligible Expenses

Medical Eligible Expenses are the following Medically Necessary expenses that are incurred while Plan coverage is in force for the Covered Individual. The Plan does not provide coverage for services if medical evidence shows that treatment is not expected to resolve, improve, or stabilize the Covered Individual's condition, or that a plateau has been reached in terms of improvement from such services. If any of the listed expenses are excluded from coverage because of a reason described in the General Limitations section or any other Plan section, those expenses will not be considered medical Eligible Expenses.

The Plan will make payment for medical Eligible Expenses subject to the Benefit Percentage and maximum amounts shown in the Plan Summary. All services are subject to the Usual, Customary, and Reasonable allowance as defined in the Plan.

Hospital Expenses

Hospital expenses are the charges made by a Hospital on its own behalf. Such charges include:

1. Semi-Private Room and Board. If a facility has only private rooms, the average semi-private rate of the area will be allowed. If a private room is Medically Necessary due to the diagnosed condition, the private-room rate will be allowed.
2. Necessary Hospital services other than Room and Board as furnished by the Hospital.
3. Special care units, including burn care units, cardiac care units, delivery rooms, Intensive Care Units, isolation rooms, operating rooms and recovery rooms.
4. Outpatient charges to include observation up to 23 hours. Observation in excess of 23 hours will be allowed based on the inpatient benefit of the Plan.

Skilled Nursing Facility/Extended Care Facility Expenses

Eligible Skilled Nursing Facility/Extended Care Facility expenses under this benefit include:

1. Room and Board, including any charges made by the facility as a condition of occupancy or on a regular daily or weekly basis, such as general nursing services. The daily Room and Board charges allowed will not exceed the average semi-private rate.
2. Medical services customarily provided by the Skilled Nursing Facility or Extended Care Facility, with the exception of private-duty or special nursing services and Physician fees.
3. Drugs, biologicals, solutions, dressings and casts furnished for use during the convalescent period, but no other supplies.

Hospice Expenses

A Hospice program provides care for patients who are terminally ill. The following services and supplies provided by a Hospice are covered:

1. Nursing care by a Registered Nurse (R.N.), or by a Licensed Practical Nurse (L.P.N.), a vocational nurse, or a public health nurse who is under the direct supervision of a Registered Nurse.
2. Physical therapy, occupational therapy and speech therapy, when rendered by a licensed therapist.
3. Medical supplies, including drugs and biologicals, and the use of medical appliances.
4. Physicians' services.
5. Services, supplies, and treatments (including Inpatient Hospice care) deemed Medically Necessary and ordered by a licensed Physician.
6. Respite Care offers rest and relief help for the Family caring for a terminally ill patient. Eligible inpatient respite care can take place in a Hospital, Skilled Nursing Facility/Extended Care Facility or nursing home. Respite care must be used in increments of not more than five (5) days at a time.

Home Health Care Expenses

Home health care expenses are the charges made by a Home Health Care Agency for the following services and supplies which are ordered by a Physician and furnished to a Covered Individual in his home in accordance with a Home Health Care Plan.

1. Part-time or intermittent nursing care provided by a Registered Nurse (R.N.), or by a Licensed Practical Nurse (L.P.N.), a vocational nurse, or a public health nurse who is under the direct supervision of a Registered Nurse.
2. Part-time or intermittent home health aide services which consist primarily of caring for the patient, and are under the supervision of an R.N. or L.P.N.
3. Medical supplies, drugs, and medicines prescribed by a Physician, and laboratory services provided by or on behalf of a licensed medical provider, but only to the extent that such charges would have been covered if the Covered Individual had remained in the Hospital or a Skilled Nursing Facility/Extended Care Facility.
4. Charges for physical, respiratory, speech or occupational therapy.
5. Charges for parenteral or enteral nutrition.
6. Charges for inhalation therapy
7. Medical social services.

Home health care expenses will not be covered if they are:

1. For services or supplies not specified in the Home Health Care Plan.
2. For services by a Close Relative or member of the household.
3. For services for a period during which an Employee or Dependent is not under the continuing care of a Physician.
4. For transportation services.

Each visit by a Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.) to provide nursing care, by a therapist to provide physical, occupational or speech therapy, and each visit of up to four (4) hours by a home health aide shall be considered as one home health care visit.

Organ/Tissue Transplant Expenses

Benefits are available to a Covered Individual who is a recipient for Medically Necessary covered services relating to bone marrow, liver, heart, lung (single and double), combination heart/lung, pancreas, pancreas/kidney, kidney, cornea and any other non-Experimental transplant. Eligible Expenses include, but are not limited to: testing to determine transplant feasibility and donor compatibility; charges related to the transplant itself, as well as follow-up care to include: diagnostic x-ray and lab; procedures to determine rejection or success of transplant, to include: Physician, lab, x-ray or Hospital charges, and anti-rejection drugs.

Organ transplant expenses are those charges for services and supplies in connection with non-Experimental, human to human, transplant procedures, subject to the following criteria:

1. The recipient must be a Covered Individual on this Plan.
2. Except for transplant of a cornea, the recipient must be in danger of death in the event the organ transplant is not performed.
3. There must be a reasonable expectation of survival if the Covered Individual were to receive the transplant.

4. Charges incurred by the donor are only payable if the donor has no other health coverage available, i.e. group health plan, a government program, or a research program.
5. Pre-approval is required.

The following will not be eligible for coverage under this benefit:

1. Expenses associated with the purchase of any organ.
2. Charges in connection with mechanical or non-human organs or a transplant involving a mechanical organ.
3. Services or supplies furnished in connection with the transportation of a living donor.

Physician Services

The Plan will allow Physician charges according to Usual, Customary, and Reasonable (UCR) guidelines for medical care and/or surgical treatments, including office or home visits, Hospital Inpatient care or Outpatient care, clinic care, ambulatory surgery care, and Medically Necessary care provided at a licensed outpatient facility. Payment for multiple Surgical Procedures (not including the primary Surgical Procedure) performed at the same time may be reduced to 50% of the UCR amount. If the multiple Surgical Procedure is determined incidental, benefits will be denied. If an assistant surgeon is required, the assistant surgeon's covered charge will not exceed 20% of the surgeon's Usual, Customary and Reasonable allowance.

Eligible Expenses In or Out of the Hospital

1. Fees for private-duty nursing when such services are: 1) provided by Registered Nurses (RNs) or Licensed Practical Nurses (LPNs) in the Covered Individual's home; 2) prescribed by a Physician for the treatment of an Illness or Injury when the Covered Individual is homebound; and 3) not more costly than alternative services that would be effective for diagnosis and treatment of the Covered Individual's condition.
2. Treatment or services rendered by a licensed Physical Therapist in a home setting or at a facility or institution which has the primary purpose of providing medical care for an Illness or Injury. Charges for restorative or rehabilitative physical therapy due to an Illness or Injury, or due to surgery performed because of an Illness or Injury will be eligible.
3. Charges for Medically Necessary local air or ground ambulance service to and from the nearest, local adequate Hospital or Skilled Nursing Facility/Extended Care Facility where Medical Emergency care or treatment is rendered, or to the nearest facility equipped to furnish necessary medical treatment if not available at a local Hospital. This Plan will only cover ambulance transportation when: 1) no other method of transportation is appropriate; 2) the services necessary to treat the Illness or Injury are not available in the Hospital or Skilled Nursing Facility/Extended Care Facility where the Covered Individual is an inpatient; and/or 3) the Hospital or Skilled Nursing Facility/Extended Care Facility where the ambulance takes the Covered Individual is the nearest with adequate facilities.
4. Charges for x-rays, diagnostic tests, and laboratory tests.
5. Charges for radiation therapy or treatment, and chemotherapy.
6. Charges for the processing and administration of blood or blood components. Charges for the processing and storage of autologous blood are not an Eligible Expense.
7. Charges for oxygen and other gases, and their administration.

8. Charges for electrocardiograms, electroencephalograms, pneumoencephalogram, basal metabolism tests, allergy tests, or similar well-established diagnostic tests generally approved by Physicians throughout the United States.
9. Charges for the cost and administration of anesthetic in conjunction with a covered surgical or medical procedure. If separate bills are received from an anesthesiologist and a Certified Registered Nurse Anesthetist (CRNA), the Plan will consider the anesthesiologist and CRNA as practicing as an “anesthesia team” and divide the UCR allowance between the providers.
10. Charges for dressings, sutures, casts, splints, crutches, braces, ostomy supplies, catheters, or other necessary medical supplies, with the exception of dental braces, orthopedic shoes, arch supports, elastic stockings, trusses, lumbar braces, garter belts and similar items which can be purchased without a prescription.
11. Charges for the rental, up to the purchase price, of a wheelchair, Hospital bed, iron lung, or other Durable Medical Equipment required for Medically Necessary temporary therapeutic use or the purchase of this equipment if economically justified, whichever is less. **It is required that the Covered Individual obtain pre-certification of the purchase or rental of equipment.**
12. Charges for prosthetic appliances used to replace a missing natural body part, and charges for repair of such an appliance. Replacement of a prosthetic appliance will be covered when due to a pathological change, or if it has been more than five (5) years since the last placement of such an item, unless replacement is needed as a result of unintentional damage of the appliance, and it cannot be made serviceable by repairs. Pre-authorization of a replacement is recommended.
13. Charges made by an Ambulatory Surgical Facility or minor emergency medical clinic when treatment has been rendered.
14. Charges for dialysis as an inpatient or at a Medicare-approved Outpatient dialysis center.
15. Charges for allergens and allergy injections.
16. Charges for drugs requiring the written Prescription of a licensed Physician. Such drugs, except contraceptives, must be necessary for the treatment of an Illness or Injury. The Plan also covers insulin, insulin supplies and syringes.
17. Charges for injectable drugs whether self-administered or administered by a physician.
18. Outpatient cardiac rehabilitation programs to provide supervised monitored exercise sessions following heart surgery or a heart attack.
19. Charges for restorative or rehabilitative speech therapy by a licensed Speech Therapist due to an Illness or Injury, or due to surgery performed because of an Illness or Injury.
20. Charges for restorative or rehabilitative occupational therapy by a licensed Occupational Therapist due to an Illness or Injury, or due to surgery performed because of an Illness or Injury.

21. Eligible Pregnancy related expenses for an Employee or a Dependent, including Medically Necessary amniocentesis tests. These expenses are considered the same as any other medical condition under the Plan. The health Plan may not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or Newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section, or require that a provider obtain authorization from the Plan for prescribing a length of stay not in excess of the above periods.
22. Charges in relation to Well Care. Eligible Expenses include items and services rated A or B in the United States Preventive Services Task Force recommendations and services set forth in comprehensive guidelines supported by the Health Resources and Services Administration. Immunizations that are recommended by the Advisory Committee on Immunizations Practices of the Centers for Disease Control and Prevention are an Eligible Expense. Charges for “Women’s Preventive Care” including: well-women visits including pre-natal care; gestational diabetes screening for women 24 -28 weeks pregnant and those at high risk for developing gestational diabetes; HPV DNA testing for women age 30 or older every three (3) years; counseling and screening for HIV and sexually transmitted infections; contraception including all FDA approved methods (includes generic contraceptives and name brand contraceptives with no generic equivalent), sterilization procedures and education and counseling (does not include abortifacient drugs); breastfeeding support (breast pumps are limited to manual breast pumps), counseling and supplies including breastfeeding equipment; and domestic violence screening are included in this benefit.
23. Charges for dental services provided by a Dentist when Medically Necessary, and limited to services provided for the repair of damage to the jaw or sound natural teeth as the direct result of, and completed within 90 days of an Accidental Injury. Injury as a result of chewing or biting will not be considered an Accidental Injury. This will not in any event be deemed to include charges for treatment for the repair or replacement of a denture.
24. Charges for the following oral surgery whether performed by a Dentist or Physician will be considered as Medical Eligible Expenses:
 - a. Correction of cleft palate/lip.
 - b. Reduction or manipulation of fractures of facial bones.
 - c. Excision of lesions of the mandible, mouth, lips or tongue.
 - d. Incision of the accessory sinuses, mouth, salivary glands or ducts.
 - e. Manipulation of dislocations of the jaw.
25. Charges for services and supplies in relation to diabetes self-management programs. Such services must be Medically Necessary and prescribed by a Physician. A Covered Individual will be limited to two (2) programs per Lifetime.
26. Charges for services in connection with surgical treatment of morbid obesity will be considered Eligible Expenses, if the Covered Individual is at least 100 pounds over ideal weight, subject to the following conditions:
 - a. A second concurring surgical opinion is required prior to the Surgical Procedure;
 - b. Pre-authorization with the Claims Administrator (SISCO) is required; and
 - c. Pre-certification with the Review Organization is required.Revision of bypass surgery is only covered if the original procedure was a technical failure. Revision bypass surgery is not covered when patient has been non-compliant and unable to follow the necessary lifestyle changes.

27. Charges in relation to individual and group Psychiatric Care or treatment of a mental health condition or substance abuse.
28. Hospital and Physician charges in relation to the routine care of a Newborn.
29. Charges for home infusion therapy, including the administration of nutrients, antibiotics, and other drugs and fluids intravenously or through a feeding tube.
30. Charges for Medically Necessary mammoplasty following a Medically Necessary mastectomy. Services include reconstruction of the breast on which the mastectomy has been performed and reconstruction of the other breast to produce symmetrical appearance. Breast prostheses, surgical brassieres and physical complications of all stages of mastectomy, including lymphedemas, are also eligible under the Plan.
31. Charges for Prescription contraceptives.
32. Charges for scheduled childbirth at home if under the supervision of an Eligible Provider.
33. Charges for routine patient costs for items and services furnished in connection with participation in an approved clinical trial with respect to the treatment of cancer or another life-threatening disease or condition. Services will be eligible when either: (1) the referring health care professional has concluded that the individual's participation in such trial would be appropriate; or (2) the participant or beneficiary provides medical and scientific information establishing that the individual's participation in such trial would be appropriate.

An approved clinical trial means a phase I, II, III, or IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition, and is either (i) a federally funded or approved study or investigation, (ii) a study or investigation conducted under an investigational new drug application reviewed by the Food and Drug Administration, or (iii) a study or investigation that is a drug trial exempt from having such an investigational new drug application.

Routine patient costs include all items and services consistent with the coverage provided in the plan that are typically covered for a qualified individual who is not enrolled in a clinical trial. However, routine patient costs do not include (i) the investigational item, device or service itself, (ii) items and services that are provided solely to satisfy data collection and analysis needs, and that are not used in the direct clinical management of the patient, or (iii) a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

34. Charges for prophylactic procedures with prior approval of HealthCorp.

COMPREHENSIVE DENTAL EXPENSE BENEFITS

Subject to the General Limitations section of this Plan and the limitations of this section, Usual, Customary and Reasonable charges incurred for the following Covered Dental Expenses will be covered in accordance with the percentage of coverage, Deductible amounts and maximums in the Plan Summary.

A pre-treatment review is recommended on all charges that will result in a payment of \$200 or more unless it can be shown that treatment was made on an emergency basis.

The Deductible

The Deductible is the amount of Covered Dental Expenses which must be paid each Calendar Year before Comprehensive Dental Expense Benefits are payable. The amount of the Deductible is shown in the Plan Summary. Each Family member is subject to the Deductible up to the Family maximum as shown in the Plan Summary.

Dental Eligible Expenses

The term "Dental Eligible Expenses" means the expenses incurred by or on behalf of a Covered Individual for charges made by a Dentist for the performance of dental service provided for in the Plan Summary when the dental service is performed by or under the direction of a Dentist, is essential for the necessary care of the teeth. If the actual performance of a dental service begins on a date other than the date the service was recommended or determined to be necessary, the dental service will be considered to begin on the date the actual performance of the service begins. For a crown, bridge, or gold restoration, an expense is considered incurred at the time the tooth or teeth are prepared. For root canal therapy, an expense is considered incurred at the time the pulp chamber is opened. For an appliance or modification of an appliance, an expense is considered incurred at the time the impression is made, except orthodontic services are subject to the information listed in that section. All other expenses are considered incurred at the time a service is rendered or a supply furnished. Covered Dental Expenses do not include any expenses that are in excess of the Usual, Customary and Reasonable amount.

If a condition is being treated for which different treatments are suitable, the benefits under this Plan will be based on the service that, according to a determination made by the Plan Administrator, would produce a professionally satisfactory result.

Class I - Diagnostic & Preventive Services

1. Oral examinations and routine cleaning (prophylaxis) of teeth, but not more than twice per Calendar Year.
2. Fluoride applied to the teeth, but not more than twice per Calendar Year.
3. Dental x-rays:
 - a. Full mouth (single or multiple films), but not more than once every 36 months.
 - b. Bitewing x-rays, but not more than two (2) times per Calendar Year.
 - c. Other x-rays when needed to diagnose and treat a specific condition.

Class II - Basic Restorative Services

1. Oral surgery, including pre- and post-operative care, general anesthesia, local anesthetic and injectable antibiotics.
2. Extraction of teeth.
3. Regular cavity fillings, including amalgam, synthetic porcelains, composite and plastic fillings and stainless steel restorations. Cast restorations for advanced tooth decay or fracture are allowable once every five (5) consecutive years beginning from the date the cast

restoration was cemented in place. Restorations include inlays, onlays, and crowns (including porcelain, porcelain fused, or precious metal crowns and related post and core). Crowns placed for the primary purpose of periodontal splinting, altering vertical dimension or restoring occlusion are not an Eligible Expense.

4. Emergency treatment to relieve pain.
5. Relining or rebasing of dentures, but not more than one of either in a 24-month period. No benefits will be paid during the first six (6) months after the denture has been placed.
6. Recementing or repair of crowns, inlays, onlays, dentures or fixed bridges.
7. Periodontics.
8. Endodontics.

Class III - Major Restorative Services

1. Fixed bridgework to replace missing permanent teeth and the repair of such bridgework. Bridges which are supported by dental implants are limited to the amount paid for a bridge supported by natural teeth.
2. Addition of teeth to an existing fixed bridge, partial or full denture, but only to replace teeth extracted after coverage begins under this Plan.
3. Fixed or partial dentures to replace missing permanent teeth; limited to once every five (5) consecutive years. Dentures which are supported by surgically placed dental implants are limited to the amount paid for a denture supported by natural teeth.
4. Implants.

Class IV – Orthodontics (treatment must begin after your effective date under the Plan)

Services for the proper alignment of teeth, limited to Dependent children up to age 19.

Orthodontic charges for newly hired Employee's (not late enrollee's) dependents will be eligible as follows:

- a. Only ongoing treatment incurred after the dependent is eligible for coverage.
- b. Charges incurred prior to the effective date are not eligible.

Benefits under this Plan for orthodontia will be payable:

- a. immediately upon receipt of proof that the initial treatment (including setting of the appliance or bands) has been completed; and
- b. at the end of each following month/calendar quarter upon receipt of proof that the period of orthodontic treatment has continued.

The benefit amount payable for the initial treatment will be actual charges, but not more than 25% of the total estimated covered charges for the entire period of orthodontic treatment. Monthly/quarterly payments will be determined by averaging the remaining estimated covered charges over the estimated time required to complete the period of orthodontic treatment. Adjustments may be made when changes occur in the estimated covered charges or estimated period of treatment.

Alternate Benefit Provision

When more than one dental service could provide suitable treatment based on common dental standards, the Claims Payer will determine the dental services on which payment is based and the expenses that will be included as Eligible Expenses.

Limitations

1. Charges for a broken appliance.
2. Charges for services or supplies which have the primary purpose of improving the appearance of the teeth, rather than restoring or improving dental form or function. Some examples include: laminate and veneers. This limitation will not apply if the service is rendered as the result of an accidental injury.
3. Charges for infection control procedures (sepsis control - rubber gloves, gowns, etc.) when billed separately from actual dental treatment.
4. Charges for oral hygiene, dietary instruction or plaque control programs.
5. Charges for services or supplies provided by a Dentist who is a Close Relative.
6. Charges for sealants.
7. Charges for services or supplies you are not legally obligated to pay for and for which you would not be charged in the absence of this Plan.
8. Charges for the replacement of lost or stolen appliances.
9. Charges for services or supplies that you are entitled to claim from any governmental program even if you waived or failed to claim rights to such services, benefits, or damages.
10. Charges for services or supplies for crowns placed for the primary purpose of periodontal splinting, altering vertical dimension, or restoring the closing of the upper and lower teeth (occlusion).
11. Charges for Prescription drugs.
12. Charges for any service or supply that could have been compensated under workers' compensation laws, including any services or supplies applied toward the satisfaction of any Deductible under your employer's workers' compensation coverage.
13. Charges for services or supplies for any treatment plan when you receive the services or supplies after the date of termination of coverage under this Plan. Prosthetic dental appliances installed or delivered more than 90 days after coverage terminates are not covered.
14. Charges for services or supplies related to a service that began prior to the effective date of coverage.
15. Charges related to TMJ (temporomandibular joint disorder).
16. Charges for services which are covered under a medical plan sponsored by the Company will not be coordinated with the Dental benefits provided by the Company.
17. Charges for any services received from a medical department, clinic or any facility provided or furnished by the Company.
18. Charges for services that are not necessary or are not normally performed for proper dental care of a condition or any service that is not approved by the attending Dentist.
19. Charges for services or supplies that do not meet accepted standards of dental practice, including experimental services and supplies.
20. Charges for anesthesia or its administration, except for oral surgery.

Late Enrollee

Enrollment for coverage is required within 31 days of the date an individual would otherwise be eligible. If enrollment is sought after that time, or after a previous termination of coverage, or because of failure to make a contribution when due, the individual will be considered a late enrollee. A late enrollee will

only be eligible for \$150 in benefits during the first twelve (12) months of coverage. If enrollment is sought to replace comparable existing coverage under another plan, the total benefits limitation will not apply.

PRESCRIPTION DRUG EXPENSE BENEFIT

The Plan will pay the Usual, Customary and Reasonable charge of Prescription drugs, less the co-payment listed in the Plan Summary which is payable by the Covered Individual for each Prescription and each refill of a Prescription. The Prescription co-payment is not an Eligible Expense under the medical benefits portion of this Plan.

The Prescription Drug Program will not cover the cost of administration of any drug.

Any prescription totaling \$1,000 or more will be reviewed for medical necessity and therapeutic interchange. Any compound prescription over \$200 will also be reviewed at the pharmacy level.

Covered Medications

1. All drugs, prescribed by a Physician that require a prescription either by federal or state law, except drugs excluded by the Plan.
2. All compound prescriptions containing at least one prescription ingredient in a therapeutic quantity.
3. Insulin and the syringes necessary for its administration when prescribed by a Physician.
4. Legend Drugs.
5. Contraceptives.
6. Specialty oral medications.

Excluded

Under this program, the following drugs are never covered, regardless of use or diagnosis:

1. Any drug for which reimbursement is available under any other group program or government program.
2. Drugs dispensed from or by any Hospital, Skilled Nursing Facility/ Extended Care Facility, clinic, or other institution to a Covered Individual as an Inpatient or Outpatient; such drugs are covered by the medical portion of the Plan.
3. Drugs dispensed by other than a retail or mail order pharmacy.
4. Drugs that do not require a written Prescription of a licensed Physician (with the exception of insulin and the syringes or needles for its administration).
5. Injectables with the exception of injectable drugs for the treatment of migraine headaches, insulin, Glucagon and EpiPen.
6. Infertility drugs.
7. Devices or appliances (except for needles and syringes necessary for the administration of insulin).
8. Refills of a Prescription that is more than one (1) year old.
9. Nutritional supplements; vitamins, except prenatal vitamins; cosmetic or growth hormone treatments; or drugs or supplies associated with weight reduction.
10. Over the counter medications, except as specifically listed.
11. Drugs for sexual dysfunction.
12. Drugs dispensed outside the United States, except as required for emergency treatment.

Some Prescription items are limited based on FDA approved dosing schedules, current medical practices, evidence based clinical guidelines, and peer-reviewed medical literature related to that particular drug.

VISION CARE EXPENSE BENEFITS

Optional Benefit

Vision care benefits apply only when vision care charges are incurred by a Covered Individual and when the charges are for services that are recommended and approved by a Physician or Optometrist. Benefits will be payable as outlined in the Plan Summary for each vision care service or supply.

No benefits will be payable for:

1. Charges for orthoptics (eye muscle exercises).
2. Charges for vision training or subnormal vision aids.
3. Charges for lenses ordered without a prescription.
4. Charges for safety goggles, including prescription type.
5. Care, treatment or supplies for which a charge was incurred before a person was covered under this Plan.
6. Charges excluded or limited by the Plan design as stated in this Document.
7. Charges for sunglasses.
8. Charges for tints, over-sizing or any cost above the basic lens fee.

GENERAL LIMITATIONS

The following exclusions and limitations apply to expenses incurred by all Covered Individuals:

1. Expenses incurred prior to the effective date of coverage under the Plan or after coverage is terminated.
2. Charges as a result of active participation in war or any act of war, whether declared or undeclared, or caused during service in the armed forces of any country.
3. No benefits or expenses will be paid or reimbursed to or for any Covered Individual for any injury, illness, occupational disease, or other loss, which arises out of or in the course of employment/activity for wage or profit.
4. Charges while confined in a Hospital owned or operated by the United States government or any agency thereof, or charges for services, treatments or supplies furnished by the United States government or any agency thereof, unless such benefits are mandated under federal law and/or regulation.
5. Charges for which the Covered Individual is not (in the absence of this Plan coverage) legally obligated to pay, or for which a charge would not ordinarily be made in the absence of this Plan coverage.
6. Charges incurred due to an Illness or Injury resulting from the Covered Individual's voluntary participation in a criminal act, or while the Covered Individual is engaged in an illegal occupation. This exclusion does not apply to any Illness or Injury that is the result of an act of domestic violence or results from a medical condition, whether physical or mental.
7. Charges for services or supplies which constitute personal comfort or beautification items; for television or telephone use; or in connection with Custodial Care, education or training, or expenses actually incurred by other persons.
8. Charges in connection with the care or treatment of or surgery performed for a Cosmetic Procedure. This exclusion will not apply when such treatment is rendered to correct a condition resulting from an Accidental Injury or disfiguring disease (does not include scarring due to acne or chicken pox), or when rendered to correct a congenital anomaly (i.e., a birth defect) of a Covered Dependent child. **Pre-authorization is recommended.**
9. Charges incurred in connection with services and supplies which are not Medically Necessary for treatment of an Injury or Illness, or are in excess of Usual, Customary and Reasonable charges, or are not recommended and approved by a Physician, or are not recognized by the American Medical Association as generally accepted and Medically Necessary for the diagnosis and/or treatment of an active Illness or Injury; or charges for procedures, surgical or otherwise, which are specifically listed by the American Medical Association as having no medical value.
10. Charges incurred for routine medical examinations, health checkups, or immunizations related to employment, insurance or travel.
11. Charges related to or in connection with elective sterilization and the reversal of a sterilization procedure. Charges for elective sterilization for female participants is covered as part of the Well Care benefit.
12. Charges incurred in connection with routine eye refractions, the purchase or fitting of eyeglasses, contact lenses, or such similar aid devices.

13. Charges in connection with external or internal mechanical hearing aids, whether removable or surgically implanted, or examinations for the prescription or fitting of hearing aids. Cochlear implants are not an Eligible Expense.
14. Charges for orthopedic shoes, arch supports, or any such similar device, or for the prescription or fitting thereof.
15. Charges for splints or braces for non-medical purposes (i.e., supports worn primarily during participation in sports or similar physical activities).
16. Charges for dental services not specifically included in benefits described in this Plan; or for Hospital charges in relation to dental care, except those services which are certified by a Physician to be Medically Necessary to safeguard the life and health of the Covered Individual due to the existence of a non-dental physical condition. **Pre-authorization is recommended.**
17. Charges for inpatient concurrent services of Physicians, unless there is a clinical necessity for supplemental skills.
18. Charges for reduction mammoplasty.
19. Charges for abortion unless Medically Necessary to safeguard the life of the mother or if due to rape, or incest. Complications of abortion will be an Eligible Expenses regardless of whether or not the abortion was covered by the Plan.
20. Charges for services rendered by a Physician, nurse, or licensed therapist if such Physician, nurse, or licensed therapist is a Close Relative of the Covered Individual, or resides in the same household of the Covered Individual. Durable medical equipment or drugs ordered by such individual will also not be eligible.
21. If a Covered Individual receives medical treatment outside of the United States or its territories, benefits shall be provided for those charges to the extent that the services rendered are included as Eligible Expenses in the Plan, and provided the Covered Individual did not travel to such a location for the sole purpose of obtaining medical services, drugs, or supplies. Prescription Drugs purchased outside of the United States are only covered if the Covered Individual is traveling outside the United States for reason other than medical care.

Additionally, charges for such treatment may not exceed the limits specified herein as Usual, Customary and Reasonable in the area of residence of the Covered Individual in the United States. Fees and charges exceeding Usual, Customary and Reasonable shall be disallowed as ineligible charges. Charges equal to or less than Usual, Customary and Reasonable shall be considered. In no event shall benefit payment exceed the actual amount charged.
22. Charges for hospitalization when such confinement occurs primarily for physiotherapy, hydrotherapy, convalescent or rest care, or any routine physical examinations or tests not connected with the actual Illness or Injury.
23. Charges for professional nursing services if rendered by other than a Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.), unless such care was vital as a safeguard of the Covered Individual's life, and unless such care is specifically listed as an Eligible Expense elsewhere in the Plan. In addition, the Plan will not cover certified Registered Nurses in independent practice (other than an anesthetist). This exclusion does not apply to private duty nurses as addressed elsewhere in this Plan.
24. Charges for Experimental procedures, drugs, or research studies, or for any services or supplies not considered legal in the United States or not recognized by the American Medical Association or the American College of Surgeons and/or the United States Food & Drug Administration. Experimental services include:

- a. Care, procedures, treatment protocol or technology which:
 - i. is not widely accepted as safe, effective and appropriate for the Injury or Illness throughout the recognized medical profession and established medical societies in the United States; or
 - ii. is Experimental, in the research or investigational stage or conducted as part of research protocol, or has not been proved by statistically significant randomized clinical trials to establish increased survival or improvement in the quality of life over other conventional therapies.
- b. Drugs, tests, and technology which:
 - i. the FDA has not approved for general use;
 - ii. are considered Experimental;
 - iii. are for investigational use; or
 - iv. are approved for a specific medical condition but are applied to another condition. Medications and procedures that are FDA approved for one diagnosis, but used in an off label manner may be covered under the Plan if approved by the Medical Director of HealthCorp as being medically appropriate and necessary for the Covered Individual's condition, or have been proven in an objective manner to have therapeutic value.

The Plan will rely on the Data project of the American Medical Association, the National Institute of Health, the U.S. Food and Drug Administration, The National Cancer Institute, the Association of Community Cancer Centers (ACCC) compendia based drug bulletin, NCCN drug compendia, Office of Health Technology Assessment, the Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services, and Congressional Office of Technology Assessment in determining Experimental services.

25. Charges related to counseling for persons suffering from gender identification problems, or services or supplies related to the performance of gender transformation procedures.
26. Charges for services or supplies for recreational or educational therapy or forms of non-medical self-help or self-cure.
27. Charges for maintenance therapies.
28. Charges for services or supplies furnished for weight reduction or in connection with morbid obesity; except as specifically shown as an Eligible Expense elsewhere in the Plan. This includes dietary supplements, foods, equipment, laboratory testing, exams and Prescription drugs, regardless of whether or not weight reduction is medically appropriate.
29. Charges for services or supplies for marital and/or Family counseling or training services.
30. Charges for hypnotherapy, biofeedback, or sleep therapy.
31. Charges for the purchase or rental of air conditioners, humidifiers, dehumidifiers, air purifiers, exercise equipment and other such equipment.
32. Charges for travel or lodging costs.
33. Charges for acupuncture.
34. Charges for penile prosthesis/implants and any charges relating thereto.
35. Charges in relation to chelation therapy except in the treatment of heavy metal poisoning.

36. Charges for routine foot care, such as removal of corns, calluses, or trimming of toenails; except the services necessary in the treatment of a peripheral-vascular disease when recommended by a medical doctor or doctor of osteopathy.
37. Charges in relation to radial keratotomy, corneal modulation, refractive keratoplasty or any similar procedure.
38. Charges in relation to self-inflicted Injury or self-induced Illness, unless the result of a medical condition whether mental or physical.
39. Charges for nutritional supplements; vitamins, except prescription prenatal vitamins; and drugs for sexual dysfunction.
40. Charges for a surrogate mother or her newborn child.
41. Charges in relation to complications of a non-covered procedure.
42. Charges for wigs and artificial hair pieces.
43. Charges for bereavement counseling or services of volunteers or clergy.
44. Charges related to maxillary or mandibular implants.
45. Charges related to the testing and treatment of communication delay, motor development delays, and growth development delays including growth hormones. Charges for hearing therapy, therapy for learning disability, communication delay, perceptual disorders, sensory deficit, mental retardation and related conditions. The diagnosis and treatment of attention deficit disorder will be considered Eligible Expenses under the Plan
46. Charges for TMJ (temporomandibular joint disorder).
47. Charges for vocational rehabilitation.
48. Charges for massage therapy.
49. Charges for infertility testing and treatment.
50. Charges for genetic testing and counseling, except as approved by the Medical Director of HealthCorp as being medically appropriate and necessary for the Covered Individual's condition/treatment, which will be based upon current literature and studies.
51. Charges incurred as a result of radioactive contamination or the hazardous properties of nuclear material.
52. Charges for services or supplies received while incarcerated in a penal institution or in legal custody.
53. Charges for appliances, or medical or surgical treatment for correction of malocclusion or protrusion or recession of the mandible, maxillary hyperplasia, or maxillary hypoplasia.
54. Charges related to congenitally missing, malpositioned or super numerary teeth, even if part of a congenital anomaly.

55. Charges for Vertebral Axial Decompression (VAX-D).
56. Charges for residential treatment.
57. Charges for telephone, computer or Internet consultations. Completion of claim forms or forms necessary for return to work or school or for missed appointments.
58. Charges for speech generating devices or augmentative communication systems.

ELIGIBILITY FOR COVERAGE

Employee Eligibility and Effective Date

An Employee is eligible for coverage under the Plan when the Employee:

1. Is employed by the Company on a regular, Full-Time Work basis as specified in the Plan Summary;
2. Is Actively at Work;
3. Has satisfied the Required Period of Service as specified in the Plan Summary; and
4. Is within the classification (if any) shown in the Plan Summary.

If the Employee has met the above eligibility requirements on or before the effective date of this Plan, the date of eligibility shall be the effective date of the Plan.

If the Employee meets the above eligibility requirements after the effective date of the Plan, the date of eligibility shall be the first day of the month following the day he first meets those eligibility requirements.

Employee Coverage under the Plan shall become effective on the date of the Employee's eligibility, provided he has made written application for such coverage on or before such date. If an Employee applies for coverage within 31 days after his date of eligibility, his coverage shall become effective on the date he makes his written application.

All Employee Coverage under the Plan shall commence at 12:01 A.M. Standard Time, on the date such coverage is effective, provided such Employee is able to be actively at work at such time. If the Employee is not Actively at Work on the date this Employee Coverage would otherwise take effect, but would have been able to be Actively at Work at 12:01 A.M. Standard Time had such work commenced at that time, such Employee shall be eligible for coverage on that date. If an eligible Employee is not able to be Actively at Work on the date this Employee Coverage would otherwise become effective, his coverage shall become effective on the day he returns to Active Work except as required by HIPAA.

An Employee who chooses not to keep his coverage in effect during a period of an approved leave of absence which qualifies under the Family and Medical Leave Act will be eligible to enroll for the same type of coverage (single or Family) which was in effect at the time of the leave of absence immediately upon return to Full-Time Work.

Each Employee will become eligible for Dependent Coverage on the latest of the following:

1. The date he becomes eligible for Employee coverage.
2. The date on which he first acquires a Dependent.
3. The date he first comes within the classification (if any) for Dependent Coverage, as stated in the Plan Summary.

If both spouses are employed by the Company and both are eligible for Dependent Coverage, either spouse, but not both, may elect Dependent Coverage for their eligible dependents.

Dependent Eligibility and Effective Date

A Dependent will be considered eligible for coverage on the date the Employee becomes eligible for Dependent Coverage, subject to all limitations and requirements of this Plan. Each Employee who makes such written request for Dependent Coverage on a form approved by the Company, shall, subject to the further provisions of this section, become covered for Dependent Coverage as follows:

1. If the Employee makes such written request on or before the date he becomes eligible for Dependent Coverage, or within the time frame listed in "Employee Eligibility" to enroll, he shall become covered, with respect to those persons who are then his dependents, on the date he becomes covered for Employee Coverage.
2. A Newborn child of an Employee will be covered from the moment of birth providing Dependent Coverage is in effect at the time of birth. If Dependent Coverage is not in effect, the Employee will have 31 days from the date of the birth to make application for Dependent Coverage and coverage will be retroactive to the date of the birth.
3. An adoptive child of an Employee or a child placed with the Employee for adoption will be covered from the date the child is placed in the physical custody of the Employee and the Employee is legally responsible for medical expenses incurred by said child if proper enrollment is completed within 31 days of the placement.
4. If a Dependent is acquired other than at the time of his birth due to a court order, decree, or marriage, coverage for this new Dependent will be effective on the date of such court order, decree, or marriage if Dependent Coverage is in effect under the Plan at that time and proper enrollment is completed within 31 days of the event. If the Employee does not have Dependent Coverage in effect under the Plan at the time of the court order, decree, or marriage and requests such coverage and properly enrolls this new Dependent within the 31 day period immediately following the date of the court order, decree, or marriage, Dependent Coverage will be retroactive to the date of the court order, decree, or marriage.

Other Eligible Participant

Other Eligible Participants are those Employees eligible to continue coverage under the Plan after termination pursuant to a negotiated separation agreement with the University.

If an individual satisfies the definition of Other Eligible Participant under this Plan and terminates employment while coverage is in effect, coverage may be continued for that individual. This continuation of coverage shall terminate on the earliest of the following:

1. The date the individual reaches age 65; or
2. The end of the continuation period as specified in the negotiated separation agreement with the University.

If the individual has not attained age 65 at the end of the period specified in the separation agreement, the individual may continue coverage until he reaches age 65 provided the required contribution for coverage is paid when due. This election to continue coverage, if provided for in the negotiated separation agreement, must be made prior to the expiration of the period specified in the separation agreement.

If dependent coverage is in effect at the time the Other Eligible Participant terminates employment, coverage may be continued for the eligible Dependents who are then covered by the Plan provided the Other Eligible Participant continues coverage under the Plan. This extension of dependent coverage shall terminate upon the earliest of the following:

1. The last day of the month in which the Other Eligible Participant fails to make any required contribution for coverage when due; or
2. With respect to any covered Dependent, the last day of the month in which said Dependent no longer satisfies the definition of Dependent under the Plan; or
3. The date the Other Eligible Participant's continued coverage terminates unless the spouse is less than 65 years old at the time the Other Eligible Participant's coverage terminates, in which case, coverage for the spouse may be continued pursuant to the negotiated separation agreement with the University until the earliest of the following:
 - a. The date the spouse becomes covered under another plan for medical benefits; or
 - b. The date the spouse fails to make any required contribution for coverage; or
 - c. The date the Plan maximum is exhausted; or
 - d. The date the spouse reaches age 65.

The election to continue dependent coverage must be prior to the Employee's termination of employment.

Annual Change Period

During the Annual change period established by the Company, an Employee currently enrolled in a Company sponsored medical plan, may elect to switch coverage for himself and his covered Dependents to the other Company sponsored medical plan. An Employee will only be eligible to switch from one plan to another during this time period or if a Special Enrollment event occurs, as required by HIPAA.

LATE ENROLLMENT

Enrollment for coverage is required within 31 days after the date an individual would otherwise be eligible. If enrollment is not completed within that time, or if a covered Employee's and/or Dependent's coverage terminates because of failure to make a contribution when due, such person will be considered a late enrollee. Some late enrollments may be made under the following Special Enrollment provision. However, if the special enrollment provisions do not apply, a late enrollee will be eligible to enroll during the Annual enrollment period designated by the Company.

Special Enrollment

Special enrollment rights may be triggered upon the occurrence of certain types of events as indicated below. When a triggering event occurs, an eligible individual who does not request enrollment in the Plan within the deadlines explained below, will lose special enrollment rights for that event.

1. First Type of Event – Loss of Other Health Coverage

Eligible Employees and their Dependents who, at the time they were offered coverage under the Plan were eligible for the coverage and declined it because of other health coverage, which they stated in writing was in place, are entitled to enroll in the plan when the other coverage ends.

Other Coverage is COBRA Coverage. If the other coverage is COBRA coverage, the eligible Employee or Dependent must exhaust COBRA coverage to be eligible for special enrollment in the Plan. Exhaustion of COBRA coverage means that COBRA coverage ends for any reason other than failure to pay contributions on time or for cause.

Other Coverage is Not COBRA Coverage. If the other coverage is not COBRA coverage, the Employee or Dependent must lose the other coverage as a result of loss of eligibility for the coverage, termination of employment, exceeding a Lifetime limit on benefits under the other coverage, or termination of the employer contribution toward the other coverage. If an individual loses coverage due to ceasing to make required premium payments when due, he will not qualify as a special enrollee.

Deadline for Special Enrollment Period. The eligible Employee is required to request special enrollment in the Plan not later than 31 days after the loss of the other coverage or the termination of employer contributions toward that other coverage. If the Plan Administrator does not receive the eligible Employee's completed request for enrollment within this deadline, the eligible Employee and/or Dependent lose special enrollment rights for that event.

Effective Date of Enrollment. Enrollment in the Plan under the Special Enrollment provision will be effective not later than the first day of the first calendar month beginning after the date the Plan Administrator receives your completed request for enrollment.

2. Second Type of Event – Addition of a Dependent

An eligible Employee's marriage, or the birth, adoption or placement for adoption of his or her child, triggers special enrollment rights. This type of event also triggers an opportunity for an Employee who is enrolled in a Company sponsored Plan to switch to another Company sponsored Plan, if the Company has multiple Plans available.

Non-Participating Employee May Also Enroll. The addition of a new Dependent triggers enrollment rights for an eligible Employee even if he or she does not participate in the Plan at the time of the event. For example, upon the birth of an eligible Employee's child, the eligible Employee (assuming that he or she did not previously enroll), his or her spouse, and his or her Newborn child may all enroll because of the child's birth. The same rule applies to the eligible Employee's marriage or adoption of a child or a child's placement for adoption if the eligible Employee had not previously enrolled in the Plan.

Deadline for Special Enrollment Period. An eligible Employee must request special enrollment within 31 days of marriage, or birth, adoption or placement for adoption of his or her child. If the Plan Administrator does not receive the eligible Employee's completed request for enrollment within this deadline, he or his Dependents lose special enrollment rights for that event.

Effective Date of Enrollment. The date of enrollment for coverage will be the date of the event in the case of birth, adoption or placement for adoption and not later than the first day of the first calendar month after the marriage occurs, and provided the Plan Administrator receives the enrollment form.

3. Third Type of Event – Loss of Medicaid or CHIP Coverage

Eligible Employees and their eligible Dependents whose Medicaid or CHIP (Children's Health Insurance Program) coverage terminates due to loss of eligibility are entitled to enroll in the Plan when the Medicaid/CHIP coverage ends.

Eligibility for Premium Assistance Subsidy Under Medicaid or CHIP. Eligible Employees and their Dependents, who become eligible for a premium assistance subsidy under Medicaid or CHIP, are entitled to enroll in the Plan when they become eligible for the premium assistance subsidy.

Deadline for Special Enrollment Period. The eligible Employee is required to request special enrollment in the Plan not later than 60 days after the loss of Medicaid/CHIP coverage or becoming eligible for the premium assistance subsidy. If the Plan Administrator does not receive the eligible Employee's completed request for enrollment within this deadline, the eligible Employee and/or Dependent lose special enrollment rights for that event.

Effective Date of Enrollment. Enrollment in the Plan under the Special Enrollment provision will be effective not later than the first day of the first calendar month beginning after the date the Plan Administrator receives your completed request for enrollment.

Pre-existing Condition Exclusion and Special Enrollees. The Plan will apply a Pre-Existing Condition exclusion period of 12 months to a special enrollee. The Plan will not apply a Pre-Existing Condition exclusion to Pregnancy or to Covered Individuals under age 19.

TERMINATION OF COVERAGE

Employee Termination

Employee Coverage will automatically terminate immediately upon the earliest of the following dates, except as provided in any Extension of Benefits provision:

1. The date the Employee terminates employment.
2. The date the Employee ceases to be in a class of participants eligible for coverage.
3. The date ending the period for which the last contribution is made if the Employee fails to make any required contributions when due.
4. The date the Plan is terminated; or with respect to any Employee benefit of the Plan, the date of termination of such benefit.
5. The date the Employee enters military duty.
6. The date of the Employee's death.

Dependent Termination

Dependent Coverage will automatically terminate immediately upon the earliest of the following dates, except as provided in any Extension of Benefits provision:

1. The date the Dependent ceases to be an eligible Dependent as defined in the Plan. When a dependent child turns age 26, coverage will terminate on the last day or the month in which the child turns age 26.
2. The date of termination of the Employee's coverage under the Plan.
3. The date the Employee ceases to be in a class of participants eligible for Dependent Coverage.
4. The date ending the period for which the last contribution is made if the Employee fails to make any required contributions when due.
5. The date the Plan is terminated; or with respect to any Dependent's benefit of the Plan, the date of termination of such benefit.
6. The date the Dependent spouse enters military duty.
7. The date the Dependent becomes covered under this Plan as an Employee.
8. The date the Employee's death occurs.

EXTENSION OF BENEFITS

Family and Medical Leave Act Provision

All provisions under the Plan are intended to be in compliance with the Family and Medical Leave Act of 1993 (FMLA). To the extent the FMLA applies to the Company, Plan benefits may be maintained during certain leaves of absence at the level and under the conditions that would have been present as if employment had not been interrupted. Employee eligibility requirements, the obligations of the Company and Employee concerning conditions of leave, and notification and reporting requirements are specified in the FMLA. Any Plan provisions which conflict with the FMLA are superseded by the FMLA to the extent such provisions conflict with the FMLA. An Employee with questions concerning any rights and/or obligations should contact the Company.

Uniformed Services Employment and Reemployment Rights Act (USERRA)

It is the intent of the Plan to adhere to the continuation of coverage provisions of The Uniformed Services Employment and Reemployment Rights Act (USERRA) effective October 14, 1994. Any Plan provisions which conflict with USERRA are superseded by USERRA. An individual who would like complete information regarding his rights under USERRA should contact the Plan Administrator.

Disability Extension

If coverage terminates while a Covered Individual is totally disabled, coverage may be extended but only for the disabled individual and only for those charges as a result of or in relation to the disabling condition. Such extension of benefits will terminate upon the earliest of the following:

1. The date Total Disability Ceases; or
2. The date the individual becomes covered under any other group plan or becomes covered under Medicare; or
3. Six (6) months from the date coverage would normally terminate.

Certification of total disability must be made by a Physician. The Covered Individual must remain under the care of a Physician and additional proof of Total Disability may be required from time to time.

This extension of benefit shall run concurrently with any federally mandated extension of benefits, such as COBRA or FMLA.

COBRA Extension of Benefits

The requirements of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended, apply to the Plan. If Plan coverage is discontinued because of any of the qualifying events described below, eligible Covered Individuals may elect continuation coverage under the Plan according to the COBRA rules.

A. Qualifying Events

An employee of the Company covered by the Plan, has the right to choose this continuation coverage if such employee loses group health coverage because of a reduction in such employee's hours of employment or the termination of such employee's employment (for reasons other than gross misconduct).

The spouse of an employee covered by the Plan, has the right to choose continuation coverage if such spouse loses group health coverage under the plan for any of the following reasons:

1. The death of the covered employee;
2. The termination of the covered employee's employment (for reasons other than gross misconduct) or reduction in the covered employee's hours of employment;
3. Divorce or legal separation from the covered employee;
4. The covered employee becomes entitled to Medicare; or
5. A proceeding in a case under Title 11, United States Code, with respect to the Company from whose employment the covered employee retired.

In the case of a dependent child of an employee covered by the Plan, the dependent child has the right to continuation coverage if group health coverage under the Plan is lost for any of the following reasons:

1. The death of the covered employee;
2. The termination of the covered employee's employment (for reasons other than gross misconduct) or reduction in the covered employee's hours of employment;
3. The covered employee's divorce or legal separation;
4. The covered employee becomes entitled to Medicare;
5. The dependent cease to be a "dependent child" as defined under the Plan; or
6. A proceeding in a case under Title 11, United States Code, with respect to the Company from whose employment the covered employee retired.

B. Important Notice Requirements

Under the law, the employee or an eligible dependent has the responsibility to inform the Plan Administrator of a divorce, legal separation or a child losing dependent status under the Plan within 60 days of the later of: 1) the date the qualifying event occurs; 2) the date coverage is lost; or 3) the date the beneficiary is notified – through the Summary Plan Description (SPD) or the general COBRA notice. Such notice must be in writing to the Director of Human Resources, and contain the name of the Covered Individuals affected by the event and the date and nature of the event. The Company has the responsibility to notify the Plan Administrator of the employee's death, termination, reduction in hours of employment or Medicare entitlement, no later than 30 days after the date the Employee loses coverage due to the qualifying event.

When the Plan Administrator is notified that one of these events has happened, the Plan Administrator will ensure that the employee and the employee's eligible covered dependents are notified within 14 days of the right to choose continuation coverage. Under the law, the employee and eligible covered dependents have 60 days from the later of: the date the employee or his eligible covered dependent(s) would lose coverage because of one of the events described above or the date the employee or his eligible covered dependent(s) are advised by the Plan Administrator of the right to continue coverage, to inform the Plan Administrator that the employee and/or the eligible covered dependents want continuation coverage.

Notice to the employee's eligible covered spouse of the right to elect continuation coverage under the Plan will be deemed notice to any eligible covered dependent children residing with the employee's spouse. If the employee or his eligible covered dependent(s) do not elect continuation coverage within this election period, then the right to continuation coverage based on COBRA rules will be lost.

An eligible employee may elect COBRA continuation coverage for an eligible child who is born to, or placed for adoption with such employee while the employee's COBRA continuation coverage (or right to elect COBRA continuation coverage) is effective, provided that the employee has notified the Plan Administrator in writing within 30 days of the child's birth, adoption or placement for adoption.

C. Payment for Continuation Coverage

The employee and his eligible covered dependent(s) will be required to pay for the cost of continuation coverage in an amount equal to the cost of Plan coverage, plus 2%. The contributions must be paid by a check made payable to the Company.

Contribution amounts and benefits for continuation coverage are subject to change. The employee will be notified of any changes in contribution amounts or benefits available under the Plan.

If the employee or his eligible covered dependent(s) elect continuation coverage after the qualifying event, then the employee or his eligible covered dependent(s) will have 45 days from the date of the election to make the required initial contribution. That initial contribution must cover the entire period from the date of the qualifying event to the date of the payment. There is no grace period for the initial contribution. Each other contribution payment is due within 30 days after the first day of each month of continuation coverage.

Covered Individuals will not be billed for any contribution payments for continuation coverage. If any contribution payment for continuation coverage is postmarked after the date that payment is due, continuation coverage under the Plan will terminate and will not be reinstated.

D. Length of Continuation Coverage

If the employee and/or his eligible covered dependents elect to continue Plan coverage, the maximum continuation period following a qualifying event involving termination of employment or reduced work hours is 18 months.

If the employee or his eligible covered dependent is found by the Social Security Administration (SSA) to be eligible for Social Security disability benefits because of a disability that existed at some time during the first 60 days of this COBRA continuation coverage, then the disabled person and his eligible covered dependents will be eligible to continue Plan coverage for up to 29 months (an additional 11 months). To be eligible for that additional time to continue Plan coverage, the disabled person must remain disabled and must notify the Plan Administrator of the Social Security determination, in writing, by supplying a copy of the SSI award letter within the initial 18-month period and within 60 days after the later of:

- The date of the Social Security disability determination;
- The date of the qualifying event;
- The date on which coverage is lost as a result of the qualifying event, and
- The date on which the beneficiary is informed (in the Summary Plan Description or general notice) about the obligation to provide the disability notice.

An increased cost of up to 150% of the cost of the Plan coverage may be required for those 11 extra months of continuation coverage. The disabled person must promptly notify the Plan Administrator of any SSA finding that he or she is no longer disabled.

If a second qualifying event occurs within the applicable 18- or 29-month period, the period to continue Plan coverage under COBRA may be extended for up to 36 months from the first qualifying event. For all other qualifying events, the maximum period to continue Plan coverage is 36 months.

E. Termination of Continuation Coverage

However, COBRA provides that this continuation coverage may be cut short for any of the following reasons:

1. The Company no longer provides group health coverage to any of its employees;
2. The premium for this continuation coverage is not paid on time;
3. The employee or his eligible covered dependent(s) become covered under another group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition such individuals may have or contains a pre-existing condition exclusion that does not apply to such individuals because of the requirements of the Health Insurance Portability and Accountability Act of 1996;
4. The employee or his eligible covered dependent(s) become entitled to Medicare; or
5. The employee or his eligible covered dependent(s) elected to extend coverage for up to 29 months due to disability and there has been a final determination by the SSA that such individual is no longer disabled.

The employee or his eligible covered dependent(s) must inform the Plan Administrator within 30 days of the date of any final determination by the SSA that the person is no longer disabled.

F. General Information about Continuation Coverage

Continuation coverage is provided subject to eligibility under the law. The Plan Administrator reserves the right to terminate continuation coverage retroactively if the employee or his dependent(s) are determined to be ineligible for continuation coverage. The Plan Administrator intends to provide continuation coverage only to the extent required by the law and will administer continuation coverage according to those requirements.

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

COORDINATION OF BENEFITS

The Coordination of Benefits provision is intended to prevent the payment of benefits which exceed Allowable Expenses. It applies when the Employee or any eligible Dependent who is covered by this Plan is also covered by any other plan or plans. When more than one coverage exists, one plan normally pays its benefits in full and the other plans pay a reduced benefit. This Plan will always pay either its benefits in full, or a reduced amount which, when added to the benefits payable by the other plan or plans, will not exceed 100% of Allowable Expenses. Only the amount paid by the Plan will be charged against the Plan maximums.

The Coordination of Benefits provision applies whether or not a claim is filed under the other plan or plans. If needed, authorization must be given this Plan to obtain information as to benefits or services available from the other plan or plans, or to recover overpayment.

All benefits contained in the Plan are subject to this provision.

Definitions

The term "plan" as used herein will mean any plan providing benefits or services for or by reason of medical, vision, or dental treatment, and such benefits or services are provided by:

1. Group insurance or any other arrangement for coverage for Covered Individuals in a group whether on an insured or uninsured basis, including but not limited to:
 - a. Hospital indemnity benefits.
 - b. Hospital reimbursement-type plans which permit the Covered Individual to elect indemnity at the time of claims.
2. Hospital or medical service organizations on a group basis, group practice, and other group pre-payment plans.
3. Hospital or medical service organizations on an individual basis having a provision similar in effect to this provision.
4. A licensed Health Maintenance Organization (HMO).
5. Any coverage for students which is sponsored by or provided through a school or other educational institution.
6. Any coverage under a governmental program, and any coverage required or provided by any statute.
7. Group automobile insurance.
8. Individual automobile insurance coverage on an automobile leased or owned by the Company.
9. Individual automobile insurance coverage based upon the principles of "No-Fault" coverage.

The term "plan" will 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 which reserves the right to take the benefits or services of other plans into consideration in determining its benefits and that portion which does not.

The term "Claim Determination Period" means a Calendar Year or that portion of a Calendar Year during which the Covered Individual for whom claim is made has been covered under this Plan.

Coordination Procedures

Notwithstanding the other provisions of this Plan, benefits that would be payable under this Plan will be reduced so that the sum of benefits and all benefits payable under all other plans will not exceed the total of Allowable Expenses incurred during any Claim Determination Period with respect to a Covered Individual eligible for:

1. Benefits either as an insured person or participant or as a dependent under any other plan which has no provision similar in effect to this provision, or
2. Dependent benefits under this Plan for a Covered Individual who is also eligible for benefits:
 - a. As an insured person or participant under any other plan, or
 - b. As a dependent covered under another group plan.
3. Benefits under this Plan for a Employee who is also eligible for benefits as an insured person or participant under any other plan and has been covered continuously for a longer period of time under such other plan, or
4. If an eligible Dependent elects membership in a Health Maintenance Organization (HMO) as an employee of another employer, benefits under this Plan are limited to copayment and/or Deductibles not covered under the HMO and Eligible Expenses that are specifically excluded under the HMO. There will be no coverage under this Plan for any item not covered by the HMO because the Dependent chose not to avail himself to the HMO participating provider.

Order of Benefit Determination

Each plan makes its claim payment according to where it falls in this order, if Medicare is not involved:

1. If a plan contains no provision for coordination of benefits, then it pays before all other plans.
2. The plan which covers the claimant as an employee or named insured pays as though no other plan existed; remaining recognized charges are paid under a plan which covers the claimant as a dependent.
3. If the claimant is a dependent child of parents not separated or divorced, the plan of the parent whose birthday occurs first in the Calendar Year shall pay first. If the parents have the same birthday, the plan that covered the parent longer will pay first and the other plan will pay second. This rule also applies to unmarried parents who are living together. However, if the parents are divorced, or unmarried and not living together, then:
 - a. The plan of the parent who by court order or decree is financially responsible for the children's medical costs is primary.
 - b. If no decree exists, the plan of the parent who has custody pays first;
 - c. The plan of any stepparent with whom the child lives pays second;
 - d. The plan of the parent without custody pays third.

If the specific terms of a court decree state that the parents have joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined above for dependent children of parents not separated or divorced.

For purposes of this sub-section, a parent's "plan" shall include any plan under which the parent has coverage (either as an employee, a dependent spouse, or otherwise).

4. The benefits of a plan which covers a person as an employee who is neither laid off nor retired are determined before those of a plan which covers that person as a laid off or retired employee. If

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

5. If the order set out above does not apply in a particular case, then the plan which has covered the claimant for the longest period of time will pay first.

The Company has the right:

1. To obtain or share information with an insurance company or other organization regarding Coordination of Benefits without the claimant's consent.
2. To require that the claimant provide the Company with information on such other plans so that this provision may be implemented.
3. To pay the amount due under this Plan to an insurer or other organization if this is necessary, in the Company's opinion, to satisfy the terms of this provision.

Facility of Payment

Whenever payments which should have been made under this Plan in accordance with this provision have been made under any other plan or plans, the Company will have the right, exercisable alone and in its sole discretion, to pay to any insurance company or other organization or person making such other payments any amounts it will determine in order to satisfy the intent of this provision, and amounts so paid will be deemed to be benefits paid under this Plan and to the extent of such payments, the Company will be fully discharged from liability under this Plan.

The benefits that are payable will be charged against any applicable maximum payment or benefit of this Plan rather than the amount payable in the absence of this provision.

Right To Receive and Release Necessary Information

For the purposes of determining the applicability of and implementing the terms of this provision of the Plan or any similar provision of any other plans, the Company may, without the consent of or notice to any person, release to or obtain from any insurance company or other organization or person any information, with respect to any person, which the Company deems to be necessary for such purposes. Any person claiming benefits under this Plan shall furnish to the Company such information as may be necessary to implement this provision.

Coordination of Benefits with Medicare

In all cases, coordination with Medicare will conform to Federal Statutes and Regulations. Each person that is eligible for Medicare will be assumed to have full Medicare coverage. Full Medicare coverage is: Part A hospital insurance; and Part B voluntary medical insurance. Full Medicare coverage will be assumed whether or not it has been taken. Benefits under this Plan are subject to the allowable limiting charges set by Medicare. Benefits will be coordinated to the extent they would have been paid under Medicare as allowed by Federal Statutes and Regulations.

If the primary payer cannot be determined due to coverage under more than one plan and Medicare, the plan that is primary to Medicare by Federal Statute will pay benefits first. This will apply whether the plan covers the person as an employee, dependent or other.

THIRD PARTY RECOVERY, SUBROGATION AND REIMBURSEMENT

Statement of Purpose

Subrogation and reimbursement represent significant Plan assets and are vital to the financial stability of the Plan. Subrogation and reimbursement recoveries are used to pay future claims incurred by Plan members. Anyone in possession of these assets holds them as a fiduciary and constructive trustee for the benefit of the Plan. The Plan Administrator has a fiduciary obligation under ERISA to pursue and recover these Plan assets to the fullest extent possible.

Payment Condition

The Plan, in its sole discretion, may elect to conditionally advance payment of benefits in those situations where an Injury, Illness, disease or disability is caused in whole or in part by, or results from the acts or omissions of Plan Participants, and/or their dependants, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this section as “Plan Participant(s)”) or a third party, where any party besides the Plan may be responsible for expenses arising from an incident, and/or other funds are available, including but not limited to no-fault, uninsured motorist, underinsured motorist, medical payment provisions, third party assets, third party insurance, and/or grantor(s) of a third party (collectively “Coverage”).

The Plan Administrator has sole discretion to determine whether expenses are related to the Illness or Injury to the extent this provision applies. Acceptance of benefits under the Plan for an Illness or Injury which the Plan Participant(s) has already received a recovery may be considered fraud, and the Plan Participant(s) will be subject to any sanctions determined by the Plan Administrator, in its sole discretion, to be appropriate, including denial of present or future benefits under the Plan.

Plan Participant(s), his or her attorney, and/or legal guardian of a minor or incapacitated individual agrees that acceptance of the Plan’s conditional payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain one hundred percent (100%) of the Plan’s conditional payment of benefits or the full extent of payment from any one or combination of first and third party sources in trust, without disruption except for reimbursement to the Plan or the Plan’s assignee. By accepting benefits the Plan Participant(s) agrees the Plan shall have an equitable lien on any funds received by the Plan Participant(s) and/or their attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The Plan Participant(s) agrees to include the Plan’s name as a co-payee on any and all settlement drafts.

In certain circumstances, a Plan Participant(s) his or her attorney, and/or legal guardian of a minor or incapacitated individual may receive a recovery that exceeds the amount of the Plan’s payments for past and/or present expenses for treatment of the Illness or Injury that is the subject of the recovery. In other situations, a Plan Participant(s) may have received a prior recovery that was intended, in part or in whole, to be compensation for future expenses for treatment of the Illness or Injury that is the subject of a current claim for benefits under the Plan. In these situations, the Plan will not provide benefits for any present or future expenses related to the Illness or Injury for which compensation was provided through a current or previous recovery. The Plan Participant(s) is required to submit full and complete documentation of any such recovery in order for the Plan to consider Eligible Expenses that exceed the recovery. To the extent a Plan Participant(s)’s recovery exceeds the amount of the Plan’s lien, the Plan is entitled to a credit or cushion in that amount against any claims for future benefits relating to the Illness or Injury. In those situations following any recovery that exceeds the amount of the Plan’s lien, the Plan Participant(s) will be solely responsible for payment of medical bills related to the Illness or Injury out of the remaining recovery. If the Plan Participant(s) fails to reimburse the Plan out of any judgment or settlement received, the Plan Participant(s) will be responsible for any and all expenses (fees and costs) associated with the Plan’s attempt to recover such money. The Plan also precludes operation of the made-whole and common-fund doctrines in applying this provision.

If there is more than one party responsible for charges paid by the Plan, or may be responsible for charges paid by the Plan, the Plan will not be required to select a particular party from whom reimbursement is due. Furthermore, unallocated settlement funds meant to compensate multiple injured parties of which the Plan Participant(s) is/are only one or a few, that unallocated settlement fund is considered designated as an “identifiable” fund from which the plan may seek reimbursement.

If the Plan Participant(s) retains an attorney, the Plan Administrator may require that attorney to sign the subrogation and reimbursement agreement as a condition to any payment of benefits and as a condition to any payment of future benefits for other Illnesses or Injuries. Additionally, the Plan Participant(s)’s attorney must recognize and consent to the fact that this provision precludes the operation of the “made-whole” and “common fund” doctrines, and the attorney must agree not to assert either doctrine against the Plan in his or her pursuit of recovery. The Plan will not pay the Plan Participant(s)’s attorneys’ fees and costs associated with the recovery of funds, nor will it reduce its reimbursement pro rata for the payment of the Plan Participant(s)’s attorneys’ fees and costs.

An attorney who receives any recovery (whether by judgment, settlement, compromise, or otherwise) has an absolute obligation to immediately tender the recovery to the Plan under the terms of this provision. As a possessor of a portion of the recovery, the Plan Participant(s)’s attorney holds the recovery as a constructive trustee and fiduciary and is obligated to tender the recovery immediately over to the Plan. A Plan Participant(s)’s attorney who receives any such recovery and does not immediately tender the recovery to the Plan will be deemed to hold the recovery in constructive trust for the Plan, because neither the Plan Participant(s) nor the attorney is the rightful owner of the portion of the recovery subject to the Plan’s lien.

Time of Payment of Benefits

The Plan may withhold benefits until such time that liability is determined

Subrogation

As a condition to participating in and receiving benefits under this Plan, the Plan Participant(s) agrees to assign to the Plan the right to subrogate and pursue any and all claims, causes of action or rights that may arise against any person, corporation and/or entity and to any Coverage to which the Plan Participant(s) is entitled, regardless of how classified or characterized, at the Plan’s discretion.

If a Plan Participant(s) receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the Plan to any claim, which any Plan Participant(s) may have against any Coverage and/or party causing the sickness or injury to the extent of such conditional payment by the Plan plus reasonable costs of collection.

The Plan may, at its discretion, in its own name or in the name of the Plan Participant(s) commence a proceeding or pursue a claim against any party or Coverage for the recovery of all damages to the full extent of the value of any such benefits or conditional payments advanced by the Plan.

If the Plan Participant(s) fails to file a claim or pursue damages against:

- a) the responsible party, its insurer, or any other source on behalf of that party;
- b) any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
- c) any policy of insurance from any insurance company or guarantor of a third party;
- d) worker’s compensation or other liability insurance company; or,
- e) any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage;

the Plan Participant(s) authorizes the Plan to pursue, sue, compromise and/or settle any such claims in the Plan Participant(s)’ and/or the Plan’s name and agrees to fully cooperate with the Plan in the

prosecution of any such claims. The Plan Participant(s) assigns all rights to the Plan or its assignee to pursue a claim and the recovery of all expenses from any and all sources listed above.

Right of Reimbursement

The Plan shall be entitled to recover 100% of the benefits paid, without deduction for attorneys' fees and costs or application of the common fund doctrine, make whole doctrine, or any other similar legal theory, without regard to whether the Plan Participant(s) is fully compensated by any recovery from all sources. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any State prohibiting assignment of rights which interferes with or compromises in any way the Plan's equitable lien and right to reimbursement. The obligation to reimburse the Plan in full exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses. If the Plan Participant(s)' recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved.

No court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of litigation may be deducted from the Plan's recovery without the prior, expressed written consent of the Plan.

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

These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgment of these rights is required by the Plan and signed by the Plan Participant(s).

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

Excess Insurance

If at the time of Injury, Illness, disease or disability there is available, or potentially available any Coverage (including but not limited to Coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of Coverage, except as otherwise provided for under the Plan's Coordination of Benefits section.

The Plan's benefits shall be excess to:

- a) the responsible party, its insurer, or any other source on behalf of that party;
- b) any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
- c) any policy of insurance from any insurance company or guarantor of a third party;
- d) worker's compensation or other liability insurance company or
- e) any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage;

Separation of Funds

Benefits paid by the Plan, funds recovered by the Plan Participant(s), and funds held in trust over which the Plan has an equitable lien exist separately from the property and estate of the Plan Participant(s), such that the death of the Plan Participant(s), or filing of bankruptcy by the Plan Participant(s), will not affect the Plan's equitable lien, the funds over which the Plan has a lien, or the Plan's right to subrogation and reimbursement.

Wrongful Death

In the event that the Plan Participant(s) dies as a result of the injuries and a wrongful death or survivor claim is asserted against a third party or any Coverage, the Plan's subrogation and reimbursement rights shall still apply.

Obligations

It is the Plan Participant(s)' obligation at all times, both prior to and after payment of medical benefits by the Plan:

- a) to cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the Plan's rights;
- b) to provide the Plan with pertinent information regarding the Illness, Injury, disease, disability, including accident reports, settlement information and any other requested additional information;
- c) to take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights;
- d) to do nothing to prejudice the Plan's rights of subrogation and reimbursement;
- e) to promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received; and
- f) to not settle or release, without the prior consent of the Plan, any claim to the extent that the Plan Participant may have against any responsible party or Coverage.

If the Plan Participant(s) and/or their attorney fails to reimburse the Plan for all benefits paid or to be paid, as a result of said Injury, Illness, or condition, out of any proceeds, judgment or settlement received, the Plan Participant(s) will be responsible for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Plan Participant(s).

The Plan's rights to reimbursement and/or subrogation are in no way dependent upon the Plan Participant(s)' cooperation or adherence to these terms.

Offset

Failure by the Plan Participant(s) and/or their attorney to comply with any of these requirements may, at the Plan's discretion, result in a forfeiture of payment by the Plan of medical benefits and any funds or payments due under this Plan on behalf of the Plan Participant(s) may be withheld until the Plan Participant(s) satisfies their obligation.

Minor Status

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

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

Language Interpretation

The Plan Administrator retains sole, full and final discretionary authority to construe and interpret the language of this provision, to determine all questions of fact and law arising under this provision, and to administer the Plan's subrogation and reimbursement rights. The Plan Administrator may amend the Plan at any time without notice.

Severability

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

RIGHTS UNDER ERISA

Your Rights

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

Receive Information about Your Plan and Benefits

Examine, without charge, at the plan administrator’s office and at other specified locations, such as worksites, all documents governing the plan, including insurance contracts, and a copy of the latest annual report (Form 5500 series), if any, filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

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

Receive a summary of the Plan’s annual financial report, if any is required by ERISA to be prepared. The Plan Administrator is required by law to furnish each participant with a copy of the summary annual report.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Plan and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Reduction or elimination of any Pre-Existing Condition exclusion under this group health Plan, if you have creditable coverage from another plan. You should be given a certificate of creditable coverage, free of charge, by the group health plan or health insurance issuer you lose coverage under. The certificate of creditable coverage should be given to you when you lose coverage, become entitled to elect COBRA continuation coverage, and when COBRA continuation coverage ends. If you request it, a certificate of creditable coverage should also be given to you at any time during the 24 months after you lose coverage. Without proof of creditable coverage, you may be subject to a Pre-Existing Condition exclusion of up to 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report (if any) from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or Federal court.

If it should happen that plan fiduciaries misuse the plans money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

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

GENERAL PROVISIONS

Notice of Claim

Written notice of claim should be submitted to the Claims Administrator within 90 days after the occurrence. All claims must be filed within one year of the event on which claim is based or payment will be denied. If coverage terminates, all claims must be filed within 90 days of termination. If the Plan terminates, all claims must be filed within 30 days of termination. Written notice of claim given by or on behalf of the Covered Individual to the Claims Administrator, with information sufficient to identify the Covered Individual, will be considered notice.

Failure to furnish proof within the time provided in the Plan will not invalidate or reduce any claim if it will be shown not to have been reasonably possible to furnish such proof and that such proof was furnished as soon as reasonably possible.

Claim Procedure and Appeal Process

Following is a description of the time frames the Plan uses to process claims for benefits. A claim is defined as any request for a Plan benefit, made by a claimant or by a representative of a claimant, that complies with the Plan's reasonable procedure for making benefit claims. The times listed are maximum times only. A period of time begins at the time the claim is filed. Decisions will be made within a reasonable period of time appropriate to the circumstances. "Days" means calendar days.

There are different types of claims and each one has a specific timetable for either approval, payment, request for further information, or denial of the claim. If you have any questions regarding the procedure, please contact the Claims Administrator.

There are three types of health claims: urgent care claims, pre-service claims, and post-service claims. Most claims are post-service claims which means a claim for a Plan benefit that is a request for payment under the Plan for covered medical services already received by the claimant. An urgent care claim is one for medical care or treatment where an untimely determination may jeopardize the life or health of the claimant. A pre-service claim means any claim for a benefit under this Plan where the Plan requires advance approval for obtaining medical care.

You have a right to appeal any decision made by the Plan that denies payment of your claims or your request for coverage of a health care service or treatment. You may request more explanation when your claim or request for coverage of a health care service or treatment is denied or the health care service or treatment you received was not fully covered. Request for appeal/explanation should be sent to:

Patient Advocate
Self Insured Services Company (SISCO)
P.O. Box 389
Dubuque, IA 52004-0389

You should contact SISCO for any of the following reasons:

- You do not understand the reason for the denial;
- You do not understand why the health care service or treatment was not fully covered;
- You do not understand why a request for coverage of a health care service or treatment was denied;
- You cannot find the applicable provision in your Summary Plan Description;
- You want a copy of the guideline, criteria or clinical rationale that was used to make the decision; or

- You disagree with the denial or the amount not covered and you want to appeal.

If a claim is denied due to missing or incomplete information, you or your health care provider may resubmit the claim with the necessary information to complete the claim.

All appeals for claim denials (or any decision that does not cover expenses you believe should have been covered) must be sent in writing to the address above within 180 days of the date you receive the denial. A full and fair review of the claims will be provided by individuals who were not involved in making the initial decision of the claim. You may provide additional information that relates to the claim and you may request copies of information that pertain to your claims. You will be notified of the decision in writing within 60 days of the Plan receiving your appeal. If you do not receive a decision within 60 days, you may be entitled to file a request for external review.

In the case of a post-service claim, the Claims Administrator will process your claims no later than 30 days after receiving it. An additional 15 days will be allowed in circumstances beyond the Plan's control, such as the need for additional information. You will be notified during the first 30 days of the need for additional information. You will have 45 days from receipt of the request to supply the information needed to complete the claim. Upon receipt of the requested information, the Plan will again review the claim and notify you within 15 days of the claim determination.

If your post-service claim is denied (in whole or in part), you will receive a written explanation of the denial. Should your claim be denied (in whole or in part), or if there is a reduction of benefits or charge amount, you (or your provider) may have your claim reviewed based on the procedures stated above. You should supply any additional pertinent documentation to support the appeal of the claim. Within 60 days after receipt of your request for review, you will receive a determination from the Claims Administrator.

For an urgent care claim, notification of benefit determination must be provided as soon as possible, taking into account any medical exigencies, but in no case later than 72 hours after the Claims Administrator receives the claim. If there is insufficient information to make a determination, a request will be made for the additional information within 24 hours of receiving the claim. This request may be in writing or orally. The claimant will then have 48 hours to provide the missing information. After receiving the information or when 48 hours has passed, the Claims Administrator will respond orally or in writing as to the benefit determination. If an urgent care claim is denied, an appeal may be filed with the Plan Administrator within 180 days of the denial. This appeal may be orally or in writing. Upon receipt of the appeal, a claim determination must be made within 72 hours. All necessary information, including the Plan's benefit determination on review, may be transmitted between the Plan and the claimant by telephone, facsimile, or other similarly expeditious method.

You will receive notice of benefit determination for a pre-service care claim within 15 days of the Claims Administrator's receipt of the claim. An additional 15 days will be allowed in circumstances beyond the Plan's control, such as the need for additional information, and you will be notified within five (5) days of receipt of the claim as to the need for additional information. You will have 45 days from receipt of the request to supply the information needed to complete the claim. Upon receipt of the requested information, the Plan will again review the claim and notify you within 15 days of the claim determination. If your pre-service care claim is denied, you may file a written appeal within 180 days of the denial. Upon receipt of the appeal, the Claims Administrator will have 30 days to make a benefit determination.

If the Plan has previously approved an ongoing course of treatment for a participant to be conducted over a period of time, any reduction or termination of that course of treatment will be deemed to be an adverse benefit determination. The Plan Administrator must then notify the claimant a sufficient time in advance of the reduction or termination to give the claimant time to obtain a review on appeal of the adverse determination before the benefit is reduced or terminated.

If your request for the provision of or payment for a health care service or course of treatment has been denied, you may have a right to an external review by an Independent Review Organization (IRO), who has no association with the Plan, if the decision involved making a judgment as to the medical necessity, appropriateness, health care setting, level of care or effectiveness of the health care service or treatment. You may request the independent external appeal by submitting a request for external review within four (4) months after receipt of an adverse benefit determination or final internal adverse benefit determination. The external review process is not available for questions of eligibility or rescissions of coverage. Requests should be submitted to SISCO at the address listed above. If there is no corresponding date four (4) months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth month following the receipt of the notice.

For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.

Within five (5) business days following the date of receipt of the external review request, the group health plan must complete a preliminary review of the request to determine whether:

- (a) The claimant is or was covered under the plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the plan at the time the health care item or service was provided;
- (b) The adverse benefit determination or the final adverse benefit determination does not relate to the claimant's failure to meet the requirements for eligibility under the terms of the group health plan (e.g., worker classification or similar determination);
- (c) The claimant has exhausted the plan's internal appeal process unless the claimant is not required to exhaust the internal appeals process under the interim final regulations; and
- (d) The claimant has provided all the information and forms required to process an external review.

Within one (1) business day after completion of the preliminary review, the plan must issue notification in writing to the claimant. If the request is complete but not eligible for external review, such notification must include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)). If the request is not complete, such notification must describe the information or materials needed to make the request complete and the plan must allow a claimant to perfect the request for external review within the four-month filing period or within the 40 hours period following the receipt of the notification, whichever is later.

The plan must assign an Independent Review Organization (IRO) that is accredited by URAC or by a similar nationally-recognized accrediting organization to conduct the external review. Moreover, the plan must take action against bias and to ensure independence. Within five (5) business days after the date of assignment of the IRO, the plan will provide the IRO the documents and any information considered in making the adverse benefit determination or final internal adverse benefit determination. Failure by the plan to timely provide the documents and information must not delay the conduct of the external review. If the plan fails to timely provide the documents and information, the assigned IRO may terminate the external review and make a decision to reverse the adverse benefit determination or final internal adverse benefit determination. Within one (1) business day after making the decision, the IRO will notify the claimant and the plan. The IRO must provide written notice of the final external review decision to the Plan and the Covered Individual within 45 days after the request for external review is received. All decisions made by the IRO will be binding on the Plan. If an adverse benefit determination is reversed by the IRO, the Plan must immediately provide coverage or payment for the claim.

Expedited Review Process

If the normal time frames set out above for an external review would seriously jeopardize the life or health of a Covered Individual or would jeopardize the individual's ability to regain maximum function, an expedited external review may be requested. Upon receipt of request for an expedited external review, the Plan will immediately determine if the request meets the guidelines for an external appeal and assign an Independent Review Organization (IRO) to review the case. Information regarding the appeal will be sent to the IRO electronically or by telephone or facsimile or any other expeditious method. The assigned IRO will review the claim information and return a decision within 72 hours after receiving the request for review. If the IRO notice is not in writing, within 48 hours after the date of providing the decision, the IRO must provide written confirmation of the decision to the claimant and the Plan.

Proof of Loss

The Plan Administrator will have the right and opportunity to have examined any individual whose Injury or Illness is the basis of a claim hereunder when and as often as it may reasonably require during the pendency of a claim, and also the right and opportunity to make an autopsy in case of death (where such autopsy is not forbidden by law).

Free Choice of Physician

The Covered Individual will have free choice of any legally qualified Physician or surgeon, and the Physician-patient relationship will be maintained.

Payment of Claims

All Plan benefits are payable to the provider of service, or subject to any written direction of the Employee. All or a portion of any payments provided by the Plan on account of Hospital, nursing, medical or surgical services may, at the Employee's option and unless the Employee requests otherwise in writing not later than the time of filing proof of such loss, be paid directly to the Hospital or person rendering such services; however, if any such benefit remains unpaid at the death of the Employee or if the participant is a minor or is, in the opinion of the Plan Administrator, legally incapable of giving a valid receipt and discharge for any payment, the Plan Administrator may, at its option, pay such benefits to any one or more of the following relatives of the Employee: spouse, mother, father, child or children, brother or brothers, sister or sisters. Any payment so made will constitute a complete discharge of the Plan's obligation to the extent of such payment, and the Plan will not be required to see the application of the money so paid.

Assignment

Benefits may not be assigned except by consent of the Company, other than to Eligible Providers and according to the provisions set forth in the Plan Document.

Rights of Recovery

Whenever payments have been made by the Company with respect to allowable expenses in excess of the maximum amount of payment necessary to satisfy the intent of this Plan, the Company will have the right, exercisable alone and in its sole discretion, to recover such excess payments or to withhold payment of any future benefits to offset for such excess payments. The Plan has the right to recover these amounts through any legal or equitable remedy, including imposition of a constructive trust.

Workers' Compensation Not Affected

This Plan is not in lieu of and does not affect any requirement for coverage by workers' compensation insurance.

Legal Proceedings

No action at law or in equity will be brought to recover on the Plan until you have followed the Plan's claims procedures and exhausted the opportunities described under the Plan's claims procedures, nor will such action be brought at all unless brought within three (3) years of receiving the final review notice under the Plan's claims procedures.

Conformity with Governing Law

If any provision of this Plan is contrary to any law to which it is subject, such provision is hereby amended to conform thereto.

Permitted and Required Uses of Protected Health Information

Protected Health Information (PHI) is individually identifiable health information that is transmitted by electronic media, maintained in electronic media or transmitted or maintained in any other form or medium. PHI will only be released to the "Privacy Officials" appointed by the Company. A list of Privacy Officials may be obtained from the Company.

Your health Plan will only provide Protected Health Information to the Plan Sponsor upon receipt of certification that the Plan Sponsor will agree to:

1. Not use or disclose the PHI other than as permitted or required by the Plan Document or as required by law;
2. Ensure that agents and subcontractors to whom the Plan Sponsor provides PHI agree to the same restrictions and conditions as the Plan Sponsor;
3. Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor;
4. Report to the group health Plan any PHI use or disclosure, of which it becomes aware, that violates the permitted uses or disclosures under HIPAA;
5. Make PHI available in accordance with HIPAA privacy regulation, 45 CFR 164.524;
6. Make PHI available for amendment and incorporate those amendments as required by HIPAA privacy regulation, 45 CFR 164.526;
7. Make information available to provide an accounting of disclosures as provided in HIPAA privacy regulation, 45 CFR 164.528;
8. Make its internal practices, books and records relating to the use and disclosure of PHI received from the group health plan available to the Secretary of the Department of Health and Human Services;
9. If feasible, at termination of the relationship, return or destroy all PHI received from the group health plan, but if return or destruction is not feasible, limit further uses or disclosures to those purposes that make return or destruction of the information infeasible; and
10. Ensure adequate separation between employees who are authorized to use PHI and those who are not.

Any information supplied to the Plan Sponsor in order to process claims and claim payment will be kept confidential by all individuals within the Company who use this information in the normal course of business. These individuals will restrict access to and use of PHI by individuals other than for plan administration functions that the Plan Sponsor performs for the group health plan. Misuse or improper disclosure of PHI by any individual in the Company will result in disciplinary sanctions, which may include dismissal. The Company shall provide a mechanism for resolving issues of noncompliance.

PHI will not be disclosed to a Plan Sponsor for employment-related activities or decisions or in connection with any other benefit plan of the Plan Sponsor.

HIPAA Security Provision

Where electronic Protected Health Information (PHI) will be created, received, maintained, or transmitted to or by the Plan Sponsor on behalf of the Plan, the Plan Sponsor shall reasonably safeguard the electronic Protected Health Information as follows:

1. Plan Sponsor shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI that Plan Sponsor creates, receives, maintains, or transmits on behalf of the Plan;
2. Plan Sponsor shall ensure that the adequate separation that is required by 45 C.F.R. sect. 164.504(f)(2)(iii) of the HIPAA Privacy Rule is supported by reasonable and appropriate security measures;
3. Plan Sponsor shall ensure that any agent, including a subcontractor, to whom it provides electronic PHI agrees to implement reasonable and appropriate security measures to protect such information; and
4. Plan Sponsor shall report to the Plan any “Security Incidents” of which it becomes aware as described below (“Security Incidents” has the meaning set forth in 45 C.F.R. sect. 164.304, as amended from time to time, and generally means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operations in an information system):
 - a) Plan Sponsor shall report to the Plan within a reasonable time after Plan Sponsor becomes aware, any “Security Incident” that results in unauthorized access, use, disclosure, modification, or destruction of the Plan’s electronic Protected Health Information; and
 - b) Plan Sponsor shall report to the Plan any other “Security Incident” on an aggregate basis every quarter, or more frequently upon the Plan’s request.

Time Limitation

If any time limitation of the Plan with respect to giving notice of claim or furnishing proof of loss, or the bringing of an action at law or in equity is less than that permitted under the guidelines of ERISA and/or any federally mandated law, such limitation is hereby extended to agree with the minimum period permitted by such law.

Statements

All statements made by the Company or by a Covered Individual will, in the absence of fraud, be considered representations and not warranties, and no statements made for the purpose of obtaining benefits under this Plan will be used in any contest to avoid or reduce the benefits provided by the Plan unless contained in a written application for benefits and a copy of the instrument containing such representation is or has been furnished to the Covered Individual.

Any Covered Individual who knowingly and with intent to defraud the Plan, files a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any material fact, commits a fraudulent act. The Covered Individual may be subject to prosecution by the United States Department of Labor. Fraudulently claiming benefits may be punishable by a substantial fine, imprisonment, or both.

Miscellaneous

Section titles are for convenience of reference only, and are not to be considered in interpreting the Plan.

Pronouns used in this Plan Document shall include both masculine and feminine gender unless the context indicates otherwise. Likewise, words used shall be construed as though they were in the plural or singular number, according to the context.

No failure to enforce any provision of this Plan will affect the Company's right thereafter to enforce such provision, nor will such failure affect the Company's right to enforce any other provision of this Plan.

If an inadvertent error should occur due to interpretation of mandated benefits, relevant laws and regulations before the final regulations are issued, the Plan, Plan Administrator, Agent for the Service of Legal Process, Trustee, Claims Administrator, and Company will be held harmless for such an error; and in no way will such an error be construed as a precedent-setting event.

Payment for expenses in relation to services which are generally accepted as cost-containment measures in large claim management cases that are not normally covered under this Plan will be reimbursable upon recommendation of the Claims Administrator and written approval by the Plan Administrator.

DEFINITIONS

Accidental Injury

A condition which is the result of bodily Injury caused by an external force; or a condition caused as the result of an incident which is precipitated by an act of unusual circumstances likely to result in unexpected consequences; this incident must be of a sufficient departure from the claimant's normal and ordinary lifestyle or routine; the condition must be an instantaneous one, rather than one which continues, progresses or develops.

Active Work/Actively at Work

An Employee is considered to be at active work or actively at work when performing, in the customary manner, all of the regular duties of his occupation with the Company. An Employee shall be deemed at active work or actively at work on each day of a regular paid vacation; or on a regular non-working day, provided he was Actively at Work on the last preceding regular working day. A Covered Individual will be considered to be Actively at Work if he is absent solely due to a health reason.

Ambulatory Surgical Center

An institution or facility, either free-standing or as part of a Hospital, with permanent facilities, equipped and operated for the primary purpose of performing Surgical Procedures and to which a patient is admitted to and discharged from within a 24 hour period.

Amendment

A formal document that changes the provisions of the Plan Document, duly signed by the authorized person or persons as designated by the Plan Administrator

Annual

Periodic, based on a Calendar Year.

Benefit Percentage

That portion of Eligible Expenses to be paid by the Plan in accordance with the coverage provisions as stated in the Plan. It is the basis used to determine any out-of-pocket expenses in excess of the annual Deductible, which are to be paid by the Employee.

Benefit Period

A time period of one Calendar Year. Such benefit period will terminate on the last day of the one-year period so established.

Calendar Year

A period of time commencing on January 1 and ending on December 31 of the same given year.

Certified Counselor

An individual qualified by education, training, and experience to provide counseling in relation to emotional disorders, psychiatric conditions, or substance abuse.

Chiropractic Care

Services performed by a person trained and licensed to practice chiropractic medicine, provided those services are for the remedy of diseases or conditions, which the chiropractor is licensed to treat.

Claim Determination Period

A Calendar Year or that portion of a Calendar Year during which the individual for whom claim is made has been covered under this Plan.

Claims Processor

The person or firm employed by the Company to provide consulting services to the Company in connection with the operation of the Plan and any other functions, including the processing and payment of claims.

Close Relative

The spouse, parent, brother, sister, child, or spouse's parent of the Covered Individual.

COBRA

The Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Coinsurance

That figure shown as a percentage in the Plan Summary used to compute the amount of benefit payable when the Plan states that a percentage is payable.

Company

University of Dubuque

Confinement

A continuous stay in the Hospital(s) or Skilled Nursing Facility/Extended Care Facility or combination thereof, due to an Illness or Injury diagnosed by a Physician.

Cosmetic Procedure

A procedure performed to:

- change the texture or appearance of the skin; or
- change the relative size or position of any part of the body;

when such surgery is performed primarily for psychological purposes or for improvement of appearance rather than for restoration or improvement of a bodily function.

Covered Individual

Any Employee or Dependent of an Employee meeting the eligibility requirements for coverage as specified in this Plan, and properly enrolled in the Plan.

Custodial Care

That type of care or service, wherever furnished and by whatever name called, which is designed primarily to assist a Covered Individual, whether or not totally disabled, in the activities of daily living. Such activities include, but are not limited to: bathing, dressing, feeding, preparation of special diets, assistance in walking or in getting in and out of bed, and supervision over medication which can normally be self-administered.

Deductible

A specified dollar amount of Eligible Expenses which must be incurred during a Benefit Period before any other Eligible Expenses can be considered for payment according to the applicable Benefit Percentage.

DEFRA

The Deficit Reduction Act of 1984, as amended.

Dentist

An individual who is duly licensed to practice dentistry or perform oral surgery in the state where the dental service is performed and who is operating within the scope of his license. For the purpose of this definition, a Physician will be considered to be a Dentist when he performs any of the dental services described herein and is operating within the scope of his license.

Dependent

The term "Dependent" means:

- A. The Employee's legal spouse who is a resident of the same country in which the Employee resides. Such spouse, including a same sex spouse, must have met all requirements of a valid marriage as defined by the state in which the Employee resides. For the purposes of this definition, "spouse" shall not mean a common law spouse or domestic partner.
- B. Children up to age 26 as defined below.
 - 1) Natural-born children.
 - 2) Stepchildren
 - 3) Legally adopted children and children placed with you for adoption. Date of placement means the assumption and retention by a person of a legal obligation in anticipation of adoption of the child. The child's placement with a person terminates upon the termination of the legal obligation.
- C. Children who are required to be covered by reason of a Qualified Medical Child Support Order ("QMCSO"), as defined in ERISA §609(a). The Plan has detailed procedures for determining whether an Order qualifies as a QMCSO. You and your family members can obtain, without charge, a copy of such procedures from the Plan Administrator.
- D. Children up to age 26 whose primary residence is with the employee and who depend upon the employee for support and maintenance, for whom the employee or employee's spouse has been named legal guardian. The company will require proof of legal responsibility in order for them to become an eligible family member.
- E. Disabled children age 26 and over if all of the following apply:
 - 1) is a child as defined in point B above.
 - 2) is unmarried.
 - 3) Is dependent upon the Employee/Employee's spouse for support and maintenance.
 - 4) is incapable of self-sustaining employment because of physical handicap, mental retardation, mental illness or mental disorders.
 - 5) is enrolled in the plan prior to reaching the limiting age.

To qualify for this disabled child coverage extension, the plan administrator must receive proof of the requirements above. After this initial proof, the plan administrator may request proof again two (2) years later, and each year thereafter.

Those situations specifically excluded from the definition of a Dependent are:

1. Any person who is not a resident of the United States of America.
2. A spouse who is legally separated or divorced from the Employee.
3. Any spouse on active military duty.
4. Any Dependent covered under this Plan as an individual Employee.
5. Any person who is covered as a Dependent by another Employee of the Company.

A Dependent is someone who meet the qualifications above and is properly enrolled in the Plan.

Dependent Coverage

Eligibility under the terms of the Plan for benefits payable or Eligible Expenses of a Dependent.

Durable Medical Equipment

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

Educational Institution

An institution accredited in the current publication of accredited institutions of higher education including vocational technical schools.

Eligible Expense

Any Medically Necessary treatment, services, or supplies that are not specifically excluded from coverage elsewhere in this Plan.

Eligible Provider

Eligible Providers shall include the following legally licensed or duly certified health care providers to the extent that same, within the scope of their license, are permitted to perform services which are considered Eligible Expenses under the Plan:

- Ambulatory Surgical Center
- Audiologist (MS)
- Birthing Center
- Certified Counselor
- Certified Registered Nurse Anesthetist
- Chiropractor
- Clinic
- Dentist
- Dialysis Center
- Home Health Agency
- Hospice
- Hospital
- Laboratory
- Licensed Practical Nurse
- Medical Supply Purveyor
- Midwife
- Nurse Practitioner
- Occupational Therapist
- Ophthalmologist
- Optometrist
- Oral Surgeon
- Osteopath
- Pharmacy/Pharmacist
- Physical Therapist
- Physician (M.D.)
- Physician's Assistant
- Podiatrist
- Professional ambulance service
- Psychiatrist
- Psychologist
- Registered Dietitian
- Registered Nurse
- Respiratory Therapist
- Skilled Nursing Facility
- Social Worker
- Speech Therapist

“Eligible Provider” shall not include the Covered Individual or any close relative of the Covered Individual.

Emergency

An "Emergency" is defined as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in 1) a condition placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; 2) serious impairment to bodily functions; or 3) serious dysfunction of any bodily organ or part.

Employee

An active Employee of the Company receiving compensation from the Company for services rendered to the Company. Employee means a person who is in an Employer-Employee relationship with the Company and who is classified by the Company as a regular Employee. The term "Employee" shall not include any individual classified by the Company as an independent contractor, a consultant, an individual performing services for the Company who has entered into an independent contractor or consultant agreement with the Company (even if a court, the Internal Revenue Service, or any other entity determines that such individual is a common-law employee) or a leased employee as defined in Section 414(n) of the Code. The term Employee does not include any employee covered by a collective bargaining agreement that does not provide for coverage under the Plan, provided that health care benefits were the subject of good faith bargaining between the employee's bargaining representative and the Company. The term Employee does not include an employee classified by the Company as a temporary employee.

Employee Coverage

Eligibility under the terms of the Plan for benefits payable for Eligible Expenses of an Employee.

ERISA

The Employee Retirement Income Security Act of 1974, as amended.

Expenses Incurred

The day supplies or services are rendered.

Experimental

Any medical procedure, equipment, treatment, or course of treatment, or drug or medicine that is limited to research, not proven in an objective manner to have therapeutic value or benefit, restricted to use at medical facilities capable of carrying out scientific studies, or is of questionable medical effectiveness. To determine whether a procedure is experimental the Company will consider, among other things, commissioned studies, opinions, and references to or by the American Medical Association, the Federal Drug Administration, the Department of Health and Human Services, the National Institute of Health, the Council of Medical Specialty Societies and any other association or federal program or agency that has the authority to approve medical testing or treatment.

Family

A Covered Employee and his eligible Dependents.

Full-Time Work

A basis whereby an Employee works for the Company for an average of at least 30 hours per week on a regular basis. Such work may occur either at the usual place of business of the Company or at a location to which the business of the Company requires the Employee to travel and for which he receives regular earnings from the Company.

Home Health Care Agency

A Medicare-approved public or private agency or organization that specializes in providing medical care and treatment in the home. Such a provider must be primarily engaged in and duly licensed by the appropriate licensing authority (if such licensing is required) to provide skilled nursing services and other therapeutic services. It must have policies established by a professional group associated with the agency or organization including at least one Physician and at least one Registered Nurse (R.N.) to govern the services provided, and it must provide for full-time supervision of such services by a Physician or Registered Nurse. Its staff must maintain a complete medical record on each individual and it must have a full-time administrator.

Home Health Care Plan

A program for continued care and treatment of the Covered Individual, established and approved in writing by the Covered Individual's attending Physician. The attending Physician must certify that the proper treatment of the Illness or Injury would require continued Confinement as a resident inpatient in a Hospital or Skilled Nursing Facility in the absence of the services and supplies provided as part of the Home Health Care Plan.

Hospice

A health care program providing a coordinated set of services rendered at home, in Outpatient settings, or in institutional settings for Covered Individuals suffering from a condition that has a terminal prognosis. A Hospice must have an interdisciplinary group of personnel which includes at least one Physician and one Registered Nurse, and its staff must maintain central clinical records on all patients. A Hospice must meet the standards of the National Hospice and Palliative Care Organization (NHPCO) and applicable state licensing.

Hospital

An institution which meets all of the following conditions:

1. It is engaged primarily in providing medical care and treatment to an ill or injured person on an inpatient basis at the patient's expense.
2. It is constituted, licensed, and operated in accordance with the laws of jurisdiction in which it is located which pertain to hospitals.
3. It maintains on its premises all the facilities necessary to provide for the diagnosis and medical and surgical treatment of an Illness or an Injury.
4. Such treatment is provided for compensation by or under the supervision of Physicians, with continuous 24 hour nursing services by Registered Nurses (R.N.'s).
5. It is accredited by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO). The JCAHO accreditation limitation may be waived at the discretion of the Plan if the only Hospital in the immediate area is not JCAHO approved.
6. It is a provider of services under Medicare.
7. It is not, other than incidentally, a place for rest, a place for the aged, or a nursing home.

The definition of "Hospital" will also include surgical centers and birthing centers licensed by the state in which they operate. Institutions qualified for the treatment of mental health or substance abuse that do not have surgical facilities and/or are not approved by Medicare will be eligible provide they meet all the other qualifications listed above. Hospital does not include services provided in facilities operating as residential treatment centers.

Hospital Miscellaneous Expenses

The actual charges made by a Hospital in its own behalf for services and supplies rendered to the Covered Individual which are Medically Necessary for the treatment of such Covered Individual. Hospital miscellaneous expenses do not include charges for room and board or for professional services (including intensive nursing care by whatever name called), regardless of whether the services are rendered under the direction of the Hospital or otherwise.

Illness

A bodily disorder, disease, physical Sickness, mental infirmity, or functional nervous disorder of a Covered Individual. Illness shall include pregnancy and any complications of pregnancy.

Injury

The term "Injury" shall mean only accidental bodily Injury caused by an external force. All injuries to one person from one accident shall be considered an "Injury."

In-Network Benefit

The benefit percentage paid if a Covered Individual utilizes the services of a Network Provider.

Inpatient Care

Hospital Room and Board and general nursing care for a person confined in a Hospital or Skilled Nursing Facility/Extended Care Facility as a bed patient. Observation care that extends beyond twenty-three (23) hours will be considered inpatient and allowed at the rate of inpatient care.

Intensive Care Unit (ICU)

An area within a Hospital which is reserved, equipped, and staffed by the Hospital for the treatment and care of critically ill patients who require extraordinary, continuous, and intensive nursing care for the preservation of life.

Licensed Practical Nurse (L.P.N.)

An individual who has received specialized nursing training and practical nursing experience, and is duly licensed to perform such nursing services by the state or regulatory agency responsible for such licensing in the state in which that individual performs such services.

Lifetime

The term "lifetime," which is used in connection with benefit maximums and limitations, means the period during which the person is covered under the Company Health Plan, whether or not coverage is continuous. Under no circumstances does "lifetime" mean during the lifetime of the Covered Individual.

Medically Necessary

The service a patient receives which is recommended by a Physician and is required to treat the symptoms of a certain Illness or Injury. Although the service may be prescribed by a Physician, it does not mean the service is Medically Necessary. The care or treatment 1) must be consistent with the diagnosis and

prescribed course of treatment for the Covered Individual's condition; 2) must be required for reasons other than the convenience of the Covered Individual or the attending Physician; 3) is generally accepted as an appropriate form of care for the condition being treated; and 4) is likely to result in physical improvement of the patient's condition which is unlikely to ever occur if the treatment is not administered.

Medicare

The medical care benefits provided under Title XVIII of the Social Security Act of 1965, as subsequently amended.

Named Fiduciary

University of Dubuque, which has the authority to control and manage the operation and administration of the Plan.

Newborn

An infant from the date of birth until the mother is discharged from the Hospital.

Occupational Therapist

A licensed practitioner who treats, primarily, the loss of motor function of skeletal muscles by educating the patient to use other muscles and/or artificial devices to enable them to perform acceptably in any particular occupation or the ordinary tasks of daily living.

Other Eligible Participant

“Other Eligible Participants are those employees eligible to continue coverage under the Plan after termination pursuant to a negotiated separation agreement with the University.

Out-of-Network Benefit

The benefit percentage paid if a Covered Individual receives services from a provider who is not contracted with the Preferred Provider Organization.

Outpatient

The classification of a Covered Individual when that Covered Individual received medical care, treatment, services, or supplies at a clinic, a Physician's office, or a Hospital if not a registered bed patient at that Hospital.

Outpatient Surgery

Outpatient surgery includes, *but is not limited to*, the following types of procedures performed in a hospital or surgi-center:

1. Operative or cutting procedures for the treatment of an illness or injury;
2. The treatment of fractures and dislocations; or
3. Endoscopic or diagnostic procedures such as biopsies, cystoscopy, bronchoscopy, and angiocardiology.

Physical Therapist

A licensed practitioner who treats patients by means of electro-, hydro-, aero-, and mechano-therapy, massage and therapeutic exercises. Where there is no licensure law, the physical therapist must be certified by the appropriate professional body.

Physician

A legally licensed medical or dental doctor or surgeon, osteopath, podiatrist, optometrist, chiropractor or registered clinical psychologist to the extent that same, within the scope of his license, is permitted to perform services provided in this Plan. A Physician shall not include the Covered Individual or any Close Relative of the Covered Individual.

Plan

The term "Plan" means without qualification the Plan outlined herein.

Plan Administrator

The Company, which is responsible for the management of the Plan. The Plan Administrator may employ persons or firms to process claims and perform other Plan-connected services.

Plan Sponsor

University of Dubuque

PPO

Preferred Provider Organization

Pre-Authorization

Pre-Authorization determines whether a proposed treatment is covered by the Health Plan. An Eligible Provider or a Covered Individual may submit information to the Claims Administrator regarding a proposed service to determine if and at what level the service is covered by the Plan.

Preferred Provider Organization

An Organization that has contracted with the Plan Sponsor to provide services to Covered Individuals at specific rates.

Pregnancy

That physical state which results in childbirth, abortion, or miscarriage, and any medical complications arising out of or resulting from such state.

Prescription

All drugs that are required under Federal law to bear the label, "Caution: Federal law prohibits dispensing without prescription," or any substitute required label, and injectable insulin (whether or not by prescription), as long as the drug was prescribed by a licensed Physician.

Primary Plan

A plan whose allowable benefits are not reduced by those of another plan.

Pronouns

Any references to "You, Yours, or Yourself" means the eligible Employee and Covered Dependents. "He, His, Him" refers to either sex; not to be discriminatory, but to avoid "he/she" type wording.

Psychiatric Care

The term "psychiatric care," also known as psychoanalytic care, means treatment for a mental illness or disorder, a functional nervous disorder, alcoholism, or drug addiction. A psychiatric condition includes but is not limited to anorexia nervosa and bulimia, schizophrenia, and depressive disorders including but not limited to manic depression.

Psychologist

A registered clinical psychologist. A provider who has a doctorate degree in psychology with two (2) years clinical experience and who meets the standards of a national register.

Qualified Medical Child Support Order (QMCSO)

In order to meet the definition of a Qualified Medical Child Support Order (QMCSO), a court order or divorce decree must contain all of the following information:

1. The Employee's name and last known address.
2. The Dependent's full name and address.
3. A reasonable description of the coverage to be provided or the manner in which coverage will be established, i.e. through the employer.
4. The period for which coverage must be provided.

A National Medical Support notice, issued pursuant to ERISA section 609(a)(5)(C) and applicable regulations, will also meet the definition of a QMCSO.

Registered Nurse (R.N.)

An individual who has received specialized nursing training and is authorized to use the designation of "R.N.," and who is duly licensed by the state or regulatory agency responsible for such licensing in the state in which the individual performs such nursing services.

Review Organization

The organization contracting with the Company to perform cost containment services.

Room and Board

All charges, by whatever name called, which are made by a Hospital, Hospice, or Skilled Nursing Facility/Extended Care Facility as a condition of occupancy. Such charges do not include the professional services of Physicians nor intensive nursing care (by whatever name called).

Semi-Private

A class of accommodations in a Hospital or Skilled Nursing Facility/Extended Care Facility in which at least two patient beds are available per room.

Skilled Nursing Facility or Extended Care Facility

An institution, or distinct part thereof, operated pursuant to law, and one which meets all of the following conditions:

1. It is licensed to provide and is engaged in providing, on an inpatient basis for persons convalescing from Injury or Illness, professional nursing services rendered by a Registered Nurse (R.N.) or by a Licensed Practical Nurse (L.P.N.) under the direction of a Registered Nurse and physical restoration services to assist patients to reach a degree of body functioning to permit self-care in essential daily living activities.
2. Its services are provided for compensation from its patients and under the full-time supervision of a Physician or Registered Nurse.
3. It provides 24-hour per day nursing services by licensed nurses, under the direction of a full-time Registered Nurse.
4. Its staff 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, mentally handicapped, custodial or educational care, or care of mental disorders.
7. It is approved and licensed by Medicare

This term shall apply to expenses incurred in an institution referring to itself as a Skilled Nursing Facility, Extended Care Facility, or any such other similar facility.

Social Worker

An individual who is qualified through education, training, and experience to provide services in relation to the treatment of emotional disorders, psychiatric conditions, or substance abuse.

Speech Therapist

An individual who is skilled in the treatment of communication and swallowing disorders due to Illness, Injury or birth defect, who is a member of the American Speech and Hearing Association and has a Certificate of Clinical Competence and who is licensed in the state in which services are provided.

Surgical Procedures

Cutting, suturing, treatment of burns, correction of fractures, reduction of dislocation, manipulation of joints under general anesthesia, electrocauterization, tapping (paracentesis), application of plaster casts, administration of pneumothorax, endoscopy, or injection of sclerosing solution by a licensed Physician.

TEFRA

The Tax Equity and Fiscal Responsibility Act of 1982, as amended from time to time.

Therapy Services

Services or supplies used for the treatment of an Illness or Injury to promote the recovery of a Covered Individual. Therapy services are covered to the extent specified in the Plan and may include:

1. Chemotherapy - the treatment of malignant disease by chemical or biological antineoplastic agents.
2. Dialysis Treatments - the treatment of acute or chronic kidney disease which may include the supportive use of an artificial kidney machine.
3. Occupational Therapy - treatment of a physically disabled person by means of constructive activities designed and adapted to promote the restoration of the person's ability to satisfactorily accomplish the ordinary tasks of daily living and those required by the person's particular occupational role.
4. Physical Therapy - the treatment by physical means, electrotherapy, hydrotherapy, heat, or similar modalities, physical agents, bio-mechanical and neuro-physiological principles, and devices to relieve pain, restore maximum function, and prevent disability following disease, Injury, or loss of body part.
5. Radiation Therapy - the treatment of disease by X-ray, radium, or radioactive isotopes.
6. Respiration Therapy - introduction of dry or moist gases into the lungs for treatment purposes.
7. Speech Therapy - treatment of communication and swallowing disorders due to an Illness, Injury or birth defect.

TMJ

"TMJ" means temporomandibular joint syndrome and all related complications or conditions.

Total Disability (Totally Disabled)

A physical state of a Covered Individual resulting from an Illness or Injury which wholly prevents:

1. An Employee from engaging in his regular or customary occupation and from performing any and all work for compensation or profit.
2. A Dependent from performing the normal activities of a person of like age and sex and in good health.

Usual, Customary and Reasonable (UCR)

The term "usual, customary, and reasonable" refers to the designation of a charge as being the usual charge made by a Physician or other provider of services, supplies, medications, or equipment that does not exceed the general level of charges made by other providers rendering or furnishing such care or treatment within the same area. The term "area" in this definition means a geographic area or such other area as is necessary to obtain a representative cross section of such charges. Due consideration will be given to the nature and severity of the condition being treated and any medical complications or unusual circumstances which require additional time, skill, or expertise.

Well-Care

The term "well-care" means medical treatment, services, or supplies rendered solely for the purpose of health maintenance and *not* for the treatment of an Illness or Injury.