

UNIVERSITY OF ST THOMAS HOUSTON TX

Health Booklet
80/60 Plan

BENEFITS ADMINISTERED BY



If you have any questions or concerns regarding your eligibility, please call the Group Services Unit – 1-800-826-9781; or FAX 1-715-841-3564.

If you have any questions or concerns regarding your claims, please call your Claim Service Representative – 1-800-826-9781; or FAX 1-715-841-7569.

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UNIVERSITY OF ST THOMAS
GROUP HEALTH BENEFIT PLAN
SUMMARY PLAN DESCRIPTION

INTRODUCTION

Effective: 07-01-2006

The purpose of this document is to provide You and Your covered Dependents, if any, with summary information on Your benefits along with information on Your rights and obligations under this Plan. As a valued Employee of UNIVERSITY OF ST THOMAS, we are pleased to provide You with benefits that can help meet Your health care needs.

UNIVERSITY OF ST THOMAS is named the Plan Administrator for this group health Plan. The Plan Administrator has retained the services of independent Third Party Administrators, to process claims and handle other duties for this self-funded Plan. The Third Party Administrators for this Plan are Fiserv Health Administrators, Inc. for medical claims, and Fiserv Health Prescription Benefits Administration (also known as Innoviant) for pharmacy claims. The Third Party Administrators do not assume liability for benefits payable under this Plan, as they are solely claims paying agents for the Plan Administrator.

The employer assumes the sole responsibility for funding the Plan benefits out of general assets, however Employees help cover some of the costs of covered benefits through contributions, Deductibles, Co-pays and Participation amounts as described in the Schedule of Benefits. All claim payments and reimbursements are paid out of the general assets of the employer and there is no separate fund that is used to pay promised benefits. The Plan is intended to comply with and be governed by the Employee Retirement Income Security Act of 1974 (ERISA) and its amendments.

Some of the terms used in this document begin with a capital letter, even though the term normally would not be capitalized. These terms have special meaning under the Plan and most will be listed in the Glossary of Terms. Other capitalized terms are defined within the provision the term is used. When reading this document, please refer to the Glossary of Terms. Becoming familiar with the terms defined in the Glossary will help You better understand the provisions of this group health Plan.

The requirements for being covered under this Plan, the provisions concerning termination of coverage, a description of the Plan benefits (including limitations and exclusions), cost sharing, the procedures to be followed in submitting claims for benefits and remedies available for appeal of claims denied are outlined in the following pages of this document. Please read this document carefully and contact Your Human Resources or Personnel office if You have questions.

If You haven't already received this, You will be getting an identification card that You should present to the provider when You receive services. This card also has phone numbers on the back so You know who to call if You have questions or problems.

This document constitutes a Plan Document and Summary Plan Description as required by ERISA Section 102.

This document becomes effective on July 1, 2005.

PLAN INFORMATION

Effective: 07-01-2006

Plan Name	UNIVERSITY OF ST THOMAS Group Benefit Plan
Name And Address Of Employer	UNIVERSITY OF ST THOMAS 3800 MONTROSE BLVD HOUSTON TX 77006
Name, Address And Phone Number Of Plan Administrator	UNIVERSITY OF ST THOMAS 3800 MONTROSE BLVD HOUSTON TX 77006 (713) 525-3813
Named Fiduciary	UNIVERSITY OF ST THOMAS
Employer Identification Number Assigned By The IRS	74-1277664
Plan Number Assigned By The Plan	501
Type Of Benefit Plan Provided	Self-Funded Health & Welfare Plan providing Group Health Benefits
Type Of Administration	The administration of the Plan is under the supervision of the Plan Administrator. The Plan is not financed by an insurance company and benefits are not guaranteed by a contract of insurance, however, a reinsurance company reimburses the Plan for certain expenses. Fiserv Health provides administrative services such as claim payments for medical and pharmacy claims.
Name And Address Of Agent For Service Of Legal Process	UNIVERSITY OF ST THOMAS 3800 MONTROSE BLVD HOUSTON TX 77006 Services of legal process may also be made upon the Plan Administrator.
Funding Of The Plan	Employer and Employee Contributions Benefits are provided by a benefit plan maintained on a self-insured basis by Your employer.
Benefit Plan Year	Begins on January 1 and ends on the following December 31.
ERISA and Other Federal Compliance	It is intended that this Plan meet all applicable requirements of ERISA and other federal regulations. In the event of any conflict between this Plan and ERISA or other federal regulations, the provisions of ERISA and the federal regulations shall be deemed controlling, and any conflicting part of this Plan shall be deemed superseded to the extent of the conflict.

Discretionary Authority

The Plan Administrator shall perform its duties as the Plan Administrator and in its sole discretion, shall determine appropriate courses of action in light of the reason and purpose for which this Plan is established and maintained. In particular, the Plan Administrator shall have full and sole discretionary authority to interpret all plan documents, and make all interpretive and factual determinations as to whether any individual is entitled to receive any benefit under the terms of this Plan. Any construction of the terms of any plan document and any determination of fact adopted by the Plan Administrator shall be final and legally binding on all parties, except that the Plan Administrator has delegated certain responsibilities to the Third Party Administrators for this Plan. Any interpretation, determination or other action of the Plan Administrator or the Third Party Administrators shall be subject to review only if it is arbitrary or capricious or otherwise an abuse of discretion. Any review of a final decision or action of the Plan Administrator or the Third Party Administrators shall be based only on such evidence presented to or considered by the Plan Administrator or the Third Party Administrators at the time it made the decision that is the subject of review. Accepting any benefits or making any claim for benefits under this Plan constitutes agreement with and consent to any decisions that the Plan Administrator or the Third Party Administrators make, in its sole discretion, and further, constitutes agreement to the limited standard and scope of review described by this section.

SCHEDULE OF BENEFITS

Benefit Plan(s) 002

Effective: 07-01-2006

All health benefits shown on this Schedule of Benefits are subject to the individual lifetime and annual maximums, individual and family Deductibles, Co-pays, Participation rates, and out-of-pocket maximums, if any. Benefits are also subject to all provisions of this Plan including Medical Necessity and any other benefit determination based on an evaluation of medical facts and covered benefits. Refer to the Covered Medical Benefits section of this document for more details.

Note: Certain covered benefits require certification before benefits will be considered for payment. Failure to obtain certification may result in a penalty or increased out-of-pocket costs. Refer to the Utilization Management section of this document for a description of these services and certification procedures.

Note: If a benefit maximum is listed in the middle of a column on the Schedule of Benefits, that means that it is a combined Maximum Benefit for services that You receive from all In-Network and Out-of-Network providers and facilities.

SUMMARY OF BENEFITS	IN-NETWORK	OUT-OF-NETWORK
Individual Lifetime Maximum Benefit	\$2,000,000	
Annual Deductible Per Calendar Year:		
• Per Person	\$250	\$500
• Per Family	\$750	\$1,500
Participation Rate, Unless Otherwise Stated Below:		
• Paid By Plan After Satisfaction Of Deductible	80%	60%
Annual Out-Of-Pocket Maximum:		
• Per Person	\$4,000	\$8,000
• Per Family	\$12,000	\$24,000
Acupuncture Treatment:		
• Maximum Benefit Per Calendar Year	\$1,000	
• Paid By Plan After Deductible	80%	60%
Adult Sleep Disorder/Sleep Apnea:		
From Age 19		
• Maximum Benefit Per Calendar Year	\$1,500	
• Paid By Plan After Deductible	80%	60%
Ambulance And Other Medically Necessary Transportation:		
Ground:		
• Paid By Plan After In-Network Deductible	60%	60%
• Paid By Plan After In-Network Deductible If Admitted	100%	100%
Air:		
• Maximum Benefit Per Calendar Year	\$5,000	
• Paid By Plan After In-Network Deductible	60%	60%
• Paid By Plan After In-Network Deductible If Admitted	100%	100%
Artificial Limbs, Eyes, And Larynx:		
• Maximum Benefit Per Calendar Year	\$5,000	
• Paid By Plan After Deductible	80%	60%

SUMMARY OF BENEFITS	IN-NETWORK	OUT-OF-NETWORK
Chiropractic Services: <ul style="list-style-type: none"> Maximum Benefit Per Calendar Year Paid By Plan After Deductible 	80%	\$2,000 60%
Durable Medical Equipment: <ul style="list-style-type: none"> Maximum Benefit Per Calendar Year Paid By Plan After Deductible 	80%	\$5,000 60%
Extended Care Facility Benefits Such As Skilled Nursing, Convalescent Or Sub-acute Facility: <ul style="list-style-type: none"> Maximum Days Per Calendar Year Paid By Plan After Deductible 	80%	100 Days 60%
Gender Dysphoria If The Result Of Congenital Abnormality: To Age 19 <ul style="list-style-type: none"> Paid By Plan After Deductible 	80%	60%
Home Health Care Benefits: <ul style="list-style-type: none"> Maximum Visits Per Calendar Year (Including Private Duty Nursing If Approved As Medically Necessary For Home Health Care Only) Paid By Plan After Deductible 	80%	100 Visits 60%
Hospice Care Benefits: Hospice Services: <ul style="list-style-type: none"> Paid By Plan After Deductible 	80%	60%
Bereavement Counseling: <ul style="list-style-type: none"> Maximum Benefit Per Lifetime Paid By Plan After Deductible 	80%	\$1,000 60%
Hospital Services - Except For Mental Health And Substance Abuse And Chemical Dependency: Inpatient Services / Inpatient Physician Charges Room And Board Subject To The Payment Of Semi-private Room Rate: <ul style="list-style-type: none"> Co-pay Per Admission Paid By Plan After Deductible 	\$250 80%	\$500 60%
Emergency Room / Emergency Physician Charges: <ul style="list-style-type: none"> Co-pay Per Visit (Waived If Admitted As Inpatient Within 24 Hours) Paid By Plan 	\$100 80% (Deductible Waived)	\$100 60% (Deductible Waived)
Outpatient Services / Outpatient Physician Charges: <ul style="list-style-type: none"> Paid By Plan After Deductible 	80%	60%
Outpatient Lab And X-ray Charges: <ul style="list-style-type: none"> Paid By Plan After Deductible 	80%	60%
Outpatient Surgery / Surgeon Charges: <ul style="list-style-type: none"> Co-pay Per Visit Paid By Plan After Deductible 	Not Applicable 80% (Deductible Waived)	\$100 60%

SUMMARY OF BENEFITS	IN-NETWORK	OUT-OF-NETWORK
Maternity Benefits: Initial Office Visit: <ul style="list-style-type: none"> • Co-pay Per Visit • Paid By Plan After Deductible All Other Physician Services: <ul style="list-style-type: none"> • Paid By Plan After Deductible 	<p style="text-align: center;">\$15 100%</p> <p style="text-align: center;">80%</p>	<p style="text-align: center;">Not Applicable 60%</p> <p style="text-align: center;">60%</p>
Mental Health Benefits: Inpatient, Partial Hospitalization Or Residential Treatment: <ul style="list-style-type: none"> • Maximum Days Per Calendar Year • Maximum Days Per Calendar Year • Paid By Plan After Deductible <p><i>Note: 2 Days Of Partial Hospitalization Will Reduce The Inpatient Maximum By One Day</i></p> Outpatient Treatment: <ul style="list-style-type: none"> • Maximum Visits Per Calendar Year • Maximum Days Per Calendar Year • Paid By Plan After Deductible 	<p style="text-align: center;">45 Days For Serious Mental Illness 20 Days For Other Than Serious Mental Illness</p> <p style="text-align: center;">80%</p> <p style="text-align: center;">60 Visits For Serious Mental Illness 20 Visits For Other Than Serious Mental Illness</p> <p style="text-align: center;">80%</p>	<p style="text-align: center;">60%</p> <p style="text-align: center;">60%</p>
Orthognathic, Prognathic And Maxillofacial Surgery: To Age 19 <ul style="list-style-type: none"> • Paid By Plan After Deductible 	<p style="text-align: center;">80%</p>	<p style="text-align: center;">60%</p>
Orthoptic (Eye Exercise) Benefits: To Age 13 <ul style="list-style-type: none"> • Paid By Plan After Deductible 	<p style="text-align: center;">80%</p>	<p style="text-align: center;">60%</p>
Physician Office Visit - Except For Mental Health, Substance Abuse And Chemical Dependency: Office Visit: <ul style="list-style-type: none"> • Co-pay Per Visit • Paid By Plan After Deductible 	<p style="text-align: center;">\$15 100% (Deductible Waived)</p>	<p style="text-align: center;">Not Applicable 60%</p>
Physician Office Services: <ul style="list-style-type: none"> • Paid By Plan After Deductible Allergy Injections: <ul style="list-style-type: none"> • Paid By Plan After Deductible 	<p style="text-align: center;">80%</p> <p style="text-align: center;">100% (Deductible Waived)</p>	<p style="text-align: center;">60%</p> <p style="text-align: center;">60%</p>
Preventive / Routine Care Benefits Include: From Age 19 <ul style="list-style-type: none"> • Maximum Benefit Per Calendar Year • Paid By Plan After \$1,000 Maximum and Deductible 	<p style="text-align: center;">80%</p>	<p style="text-align: center;">\$1,000 60%</p>

SUMMARY OF BENEFITS	IN-NETWORK	OUT-OF-NETWORK
<p>Preventive / Routine Physical Exams: Included In Maximum</p> <ul style="list-style-type: none"> • Co-pay Per Visit • Paid By Plan After Deductible 	<p>\$15 100% (Deductible Waived)</p>	<p>Not Applicable 60%</p>
<p>Immunizations (Including Only Flumist Or Any Flu Vaccine): Included In Maximum</p> <ul style="list-style-type: none"> • Paid By Plan After Deductible 	<p>100% (Deductible Waived)</p>	<p>60%</p>
<p>Preventive / Routine Diagnostic Tests, Lab And X-rays: Included In Maximum</p> <ul style="list-style-type: none"> • Paid By Plan After Deductible 	<p>100% (Deductible Waived)</p>	<p>60%</p>
<p>Preventive / Routine Mammograms And Breast Exams: From Age 35</p> <ul style="list-style-type: none"> • Maximum Exams Per Calendar Year • Paid By Plan After Deductible 	<p>100% (Deductible Waived)</p>	<p>1 Exam 60%</p>
<p>Preventive / Routine Pelvic Exams And Pap Test: Included In Maximum</p> <ul style="list-style-type: none"> • Paid By Plan After Deductible 	<p>100% (Deductible Waived)</p>	<p>60%</p>
<p>Preventive / Routine PSA Test and Prostate Exams: From Age 50 If Asymptomatic From Age 40 With A Family History Of Prostate Cancer Or Another Prostate Cancer Risk Factor Included In Maximum</p> <ul style="list-style-type: none"> • Paid By Plan After Deductible 	<p>100% (Deductible Waived)</p>	<p>60%</p>
<p>Preventive / Routine Colonoscopy, Sigmoidoscopy And Similar Routine Surgical Procedures Done For Preventive Reasons:</p> <ul style="list-style-type: none"> • Paid By Plan After Deductible 	<p>80%</p>	<p>60%</p>

SUMMARY OF BENEFITS	IN-NETWORK	OUT-OF-NETWORK
<p>Preventive / Routine Care Benefits For Children Include: To Age 19</p> <p>Preventive / Routine Physical Exams:</p> <ul style="list-style-type: none"> • Co-pay Per Visit • Paid By Plan After Deductible <p>Immunizations (Including Flumist Vaccine):</p> <ul style="list-style-type: none"> • Paid By Plan After Deductible <p>Preventive / Routine Diagnostic Tests, Lab And X-rays:</p> <ul style="list-style-type: none"> • Paid By Plan After Deductible 	<p>\$15 100% (Deductible Waived)</p> <p>100% (Deductible Waived)</p> <p>100% (Deductible Waived)</p>	<p>Not Applicable 60%</p> <p>100%</p> <p>60%</p>
<p>Substance Abuse And Chemical Dependency Benefits:</p> <ul style="list-style-type: none"> • Maximum Benefit Per Lifetime <p>Inpatient, Partial Hospitalization Or Residential Treatment:</p> <ul style="list-style-type: none"> • Paid By Plan After Deductible <p><i>Note: 2 Days Of Partial Hospitalization Will Reduce The Inpatient Maximum By One Day</i></p> <p>Outpatient Treatment:</p> <ul style="list-style-type: none"> • Paid By Plan After Deductible 	<p>3 Courses Of Treatment</p> <p>80%</p> <p>80%</p>	<p>60%</p> <p>60%</p> <p>60%</p>
<p>Temporomandibular Joint Disorder Benefits:</p> <ul style="list-style-type: none"> • Maximum Benefit Per Calendar Year • Paid By Plan After Deductible 	<p>\$2,000</p> <p>80%</p>	<p>60%</p>
<p>Therapy Services:</p> <p>Occupational / Physical Outpatient Hospital And Office Therapy:</p> <ul style="list-style-type: none"> • Maximum Visits Per Calendar Year • Maximum Benefit Per Visit • Paid By Plan After Deductible <p>Speech Outpatient Hospital And Office Therapy:</p> <ul style="list-style-type: none"> • Paid By Plan After Deductible <p>Aquatic Therapy:</p> <ul style="list-style-type: none"> • Maximum Visits Per Calendar Year • Paid By Plan After Deductible 	<p>24 Visits</p> <p>Not Applicable 80%</p> <p>80%</p> <p>80%</p>	<p>\$20 60%</p> <p>60%</p> <p>60%</p>
<p>Wigs, Toupees Or Hairpieces Related To Cancer Treatment For Alopecia Areata:</p> <ul style="list-style-type: none"> • Maximum Benefit Per Lifetime • Paid By Plan After Deductible 	<p>\$500</p> <p>80%</p>	<p>60%</p>
<p>All Other Covered Expenses:</p> <ul style="list-style-type: none"> • Paid by Plan After Deductible 	<p>80%</p>	<p>60%</p>

TRANSPLANT BENEFITS SUMMARY

Benefit Plan(s) 002

<p>Transplant Services At A Designated Transplant Facility:</p> <p>Transplant Services:</p> <ul style="list-style-type: none"> • Paid By Plan <p>Travel And Housing:</p> <ul style="list-style-type: none"> • Maximum Benefit Per Transplant • Paid By Plan <p>Travel And Housing At Designated Transplant Facility For Up To One Year From Date Of Transplant.</p>	<p>100% (Deductible Waived)</p> <p>\$10,000</p> <p>100% (Deductible Waived)</p>	
	IN-NETWORK	OUT-OF-NETWORK
<p>Transplant Services At A Non-designated Transplant Facility:</p> <p>Transplant Services:</p> <ul style="list-style-type: none"> • Out-of-pocket Per Disability • Paid By Plan After Deductible <p>Donor Services - Acquisition And Procurement Costs:</p> <ul style="list-style-type: none"> • Maximum Benefit Per Transplant • Paid By Plan After Deductible 	<p>\$8,000</p> <p>80%</p> <p>\$75,000</p> <p>80%</p>	<p>No Benefit</p>

**PRESCRIPTION SCHEDULE OF BENEFITS
FISERV HEALTH PRESCRIPTION BENEFITS ADMINISTRATION**

Effective: 07-01-2006

<p>By Participating Retail Pharmacy</p> <ul style="list-style-type: none"> • Your Co-pay Amount <p>Generic Products Preferred Brand Products Nonpreferred Brand Products</p>	<p>For Up To A 30-Day Supply:</p> <p>\$10 \$25 \$35</p>
<p>By Participating Retail Pharmacy</p> <ul style="list-style-type: none"> • Your Co-pay Amount <p>Generic Products Preferred Brand Products Nonpreferred Brand Products</p>	<p>For Up To A 3-Month Supply:</p> <p>\$30 \$75 \$105</p>
<p>By Participating Mail Order Pharmacy</p> <ul style="list-style-type: none"> • Your Co-pay Amount Per Prescription Product <p>Generic Products Preferred Brand Products Nonpreferred Brand Products</p>	<p>For Up To A 90-Day Supply:</p> <p>\$20 \$50 \$70</p>
<p>By Specialty Pharmacy Vendor</p> <ul style="list-style-type: none"> • Your Co-pay Amount 	<p>For Up To A 30-Day Supply:</p> <p>20% Up To A \$150 Maximum</p>
<p>By Non-Participating Pharmacy</p>	<p>If You Use A Non-Participating Pharmacy, You Will Need To Pay For The Prescription Upfront, And Then Submit A Claim Reimbursement Form With A Receipt To Fiserv Health For Reimbursement. Reimbursement For Covered Prescription Products Will Be Based On The Lowest Contracted Amount Of A Participating Pharmacy Minus Any Applicable Deductible And/Or Retail Co-pay Shown In This Schedule.</p>

OUT-OF-POCKET EXPENSES AND MAXIMUMS

CO-PAYS

A Co-pay is the amount that You must pay to the provider each time certain services are received. Co-pays do not apply toward satisfaction of Deductibles or out-of-pocket maximums. Your Co-pay and out-of-pocket maximum is shown on the Schedule of Benefits.

DEDUCTIBLES

Deductible amounts are shown on the Schedule of Benefits. The applicable Deductible must be met before any benefits will be paid under this Plan, unless indicated otherwise. A new Deductible must be met each year.

Only Covered Expenses will count toward meeting the Deductible. Pharmacy expenses do not count toward meeting the Deductible of this Plan. The Deductible amounts that You incur for Covered Expenses will be used to satisfy the Deductible(s) shown on the Schedule of Benefits.

If You have family coverage, any combination of covered family members can help meet the maximum family Deductible, up to each person's individual Deductible amount.

All Covered Expenses which are Incurred during the last three months of a calendar year and applied toward satisfaction of the individual and family Deductible for that year, will also be applied toward the individual and family Deductible requirement for the next year.

PARTICIPATION

Participation means that, after You pay the Deductible, You and the Plan each pay a percentage of the Covered Expenses, as shown on the Schedule of Benefits, until the annual out-of-pocket maximum is reached. You will be responsible for paying any remaining charges due to the provider after the Plan has paid its portion of the Covered Expense, subject to the Plan's maximum fee schedule, negotiated rate, or Usual and Customary amounts as applicable. Once the out-of-pocket maximum has been reached, the Plan will pay 100% of the Covered Expense for the remainder of the plan year.

Any payment for an expense that is not covered under this Plan will be Your responsibility.

ANNUAL OUT-OF-POCKET MAXIMUMS

The annual out-of-pocket maximum is shown on the Schedule of Benefits. Amounts You incur for Covered Expenses, such as Your Deductible, Your Co-pays and any Participation expense, will be used to satisfy Your annual out-of-pocket maximum(s). Pharmacy expenses You incur do not apply toward the out-of-pocket maximum of this Plan.

The following will not be used to meet the out-of-pocket maximums:

- Co-pays.
- Penalties, legal fees and interest charged by a provider.
- Expenses for excluded services.
- Any charges above the limits specified elsewhere in this document.
- Co-pays and Participation amounts for Prescription products.
- Individual and family Deductibles.
- Expenses for Mental Health Disorders.
- Expenses for substance abuse and chemical dependency.
- Any amounts over the Usual and Customary amount, negotiated rate or established fee schedule that this Plan pays.

All Covered Expenses which are Incurred during the last three months of a calendar year and applied toward satisfaction of the individual and family out-of-pocket maximum for that year, will also be applied toward the individual and family out-of-pocket maximum requirement for the next year.

INDIVIDUAL LIFETIME MAXIMUM BENEFIT

All Covered Expenses excluding pharmacy expenses will count toward Your individual medical lifetime Maximum Benefit that is shown on the Schedule of Benefits.

NO FORGIVENESS OF OUT-OF-POCKET EXPENSES

You must notify the Plan if You have entered into an agreement with Your provider to waive Your Deductible, Co-pay or required Participation percentage. The requirement that You and Your Dependent pay the applicable Deductible and required out-of-pocket expenses of this Plan cannot be waived by You or Your provider under any “fee forgiveness”, “not out-of-pocket” or similar arrangement.

ELIGIBILITY AND ENROLLMENT

Effective: 07-01-2006

ELIGIBILITY AND ENROLLMENT PROCEDURES

You are responsible for enrolling in the manner and form prescribed by Your employer. The Plan's eligibility and enrollment procedures include administrative safeguards and processes designed to ensure and verify that eligibility and enrollment determinations are made in accordance with the Plan document. The Plan may request documentation from You in order to make these determinations. The coverage choices that will be offered to You will be the same choices offered to other similarly situated Employees.

ELIGIBILITY REQUIREMENTS

An **eligible Employee** is a person who is classified by the employer on both payroll and personnel records as:

- Staff and administrators who are employed in positions that require 30 or more hours of work per week and at least 1,560 hours each year;
- All full-time faculty;
- Part-time teaching faculty who are appointed annually or per semester and teach at least 27 undergraduate credit hours or 18 graduate credit hours per academic year; or,
- Staff, administrators and faculty who have been benefit-eligible under any bullet above for the 5 years prior to entering a phased retirement period as defined under university policy #323, for a maximum of three years prior to retirement.

For purposes of this Plan, an eligible Employee does not include the following classifications of workers as determined by the employer in its sole discretion:

- Temporary or leased employees.
- Students on work study programs.
- An Independent Contractor who signs an agreement with the employer as an Independent Contractor or other Independent Contractors as defined in this document.
- A consultant who is paid on other than a regular wage or salary by the employer.
- A member of the employer's Board of Directors, an owner, partner, or officer, unless engaged in the conduct of the business on a full-time regular basis.

For purposes of this Plan, eligibility requirements are used only to determine a person's initial eligibility for coverage under this Plan. An Employee will retain eligibility for coverage under this Plan if the Employee is temporarily absent on an approved sabbatical or medical leave of absence, with the expectation of returning to work following the approved leave as determined by the employer. The employer's classification of an individual is conclusive and binding for purposes of determining eligibility under this Plan. No reclassification of a person's status, for any reason, by a third-party, whether by a court, governmental agency or otherwise, without regard to whether or not the employer agrees to such reclassification, shall change a person's eligibility for benefits.

An **eligible Dependent** includes:

Your legal spouse who is a husband or wife of the opposite sex in accordance with the federal Defense of Marriage Act provided he or she is not covered as an Employee under this Plan. For purposes of eligibility under this Plan, a legal spouse also includes a Common Law Marriage spouse if such partnership is recognized as a legal marriage in the State of Texas. When a person is no longer Your legal spouse due to legal separation or divorce, or not meeting the definition of Common Law Marriage spouse, that person no longer qualifies as Your Dependent.

Effective: 07-01-2006

- A Dependent child until the child reaches his or her 19th birthday. The term “**child**” includes the following Dependents who meet the eligibility criteria listed below:
 - A natural biological child;
 - A step child;
 - A legally adopted child or a child legally Placed for Adoption as granted by action of a federal, state or local governmental agency responsible for adoption administration or a court of law if the child has not attained age 18 as of the date of such placement;
 - A child under Your legal guardianship as ordered by a court;
 - A child who is considered an alternate recipient under a Qualified Medical Child Support Order;

Eligibility Criteria: To be an eligible Dependent child, the following conditions must all be met:

- Legally qualify to be claimed as a tax exemption on the Employee's or spouse's federal income tax return.
- A Dependent child must be unmarried.
- A Dependent child will not be covered if the child is covered as a Dependent of another Employee at this company.

Dependents covered by this Plan must qualify as a Dependent for purposes of Section 105(b) of the Internal Revenue Code. In the event of conflict, Section 105(b) will govern.

EXTENDED COVERAGE FOR DEPENDENT CHILDREN:

Coverage under this Plan may be extended for a Dependent child if that child was covered by this Plan on the day before the child's 19th birthday, and the following conditions are met:

- A covered Dependent child who is attending high school or an Accredited Institution of Higher Education as a Full-Time Student will continue to be eligible until the end of the month in which the child turns age 25 or graduates, whichever is earlier. For purposes of this definition, a student who finishes the spring term shall be deemed a student throughout the summer if the student has enrolled for the following fall term, regardless of whether or not such student enrolls for the summer term. If the student fails to return to an accredited school on a full-time basis following the summer break for reasons other than Illness or Injury, the Plan has the right to be reimbursed from the student or Employee for any medical claims paid during the summer months; or
- If You have a Dependent child covered under this Plan who is mentally or physically disabled, that child's health coverage may continue beyond the day the child would cease to be a Dependent under the terms of this Plan. You must submit written proof that the child meets these conditions within 30 days after the day coverage would normally end. The Plan may, for two years, ask for additional proof at any time, after which the Plan can ask for proof not more than once a year. Coverage will continue for as long as he or she is:
 - Dependent on You for more than half of his or her support; and
 - Not able to hold a self-sustaining job due to the disability; and
 - Required proof is submitted as described above; and
 - The Employee is still covered under this Plan.

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

EFFECTIVE DATE OF EMPLOYEE'S COVERAGE

Your coverage will begin on the later of:

- If You apply within 30 days of hire, Your coverage will become effective the first day of the month following Your date of hire; or
- If You apply after 30 days of hire, You will be considered a Late Enrollee. Coverage for a Late Enrollee will become effective on the first of the month following the completion of a six-month waiting period or July 1 following application during the annual open enrollment period, whichever comes first. (Persons who apply under the Special Enrollment provision are not considered Late Enrollees).
- If You are eligible to enroll under the Special Enrollment Provision, Your coverage will become effective on the date set forth under the Special Enrollment Provision if application is made within 30 days of the event.

EFFECTIVE DATE OF COVERAGE FOR YOUR DEPENDENTS

Your Dependent will become covered on the later of:

- The date Your coverage with the Plan begins if You enroll the Dependent at that time; or
- The date You acquire Your Dependent if application is made within 30 days of acquiring the Dependent; or
- July 1 following application during the annual open enrollment period. If You request coverage for Your Dependent more than 30 days from Your hire date, or more than 30 days following the date You acquire the Dependent, the Dependent will be considered a Late Enrollee and coverage will start either on the first of the month following the completion of a six-month waiting period or July 1 following application during the annual open enrollment period, whichever comes first; or
- If Your Dependent is eligible to enroll under the Special Enrollment Provision, the Dependent's coverage will become effective on the date set forth under the Special Enrollment Provision, if application is made within 30 days following the event; or
- The date specified in a Qualified Medical Child Support Order.

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

ANNUAL OPEN ENROLLMENT PERIOD

Eligible Employees and/or their Dependents who have previously waived coverage under this Plan can apply for coverage during the annual open enrollment period. Similarly, Covered Persons who wish to switch to a different health plan that this company offers may request the change during the annual open enrollment period.

If You and/or Your Dependent become covered under this Plan as a result of electing coverage during the annual group open enrollment period, the following shall apply:

- The annual open enrollment period shall typically take place in May of each year. Exact dates for Open Enrollment are communicated in writing to the Employees prior to April 30th of each Plan year; and
- This Plan does not apply to charges for services performed or treatment received prior to the Effective Date of the Covered Person's coverage; and

The Effective Date of coverage shall be July 1 following the annual open enrollment period.

SPECIAL ENROLLMENT PROVISION

Under the Health Insurance Portability and Accountability Act

Effective: 07-01-2006

This Plan gives eligible persons special enrollment rights under this Plan if there is a loss of other health coverage or a change in family status as explained below. The coverage choices that will be offered to You will be the same choices offered to other similarly situated Employees.

LOSS OF HEALTH COVERAGE

Current Employees and their Dependents have a special opportunity to enroll for coverage under this Plan if there is a loss of other health coverage. Your loss of other health coverage triggers special enrollment rights only if other coverage was in effect at the time You declined coverage. The Plan will not recognize Your special enrollment right due to a loss of coverage if other coverage was not in effect at the time You declined enrollment. You declined enrollment if You do not enroll in the Plan during the Plan's annual open enrollment period, a special enrollment period or upon COBRA being offered.

You and/or Your Dependents may enroll for health coverage under this Plan due to loss of health coverage if the following conditions are met:

- You and/or Your Dependents were covered under a group health plan or health insurance policy at the time coverage under this Plan is offered; and
- You and/or Your Dependent stated in writing that the reason for declining coverage was due to coverage under another group health plan or health insurance policy; and
- The coverage under the other group health plan or health insurance policy was:
 - COBRA continuation coverage and that coverage was exhausted; or
 - Terminated because the person was no longer eligible for coverage under the terms of that plan or policy; or
 - Terminated and no substitute coverage is offered; or
 - Exhausted due to an individual meeting or exceeding a lifetime limit on all benefits; or
 - No longer receiving any monetary contribution toward the premium from the employer.

You or Your Dependent must request and apply for coverage under this Plan no later than 30 calendar days after the date the other coverage ended, or in situations where a Covered Person meets or exceeds a lifetime limit on all benefits, no later than 30 calendar days after a claim is denied for that reason. The Plan will assume that the written explanation of benefits (EOB) form is received five calendar days after the Plan mails the EOB form.

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

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

CHANGE IN FAMILY STATUS

Current Employees and their Dependents, COBRA Qualified Beneficiaries and other eligible persons have a special opportunity to enroll for coverage under this Plan if there is a change in family status.

If a person becomes Your eligible Dependent through marriage, birth, adoption or Placement for Adoption, the Employee, spouse and newly acquired Dependent(s) who are not already enrolled, may enroll for health coverage under this Plan during a special enrollment period. You must request and apply for coverage within 30 calendar days of marriage, birth, adoption or Placement for Adoption.

EFFECTIVE DATE OF COVERAGE UNDER SPECIAL ENROLLMENT PROVISION

If You properly apply for coverage during this special enrollment period, the coverage will become effective:

- In the case of marriage, on the first day of the first calendar month following the date of marriage; or
- In the case of a Dependent's birth, on the date of such birth; or
- In the case of a Dependent's adoption, the date of such adoption or Placement for Adoption; or
- In the case of loss of coverage, the first day of the month following loss of coverage.

TERMINATION

Effective: 07-01-2006

EMPLOYEE'S COVERAGE

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

- The end of the period for which Your last contribution is made, if You fail to make any required contribution towards the cost of coverage when due; or
- The date this Plan is canceled; or
- The date coverage for Your benefit class is canceled; or
- The last day of the month in which You tell the Plan to cancel Your coverage if You are voluntarily canceling it while remaining eligible because of change in status, special enrollment, or at open enrollment periods; or
- The last day of the month in which You are no longer a member of a covered class, as determined by the employer except as follows:
 - Coverage is being continued during a period of approved Sabbatical Leave or other authorized Leave of Absence (other than under the Family Medical Leave Act). Under such circumstances, coverage may be continued in accordance with the Employer's Personnel Policies and Procedures, but no longer than 365 days from the date active work ceased. At the end of the specified period, the Employee's employment will be deemed to have terminated for the purposes of coverage under this Plan, and the Employee may be eligible for continuation under COBRA.
 - Cessation of work is due to an approved Leave of Absence under the Family Medical Leave Act of 1993, and any amendments thereto. In that event, coverage may be continued for up to twelve (12) weeks, in compliance with the Family and Medical Leave Act of 1993.

If coverage is to be continued as shown above, required contributions, if any, must be made by the covered Employee in accordance with the agreement reached between the Employee and Employer prior to the leave or layoff becoming effective. Failure to do so will result in a loss of eligibility for continuance under this Plan provision.

Continuation of Coverage During Family and Medical Leave: If absent from work because of an approved leave of absence under the Family and Medical Leave Act of 1993 coverage may be continued, until terminated by the Company, but no longer than 12 weeks. In such case: (1) the amount of coverage shall be the amount for which the Employee was covered on his last day of active work, and (2) the Employee may be required to pay the full, unsubsidized cost for such coverage. At the end of the specified period, the Employee's employment will be deemed to have terminated for the purposes of coverage under this Plan, and the Employee may be eligible for continuation under COBRA.

- If You are temporarily absent from work due to active military duty, refer to USERRA under USERRA section; or

- The last day of the month in which Your employment ends; or
- The date in which You reach Your individual lifetime maximum under this Plan; or
- The date You submit a false claim or are involved in any other form of fraudulent act related to this Plan.

YOUR DEPENDENT'S COVERAGE

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

- The end of the period for which Your last contribution is made, if You fail to make any required contribution toward the cost of Your Dependent's coverage when due; or
- The last day of the month in which Your coverage ends; or
- The last day of the month in which Your Dependent no longer meets the definition of Dependent; or
- The date Dependent coverage is no longer offered under this Plan; or
- The last day of the month in which You tell the Plan to cancel Your Dependent's coverage if You are voluntarily canceling it while remaining eligible because of change in status, special enrollment, or at open enrollment periods; or
- The date in which the Dependent reaches the individual lifetime maximum under this Plan; or
- The last day of the month in which the Dependent becomes covered as an Employee under this Plan; or
- The date You or Your Dependent submits a false claim or are involved in any other form of fraudulent act related to this Plan.

REINSTATEMENT OF COVERAGE

If Your coverage ends due to termination of employment, leave of absence or lay-off and You later return to active work, You must meet all requirements of a new Employee. Refer to the information on Family and Medical Leave Act or Uniformed Services Employment and Reemployment Act for possible exceptions, or contact Your Human Resources or Personnel office.

PRE-EXISTING CONDITION PROVISION

Effective: 07-01-2006

A Pre-Existing Condition means an Illness or Injury for which medical advice, diagnosis, care or treatment was recommended or received within the six consecutive month period ending on the Covered Person's Enrollment Date. Medical advice, diagnosis, care or treatment (including taking prescription drugs) is taken into account only if it is recommended or received from a licensed Physician.

This Plan has an exclusion for Pre-Existing Conditions. Benefits will not be paid for Covered Expenses for a Pre-Existing Condition until the earliest of the following:

- 12 consecutive months from the Covered Person's Enrollment Date, if You apply for coverage within 30 days of hire or under special enrollment; or
- 12 consecutive months from the Covered Person's Enrollment Date, if the Covered Person is considered a Late Enrollee.

Benefits will then be payable for Covered Expenses Incurred for a Pre-Existing Condition after such period of time, reduced by Creditable Coverage as described below.

EXCEPTIONS

The Pre-Existing Condition exclusion does not apply to:

- Any person who, on the Enrollment Date, had 12 consecutive months of Creditable Coverage.
- Pregnancy, including complications.
- A newborn Dependent child if application for enrollment is made within 30 days of birth, or if any Creditable Coverage is obtained for the newborn within 30 days after the date of birth.
- An adopted Dependent child or Dependent child Placed for Adoption under the age of 18, if application for enrollment is made within 30 days of adoption or Placement for Adoption, or if any Creditable Coverage is obtained for the Dependent child within 30 days of adoption or Placement for Adoption.
- Genetic information, in the absence of a diagnosis of an Illness related to such information. For example, if You have a family history of diabetes but You Yourself have had no problem with diabetes, the Plan will not consider diabetes to be a Pre-Existing Condition just because You have a family history of this disease.
- Treatment recommendations made prior to the six consecutive month period before the Enrollment Date when the Covered Person did not act upon the recommendation.

REDUCTION OF PRE-EXISTING CONDITION EXCLUSION TIME PERIOD (Creditable Coverage)

If on the Enrollment Date, a Covered Person has less than 12 consecutive months of Creditable Coverage, the Plan will reduce the length of the Pre-Existing Condition exclusion period for each day of Creditable Coverage the Covered Person had in determining whether the Pre-Existing Condition exclusion applies.

Creditable Coverage means that You had coverage under a group health plan, health insurance policy, Medicare or any one of several other health plans as described in the Glossary of Terms section of this document, and Your coverage was not interrupted by a Significant Break in Coverage.

If a Covered Person has a Significant Break in Coverage, any days of Creditable Coverage that occur before the Significant Break in Coverage will not be counted by the Plan to reduce the Pre-Existing Condition exclusion time period. Waiting Periods will not count towards a Significant Break in Coverage.

CERTIFICATES OF CREDITABLE COVERAGE

New Employees and covered Dependents are encouraged to get a Certificate of Creditable Coverage from the person's prior employer or insurance company as soon as possible. If You are having difficulty getting this, contact Your Human Resources or Personnel office for assistance.

In addition, Covered Persons will receive a Certificate of Creditable Coverage from the Plan when the person loses coverage under this group health Plan, when the person loses COBRA coverage, or upon a written request to the Plan.

You are encouraged to keep these Certificates in a safe place in case You get coverage under another health plan that has a pre-existing condition exclusion provision. By proving that You had prior Creditable Coverage, You may be able to have the pre-existing condition exclusion period reduced or eliminated.

YOUR RIGHT TO REQUEST A REVIEW OF A DETERMINATION OF PRE-EXISTING CONDITION EXCLUSION PERIOD

If You feel that a determination of the pre-existing condition exclusion (PCE) period is incorrect, You may submit a written request for the review.

Send Your request to:

FISERV HEALTH PLAN ADMINISTRATORS INC
ENROLLMENT SERVICES
PO BOX 8052
WAUSAU WI 54402-8052

Your written request must be made within 60 days from the date of the notice. However, if Your request is based on additional evidence that shows that You had more Creditable Coverage than recognized originally, You may take longer.

Your written request should state the reasons that You believe the original determination is incorrect and include any additional facts that support Your position. You should submit any additional evidence that shows that You had more Creditable Coverage.

Your request will usually be decided within 60 days after it is submitted. If additional time is needed to complete the review, You will be notified. You will be notified in writing of the decision on Your request if You submit additional evidence to consider or if the original Determination of PCE period is modified. If You do not receive notice of a decision within 60 calendar days after You submit the request, this means that the original decision was upheld.

Similar to an initial determination, any new determination will set forth:

- The specific reason(s) for the decision; and
- The specific Plan provision(s) and other documents or information on which the decision is based.

COBRA CONTINUATION OF COVERAGE

Effective: 07-01-2006

Important. Read this entire provision to understand Your COBRA rights and obligations.

The following is a summary of the federal continuation requirements under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended. This summary provides You with general notice of Your rights under COBRA, but is not intended to satisfy all of the requirements of federal law. Your employer or the COBRA Administrator will provide additional information to You as required.

The COBRA Administrator for this Plan is: Fiserv Health Plan Administrators, Inc.

INTRODUCTION

Federal law gives certain persons, known as Qualified Beneficiaries, the right to continue their health care benefits beyond the date that they might otherwise terminate. The Qualified Beneficiary must pay the entire cost of the COBRA continuation coverage, plus an administrative fee. In general, a Qualified Beneficiary has the same rights and obligations under the Plan as an active participant.

A Qualified Beneficiary may elect to continue coverage under this Plan if such person's coverage would terminate because of a life event known as a Qualifying Event, outlined below. When a Qualifying Event causes (or will cause) a Loss of Coverage, then the Plan must offer COBRA continuation coverage. Loss of Coverage means more than losing coverage entirely. It means that a person ceases to be covered under the same terms and conditions that are in effect immediately before the Qualifying Event. In short, a Qualifying Event plus a Loss of Coverage triggers COBRA.

Generally, You, Your covered spouse, and Dependent children may be Qualified Beneficiaries and eligible to elect COBRA continuation coverage even if the person is already covered under another employer-sponsored group health plan or is enrolled in Medicare at the time of the COBRA election.

COBRA CONTINUATION COVERAGE FOR QUALIFIED BENEFICIARIES

The length of COBRA continuation coverage that is offered varies based on who the Qualified Beneficiary is and what **Qualifying Event** is experienced as outlined below.

If You are an Employee, You will become a Qualified Beneficiary if You lose coverage under the Plan because either one of the following Qualifying Events happens:

Qualifying Event	Length of Continuation
• Your employment ends for any reason other than Your gross misconduct	up to 18 months
• Your hours of employment are reduced	up to 18 months

(There are two ways in which this 18 month period of COBRA continuation coverage can be extended. See the section below entitled "Your Right to Extend Coverage" for more information.)

Effective: 07-01-2006

If you are the spouse of an Employee, you will become a Qualified Beneficiary if you lose coverage under the Plan because any of the following Qualifying Events happen:

Qualifying Event	Length of Continuation
• Your spouse dies	up to 36 months
• Your spouse's hours of employment are reduced	up to 18 months
• Your spouse's employment ends for any reason other than his or her gross misconduct	up to 18 months
• Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both)	up to 36 months
• You become divorced or legally separated from your spouse	up to 36 months

The Dependent children of an Employee become Qualified Beneficiaries if they lose coverage under the Plan because any of the following Qualifying Events happen:

Qualifying Event	Length of Continuation
• The parent-Employee dies	up to 36 months
• The parent-Employee's employment ends for any reason other than his or her gross misconduct	up to 18 months
• The parent-Employee's hours of employment are reduced	up to 18 months
• The parent-Employee becomes entitled to Medicare benefits (Part A, Part B, or both)	up to 36 months
• The parents become divorced or legally separated	up to 36 months
• The child stops being eligible for coverage under the plan as a Dependent	up to 36 months

COBRA NOTICE PROCEDURES

ABOUT THE NOTICE(S) YOU ARE REQUIRED TO PROVIDE UNDER THIS SUMMARY PLAN DESCRIPTION

To be eligible to receive COBRA continuation coverage, covered Employees and Qualified Beneficiaries have certain obligations to provide written notices to the administrator. You should follow the rules described in this procedure when providing notice to the administrators, either Your employer or the COBRA Administrator.

A Qualified Beneficiary's written notice must include all of the following information: (A form to notify Your COBRA Administrator is available upon request.)

- The Qualified Beneficiary's name, their current address and complete phone number,
- The group number, name of the employer that the Employee was with,
- Description of the Qualifying Event (i.e., the life event experienced), and
- The date that the Qualifying Event occurred.

Send all notices or other information required to be provided by this Summary Plan Description in writing to:

**FISERV HEALTH PLAN ADMINISTRATORS INC
COBRA ADMINISTRATION
PO BOX 8046
WAUSAU WI 54402-8046
Phone Number: (715) 841-2918 or (800) 826-9781 x2918**

COBRA NOTICE REQUIREMENTS AND ELECTION PROCESS

PROVIDING NOTICE OF THE QUALIFYING EVENT

Your employer will give notice when coverage terminates due to Qualifying Events that are the Employee's termination of employment or reduction in hours, death of the Employee, or the Employee becoming eligible for Medicare benefits (Part A, Part B, or both). Your employer will notify the COBRA Administrator within 30 calendar days when these events occur.

You must give notice in the case of other Qualifying Events that are divorce or legal separation of the Employee and a spouse, a Dependent child ceasing to be covered under a plan, or a second Qualifying Event. The covered Employee or Qualified Beneficiary must provide written notice to Your employer in order to ensure rights to COBRA continuation coverage. You must provide this notice within the 60-calendar day period that begins on the latest of:

- The date of the Qualifying Event; or
- The date on which there is a Loss of Coverage (or would lose coverage); or
- The date on which the Qualified Beneficiary is informed of this notice requirement by receiving this Summary Plan Description or the General COBRA Notice.

Once You have provided notice of the Qualifying Event, then Your employer will notify the COBRA Administrator within 30 calendar days from that date.

The COBRA Administrator will, in turn, provide an election notice to each Qualified Beneficiary within 14 calendar days of receiving notice of a Qualifying Event from the employer, covered Employee or the Qualified Beneficiary.

MAKING AN ELECTION TO CONTINUE YOUR GROUP HEALTH COVERAGE

Each Qualified Beneficiary has the independent right to elect COBRA continuation coverage. You will receive a COBRA Election Form that You must complete if You wish to elect to continue Your group health coverage. A Qualified Beneficiary may elect COBRA coverage at any time within the 60-day election period. The election period ends 60 calendar days after the later of:

- The date Your Plan coverage terminates due to a Qualifying Event; or
- The date the Plan Administrator provides the Qualified Beneficiary with an election notice.

A Qualified Beneficiary must notify the COBRA Administrator of their election in writing to continue group health coverage and must make the required payments when due in order to remain covered. If You do not choose COBRA continuation coverage within the 60-day election period, Your group health coverage will end on the day of Your Qualifying Event.

PAYMENT OF CLAIMS

No claims will be paid under this Plan for services that You receive on or after the date You lose coverage due to a Qualifying Event. If, however, You decide to elect COBRA continuation coverage, Your group health coverage will be reinstated back to the date You lost coverage, provided that You properly elect COBRA on a timely basis and make the required payment when due. Any claims that were denied during the initial COBRA election period will be reprocessed once the COBRA Administrator receives Your completed COBRA Election Form and required payment.

PAYMENT FOR CONTINUATION COVERAGE

Qualified Beneficiaries are required to pay the entire cost of continuation coverage, which includes both the employer and Employee contribution. This may also include a 2% additional fee to cover administrative expenses (or in the case of the 11-month extension due to disability, a 50% additional fee). Fees are subject to change at least once a year.

If Your employer offers annual open enrollment opportunities for active Employees, each Qualified Beneficiary will have the same options under COBRA (for example, the right to add or eliminate coverage for Dependents). The cost of continuation coverage will be adjusted accordingly.

The **initial payment** is due no later than 45 calendar days after the Qualified Beneficiary elects COBRA as evidenced by the postmark date on the envelope. This first payment must cover the cost of continuation coverage from the time Your coverage under the Plan would have otherwise terminated, up to the time You make the first payment. If the initial payment is not made within the 45-day period, then Your coverage will remain terminated without the possibility of reinstatement. There is no grace period for the initial payment.

The due date for **subsequent payments** is typically the first day of the month for any particular period of coverage, however You will receive specific payment information including due dates, when You become eligible for and elect COBRA continuation coverage. Payments postmarked within a 30 day grace period following the due date are considered timely payments.

If, for whatever reason, any Qualified Beneficiary receives any benefits under the Plan during a month for which the payment was not made on time, then You will be required to reimburse the Plan for the benefits received.

NOTE: Payment will not be considered made if a check is returned for non-sufficient funds.

YOUR NOTICE OBLIGATIONS WHILE ON COBRA

Always keep the COBRA Administrator informed of the current addresses of all Covered Persons who are or who may become Qualified Beneficiaries. Failure to provide this information to the COBRA Administrator may cause You or Your Dependents to lose important rights under COBRA.

In addition, after any of the following events occur, written notice to the COBRA Administrator is **required within 30 calendar days of:**

- The date any Qualified Beneficiary gets married. Refer to the Special Enrollment section of this Plan for additional information regarding special enrollment rights.
- The date a child is born to, adopted by, or Placed for Adoption by a Qualified Beneficiary. Refer to the Special Enrollment section of this Plan for additional information regarding special enrollment rights.
- The date of a final determination by the Social Security Administration that a disabled Qualified Beneficiary is no longer disabled.
- The date any Qualified Beneficiary becomes covered by another group health plan.
- The date the COBRA Administrator or the Plan Administrator requests additional information from You. You must provide the requested information within 30 calendar days.

LENGTH OF CONTINUATION COVERAGE

COBRA coverage is available up to the maximum periods described below, subject to all COBRA regulations and the conditions of this Summary Plan Description:

- For Employees and Dependents. 18 months from the Qualifying Event if due to the Employee's termination of employment or reduction of work hours. (If an active Employee enrolls in Medicare before his or her termination of employment or reduction in hours, then the covered spouse and Dependent children would be entitled to COBRA continuation coverage for up to the greater of 18 months from the Employee's termination of employment or reduction in hours, or 36 months from the earlier Medicare enrollment date, whether or not Medicare enrollment is a Qualifying Event.)

- For Dependents only. 36 months from the Qualifying Event if coverage is lost due to one of the following events:
 - Employee's death.
 - Employee's divorce or legal separation.
 - Former Employee becomes enrolled in Medicare.
 - A Dependent child no longer being a Dependent as defined in the Plan.

YOUR RIGHT TO EXTEND THE LENGTH OF COBRA CONTINUATION COVERAGE

While on COBRA continuation coverage, certain Qualified Beneficiaries may have the right to extend continuation coverage provided that written notice to the COBRA Administrator is given as soon as possible but no later than the **required** timeframes stated below.

Social Security Disability Determination (For Employees and Dependents): In the event that You are determined by the Social Security Administration to be disabled, You may be eligible for up to 29 months of COBRA continuation coverage.

You must give the COBRA Administrator the Social Security Administration letter of disability determination within 60 days of the later of:

- The date of the SSA disability determination;
- The date the Qualifying Event occurs;
- The date the Qualified Beneficiary loses (or would lose) coverage; or
- The date on which the Qualified Beneficiary is informed of the requirement to notify the COBRA Administrator of the disability by receiving this Summary Plan Description or the General COBRA Notice.

Second Qualifying Events: (Dependents Only) If Your family experiences another Qualifying Event while receiving 18 months of COBRA continuation coverage, the spouse and Dependent children in Your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second event is provided to the COBRA Administrator. This additional coverage may be available to the spouse or Dependent children if the Employee or former Employee dies, becomes entitled to Medicare (part A, part B or both) or is divorced or legally separated, or if the Dependent child stops being eligible under the Plan as a Dependent. These events will only lead to the extension when the event would have caused the spouse or Dependent child to lose coverage under the Plan had the first qualifying event not occurred.

You must provide the notice of a second Qualifying Event within a 60-day period that begins to run on the latest of:

- The date of the Second Qualifying Event; or
- The date the Qualified Beneficiary loses (or would lose) coverage; or
- The date on which the Qualified Beneficiary is informed of the requirement to notify the COBRA Administrator of the second Qualifying Event by receiving this Summary Plan Description or the General COBRA Notice.

EARLY TERMINATION OF COBRA CONTINUATION

COBRA continuation coverage may terminate before the end of the above maximum coverage periods for any of the following reasons:

- The employer ceases to maintain a group health plan for any Employees. (Note that if the employer terminates the group health plan that You are under, but still maintains another group health plan for other similarly-situated Employees, You will be offered COBRA continuation coverage under the remaining group health plan, although benefits and costs may not be the same).

- The required contribution for the Qualified Beneficiary's coverage is not paid on time.
- After electing COBRA continuation coverage, the Qualified Beneficiary becomes entitled to and enrolled with Medicare.
- After electing COBRA continuation coverage, the Qualified Beneficiary becomes covered under another group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition(s) for the beneficiary.
- The Qualified Beneficiary is found not to be disabled during the disability extension. The Plan will terminate the Qualified Beneficiary's COBRA continuation coverage one month after the Social Security Administration makes a determination that the Qualified Beneficiary is no longer disabled.
- Termination for cause, such as submitting fraudulent claims.

SPECIAL NOTICE (Read This If You Are Thinking Of Declining COBRA Continuation Coverage)

If You think You might need to get an **individual health insurance policy** soon, then electing COBRA continuation coverage now may protect some of Your rights. The Health Insurance Portability and Accountability Act (HIPAA) requires that all health insurance carriers who offer coverage in the individual market must accept any eligible individuals who apply for coverage without imposing pre-existing condition exclusions, under certain conditions. Some of those conditions pertain to COBRA continuation coverage. To take advantage of this HIPAA right, You must elect COBRA continuation coverage under this Plan and maintain it (by paying the cost of coverage) for the duration of Your COBRA continuation period. In the event that You need an individual health insurance policy, You must apply for coverage with an individual insurance carrier after You have exhausted Your COBRA continuation coverage and before You have a 63-day break in coverage.

If You think You will be getting **group health coverage** through a new employer, keep in mind that HIPAA requires employers to reduce pre-existing condition exclusion periods if You have less than a 63-day break in health coverage (Creditable Coverage).

DEFINITIONS

Qualified Beneficiary means a person covered by this group health Plan immediately before the Qualifying Event who is the Employee, the spouse of a covered Employee or the Dependent child of a covered Employee. This includes a child who is born to or Placed for Adoption with a covered Employee during the Employee's COBRA coverage period if the child is enrolled within the Plan's Special Enrollment Provision for newborns and adopted children. This also includes a child who was receiving benefits under this Plan pursuant to a Qualified Medical Child Support Order (QMCSO) immediately before the Qualifying Event.

Qualifying Event means Loss of Coverage due to one of the following:

- The death of the covered Employee.
- Voluntary or involuntary termination of the covered Employee's employment (other than for gross misconduct).
- A reduction in work hours of the covered Employee.
- Divorce or legal separation of the covered Employee from the Employee's spouse. (Also, if an Employee terminates coverage for his or her spouse in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the later divorce or legal separation may be considered a Qualifying Event even though the ex-spouse lost coverage earlier. If the ex-spouse notifies the Plan or the COBRA Administrator in writing within 60 calendar days after the later divorce or legal separation and can establish that the coverage was originally eliminated in anticipation of the divorce or legal separation, then COBRA coverage may be available for the period after the divorce or legal separation).

- The covered former Employee becomes enrolled in Medicare.
- A Dependent child no longer being a Dependent as defined by the Plan.

Loss of Coverage means any change in the terms or conditions of coverage in effect immediately before the Qualifying Event. Loss of Coverage includes change in coverage terms, change in plans, termination of coverage, partial Loss of Coverage, increase in Employee cost, as well as other changes that affect terms or conditions of coverage. Loss of Coverage does not always occur immediately after the Qualifying Event, but it must always occur within the applicable 18 or 36-month coverage period. A Loss of Coverage that is not caused by a Qualifying Event may not trigger COBRA.

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994

Effective: 07-01-2006

INTRODUCTION

Employers are required to offer COBRA-like health care continuation coverage to persons in the armed service if the absence for military duty would result in loss of coverage as a result of active duty. Employees on leave for military service must be treated like they are on leave of absence and are entitled to any other rights and benefits accorded to similarly situated Employees on leave of absence or furlough. If an employer has different types of benefits available depending on the type of leave of absence, the most favorable benefits must apply to Employees on military leave. Reinstatement following the military leave of absence cannot be subject to Pre-Existing Conditions and Waiting Periods.

COVERAGE

The maximum length of health care continuation coverage required under USERRA is the lesser of:

- 24 months beginning on the day that the Uniformed Service leave begins, or
- a period beginning on the day that the Service leave begins and ending on the day after the Employee fails to return to or reapply for employment within the time allowed by USERRA.

USERRA NOTICE AND ELECTION

An Employee or an appropriate officer of the uniformed service in which his or her service is to be performed must notify the employer that the Employee intends to leave the employment position to perform service in the uniformed services. An Employee should provide notice as far in advance as is reasonable under the circumstances. The Employee is excused from giving notice due to military necessity, or if it is otherwise impossible or unreasonable under all the circumstances.

Upon notice of intent to leave for uniformed services, Employees will be given the opportunity to elect USERRA continuation. Unlike COBRA, Dependents do not have an independent right to elect USERRA coverage. Election, payment and termination of the USERRA extension will be governed by the same requirements set forth under the COBRA Section, to the extent these COBRA requirements do not conflict with USERRA.

PAYMENT

If the military leave orders are for a period of 30 days or less, the Employee is not required to pay more than the amount he or she would have paid as an active Employee. If an Employee elects to continue health coverage pursuant to USERRA, such Employee and covered Dependents will be required to pay up to 102% of the full premium for the coverage elected.

EXTENDED COVERAGE RUNS CONCURRENT

Employees and their Dependents may be eligible for both COBRA and USERRA at the same time. Election of either the COBRA or USERRA extension by an Employee on leave for military service will be deemed an election under both laws, and the coverage offering the most benefit to the Employee will generally be extended. Coverage under both laws will run concurrently. Dependents who chose to independently elect extended coverage will only be deemed eligible for COBRA extension because they are not eligible for a separate, independent right of election under USERRA.

PROVIDER NETWORK

Knowing which Network Your provider belongs to will help You determine how much You will need to pay for certain services. To obtain the highest level of benefits under this Plan, Covered Persons need to see an In-Network provider, however this Plan does not limit a Covered Person's right to choose his or her own provider or medical care. If a medical expense is not a Covered Expense under this Plan, or is subject to a limitation or exclusion, a Covered Person still has the right and privilege to receive such medical service at his or her own personal expense.

The word "**Network**" means that an outside organization has contracted with various providers to provide health care services to Covered Persons at negotiated fees. Providers who participate in a Network have agreed to accept the negotiated fees as payment in full, including any portion of the fees that the Covered Person must pay due to the Deductible, Participation amounts or other out-of-pocket expenses. A provider who does not participate in a Network may bill You for additional fees over and above what the Plan pays.

To find out which Network Your provider belongs to, please refer to the Provider Directory, or call the toll-free number that is listed on the back of the identification card that You receive for this Plan. The participation status of providers may change from time to time.

- If Your provider belongs to one of the following Networks, Your claims for Covered Expenses will normally be processed in accordance with the **In-Network** benefit levels that are listed on the Schedule of Benefits:

Texas True Choice

- If Your provider belongs to one of the following Networks, Your claims for Covered Expenses will normally be processed in accordance with the **Out-of-Network** benefit levels that are listed on the Schedule of Benefits, but the providers have agreed to discount their fees. This means that the Covered Person may pay a little less for a particular claim.

PHCS Healthy Directions

- If You receive services from any other provider, Your claims for Covered Expenses will normally be processed in accordance with the **Out-of-Network** benefit levels that are listed on the Schedule of Benefits. These providers charge their normal rates for services, so Covered Persons may need to pay more. The Covered Person is responsible for paying the balance of these claims after the Plan pays its portion, if any.

- **For Transplant Services at a Designated Transplant Facility, the Network is:**

United Resource Network

Provider Directory Information

Each covered Employee, those on COBRA, and children or guardians of children who are considered alternate recipients under a Qualified Medical Child Support Order, will automatically be given or electronically made available, a separate document, at no cost, that lists the participating Network providers for this Plan. The Employee should share this document with other covered individuals in Your household. If a covered spouse or Dependent wants a separate provider list, they can give the Plan Administrator a written request. The Plan Administrator may make a reasonable charge to cover the cost of furnishing complete copies to the spouse or other covered Dependents.

Note: Students residing and enrolled in an out of state university will have coverage at the In-Network level of benefits. However, utilization of a PHCS participating provider will allow You access to discounts negotiated by PHCS. If You choose an Out-of-Network provider, any amount over the Usual and Customary amounts for that geographical area, will solely be Your responsibility in addition to Your Deductible, Co-pay, and any Out-of-Pocket expenses. Any amounts over Usual and Customary do not apply to the satisfaction of Your Deductible or Out-of-Pocket.

COVERED MEDICAL BENEFITS

Effective: 07-01-2006

This Plan provides coverage for the following covered benefits if services are authorized by a Physician and are Medically Necessary for the treatment of an Illness or Injury, subject to any limits, maximums, exclusions or other Plan provisions shown in this document. The Plan does not provide coverage for services if medical evidence shows that treatment is not expected to resolve, improve, or stabilize the Covered Person's condition, or that a plateau has been reached in terms of improvement from such services.

1. **Abortions (Elective):** Unless a Physician states in writing that:
 - The mother's life would be in danger if the fetus were to be carried to term, or
 - Abortion is medically indicated due to complications with the pregnancy.
2. **Abortions (Complications).** Complications arising from the result of an abortion are covered under the Plan.
3. **Acupuncture Treatment.** Treatment by acupuncture or acupressure when performed by a M.D. (Doctor of Medicine) or a D.O. (Doctor of Osteopathy.) Such treatment by any other provider will not be considered under this Plan.
4. **Allergy Testing and Treatment.**
5. **Ambulance Transportation:** Ground and air for Emergencies or Medically Necessary transportation.
6. **Anesthetics and their Administration.**
7. **Artificial Limbs, Eyes, and Larynx** when Medically Necessary for Activities of Daily Living, as a result of an Illness or Injury.
8. **Braces, Supports, Trusses, Elastic Compression Stockings and Casts.**
9. **Cardiac Pulmonary Rehabilitation** when Medically Necessary for Activities of Daily Living, as well as a result of an Illness or Injury.
10. **Cardiac Rehabilitation** includes:
 - Phase I, while the Covered Person is an Inpatient.
 - Phase II, while the Covered Person is in a Physician supervised Outpatient monitored exercise program. Services generally begin within 30 days after discharge from the Hospital.
11. **Chiropractic Treatment** by a Qualified chiropractor. Services for diagnosis by physical examination and plain film radiography, and Medically Necessary treatments for musculoskeletal conditions.
12. **Cleft Palate and Cleft Lip:** Benefits will be provided for the treatment of cleft palate or cleft lip. Such coverage includes Medically Necessary oral surgery and pre-graft palatal expander.
13. **Congenital Heart Disease:** If a Covered Person is being treated for congenital heart disease, and chooses to obtain the treatment at a United Resource Transplant Network (URN) facility, the Plan will provide the same housing and travel benefits that are outlined in the Transplant Benefits section and on the Transplant Schedule of Benefits.
14. **Contraceptives:** This Plan provides benefits for Prescription contraceptives, regardless of purpose. Prescription contraceptives that You self-administer will be processed under the Prescription Benefits section of this document (oral tablets, patches, and self-insertable vaginal devices containing contraceptive hormones). Prescription contraceptives that require a Physician to administer a hormone shot or insert a device will be processed under the Covered Medical Benefits in this document.

Effective: 07-01-2006 Durable Medical Equipment

Effective: 07-01-2005 Foot Care

15. **Cornea Transplants** are payable at the percentage listed under All Other Covered Expenses on the Schedule of Benefits.

16. **Dental Services** include:

- The care and treatment of natural teeth and gums if an Injury is sustained in an Accident, excluding implants.
- Inpatient or Outpatient Hospital charges including professional services for x-ray, lab, and anesthesia while in the Hospital if Medically Necessary.
- Removal of all teeth at an Inpatient or Outpatient Hospital or dentist's office if removal of the teeth is part of standard medical treatment that is required before the Covered Person can undergo radiation therapy for a covered medical condition.
- Dental prostheses used to treat birth defects, trauma, or Accidental Injury; or as used with respect to radiation, chemotherapy, or surgery for cancer.

17. **Diabetes Treatment:** Charges Incurred for the treatment of diabetes and diabetic self-management education programs and nutritional counseling. This also includes use of equipment or supplies, unless covered through the Prescription Benefits section. Charges are paid the same as any other illness.

18. **Durable Medical Equipment** subject to all of the following:

- The equipment must meet the definition of Durable Medical Equipment as defined in the Glossary of Terms. Examples include, but are not limited to crutches, wheelchairs, hospital-type beds and oxygen equipment.
- The equipment must be prescribed by a Physician.
- The equipment is subject to review under the Utilization Management Provision of this Plan, if applicable.
- The equipment will be provided on a rental basis, however such equipment may be purchased at the Plan's option. Any amount paid to rent the equipment will be applied towards the purchase price. In no case will the rental cost of Durable Medical Equipment exceed the purchase price of the item.
- The Plan will pay benefits for only ONE of the following: a manual wheelchair, motorized wheelchair or motorized scooter, unless Medical Necessity due to growth of the person or changes to the person's medical condition require a different product, as determined by the Plan.
- If the equipment is purchased, benefits will be payable for subsequent repairs excluding batteries, necessary to restore the equipment to a serviceable condition. If such equipment cannot be restored to a serviceable condition, replacement will be payable subject to prior approval by the Plan. In all cases, repairs or replacement due to abuse or misuse, as determined by the Plan, are not covered.
- This Plan covers taxes, shipping and handling charges for Durable Medical Equipment.

19. **Extended Care Facility Services:** Must be certified in advance. (Refer to the Utilization Management section). The following benefits are covered:

- Room and board.
- Miscellaneous services, supplies and treatments provided by an Extended Care Facility.

19. **Family Planning:** Consultation for family planning.

20. **Foot Care:** Removal of corns, calluses, toenails or subcutaneous tissue.

21. **Genetic Counseling or Testing.** Charges for amniocentesis testing, genetic testing, counseling and treatment when recommended by a Physician for a Covered Person who is 35 years of age or older at the time of delivery, or for a Physician-documented high-risk pregnancy or Physician-documented family history of genetic disorder. Any procedure intended solely for sex determination is not covered.
22. **Hearing Deficit Services** include exams, tests, services and supplies for other than preventive care, to diagnose and treat a medical condition.
23. **Home Health Care Services:** (Refer to Home Health Care section). The benefits also include Private Duty Nursing Services if medically necessary and pre-certified with Home Health Care under Home Health Care benefits and will apply to the Home Health Care maximum.
24. **Hospice Care Services:** Treatment given at a Hospice Care Facility must be in place of a stay in a Hospital or Extended Care Facility, and can include:
 - **Assessment:** includes an assessment of the medical and social needs of the Terminally Ill person, and a description of the care to meet those needs.
 - **Inpatient Care:** in a facility when needed for pain control and other acute and chronic symptom management, psychological and dietary counseling, physical or occupational therapy and part-time Home Health Care services.
 - **Outpatient Care:** Provides or arranges for other services as related to the Terminal Illness which include: Services of a Physician; physical or occupational therapy; nutrition counseling provided by or under the supervision of a registered dietitian.
 - **Bereavement Counseling:** Benefits are payable for bereavement counseling services which are received by a Covered Person's Close Relative. Counseling services must be given by a licensed social worker, licensed pastoral counselor, psychologist or psychiatrist. The services must be furnished within six months of death.

The Covered Person must be Terminally Ill with an anticipated life expectancy of about six months. Services, however, are not limited to a maximum of six months if continued Hospice Care is deemed appropriate by the Physician, up to the maximum hospice benefits available under the Plan.

25. **Hospital Services (Includes Inpatient Services, Surgical Centers and Birthing Centers).** The following benefits are covered:
 - Semi-private room and board. Any charge over a semi-private room charge will be a Covered Expense if determined by the Plan to be Medically Necessary.
 - Intensive care unit room and board.
 - Miscellaneous and ancillary services.
 - Blood, blood plasma and plasma expanders, when not available without charge.
26. **Hospital Services (Outpatient).**
27. **Infant Formula** administered through a tube as the sole source of nutrition for the Covered Person.
28. **Laboratory or Pathology Tests and Interpretation Charges** for covered benefits.
29. **Maternity Benefits** for Covered Persons include:
 - Prenatal and postnatal care.
 - Hospital room and board.
 - Obstetrical fees for routine prenatal care.
 - Vaginal delivery or Cesarean section.
 - Medically Necessary diagnostic testing.
 - Abdominal operation for intrauterine pregnancy or miscarriage.
 - Outpatient Birthing Centers.
 - Home deliveries.

30. **Mental Health Treatment** (Refer to Mental Health section).
31. **Nursery and Newborn Expenses Including Circumcision** are covered for the following children of the covered Employee or covered spouse: natural (biological) children and newborn children who are adopted or Placed for Adoption at the time of birth.
32. **Nutritional Supplements, Vitamins and Electrolytes** which are prescribed by a Physician and are administered through enteral feedings, provided they are the sole source of nutrition including supplies related to the feedings.
33. **Oral Surgery** includes:
- Excision of partially or completely impacted teeth.
 - Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth when such conditions require pathological examinations.
 - Surgical procedures required to correct accidental injuries of the jaws, cheeks, lips, tongue, roof and floor of the mouth.
 - Reduction of fractures and dislocations of the jaw.
 - External incision and drainage of cellulitis.
 - Incision of accessory sinuses, salivary glands or ducts.
 - Frenectomy (the cutting of the tissue in the midline of the tongue).
34. **Orthognathic, Prognathic and Maxillofacial Surgery** when Medically Necessary for a covered dependent child under age 19.
35. **Orthotic Appliances and Devices**, including the exam for required Prescription and fitting.
36. **Oxygen and Its Administration.**
37. **Physician Services** for covered benefits.
38. **Prescription Medication** which is administered or dispensed as take home drugs as part of treatment while in the Hospital or at a medical facility and that require a Physician's Prescription.
- (Refer to the Prescription Benefits section for coverage if You have a written Physician's Prescription and obtain medication from a pharmacy).
39. **Preventive / Routine Care** as listed under the Schedule of Benefits. This also includes preventive / routine care benefits for children.
40. **Radiation Therapy and Chemotherapy.**
41. **Radiology and Interpretation Charges.**
42. **Reconstructive Surgery** includes:
- Following a mastectomy (Women's Health and Cancer Rights Act)
The Covered Person must be receiving benefits in connection with a mastectomy in order to receive benefits for reconstructive treatments. Covered Expenses are reconstructive treatments which include all stages of reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance; and prostheses and complications of mastectomies, including lymphedemas. Charges for or in connection with implants or injections for augmentation or shaping of breast are not covered except following a Medically Necessary mastectomy.
Charges for or in connection with removal of breast prosthesis due to documented medical complications are covered; however, benefits will not be payable for replacement of any breast prosthesis that was originally placed as part of a voluntary breast augmentation. Charges for or in connection with breast reduction will not be covered.

- Surgery to restore bodily function that has been impaired by a congenital illness or anomaly, Accident, or from an infection or other disease of the involved part.
43. **Second Surgical Opinion** must be given by a board-certified specialist in the medical field relating to the surgical procedure being proposed. The Physician providing the second opinion must not be affiliated in any way with the Physician who rendered the first opinion.
 44. **Sleep Disorder/Sleep Apnea.** Charges for diagnosis and/or treatment of sleep disorders or sleep apnea of a covered dependent child will be considered and processed as any other illness. Charges for the Medically Necessary diagnostic testing and/or treatment of any kind of adult sleep disorders or sleep apnea (by any name called) will be covered under this Plan, subject to the maximum benefit shown on the Schedule of Benefits.
 45. **Sterilizations (Voluntary).**
 46. **Substance Abuse Services** (Refer to Substance Abuse section).
 47. **Surgery and Assistant Surgeon Services** if determined Medically Necessary by the Plan.
 48. **Temporomandibular Joint Disorder (TMJ) Services:** Benefits will be provided for the surgical and non-surgical treatment of TMJ. Surgical treatment is covered the same as any other illness. Covered services include intraoral devices or any other non-surgical method to alter the occlusion and/or vertical dimension. This does not cover orthodontic services.
 49. **Therapy Services:** Therapy must be ordered by a Physician and provided as part of the Covered Person's treatment plan. Services include:
 - **Occupational therapy** by a Qualified occupational therapist.
 - **Physical therapy** by a Qualified physical therapist.
 - **Respiratory therapy** by a Qualified respiratory therapist.
 - **Aquatic therapy** by a Qualified physical therapist.
 - **Massage therapy** by a Qualified chiropractor.
 - **Speech therapy** by a Qualified speech therapist.

The Plan allows coverage for occupational, physical, or speech therapy for Developmental Delays due to an Accident or illness such as Bell's palsy, CVA (stroke), apraxia, cleft palate/lip, recurrent/chronic otitis media, vocal cord nodules, Down's syndrome and cerebral palsy.

This Plan does not cover services that should legally be provided by a school.

50. **Tobacco Addiction:** Services, treatment or supplies related to addiction to or dependency on nicotine.
51. **Transplant Services** (Refer to Transplant section).
52. **Vision Care Services** (Refer to Vision Care section).
53. **Wigs, Toupees, Hairpieces** for hair loss due to cancer treatment or alopecia related to a medical condition.
54. **X-ray Services** for covered benefits.

HOME HEALTH CARE BENEFITS

Home Health Care services are provided for patients who are unable to leave their home, as determined by the Utilization Review Organization. You must be certified in advance before receiving services. Please refer to the Utilization Management section for more details. Covered services that are Medically Necessary include:

- Home visits that are in lieu of visits to the provider's office, and that do not exceed the Usual and Customary charge to perform the same service in a provider's office.
- Intermittent Nurse Services. Benefits are paid for only one nurse at any one time, not to exceed four hours per 24-hour period.
- Nutrition counseling provided by or under the supervision of a registered dietitian.
- Physical, occupational, respiratory and speech therapy provided by or under the supervision of a licensed therapist.
- Medical supplies, drugs, or medication prescribed by a Physician, and laboratory services to the extent that the Plan would have covered them under this Plan if the Covered Person had been in a Hospital.
- Private Duty Nursing.

A Home Health Care Visit is defined as: A visit by a nurse providing intermittent nurse services. Each visit includes up to a four-hour consecutive visit in a 24-hour period if Medically Necessary.

EXCLUSIONS

In addition to the items listed in the General Exclusions section, benefits will NOT be provided for any of the following:

- Homemaker or housekeeping services.
- Supportive environment materials such as handrails, ramps, air conditioners and telephones.
- Services performed by family members or volunteer workers.
- "Meals on Wheels" or similar food service.
- Separate charges for records, reports or transportation.
- Expenses for the normal necessities of living such as food, clothing and household supplies.
- Legal and financial counseling services.

TRANSPLANT BENEFITS (Dual Choice)

Effective: 07-01-2006

Refer to the Utilization Management section of this document for certification requirements

Your coverage provides a choice for transplant care. Use of a Designated Transplant Facility provides incentives to You and Your covered Dependents. Your coverage does not require that a Designated Transplant Facility be used in order to receive benefits, but it is preferred. Designated Transplant Facilities are facilities that must meet extensive criteria in the areas of patient outcomes to include patient and graft survival, patient satisfaction, Physician and program experience, program accreditations, and patient and caregiver education.

DEFINITIONS

Approved Transplant Services means services and supplies for certified transplants when ordered by a Physician. Such services include, but are not limited to, Hospital charges, Physician's charges, organ and tissue procurement, tissue typing and ancillary services.

Designated Transplant Facility means a facility which has agreed to provide Approved Transplant Services to Covered Persons pursuant to an agreement with a transplant provider network or rental network with which the Plan has a contract.

Non-Designated Transplant Facility means a facility that does not have an agreement with the transplant provider network with whom the Plan has a contract. This may include facilities that are listed as participating providers.

Organ and Tissue Acquisition/Procurement means the harvesting, preparation, transportation and the storage of human organ and tissue which is transplanted to a Covered Person. This includes related medical expenses of a living donor.

Stem Cell Transplant includes autologous, allogeneic and syngeneic transplant of bone marrow, peripheral and cord blood stem cells.

BENEFITS

The Plan will pay for Covered Expenses Incurred by a Covered Person at a Designated or Non-designated Transplant Facility for an Illness or Injury, subject to any Deductibles, Participation amounts, maximums or limits shown on the Schedule of Benefits. Benefits are based on the Usual and Customary charge or the Plan's negotiated rate.

It will be the Covered Person's responsibility to obtain prior certification for all transplant related services. If prior certification is not obtained, benefits may not be payable for such services. Benefits may also be subject to reduced levels as outlined in individual plan language. The approved transplant and medical criteria for such transplant must be considered Medically Necessary, and medically appropriate for the medical condition for which the transplant is recommended. The medical condition must not be included on individual Plan exclusions.

COVERED EXPENSES

The Plan will pay for Approved Transplant Services at a Designated or Non-designated Transplant Facility for Organ and Tissue Acquisition/Procurement and transplantation, if a Covered Person is the recipient.

If a Covered Person requires a transplant, including bone marrow or stem cell transplant, the cost of Organ and Tissue Acquisition/Procurement from a living human or cadaver will be included as part of the Covered Person's Covered Expenses when the donor's own plan does not provide coverage for Organ and Tissue Acquisition/Procurement. This includes the cost of donor testing, blood typing and evaluation to determine if the donor is a suitable match.

The Plan will provide donor services at a non-designated facility for initial acquisition/procurement only, up to the maximum listed on the Schedule of Benefits, if any. Complications, side effects or injuries are not covered unless the donor is a Covered Person on the Plan.

Benefits are payable for the following transplants:

- Kidney.
- Kidney/Pancreas.
- Pancreas, which meets the criteria as determined by the Utilization Management.
- Liver.
- Heart.
- Heart/Lung.
- Lung.
- Bone Marrow or Stem Cell transplant (allogeneic and autologous) for certain conditions.
- Small Bowel

SECOND OPINION

The Plan will notify the Covered Person if a second opinion is required at any time during the determination of benefits period. If a Covered Person is denied a transplant procedure by the Designated or Non-designated Transplant Facility, the Plan will allow them to go to a second Designated Transplant Facility for evaluation. If the second facility determines, for any reason, that the Covered Person is an unacceptable candidate for the transplant procedure, benefits will not be paid for further transplant related services and supplies, even if a third transplant facility accepts the Covered Person for the procedure.

ADDITIONAL PROVISION FOR DESIGNATED TRANSPLANT FACILITIES

TRAVEL EXPENSES

If a transplant is performed at a Designated Transplant Facility and the Covered Person lives more than 50 miles from the transplant facility, the Plan will pay for the following, up to the maximum listed on the Schedule of Benefits:

- Transportation to and from the Designated Transplant Facility for:
 - The Covered Person; and
 - One or two parents of the Covered Person (if the Covered Person is a Dependent child, as defined in this Plan); or
 - An adult to accompany the Covered Person;
 - Living donor if the donor lives more than 50 miles from the transplant facility.
- Lodging at or near the Designated Transplant Facility for the living donor, Covered Person and/or adult(s) who accompanied the Covered Person while the Covered Person is receiving transplant-related services at such Designated Transplant Facility. Lodging for purposes of this Plan does not include private residences.

Benefits shall be payable for up to one year from the date of the transplant while the Covered Person is receiving services at the Designated Transplant Facility.

Lodging reimbursement that is greater than \$50 per person per day, may be subject to IRS codes for taxable income.

TRANSPLANT EXCLUSIONS AT DESIGNATED AND NON-DESIGNATED TRANSPLANT FACILITIES

In addition to the items listed in the General Exclusions section, benefits will NOT be provided for any of the following:

- Expenses if a Covered Person donates an organ and/or tissue and the recipient is not a Covered Person under this Plan.
- Expenses for Organ and Tissue Acquisition/Procurement and storage of cord blood, stem cells or bone marrow, unless the Covered Person has been diagnosed with a condition for which there would be a transplant benefit approved by the Plan.
- Expenses for any post-transplant complications of the donor, if the donor is not a Covered Person under this Plan.
- Transplants considered Experimental, Investigational or unproven.
- Solid organ transplant in patients with carcinoma unless the carcinoma is in complete remission for five (5) years or considered cured.
- Autologous transplant (bone marrow or peripheral stem cell), or allogeneic transplant (bone marrow or peripheral stem cell) for the treatment of but not limited to:
 - Wilm's Tumor.
 - Testicular cancer.
 - Brain tumors of any kind (including but not limited to gliomas, astrocytomas, rhabdomyosarcomas, and peripheral neuroectodermal tumors).
 - Sarcomas.
 - Lung cancers.
 - Ovarian, uterine and cervical cancer.
 - Malignant melanoma and other skin cancer.
 - Cancer of the genitourinary tract including but not limited to prostate and bladder cancer.
 - Peripheral neuroepithelioma.
 - AIDS.
 - Gastrointestinal tract cancer including esophagus, gastric, small intestine, colon.
 - Cancer of the pancreas.
 - Patients with brain metastases.
 - Head and neck cancer.
 - Sickle cell anemia.
 - Immune thrombocytopenic purpura.
 - Multiple sclerosis.
- Solid organ transplantation, autologous transplant (bone marrow or peripheral stem cell) or allogeneic transplant (bone marrow or peripheral stem cell), for conditions that are not considered Medically Necessary and/or appropriate, as determined by the Plan.
- Expenses related to the purchase of any organ.

PRESCRIPTION BENEFITS

Effective: 07-01-2006

The Pharmacy Benefits Administrator for this Plan is: Fiserv Health Prescription Benefits Administration

NOTE: The Medicare Prescription Drug Improvement and Modernization Act of 2003 provides all Medicare eligible individuals the opportunity to obtain Prescription Drug coverage through Medicare. Medicare eligible individuals generally must pay an additional monthly premium for this coverage. You may be able to postpone enrollment in the Medicare Prescription Drug coverage if Your current drug coverage is at least as good as Medicare Prescription Drug coverage. If You decline Medicare Prescription Drug coverage and do not have coverage at least as good as Medicare Prescription Drug coverage, You may have to pay an additional monthly penalty if You change Your mind and sign up later. You should have received a Notice telling You whether Your current Prescription Drug coverage provides benefits that are at least as good as benefits provided by the Medicare Prescription Drug coverage. If You need a copy of this notice, please contact Your Plan Administrator.

DEFINITIONS

Brand Product means a brand name or trademark name which is typically the originator of the product. A brand status is determined by First Data Bank or any other industry source. Brand status may change depending on the cost of the product as issued by the manufacturer.

Contracted Amount means the discounted amount negotiated by the Pharmacy Benefits Administrator with the Plan that is providing the Prescription benefit. This amount may include applicable sales tax and pharmacy dispensing fees associated with the dispensing of any Prescription.

Generic Product means a non-Brand Product, which is a pharmaceutical equivalent to a Brand Product, but is typically sold at a lower cost. The generic status is determined by First Data Bank or any other industry source. Generic status often changes depending on the cost of the product as issued by the manufacturer.

Medical Professional means any person licensed under the laws of any state to prescribe and administer Medicines and supplies.

Medicine or Medication means a substance or preparation that alleviates or treats a sickness, disease, or Injury and may be available by Prescription only or over-the-counter (OTC). Medicine includes only substances and preparations that qualify as a medical care under the Internal Revenue Code §213. In general, medical care means care for the diagnosis, cure, mitigation, treatment or prevention of disease or for the purpose of affecting any structure or function of the body.

Non-Participating Pharmacy means any retail or mail order pharmacy that is not contracted by the Pharmacy Benefits Administrator and is excluded from the network of pharmacies.

Non-Prescription Drugs means an over-the-counter (OTC) Medication or supply, normally purchased without a Prescription and which are prepackaged for use by the consumer and labeled in accordance with the requirements and statutes and regulations of any state and the federal government.

Participating Pharmacy means any retail or mail order pharmacy that is contracted by Pharmacy Benefits Administrator to be included in a network of pharmacies at a contracted amount.

Pharmacy and Therapeutics Committee is a committee comprised of independent Physicians and pharmacists, organized by the Pharmacy Benefits Administrator that meets on a quarterly basis to review Medications and supplies.

Pharmacy Benefits Administrator is an organization that manages payment for Prescriptions and services under the Plan.

Preferred Products List means a list of products that have been determined by the Pharmacy and Therapeutics Committee to be clinically appropriate for reimbursement at the "Preferred" level of benefits as indicated in the Prescription Benefits Summary. The Pharmacy and Therapeutics Committee will review and modify this list periodically as new information becomes available. The Pharmacy Benefits Administrator will make available a copy of the Preferred Products List to the Plan, providers, Covered Persons and pharmacists.

Prescription means any order authorized by a Medical Professional for a Prescription or Non-Prescription Drug, that could be a Medication or supply for the person for whom prescribed. The Prescription must be compliant with applicable laws and regulations and identify the name of the Medical Professional and the name of the person for whom prescribed. It must also identify the name, strength, quantity and the directions for use of the Medication or supply prescribed.

Prescription Drug means licensed Medicine that is regulated by legislation to require a Prescription before it can be obtained.

Prior Authorization means if Your Medical Professional believes that You need a Prescription product that is on the Prior Authorization List, or is not covered for other reasons, he or she may contact the Pharmacy Benefits Administrator to request the Plan's review of the situation. Your Medical Professional will provide the Pharmacy Benefits Administrator required information on Your medical condition so the Plan can properly evaluate Your need for the requested products. Upon review by a licensed pharmacist, the Pharmacy Benefits Administrator may do one of the following:

- Approve the Medical Professional's request and authorize coverage of this Medication for a certain period of time at the appropriate Co-pay.
- Recommend an alternate Medication for consideration by the Medical Professional.
- Deny the request to cover the requested Medication.

If the Prescription Medication that You need requires Prior Authorization but You can't wait for the Prior Authorization review to take place, You can ask Your Medical Professional if a drug sample is available, or Your pharmacy may provide You with a short-term supply (such as a 5-day supply) while the Prior Authorization review is taking place. You will be responsible for the Co-pay at this time. This Co-pay will not be credited toward this Prescription if dispensed on a later date.

PROGRAMS

DACON, or Daily Allowable Consumption (also referred to as Dose Over Time) means limiting the quantity of certain Medications that are available in multiple dosage strengths and are routinely intended for once daily administration. In cases where the daily prescribed dose may be dispensed using one dosage unit in place of two or more units, the quantity allowed will be limited to one dosage unit per day.

Quantity Limits means limiting the dispensing quantities applied to Medications that are appropriate for acute use. Quantity Limits are designed to provide sufficient amounts for the treatment of one or more acute episodes. Quantity Limits are established based on FDA (Food and Drug Administration) guidelines, clinical recommendations published in peer review journals, as well as manufacturer packaging and labeling instructions. Some Quantity Limits are based on the number of units per dispensing while others are specified as a per month limit. The Pharmacy and Therapeutics Committee or the Pharmacy Benefits Administrator will review and modify this list periodically as new information becomes available.

Prior Authorization List means a list of Prescription products that are FDA (Food and Drug Administration) approved for a specific diagnosis or as second line therapy, identified by the Pharmacy and Therapeutics Committee for which the Pharmacy Benefits Administrator requires information from the Medical Professional to determine the appropriate level of coverage. The Pharmacy and Therapeutics Committee or Pharmacy Benefits Administrator will review and modify this list periodically as new information becomes available.

Specialty Pharmacy Program means a program that has been determined by the Pharmacy Benefits Administrator to require reimbursement only through the approved specialty pharmacy vendor(s) at the “specialty pharmacy program” level of benefits as indicated in the Prescription Benefits Summary for Medications determined to be part of the Specialty Pharmacy Program. The Pharmacy and Therapeutics Committee or Pharmacy Benefit Administrator will review and modify the list of products included in the Specialty Pharmacy Program periodically as new information becomes available.

BENEFITS

The Plan will pay for Covered Expenses Incurred for the dispensing of Prescription products. The Plan will pay for the benefits in accordance with the Prescription Schedule of Benefits and at the Contracted Amount minus the Co-pays.

Benefits will not be paid for Prescription products purchased before coverage with this Plan begins, or after coverage under this Plan or this provision terminates.

COVERED BENEFITS

- **Prescription products which are:**
 - Necessary for the care and treatment of an Illness or Injury and are prescribed by a duly licensed Medical Professional; and
 - Can be obtained only by Prescription and are dispensed in a container labeled “Rx only”; and
 - The following Non-Prescription products prescribed by a duly licensed Medical Professional:
 - Compounded Medications of which at least one ingredient is a Prescription drug;
 - Any other Medications which due to state law may only be dispensed when prescribed by a duly licensed Medical Professional; and
 - Non-Prescription, (or over-the-counter) products determined by the Pharmacy and Therapeutics Committee to be appropriate for coverage when accompanied by a Prescription; and
 - In an amount not to exceed the day’s supply outlined in the Prescription Schedule of Benefits.
- **Injectable insulin and the following diabetic supplies** as prescribed by a duly licensed Medical Professional:
 - Lancets, alcohol swabs, reaction treating tablets, blood glucose monitors, urine test strips, blood test strips, insulin syringes and needles and anti-diabetic products.
- **Non-combination Prescription** requiring products containing vitamins A, D, E or K.
- **Prescription prenatal vitamins.**
- **Prescription Drugs obtained in a foreign country** when a Foreign Claim Form is signed. Retail brand discounts and preferred brand Co-pays will apply.
- **Prescription smoking deterrent products.**
- **Prescription vitamins with fluoride.**
- **Contraceptive products**, which are self administered and limited to oral tablets, patches, and self-insertable vaginal devices containing contraceptive hormones, regardless of the purpose.
- **Prescription Drugs lost as a direct result of a natural disaster.** You will be given the opportunity to prove that Medically Necessary Prescriptions were lost due to a natural disaster. Acceptable proof could include, but not necessarily be limited to, proof of other filed claims of loss (homeowner’s, property, etc.).

- **Mail Order Prescriptions**

The Plan will pay for Covered Expenses Incurred by a Covered Person for Prescription products dispensed through the Mail Order pharmacy identified by the Pharmacy Benefit Administrator. Prescription products may be ordered by mail with a Co-pay from the Covered Person for each Prescription or refill. The Co-pay is shown on the Prescription Benefits Summary. By law, Prescription products cannot be mailed to a Covered Person outside the United States.

- **Specialty Pharmacy Program**

The Plan will pay for Covered Expenses Incurred by a Covered Person through the Specialty Pharmacy Program vendor identified by the Pharmacy Benefit Administrator. Prescription products included in the Specialty Pharmacy Program shall be ordered from the specialty pharmacy vendor with a Co-pay from the Covered Person for each Prescription or refill. The Co-pay is shown on the Prescription Benefits Summary.

PRESCRIPTION PRODUCT EXCLUSIONS

In addition to the items listed in the General Exclusions section, benefits will NOT be provided for any of the following:

- Charges which are in excess of the contracted amount.
- Therapeutic devices or appliances, including hypodermic needles, syringes (except as stated above), support garments and other non-medical substances, without regard to their intended use.
- Immunization agents, biological sera, blood or blood plasma.
- Products labeled: "Caution-limited by federal law to Investigational use", or Experimental drugs even though a charge is made to the Covered Person. Approved Prescription products which are prescribed for Experimental or Investigational purposes or in Experimental or Investigational dosages.
- Any charge for the administration of Prescription products.
- Any Medication, Prescription or Non-Prescription, which is taken or administered at the place where it is dispensed.
- Any Medication which is meant to be taken by or administered to the Covered Person, in whole or in part, while the Covered Person is treated at a Hospital, a Physician's office or Extended Care Facility (but is instead self-administered or administered elsewhere), unless expressly designated by the Pharmacy Benefits Administrator.
- Refilling a Prescription in excess of the number specified on the Prescription or any refill dispensed after one year from the order of the Medical Professional.
- Prescription products which are not dispensed by a licensed pharmacist or Medical Professional.
- Prescriptions that are cosmetic in nature, unless the Prescription is necessary to ameliorate a deformity arising from, or directly related to a congenital abnormality, a personal Injury resulting from an Accident or trauma, or disfiguring disease.
- Prescription products which may be received without charge under local, state or federal programs, including worker's compensation.
- Replacement Prescription products resulting from loss, theft, or damage, except in the case of loss due directly to a natural disaster.
- Rogaine, or any other cosmetic hair growth Prescription products.
- Prescription products, if a prior authorization – was needed but not requested; and Prescription products, if prior authorization was requested but denied.
- Anabolic steroids.
- Prescription products available over-the-counter that do not require a Prescription order by federal or state law and any Medication that is equivalent to an over-the-counter Medication unless the product is a Non-Prescription (or over-the-counter) product determined by the Pharmacy and Therapeutics Committee to be appropriate for coverage when accompanied by a Prescription.
- Anorectics or any other products used for the purpose of weight control.
- Legend topical acne products for a Covered Person who is over age 26.

- Approved Prescription products with no approved Food and Drug Administration (FDA) indications for the purpose for which prescribed.
- Oral medications for cosmetic management of onychomycosis, unless determined Medically Necessary by the Plan.
- Prescription products used to enhance sexual function or satisfaction.
- Infertility products, unless used to sustain a Covered Person's pregnancy.
- Prescription products that are determined by the Pharmaceutical and Therapeutics Committee to be either marginally effective and/or are excessive in cost when compared to alternative Medication for the same condition.
- Growth hormone products.
- All illegal Medications or supplies, even if prescribed by a duly licensed Medical Professional.
- The difference in cost between a Generic product and Brand Product when the Medical Professional has not specified a Brand Product or has not indicated that the Brand is necessary.

If Your requested Medication or supply is not covered, in whole or in part, You still have a right to purchase that product, however the entire cost of the product will be Your responsibility.

Review of Medications and Supplies by the Pharmacy and Therapeutics Committee

The Pharmacy and Therapeutics Committee may, in its professional judgment modify Medications and supplies on the Preferred Products List as follows:

- Place products on the Preferred Products List and remove products from the Preferred Products List.
- Place certain products on the Prior Authorization List and remove products from the Prior Authorization List.
- Categorize certain Non-Prescription Products (over-the-counter products) as a Covered Expense.
- Place Medications into and remove Medications from the Specialty Pharmacy Program.

Actions by the Pharmacy and Therapeutics Committee take place quarterly, as medical technology evolves, as indications, or FDA (Food and Drug Administration) guidelines change.

The Pharmacy Benefits Administrator will inform You of the actions taken by the Pharmacy and Therapeutics Committee as appropriate, including when Your benefits are affected.

Coordination of Benefits

If a Covered Person has benefits through more than one Prescription Drug program and the Covered Person's primary plan is not administered by Fiserv Health, the Covered Person should pay the required Co-pay for the primary plan and then submit the Co-pay due on a paper claim form to Fiserv Health. This Plan sponsor will waive the required Co-pay and then pay the balance due as outlined in the Prescription Schedule of Benefits.

Appeal Procedures

Refer to the Claims and Appeal section of this document for additional details.

FOR MORE INFORMATION ON PRESCRIPTION BENEFITS

If You need more information about Your Prescription benefits, please call the Pharmacy Benefits Administrator at 877-559-2955, or visit the website at www.fiservhealthservices.com.

VISION CARE BENEFITS

The Plan will pay for covered services for vision care Incurred by a Covered Person, subject to any required Deductible, Co-pay if applicable, Participation amount, maximums and limits shown on the Schedule of Benefits. Benefits are based on the Usual and Customary charge, maximum fee schedule or the negotiated rate.

COVERED BENEFITS

- Orthoptics (eye exercise) services or supplies.

EXCLUSIONS

Benefits will NOT be provided for any of the following:

- Eye exam.
- Refraction.
- Lenses.
 - Single.
 - Bifocal.
 - Trifocal.
- Frames.
- Contacts.
- Safety lenses and frames.
- Protective lenses following cataract or aphakia surgery.
- Eye surgeries used to improve/correct eyesight for refractive disorders including lasik surgery, radial keratotomy, refractive keratoplasty or similar surgery.
- Sunglasses or subnormal vision aids.
- The fitting and/or dispensing of non-prescription glasses or vision devices whether or not prescribed by a Physician or optometrist.
- Vision therapy services or supplies.
- Correction of visual acuity or refractive errors.
- Aniseikonia.

MENTAL HEALTH BENEFITS

The Plan will pay the following Covered Expenses for services authorized by a Physician and deemed to be Medically Necessary for the treatment of a Mental Health Disorder, subject to any Deductibles, Co-pays if applicable, Participation amounts, maximum or limits shown on the Schedule of Benefits. Benefits are based on the Usual and Customary amount, maximum fee schedule or the negotiated rate.

COVERED BENEFITS

Inpatient Services subject to the following:

- The Hospital or facility must be accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or other recognized accrediting body or licensed by the state as an acute care psychiatric, chemical dependency or dual diagnosis facility for the treatment of Mental Health Disorders.
- This Plan also covers services provided at a Residential Treatment Facility that is licensed by the state in which it operates as a Residential Treatment Facility providing treatment of Mental Health Disorders. This does not include services provided at a group home.
- The Covered Person must have the ability to accept treatment.
- The Covered Person must be suicidal, homicidal, delusional, psychotic or ill in more than one area of daily living to such an extent that they are rendered dysfunctional and require the intensity of an Inpatient setting for treatment. Without such Inpatient treatment, the Covered Person's condition would deteriorate.
- The Covered Person's Mental Health Disorder must be treatable in an Inpatient facility.
- The Covered Person's Mental Health Disorder must meet diagnostic criteria as described in the most recent edition of the American Psychiatric Association Diagnostic and Statistical Manual (DSM).
- The attending Physician must be a psychiatrist. If the admitting Physician is not a psychiatrist, a psychiatrist must be attending to the Covered Person within 24 hours of admittance. Such psychiatrist must be United States board eligible or board certified.

Partial Hospitalization means a treatment program that offers intensive, multidisciplinary services not otherwise offered in an Outpatient setting. The treatment program is generally a minimum of 20 hours of scheduled programming extended over a minimum of five days per week. The program is designed to treat patients with serious mental or nervous disorders and offers major diagnostic, psychosocial and prevocational modalities. Such programs must be a less restrictive alternative to Inpatient treatment. Each two days of Partial Hospitalization will reduce the number of Inpatient days available to the Covered Person by one day.

Outpatient Services subject to the following:

- Must be in person at a therapeutic medical facility; and
- Include measurable goals and continued progress toward functional behavior and termination of treatment. Continued certification may be denied when positive response to treatment is not evident; and
- Must be provided by:
 - A United States board eligible or board certified psychiatrist in the state where the treatment is provided.
 - A therapist with a Ph.D. or master's degree that denotes a specialty in psychiatry (Psy.D.).

- A state licensed psychologist.
- A state licensed or certified Social Worker practicing within the scope of his or her license or certification.
- Licensed Professional Counselor.

ADDITIONAL PROVISIONS AND BENEFITS

- A medication evaluation by a psychiatrist may be required before a Physician can prescribe medication for psychiatric conditions. Periodic evaluations may be requested by the Plan.
- Any diagnosis change after a payment denial will not be considered for benefits unless the Plan is provided with all pertinent records along with the request for change that justifies the revised diagnosis. Such records must include the history and initial assessment and must reflect the criteria listed in the most recent American Psychiatric Association Diagnostic and Statistical Manual (DSM) for the new diagnosis.
- Pharmacological Medical Case Management (medication management and lab charges) are Covered Benefits.
- Serious Mental Illness means the following Illnesses as defined by the American Psychiatric Association in the Diagnostic and Statistical Manual:
 - Schizophrenia;
 - Paranoid and other psychotic disorders;
 - Bipolar disorders (mixed, manic and depressive);
 - Major depressive disorders (single episode and recurrent);
 - Schizo-affective disorders (bipolar and depressive);
 - Pervasive developmental disorders;
 - Obsessive-compulsive disorders; and
 - Depression in childhood and adolescence.

This term shall not be deemed to include treatment of addiction to a controlled substance or marijuana that is used in violation of law or mental illness resulting from the use of a controlled substance or marijuana in violation of the law.

MENTAL HEALTH EXCLUSIONS

In addition to the items listed in the General Exclusions section, benefits will NOT be provided for any of the following:

- Treatment or care that is not considered Medically Necessary or appropriate, as determined by the Plan.
- Inpatient charges for the period of time when full, active Medically Necessary treatment for the Covered Person's condition is not being provided.
- Bereavement counseling, unless specifically listed as a covered benefit elsewhere in this document.
- Services provided for conflict between the Covered Person and society which is solely related to criminal activity.
- Conditions listed in the most recent American Psychiatric Association Diagnostic and Statistical Manual (DSM) in the following categories: sexual/gender identity disorders for actual Sex Transformation surgery only.
- Services for biofeedback.

SUBSTANCE ABUSE AND CHEMICAL DEPENDENCY BENEFITS

The Plan will pay the following Covered Expenses for a Covered Person subject to any Deductibles, Co-pays if applicable, Participation amounts, maximum or limits shown on the Schedule of Benefits. Benefits are based on the maximum fee schedule, Usual and Customary amount or the negotiated rate as applicable.

COVERED BENEFITS

Inpatient Services subject to the following:

- The Hospital or facility must be accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or other recognized accrediting body or licensed by the state as an acute care psychiatric, chemical dependency or dual diagnosis facility for the treatment of substance abuse and chemical dependency.
- This Plan also covers services provided at a Residential Treatment Facility that is licensed by the state in which it operates as a Residential Treatment Facility providing treatment of substance abuse and chemical dependency disorders. This does not include services provided at a group home.
- The Covered Person must have the ability to accept treatment.
- The Covered Person must be suicidal, homicidal, delusional or psychotic, or ill to such an extent that they are rendered dysfunctional and require the intensity of an Inpatient setting for treatment. Without such Inpatient treatment, the Covered Person's condition would deteriorate.
- The Covered Person's condition must be treatable in an Inpatient facility.
- The Covered Person's condition must meet diagnostic criteria as described in the most recent edition of the American Psychiatric Association Diagnostic and Statistical Manual (DSM).

Partial Hospitalization means a treatment program that offers intensive, multidisciplinary services not otherwise offered in an Outpatient setting. The treatment program is generally a minimum of 20 hours of scheduled programming extended over a minimum of five days per week. Such programs must be a less restrictive alternative to Inpatient treatment. Each two days of Partial Hospitalization will reduce the number of Inpatient days available to the Covered Person by one day.

Outpatient Services subject to the following:

- Must be in person at a therapeutic medical facility; and
- Include measurable goals and continued progress toward functional behavior and termination of treatment. Continued certification may be denied when positive response to treatment is not evident; and
- Must be provided by:
 - A United States board eligible or board certified psychiatrist in the state where the treatment is provided.
 - A therapist with a Ph.D. or master's degree that denotes a specialty in psychiatry (Psy.D.).
 - A state licensed psychologist.
 - A certified addiction counselor.
 - A state licensed or certified social worker practicing within the scope of his or her license or certification.

ADDITIONAL PROVISIONS AND BENEFITS

- Any diagnosis change after a payment denial will not be considered for benefits unless the Plan is provided with all records along with the request for change. Such records must include: the history, initial assessment and all counseling or therapy notes, and must reflect the criteria listed in the most recent American Psychiatric Association Diagnostic and Statistical Manual (DSM) for the new diagnosis.

SUBSTANCE ABUSE EXCLUSIONS

In addition to the items listed in the General Exclusions section, benefits will NOT be provided for any of the following:

The Plan will not pay for:

- Treatment or care considered inappropriate or substandard as determined by the Plan.
- Inpatient charges for the period of time when full, active, Medically Necessary treatment for the Covered Person's condition is not being provided.

UTILIZATION MANAGEMENT And Other Medical Management Services

Effective: 07-01-2006

The benefit amounts payable under the Schedule of Benefits may be affected if the requirements described for Utilization Management are not satisfied.

Special Note: The Covered Person will not be penalized for failure to obtain Certification if a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that the absence of immediate medical attention would jeopardize the life or long-term health of the individual. However, Covered Persons who received care on this basis should contact the Utilization Review Organization as soon as possible within 24 hours of receiving care or Hospital admittance. The Utilization Review Organization will then review services provided within 48 hours of notification.

UTILIZATION REVIEW ORGANIZATION

The Utilization Review Organization is: **Fiserv Health Care Management**

DEFINITIONS

Utilization Management means an assessment of the facility in which the treatment is being provided. Except in the case of inpatient stay in a Hospital or Birthing Center for the purpose of giving birth, it also includes a formal assessment of the Medical Necessity, effectiveness, and appropriateness of health care services and treatment plans. Such assessment can be conducted on a prospective basis (prior to treatment), concurrent basis (during treatment), or retrospective basis (following treatment).

Certified or Certification for the purpose of Hospital admission for giving birth means notification to the Utilization Review Organization of the upcoming need for medical treatment and where services will be provided. For all other purposes, Certification means a determination by the Utilization Review Organization on behalf of the Plan, with respect to whether a service, treatment, supply or facility is Medically Necessary for the care and treatment of an Illness or Injury.

SERVICES REQUIRING CERTIFICATION

Call the Utilization Review Organization **before** You receive services for the following:

- Inpatient stay in a Hospital, Extended Care Facility, or Birthing Center.
- Organ and tissue transplants.
- Home Health Care.
- Durable Medical Equipment over \$500 or any Durable Medical Equipment rentals.
- Prosthetics over \$1,000.
- All Inpatient stays and Day Treatment (Partial Hospitalization) for Mental Health Disorders, substance abuse and chemical dependency and Residential Treatment Facility.
- Rehabilitation Hospital Services.

Note that if a Covered Person receives Certification for one facility, but then the person is transferred to another facility, Certification is also needed before going to the new facility.

Special Notes:

This Plan complies with the Newborns and Mothers Health Protection Act. The Certification requirement is not required to certify Medical Necessity for Hospital or Birthing Center stays of 48 hours or less following a normal vaginal delivery or 96 hours or less following a Cesarean section. Certification is required to use certain providers or facilities, or to reduce Your out-of-pocket costs.

The phone number that You should call for certification is listed on the back of Your identification card.

Even though a Covered Person receives Certification from the Utilization Review Organization, that does not guarantee that this Plan will pay for the medical care. The Covered Person still needs to be eligible for coverage on the date services are provided. Coverage is also subject to all of the provisions described in this document.

Other Medical Management Services

Disease Management program utilizes a health condition survey to identify individuals who have certain chronic disease and would benefit from this program. Fiserv Health nurse case managers actively work with Covered Persons to help them improve their chronic disease and maintain quality of life.

Services are provided over the telephone or through the mail. The Disease Management program utilizes an Opt-Out approach. The Opt-Out approach means that if You are identified with one of the chronic diseases, You may receive information in the mail or be contacted by Fiserv Health, unless You tell the Plan in writing that You do not want to participate in this program.

BirthLineSM is a prenatal education and health assessment program designed to help mothers carry their babies to full term. This approach aims to avoid the stress and potential trauma of premature births. The program provides a phone link to case managers who answer questions about pregnancy, delivery and prenatal care. Women are encouraged to enroll early in their pregnancy. When a high-risk pregnancy is identified, the mother is enrolled in the high-risk case management program. BirthLineSM also provides educational material about pregnancy and the first year of life of the baby.

Case Management services is a planned approach aimed at promoting more effective treatment for patients with serious medical problems. Fiserv Health's Case Management Specialists communicate directly with the patient's attending Physician to address the specific medical or psychological needs of the patient, and to mobilize appropriate resources for patient care. Our philosophy is that quality care from the beginning of a serious illness helps avoid major complications in the future. The Covered Person can request that the Plan provide case management services, or in some cases, the Plan may contact You if the Plan believes case management services may be beneficial.

Health Information Line is a member information service which provides information on a wide variety of topics including wellness, pregnancy, medications, surgery, diagnostic testing, and medical conditions.

Members are provided with telephonic access to a nurse, who can provide current and reliable health information. This service is available daily from 7 a.m. to 9 p.m. central time. This call line is a member information service only and is not intended to be a telephone triage program. Health information provided does not replace or question the diagnosis of a Physician or health care provider. At all times, the provider remains responsible for the member's medical care.

COORDINATION OF BENEFITS

Effective: 07-01-2006

Coordination of Benefits (COB) applies whenever a Covered Person has health coverage under more than one Plan, as defined below. The purpose of coordinating benefits is to help You pay for Covered Expenses, but not to result in total benefits that are greater than the Covered Expenses Incurred.

The Order of Benefit Determination rules determine which plan will pay first (Primary Plan). The Primary Plan pays without regard to the possibility that another Plan may cover some expenses. A Secondary Plan pays for Covered Expenses after the Primary Plan has processed Your claim, and will reduce the benefits it pays so that the total payment between the Primary Plan and Secondary Plan does not exceed the Covered Expenses Incurred. Up to 100% of charges Incurred may be paid between both plans.

Definition of Plan:

The Plan will coordinate benefits with the following types of medical or dental plans:

- Group health plans, whether insured or self-insured.
- Hospital indemnity benefits in excess of \$200 per day.
- Specified disease policies.
- Foreign health care coverage.
- Medical care components of group long-term care contracts such as skilled nursing care.
- Medical benefits under group or individual automobile policies.
- Medicare or other governmental benefits, as permitted by law. This does not include Medicaid.

Each contract for coverage is considered a separate plan. If a plan has two parts and COB rules apply to only one of the two parts, each of the parts is treated as a separate plan.

ORDER OF BENEFIT DETERMINATION RULES

The first of the following rules that apply to Your situation is the rule to use:

- The plan that has no coordination of benefits provision in its plan document is considered primary.
- The plan that covers the person as an Employee, member or subscriber (that is, other than as a Dependent) is considered primary. The Plan will deem any Employee plan beneficiary to be eligible for primary benefits from their employer's benefit plan. Employee plan beneficiaries do not include COBRA Qualified Beneficiaries or retirees.
- The plan that covers a person as a Dependent is secondary. (See the section on Medicare for exceptions).
- If one or more plans cover the same person as a Dependent child:
 - The Primary Plan is the plan of the parent whose birthday is earlier in the year if:
 - The parents are married; or
 - The parents are not separated (whether or not they have been married); or
 - A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.
 - If both parents have the same birthday, the plan that covered either of the parents longer is primary.
 - If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary.

- If the parents are not married, or are separated (whether or not they ever have been married) or are divorced, the order of benefits is:
 - The plan of the custodial parent;
 - The plan of the spouse of the custodial parent;
 - The plan of the non-custodial parent; and then
 - The plan of the spouse of the non-custodial parent.
- Active or Inactive Employee: If the same individual is covered under one plan as an active Employee, and is also covered under another plan as a retired or laid off worker, the plan that covers the person as an active worker will be primary for the Employee as well as the Employee's Dependents.
- COBRA Continuation Coverage: If a person has COBRA continuation coverage and also has coverage under another plan, COBRA coverage is usually secondary. If the two plans do not agree on the order of benefits, this rule is ignored. (See exception in the Medicare section.)
- Longer or Shorter Length of Coverage: The plan that covered the person as an Employee, member, subscriber or retiree longer is primary.
- If an active Employee is on leave due to active duty in the military in excess of 30 days, the plan that covers the person as an active Employee, member or subscriber is considered primary.
- If the above rules do not determine the Primary Plan, the Covered Expenses can be shared equally between the plans. This Plan will not pay more than it would have paid, had it been primary.

MEDICARE

If You or Your covered spouse is also receiving benefits under Medicare, federal law may require this Plan to be primary over Medicare. When this Plan is not primary, the Plan will coordinate benefits with Medicare.

The Order of Benefit Determination rules determine which plan will pay first (Primary Plan). The Primary Plan pays without regard to the possibility that another Plan may cover some expenses. A Secondary Plan pays for Covered Expenses after the Primary Plan has processed Your claim, and will reduce the benefits it pays so that the total payment between the Primary Plan and Secondary Plan does not exceed the Covered Expenses Incurred. Up to 100% of charges Incurred may be paid between both plans.

When this Plan is not Primary and a Covered Person is receiving Part A Medicare but has chosen not to elect Part B, this Plan will reduce its payments on Part B services as though Part B Medicare was actually in effect.

ORDER OF BENEFIT DETERMINATION RULES FOR MEDICARE

This Plan complies with the Medicare Secondary Payer regulations. Examples of these regulations are as follows:

- This Plan generally has primary responsibility to pay claims before Medicare under the following circumstances:
 - You continue to be actively employed by the employer and You or Your covered spouse becomes eligible for Medicare because of age or disability.
 - You continue to be actively employed by the employer, Your covered spouse becomes eligible for Medicare, and is also covered under a retiree plan through Your spouse's former employer. In this case, this Plan will be primary for You and Your covered spouse, Medicare pays second, and the retiree plan would pay last.

- For a Covered Person with End-Stage Renal Disease (ESRD), this Plan usually has primary responsibility for the claims of a Covered Person for 30 months from the date of Medicare entitlement based on ESRD. The 30-month period can also be covered by COBRA continuation coverage or another source of coverage. At the end of the 30 months, Medicare becomes the primary payer.
- Medicare generally pays first (has primary responsibility) under the following circumstances:
 - You are no longer actively employed by the Plan; and
 - You or Your spouse has Medicare coverage due to Your age, plus You also have COBRA continuation coverage through the Plan; or
 - You or a covered family member has Medicare coverage based on a disability, plus You also have COBRA continuation coverage through the Plan. Medicare normally pays first, however an exception is that COBRA may pay first for Covered Persons with End-Stage Renal Disease until the end of the 30-month period; or
 - You or Your covered spouse have coverage under a retiree plan plus Medicare coverage; or
 - Upon completion of 30 months coverage for an individual with ESRD, Medicare becomes the primary payer. (Note that if a person with ESRD was entitled to Medicare based on age or other disability **before** being diagnosed with ESRD and Medicare was previously paying primary, then the person can continue to receive Medicare benefits on a primary basis).
- Medicare is the secondary payer when no-fault insurance, worker's compensation, or liability insurance is available as primary payer.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other plans. The Plan may get the facts it needs from or give them to other organizations or persons for the purpose of applying those rules and determining benefits payable under this Plan and other plans covering the person claiming benefits. The Plan need not tell, or get the consent of, any person to do this. Each person claiming benefits under this Plan must give the Plan any facts it needs to apply those rules and determine benefits payable.

REIMBURSEMENT TO THIRD PARTY ORGANIZATION

A payment made under another plan may include an amount which should have been paid under this Plan. If it does, the Plan may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under this Plan. The Plan will not have to pay that amount again.

RIGHT OF RECOVERY

If the amount of the payments made by the Plan is more than it should have paid under this COB provision, the Plan may recover the excess from one or more of the persons it paid or for whom the Plan has paid; or any other person or organization that may be responsible for the benefits or services provided for the Covered Person.

RIGHT OF SUBROGATION, THIRD PARTY LIABILITY AND ASSIGNMENT OF RIGHTS

You, the Covered Person, are being provided benefits pursuant to the Plan implemented by Your employer. This Plan is designed to cover You and Your Dependent(s) with health benefits. This Plan is not intended to serve as a supplement to, or replacement for, any benefits You may recover from any Other Party with respect to any charges Incurred with respect to an Accident, Illness, Injury or other medical condition caused by an act or omission of said Other Party.

For purposes of this section, **Other Party** is defined to include, but is not limited to, the following:

- The party or parties that caused the Accident, Illness, Injury or other medical condition;
- The insurer or other indemnifier of the party or parties who caused the Accident, Illness, Injury or other medical condition;
- The Covered Person's own insurer including, but not limited to, uninsured motorist, underinsured motorist, medical payment or no-fault insurers;
- A worker's compensation or school insurer;
- Any other person, entity, policy or plan that is liable or legally responsible to make payments in relation to the Accident, Illness, Injury or other medical condition.

This section is applicable when a Covered Person and/or his or her Dependent(s) have Incurred charges for an Accident, Illness, Injury or other medical condition for an act or omission of any Other Party which gives the Covered Person and/or his or her Dependent(s) the legal right to seek restitution from such Other Party. In such cases, no benefits shall be due and all claims submitted thereon shall be denied under this Plan unless You, the Covered Person, agree to the following:

- That the Covered Person, or their legal representative, shall notify the Plan of any claim or potential claim the Covered Person and/or their Dependent(s) have against any Other Party within 30 days of the act which gives rise to such claim. That, if requested, the Covered Person or his or her Dependent(s) or legal representative shall supply the Plan with any information that is reasonably necessary to protect the Plan's subrogation interests.
- If such act also results in payments being made under the Plan, that neither the Covered Person nor their Dependent(s) do anything that would prejudice the Plan's rights to recover payments.
- That, if requested, the Covered Person shall enter into a written agreement which shall expressly assign any payments made to them or their Dependent by any Other Party to the Plan, and which shall require them to direct their attorney (and other representatives) in writing to retain separately from any judgment, settlement or otherwise that the attorney or representative receive on the Covered Person's behalf an amount of money sufficient to reimburse the Plan as required by such agreement and to pay such money to the Plan. In the event the Covered Person does not sign or refuses to sign such an agreement, the Plan has no obligation to make any payment for any treatment required as a result of the act or omission of any Other Party. The form of the agreement issued by the Plan for this purpose is expressly incorporated in this Plan and will be provided to the Covered Person at anytime upon request.
- That the Plan is subrogated to all rights they may have, and acknowledge that the Plan will have a first priority lien and right of recovery, on any sum of money received from any Other Party, whether the recovery is by settlement, judgment, mediation, arbitration, or other means.

- That the Plan has a right to recover, either through subrogation, reimbursement or other appropriate equitable relief, the following:
 - Any payments, from the first dollar, that the Covered Person or any other person or organization on behalf of the Covered Person is entitled to receive as a result of the Accident, Illness, Injury or other medical condition, to the full extent of benefits paid or provided by the Plan; and
 - Any overpayments made directly to providers on behalf of the Covered Person for the Accident, Illness, Injury or other medical condition.
- That the Plan's right of recovery shall be in first priority, to the full extent of any and all benefits paid under the Plan, and will not be reduced due to the Covered Person's own negligence or due to the Covered Person not being made whole.
- That the Covered Person shall be solely responsible for all expenses of recovery from any Other Party, including but not limited to all attorney's fees and costs, which amounts will not reduce the amount of reimbursement payable to the Plan under the operation of any common fund doctrines.
- That the Plan will not pay any fees or costs associated with any claim or lawsuit without the Plan's express written consent in advance.
- That the Covered Person or their legal representative or guardian, shall be considered a constructive trustee with respect to any money received from any Other Party in consideration of an Accident, Illness, Injury or other medical condition for which they have received benefits, and that any such funds will be held separate by said trustee until the Plan's lien is addressed.
- The Plan's rights to recovery apply to the Covered Person, to the spouse and Dependent(s) of a Covered Person, COBRA beneficiaries, and any other person who may recover on behalf of a participant, including the Covered Person's estate.
- That the Plan reserves the right to independently pursue and recover paid benefits.

If the Plan has already made payments or provided benefits to You for charges Incurred as a result of an Accident, Illness, Injury or other medical condition for which any Other Party may be liable and You fail to comply with the requirements set forth above, the Plan may reduce future benefits otherwise payable under the Plan for *any* Illness, Injury or medical condition by the amounts recovered by You or Your Dependent(s) from the Other Party.

GENERAL EXCLUSIONS

Effective: 07-01-2006

Exclusions, including complications from excluded items are not considered benefits under this Plan and will not be considered for payment as determined by the Plan.

The Plan does not pay for Expenses Incurred for the following, even if deemed to be Medically Necessary, unless otherwise stated below. The Plan does not apply exclusions to treatment listed in the Covered Services section when the Plan has information that the Illness or Injury is due to a medical condition (including both physical and mental health conditions) or domestic violence.

1. **Abortions (Elective):** Unless a Physician states in writing that:
 - The mother's life would be in danger if the fetus were to be carried to term, or
 - Abortion is medically indicated due to complications with the pregnancy.
2. **Acts of War:** Injury or Illness cause or contributed to by international armed conflict, hostile acts of foreign enemies, invasion, or war or acts of war, whether declared or undeclared.
3. **Alcohol/Controlled Substance Abuse:** services, supplies, care or treatment to a Covered Person for an Injury or Illness which occurs as a result of that Covered Persons illegal use of alcohol, or which is the result of the individuals intentional misuse of controlled substance, drug, hallucinogen, inhalant or narcotic (whether or not the substance was prescribed by a Physician), except as provided under the limited Substance Abuse and Chemical Dependency provision of this Plan. Expenses will be covered for an injured Covered Person other than the person illegally using alcohol or a controlled substance.
4. **Alternative/Complimentary Treatment** includes: Treatment, services or supplies for holistic or homeopathic medicine, hypnosis, or other alternate treatment that is not accepted medical practice as determined by the Plan.
5. **Appointments Missed:** An appointment the Covered Person did not attend.
6. **Aquatic Therapy** unless provided by a Qualified physical therapist.
7. **Assistance With Activities of Daily Living.**
8. **Assistant Surgeon Services**, unless determined Medically Necessary by the Plan.
9. **Augmentation Communication Devices** and related instruction or therapy.
10. **Autism Services.**
11. **Before Enrollment and After Termination:** Services, supplies or treatment rendered before coverage begins under this Plan, or after coverage ends, are not covered.
12. **Biofeedback Services.**
13. **Blood:** Blood donor expenses.
14. **Breast Reductions.**
15. **Cardiac Rehabilitation** beyond Phase II which includes self-regulated physical activity that the Covered Person performs to maintain health, and is not considered to be a treatment program.
16. **Chelation Therapy**, except in the treatment of conditions considered Medically Necessary, medically appropriate and not Experimental or Investigational for the medical condition for which the treatment is recognized.

Effective: 07-01-2006

17. **Cosmetic Treatment, Cosmetic Surgery**, or any portion thereof, unless the procedure is otherwise listed as a covered benefit.
18. **Counseling Services** in connection with marriage or financial counseling.
19. **Court-Ordered:** Any treatment or therapy which is court-ordered, ordered as a condition of parole, probation, or custody or visitation evaluation, unless such treatment or therapy is normally covered by this Plan. This Plan does not cover the cost of driving while intoxicated classes or other classes ordered by the court.
20. **Criminal Activity:** Illness or Injury resulting from taking part in the commission of an assault or battery (or a similar crime against a person) or a felony. The Plan shall enforce this exclusion based upon reasonable information showing that this Criminal Activity took place.
21. **Custodial Care** as defined in the Glossary of Terms.
22. **Dental Services:**
 - The care and treatment of teeth, gums or alveolar process or for dentures, appliances or supplies used in such care or treatment, or drugs prescribed in connection with dental care. This exclusion does not apply to Hospital charges including professional charges for x-ray, lab and anesthesia, or for charges for treatment of injuries to natural teeth, including replacement of such teeth with dentures, or for setting of a jaw which was fractured or dislocated in an Accident.
 - Injuries or damage to teeth, natural or otherwise, as a result of or caused by the chewing of food or similar substances.
 - Dental implants including preparation for implants.
23. **Duplicate Services and Charges or Inappropriate Billing.**
24. **Education:** Charges for education, special education, job training, music therapy and recreational therapy, whether or not given in a facility providing medical or psychiatric care.
25. **Employment or Worker's Compensation:** An Illness or Injury arising out of or in the course of any employment for wage or profit, including self-employment, for which the Covered Person was or could have been entitled to benefits under any Worker's Compensation, U.S. Longshoremen and Harbor Worker's or other occupational disease legislation, policy or contract, whether or not such policy or contract is actually in force.
26. **Environmental Devices:** Environmental items such as but not limited to, air conditioners, air purifiers, humidifiers, dehumidifiers, furnace filters, heaters, vaporizers, or vacuum devices.
27. **Examinations:** Examinations for employment, insurance, licensing or litigation purposes.
28. **Excess Charges:** Charges or the portion thereof which are in excess of the Usual and Customary charge, the negotiated fee or fee schedule.
29. **Experimental or Investigational:** Services, supplies, medicines, treatment, facilities or equipment which the Plan determines are Experimental or Investigational, including gene and stem cell therapies.
30. **Extended Care:** Any Extended Care Facility Services which exceed the appropriate level of skill required for treatment as determined by the Plan.
31. **Fitness Programs:** General fitness programs, exercise programs, exercise equipment and health club memberships, or other utilization of services, supplies, equipment or facilities in connection with weight control or body building.

Effective: 07-01-2006

32. Foot Care:

- Routine foot care.
- Non-custom-molded Orthotics

33. Hearing Deficit Services:

- Purchase or fitting of hearing aids.
- Implantable hearing devices.

34. Home Modifications: Modifications to Your home or property such as but not limited to, escalator(s), elevators, saunas, steambaths, pools, hot tubs, whirlpools, or tanning equipment, wheelchair lifts, stair lifts or ramps.

35. Infertility Services:

- Charges for diagnostic services. If another medical condition is identified through the course of diagnostic testing, any coverage of that condition will be subject to Plan provisions.
- Fertility tests and drugs.
- Tests and exams done to prepare for induced conception.
- Surgical reversal of a sterilized state which was a result of a previous surgery.
- Sperm enhancement procedures.
- Direct attempts to cause pregnancy by any means including, but not limited to hormone therapy or drugs.
- Artificial insemination, In vitro fertilization, Gamete Intrafallopian Transfer (GIFT), or Zygote Intrafallopian Transfer (ZIFT).
- Embryo transfer.
- Freezing or storage of embryo, eggs, or semen.

36. Lamaze Classes or other child birth classes.

37. Learning Disability: Special education, remedial reading, school system testing and other rehabilitation treatment for a Learning Disability. If another medical condition is identified through the course of diagnostic testing, any coverage of that condition will be subject to Plan provisions.

38. Liposuction regardless of purpose.

39. Maintenance Therapy: Such services are excluded if, based on medical evidence, treatment or continued treatment could not be expected to resolve or improve the condition, or that clinical evidence indicates that a plateau has been reached in terms of improvement from such services.

40. Mammoplasty or Breast Augmentation unless covered elsewhere in this document.

41. Massage Therapy unless provided by a Qualified chiropractor.

42. Military: A military related Illness or Injury to a Covered Person on active military duty.

43. No-Fault State: Benefits are not payable under this Plan for any Illness or Injury received in an Accident involving a car or other motor vehicle for participants who are residents of a no-fault state and eligible for benefits under the no-fault motor vehicle law, until such time as the benefits under no-fault have been exhausted.

44. Non-Professional Care: Medical or surgical care that is not performed according to generally accepted professional standards.

45. Nocturnal Enuresis Alarm (Bed wetting).

46. **Not Medically Necessary:** Services, supplies, treatment, facilities or equipment which the Plan determines are not Medically Necessary.
47. **Nursery and Newborn Expenses** for grandchildren of a covered Employee or spouse.
48. **Nutrition Counseling** unless covered elsewhere in this document.
49. **Over-the-Counter Medication, Products, Supplies or Devices** unless covered elsewhere in this document.
50. **Panniculectomy/Abdominoplasty** unless determined by the Plan to be Medically Necessary.
51. **Personal Comfort:** Services or supplies for personal comfort or convenience, such as but not limited to private room, television, telephone and guest trays.
52. **Private Duty Nursing** unless covered elsewhere in this document.
53. **Reconstructive Surgery** performed only to achieve a normal or nearly normal appearance, or any portion thereof, as determined by the Plan, unless covered elsewhere in this document.
54. **Return to Work/School:** Telephone or Internet consultations or completion of claim forms or forms necessary for the return to work or school.
55. **Reversal of Sterilization:** Procedures or treatments to reverse prior voluntary sterilization.
56. **Room and Board Fees** when surgery is performed other than at a Hospital or Surgical Center.
57. **Self-Administered Services.**
58. **Services at no Cost:** Services which the Covered Person would not be obligated to pay in the absence of this Plan or which are available to the Covered Person at no cost, except for care provided in a facility of the uniformed services as per Title 32 of the National Defense code, or as required by law.
59. **Sex Therapy.**
60. **Sexual Function:** Any medications, oral or other, used to increase sexual function or satisfaction or penile pumps and erectaid devices.
61. **Sex Transformation:** Treatment, drugs, medicines, services and supplies for, or leading to, sex transformation surgery.
62. **Speech Therapy** for stuttering.
63. **Surrogate Motherhood or Gestational Carrier Services.**
64. **Telemedicine, Telephone or Internet Consultations.**
65. **Third Party Liabilities:** Any Covered Expenses to the extent of any amount received from others for the bodily injuries or losses which necessitate such benefits. "Amounts received from others" specifically include, without limitation, liability insurance, worker's compensation, uninsured motorists, underinsured motorists, "no-fault" and automobile medical payments, and homeowner's insurance.
66. **Transportation:** Transportation services which are solely for the convenience of the Covered Person, the Covered Person's Close Relative, or the Covered Person's Physician.
67. **Travel:** Travel costs, whether or not recommended or prescribed by a Physician, unless authorized in advance by the Plan.

68. **Vision Care** unless covered elsewhere in this document. (Refer to the Vision Care Benefits).
69. **Vitamins, Minerals and Supplements**, even if prescribed by a Physician, except for Vitamin B-12 injections that are prescribed by a Physician for Medically Necessary purposes or as provided under the Prescription Benefits provision.
70. **Vocational Services:** Vocational and educational services rendered primarily for training or education purposes. This Plan also excludes work hardening, work conditioning and industrial rehabilitation services rendered for Injury prevention education or return-to-work programs.
71. **Weight Control:** Treatment, services or surgery for weight control, whether or not prescribed by a Physician or associated with an illness.
72. **Wigs, Toupees, Hairpieces, Hair Implants or Transplants or Hair Weaving**, or any similar item for replacement of hair regardless of the cause of hair loss unless covered elsewhere in this document.

The Plan does not limit a Covered Person's right to choose his or her own medical care. If a medical expense is not a covered benefit, or is subject to a limitation or exclusion, a Covered Person still has the right and privilege to receive such medical service or supply at the Covered Person's own personal expense.

CLAIMS AND APPEAL PROCEDURES

Effective: 07-01-2006

REASONABLE AND CONSISTENT CLAIMS PROCEDURES

The Plan's claims procedures include administrative safeguards and processes that are designed to ensure and verify that benefit claims determinations are made in accordance with the Plan document. The Plan provisions will be applied consistently with respect to similarly situated individuals. Fiserv Health will normally send payment for Covered Expenses directly to Your provider.

TYPE OF CLAIMS AND DEFINITIONS

- **Pre-Service Claim needing certification as required by the Plan and stated in this document.** This is a claim for a benefit where the Covered Person is required to get approval from the Plan **before** obtaining the medical care such as in the case of certification of health care items or service that the Plan requires. If a Covered Person or provider calls the Plan just to find out if a claim will be covered, that is not a Pre-Service Claim, unless the Plan and this document specifically require the person to call for certification. Obtaining certification does not guarantee that the Plan will ultimately pay the claim.

Note that this Plan does not require certification for urgent or Emergency care claims, however You may be required to notify the Plan following stabilization. Please refer to the Utilization Management section for more details. A condition is considered to be an urgent or Emergency care situation if it could seriously jeopardize the person's life, health or ability to regain maximum function, or if, in the opinion of a Physician who has knowledge of the person's medical condition, would subject the person to severe pain that could not be adequately managed without the treatment or care being requested.

- **Post-Service Claim** means a claim that involves payment for the cost of health care that has already been provided.
- **Concurrent Care Claim** means that an ongoing course of treatment to be provided over a period of time or for a specified number of treatments has been approved by the Plan.

AUTHORIZED REPRESENTATIVE

Authorized Representative means a person who can contact the Plan on Your behalf to help with claims, appeals or other benefit issues.

If a Covered Person chooses to use an Authorized Representative, the Covered Person must submit a written letter to the Plan stating the following: The name of the Authorized Representative, the date and duration of the appointment and any other pertinent information. In addition, the Covered Person must agree to grant their Authorized Representative access to their Protected Health Information. This letter must be signed by the Covered Person to be considered official.

PROCEDURES FOR SUBMITTING CLAIMS

Most providers will submit claims directly to the Plan on Your behalf. If the provider You use will not send claims directly to the Plan for processing, then You will need to send the claim to the Plan within the timelines discussed below. The address for submitting claims is on the back of Your identification card.

Covered Persons who receive services in a country other than the United States will need to pay the claim up front and then submit the claim to the Plan for reimbursement. The Plan will reimburse You for any covered amount in U.S. currency. The reimbursed amount will be based on the U.S. equivalency rate that is in effect on the date the Covered Person paid the claim, or on the date of service if paid date is not known.

Effective: 07-01-2006

PROOF OF LOSS

Complete claims must be submitted to the Third Party Administrator as soon as possible after services are received, but no later than 12 months from the date of service. Prescription benefit claims must be submitted within 12 months from the date of service. A complete claim means that the Plan has all information that is necessary to process the claim. Claims received after the proof of loss period will not be allowed.

INCORRECTLY FILED CLAIMS (Applies to Pre-Service Claims only)

If a Covered Person or Authorized Representative does not properly follow the Plan's procedures for requesting certification, the Plan will notify the person to explain proper procedures within five calendar days following receipt of a Pre-Service claim request. The notice will usually be oral, unless written notice is requested by the Covered Person or Authorized Representative.

HOW HEALTH BENEFITS ARE CALCULATED

When Fiserv Health receives a claim for services that have been provided to You, it will determine if the service is a covered benefit under Your group health plan. If it is not a covered benefit, the claim will be denied and You will be responsible for paying the provider for these costs. If it is a covered benefit, Fiserv Health will establish the allowable payment amount for that service, in accordance with the provisions of this document.

Claims for covered benefits are paid according to an established fee schedule, a negotiated rate for certain services, or as a percentage of the Usual and Customary fees.

Fee Schedule: Providers are paid the lesser of the billed amount or the maximum fee schedule for the particular covered service, minus any Deductible, Participation rate, Co-pay or penalties that You are responsible for paying.

Negotiated Rate: On occasion, Fiserv Health will negotiate a payment rate with a provider for a particular covered service such as transplant services, Durable Medical Equipment, Extended Care Facility treatment or other services. The negotiated rate is what the Plan will pay to Your provider, minus any Co-pay, Deductible, Participation rate or penalties that You are responsible for paying.

Usual and Customary (U&C) is the amount that is usually charged by health care providers in the same geographical area for the same services, treatment or materials. An industry fee file is used to determine U&C fee allowances. The U&C level is at the 85th percentile. For multiple or bilateral procedures during the same operative session, it is customary for the health care provider to reduce their fees for any secondary procedures. The industry guidelines are to allow the full U&C fee allowance for the primary procedure, and 50 percent of the U&C fee allowance for all secondary procedures. These allowable amounts are then processed according to Plan provisions. A global package includes the services that are a necessary part of a procedure. For individual services that are part of a global package, it is customary for the individual services not to be billed separately. A separate charge will not be allowed under the Plan.

NOTIFICATION OF BENEFIT DETERMINATION

Each time a claim is submitted by You or Your provider, You will receive an Explanation of Benefits (EOB) form that will explain how much the Plan paid towards the claim, and how much of the claim is Your responsibility due to cost-sharing obligations, non-covered benefits, penalties or other Plan provisions. Please check the information on each EOB form to make sure You actually received those services from the provider and that the information appears correct. If You have any questions or concerns about the EOB form, please feel free to call the Plan at the number listed on the EOB or on the back of Your identification card. Your provider will receive a similar form on each claim that is submitted.

Effective: 07-01-2006

TIMELINES FOR INITIAL BENEFIT DETERMINATION

Fiserv Health will process Your claims within the following timelines, although the Covered Person may voluntarily extend these timelines:

- **Pre-Service Claim:** A decision will be made within 15 calendar days following receipt of a claim request, but the Plan can have an extra 15-day extension, when necessary for reasons beyond control of the Plan, if written notice is given to You within the original 15 day period.
- **Post-Service Claims:** Claims will be processed within 30 calendar days, but the Plan can have an additional 15 day extension, when necessary for reasons beyond control of the Plan, if written notice is provided to You within the original 30 day period.
- **Concurrent Care Claims:** If the Plan is reducing or terminating benefits before the end of the previously approved course of treatment, the Plan will notify You prior to the treatment authorization ending or being reduced.

A claim is considered to be filed when the claim for benefits has been submitted to Fiserv Health for formal consideration under the terms of this Plan.

Determination Period On Hold: The time period that the Plan has to decide a claim may be put on hold ("tolled") when additional information is necessary from You to process the claim. When claims information is missing, a notice requesting the necessary information will be sent to the Covered Person. The Covered Person then has 60 calendar days within which to provide the missing information.

If the Covered Person does not provide needed information to the Plan within 60 calendar days of the date on the notice, the Plan will make a decision on the claim based upon the information it has at that time, which may result in a denial or partial denial. The Covered Person will be fully responsible for payment of expenses not covered because of a denied or partially denied claim.

CIRCUMSTANCES CAUSING LOSS OR DENIAL OF PLAN BENEFITS

Claims can be denied for any of the following reasons:

- Termination of Your employment.
- Covered Person is no longer eligible for coverage under the health Plan.
- Charges Incurred prior to Your Effective Date or following termination of coverage.
- Covered Person reached the Maximum Benefit under this Plan.
- Amendment of group health Plan.
- Termination of the group health Plan.
- Employee, Dependent or provider did not respond to a request for additional information needed to process the claim or appeal.
- Application of Coordination of Benefits.
- Enforcement of subrogation.
- Services are not a covered benefit under this Plan.
- Services are not considered Medically Necessary.
- Failure to have required services certified before receiving services.
- Misuse of the plan identification card or other fraud.
- Failure to pay premiums if required.
- Employee or Dependent is responsible for charges due to Deductible, Participation obligations or penalties.
- Application of the Usual and Customary fee limits, fee schedule or negotiated rates.
- Incomplete or inaccurate claim submission.
- Application of utilization review.
- Experimental or Investigational procedure.
- Other reasons as stated elsewhere in this document.

Effective: 07-01-2006

ADVERSE BENEFIT DETERMINATION (DENIED CLAIMS)

Adverse Benefit Determination means a denial, reduction or termination of a benefit, or a failure to provide or make payment, in whole or in part, for a benefit. It also includes any such denial, reduction, termination or failure to provide or make payment that is based on a determination that the Covered Person is no longer eligible to participate in a plan.

If a claim is being denied in whole or in part, You will receive an initial claim denial notice within the timelines described above. A claim denial notice, usually referred to as an Explanation of Benefits (EOB) form will:

- Explain the specific reasons for the denial.
- Provide a specific reference to pertinent Plan provisions on which the denial was based.
- Provide a description of any material or information that is necessary for the Covered Person to perfect the claim, along with an explanation of why such material or information is necessary, if applicable.
- Provide appropriate information as to the steps the Covered Person can take to submit the claim for appeal (review).
- If an internal rule or guideline was relied upon, or if the denial was based on Medical Necessity or Experimental treatment, the Plan will notify You of that fact. You have the right to request a copy of the rule/guideline or clinical criteria that was relied upon, and such information will be provided to You free of charge.

APPEALS PROCEDURE FOR ADVERSE BENEFIT DETERMINATIONS

If You disagree with the denial of a claim, You or Your Authorized Representative can request that the Plan review its initial determination by submitting a written request to the Plan as described below:

First Level of Appeal: This is a **mandatory** appeal level. The Covered Person must exhaust the following internal procedures before any outside action is taken.

- You must file Your appeal within 180 days of the date You received the Explanation of Benefits (EOB) form from the Plan showing that Your claim was denied. The Plan will assume that You received the written EOB form five days after the Plan mailed the EOB form to You.
- You or Your Authorized Representative will be allowed reasonable access to review or copy pertinent documents, at no charge.
- You may submit written comments, documents, records and other information relating to the claim to explain why You believe the denial should be overturned. This information should be submitted at the time You submit the written request for a review.
- You have the right to submit evidence that Your claim is due to the existence of a physical or mental medical condition or domestic violence, under applicable federal nondiscrimination rules.
- The review will take into account all comments, documents, records and other information submitted that relates to the claim. This would include comments, documents, records and other information that either were not submitted previously or were not considered in the initial benefit decision. The review will be conducted by individuals who were not involved in the original denial decision and are not under the supervision of the person who originally denied the claim.
- If Your benefit denial was based in whole or in part on a medical judgment, the Plan will consult with a health care professional with training and experience in the relevant medical field. This health care professional may not have been involved in the original denial decision, nor be supervised by the health care professional who was involved. If the Plan has obtained medical or vocational experts in connection with Your claim, they will be identified upon Your request, regardless of whether the Plan relies on their advice in making any benefit determinations.
- After Your claim has been reviewed, You will receive written notification letting You know if the claim is being approved or denied. The notification will provide You with the information outlined under the Adverse Benefit Determination section above. It will also notify You of Your right to file suit under ERISA after You have completed all mandatory appeal levels described in this document.

Effective: 07-01-2006

Second Level of Appeal: This is a **voluntary** appeal level. The Covered Person is not required to follow this internal procedure before taking outside legal action.

- If You are not satisfied with the decision following the first appeal, You have the right to appeal the denial a second time.
- You or Your Authorized Representative must submit a written request for a second review within 60 calendar days following the date You received the Plan's decision regarding the first appeal. The Plan will assume that You received the determination letter regarding the first appeal five days following the date the Plan sends the determination letter to You.
- You may submit written comments, documents, records and other pertinent information to explain why You believe the denial should be overturned. This information should be submitted at the time You submit the written request for a second review.
- You have the right to submit evidence that Your claim is due to the existence of a physical or mental medical condition or domestic violence, under applicable federal nondiscrimination rules.
- The second review will take into account all comments, documents, records and other information submitted that relates to the claim that either were not submitted previously or were not considered in the initial benefit decision. The review will be conducted by individuals who were not involved in the original denial decision or the first appeal, and are not under the supervision of those individuals.
- If Your benefit denial was based in whole or in part on a medical judgment, the Plan will consult with a health care professional with training and experience in the relevant medical field. This health care professional may not have been involved in the original denial decision or first appeal, nor be supervised by the health care professional who was involved. If the Plan has obtained medical or vocational experts in connection with Your claim, they will be identified upon Your request, regardless of whether the Plan relies on their advice in making any benefit determinations.
- After Your claim has been reviewed, You will receive written notification letting You know if the claim is being approved or denied. The notification will provide You with the information outlined under the Adverse Benefit Determination section above. It will also notify You of Your right to file suit under ERISA after You have completed all mandatory appeal levels described in this document.

Regarding the above voluntary appeal level, the Plan agrees that any statutory limitations that are applicable to pursuing the claim in court will be put on hold during the period of this voluntary appeal process. The voluntary appeal process is available only after You have followed the mandatory appeal level as required above. This Plan also agrees that it will not charge You a fee for going through the voluntary appeal process, and it will not assert a failure to exhaust administrative remedies if You elect to pursue a claim in court before following this voluntary appeal process. Your decision about whether to submit a benefit dispute through this voluntary appeal level will have no affect on Your rights to any other benefits under the Plan. If You have any questions regarding the voluntary level of appeal including applicable rules, Your right to representation (Authorized Representative) or other details, please contact the Plan. Refer to the ERISA Statement of Rights section of this document for details on Your additional rights to challenge the benefit decision under section 502(a) of ERISA.

Appeals should be sent within the prescribed time period as stated above to:

FISERV HEALTH PLAN ADMINISTRATORS INC
CLAIMS APPEAL UNIT
PO BOX 8086
WAUSAU WI 54402-8086

Send Pharmacy appeals to:
FISERV HEALTH PRESCRIPTION BENEFITS ADMINISTRATION
PO BOX 8082
WAUSAU WI 54402-8082

TIME PERIODS FOR MAKING DECISION ON APPEALS

After reviewing a claim that has been appealed, the Plan will notify You of its decision within the following timeframes, although You may voluntarily extend these timelines:

The timelines below will only apply to the mandatory appeal level. The voluntary appeal level will not be subject to specific timelines.

- Pre-Service Claim: Within a reasonable period of time appropriate to the medical circumstances but no later than 30 calendar days after the Plan receives Your request for review.
- Post-Service Claim: Within a reasonable period of time but no later than 60 calendar days after the Plan receives Your request for review.
- Concurrent Care Claims: Before treatment ends or is reduced.

LEGAL ACTIONS FOLLOWING APPEALS

After completing all mandatory appeal levels through this Plan, You have the right to further appeal Adverse Benefit Determinations by bringing a civil action under the Employee Retirement Income Security Act (ERISA). Please refer to the ERISA Statement of Rights section for more details. No such action may be filed against the Plan after three years from the date the Plan gives You a final determination on Your appeal.

PHYSICAL EXAMINATION AND AUTOPSY

The Plan may require that a Covered Person have a physical examination, at the Plan's expense, as often as is necessary to settle a claim. In the case of death, the Plan may require an autopsy unless forbidden by law.

RIGHT TO REQUEST OVERPAYMENTS

The Plan reserves the right to recover any payments made by the Plan that were:

- Made in error; or
- Made after the date the person should have been terminated under this Plan; or
- Made to You or any party on Your behalf where the employer determines the payment to You or any party is greater than the amount payable under this Plan.

The Plan has the right to recover against You if the Plan has paid You or any other party on Your behalf.

FRAUD

Fraud is a crime that can be prosecuted. Any Covered Person who willfully and knowingly engages in an activity intended to defraud the Plan is guilty of fraud. The Plan will utilize all means necessary to support fraud detection, investigation, and prosecution. It is a crime if You file a claim containing any false, incomplete or misleading information with intent to injure, defraud or deceive the Plan. These actions, as well as submission of false information, will result in denial of Your claim, and are subject to prosecution and punishment to the full extent under state and/or federal law. The Plan will pursue all appropriate legal remedies in the event of fraud.

As a Covered Person, You must:

- File accurate claims. If someone else - such as Your spouse or another family member - files claims on Your behalf, You should review the form before You sign it;
- Review the Explanation of Benefits (EOB) form when it is returned to You. Make certain that benefits have been paid correctly based on Your knowledge of the expenses Incurred and the services rendered;
- Never allow another person to seek medical treatment under Your identity. If Your Plan identification card is lost, You should report the loss to the Plan immediately; and
- Provide complete and accurate information on claim forms and any other forms. Answer all questions to the best of Your knowledge.

To maintain the integrity of Your Plan, You are encouraged to notify the Plan whenever a provider:

- Bills You for services or treatment that You have never received;
- Asks You to sign a blank claim form; or
- Asks You to undergo tests that You feel are not needed.

If You are concerned about any of the charges that appear on a bill or EOB form, or if You know of or suspect any illegal activity, call the toll-free hotline 1-800-356-5803. All calls are strictly confidential.

OTHER FEDERAL PROVISIONS

FAMILY AND MEDICAL LEAVE ACT (FMLA)

If an Employee is on a family or medical leave of absence that meets the eligibility requirements under FMLA, Your employer will continue coverage under this Plan in accordance with state and federal FMLA regulations, provided that the following conditions are met:

- Contribution is paid; and
- The Employee has written approved leave from the employer.

Coverage will be continued for up to the greater of:

- The leave period required by the federal Family and Medical Leave Act of 1993 and any amendment; or
- The leave period required by applicable state law.

An Employee can choose not to retain group health coverage during an FMLA leave. When the Employee returns to work following the FMLA leave, the Employee's coverage will usually be restored to the level the Employee would have had if the FMLA leave had not been taken, and no new pre-existing requirements will be imposed. For more information, please contact Your Human Resources or Personnel office.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS PROVISION

A Dependent child will become covered as of the date specified in a judgment, decree or order issued by a court of competent jurisdiction or through a state administrative process.

The order must clearly identify all of the following:

- The name and last known mailing address of the participant;
- The name and last known mailing address of each alternate recipient (or official state or political designee for the alternate recipient);
- A reasonable description of the type of coverage to be provided to the child or the manner in which such coverage is to be determined; and
- The period to which the order applies.

Please contact the Plan Administrator if You would like a copy of the written procedures, at no charge, that the Plan uses when administering Qualified Medical Child Support Orders.

Effective: 07-01-2006

NEWBORNS AND MOTHERS HEALTH PROTECTION ACT

Group health plans and health insurance issuers offering group health coverage generally may not, under federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a Cesarean section. 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). In any case, health plans and issuers may not, under federal law, require that a provider obtain authorization from the Plan or insurance issuer for prescribing a length of stay not in excess of the above periods. However, to use certain providers or facilities, or to reduce Your out-of-pocket costs, You may be required to obtain certification. Also under federal law, plans may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner that is less favorable to the mother or newborn than any earlier portion of the stay.

This group health Plan also complies with the provisions of the:

- Mental Health Parity Act.
- Women's Health and Cancer Rights Act of 1998 regarding breast reconstruction following a mastectomy.
- Pediatric Vaccines regulation, whereby an employer will not reduce its coverage for pediatric vaccines below the coverage it provided as of May 1, 1993.
- Coverage of Dependent children in cases of adoption or Placement for Adoption as required by ERISA.
- Health Insurance Portability provisions of the Health Insurance Portability and Accountability Act (HIPAA).
- Medicare Secondary Payer regulations, as amended.

HIPAA ADMINISTRATIVE SIMPLIFICATION MEDICAL PRIVACY AND SECURITY PROVISION

This Plan has been modified as required under the Administrative Simplification requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). These modifications have or will become effective as required by applicable provisions of the Privacy and Security Regulations.

First, under HIPAA Privacy Regulations, this Plan has been modified to allow the Disclosure of Protected Health Information (PHI), as defined under HIPAA, to the Plan Sponsor. The USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION UNDER HIPAA section of this document specifies the terms under which the Plan may share PHI with the Plan Sponsor and limits the Uses and Disclosures that the Plan Sponsor may make of Your PHI.

This Plan agrees that it will only Disclose Your PHI to the Plan Sponsor upon receipt of a certification from the Plan Sponsor that the terms contained in the USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION UNDER HIPAA section have been adopted and the Plan Sponsor agrees to abide by these terms.

The HIPAA Privacy Regulation provision of this Plan took effect April 14, 2003.

Second, under HIPAA Security Regulations, this Plan has been modified to require the Plan Sponsor to reasonably and appropriately safeguard Electronic Protected Health Information (Electronic PHI), as defined under HIPAA, created, received, maintained or transmitted to or by the Plan Sponsor on behalf of this Plan.

Modifications made for the HIPAA Security Regulations are effective as of April 21, 2005 and can be identified in this provision by reference to Security Regulations or Electronic PHI.

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION UNDER HIPAA PRIVACY AND SECURITY REGULATIONS

This Plan will Use Your Protected Health Information (PHI) to the extent of and in accordance with the Uses and Disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Specifically, this Plan will Use and Disclose Your PHI for purposes related to health care Treatment, Payment for health care and Health Care Operations. Additionally, this Plan will Use and Disclose Your PHI as required by law and as permitted by authorization. This section establishes the terms under which the Plan may share Your PHI with the Plan Sponsor, and limits the Uses and Disclosures that the Plan Sponsor may make of Your PHI.

This Plan shall Disclose Your PHI to the Plan Sponsor only to the extent necessary for the purposes of the administrative functions of Treatment, Payment for health care or Health Care Operations.

The Plan Sponsor shall Use and/or Disclose Your PHI only to the extent necessary for the administrative functions of Treatment, Payment for health care or Health Care Operations which it performs on behalf of this Plan.

This Plan agrees that it will only Disclose Your PHI to the Plan Sponsor upon receipt of a certification from the Plan Sponsor that the terms of this section have been adopted and that the Plan Sponsor agrees to abide by these terms.

The Plan Sponsor is subject to all of the following restrictions that apply to the Use and Disclosure of Your PHI:

- The Plan Sponsor will only Use and Disclose Your PHI (including Electronic PHI) for Plan Administrative Functions, as required by law or as permitted under the HIPAA regulations. Your Plan's Notice of Privacy Practices also contains more information about permitted Uses and Disclosures of PHI under HIPAA;

- The Plan Sponsor will implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan;
- The Plan Sponsor will require each of its subcontractors or agents to whom the Plan Sponsor may provide Your PHI to agree to the same restrictions and conditions imposed on the Plan Sponsor with regard to Your PHI;
- The Plan Sponsor will ensure that each of its subcontractors or agents to whom the Plan Sponsor may provide Electronic PHI to agree to implement reasonable and appropriate security measures to protect Electronic PHI;
- The Plan Sponsor will not Use or Disclose PHI for employment-related actions and decisions or in connection with any other of the Plan Sponsor's benefits or Employee benefit plans;
- The Plan Sponsor will promptly report to this Plan any impermissible or improper Use or Disclosure of PHI not authorized by the Plan documents;
- The Plan Sponsor will report to the Plan any security incident with respect to Electronic PHI of which Plan Sponsor becomes aware;
- The Plan Sponsor will allow You or this Plan to inspect and copy any PHI about You contained in the Designated Record Set that is in the Plan Sponsor's custody or control. The HIPAA Privacy Regulations set forth the rules that You and the Plan must follow and also sets forth exceptions;
- The Plan Sponsor will amend or correct, or make available to the Plan to amend or correct, any portion of Your PHI contained in the Designated Record Set to the extent permitted or required under the HIPAA Privacy Regulations;
- The Plan Sponsor will keep a Disclosure log for certain types of Disclosures set forth in the HIPAA Regulations. You have a right to see the Disclosure log. The Plan Sponsor does not have to maintain a log if Disclosures are for certain Plan-related purposes such as Payment of benefits or Health Care Operations;
- The Plan Sponsor will make its internal practices, books and records relating to the Use and Disclosure of Your PHI available to this Plan and to the Department of Health and Human Services or its designee for the purpose of determining this Plan's compliance with HIPAA;
- The Plan Sponsor must, if feasible, return to this Plan or destroy all Your PHI that the Plan Sponsor received from or on behalf of this Plan when the Plan Sponsor no longer needs Your PHI to administer this Plan. This includes all copies in any form, including any compilations derived from the PHI. If return or destruction is not feasible, the Plan Sponsor agrees to restrict and limit further Uses and Disclosures to the purposes that make the return or destruction infeasible;
- The Plan Sponsor will provide that adequate separation exists between this Plan and the Plan Sponsor so that Your PHI (including Electronic PHI) will be used only for the purpose of plan administration; and
- The Plan Sponsor will use reasonable efforts to request only the minimum necessary type and amount of Your PHI to carry out functions for which the information is requested.

The following Employees, classes of Employees or other workforce members under the control of the Plan Sponsor may be given access to Your PHI for Plan Administrative Functions that the Plan Sponsor performs on behalf of the Plan as set forth in this section:

Assistant Vice President, Human Resources & Auxiliary Operations, Payroll and Benefits Manager

This list includes every Employee, class of Employees or other workforce members under the control of the Plan Sponsor who may receive Your PHI. If any of these Employees or workforce members Use or Disclose Your PHI in violation of the terms set forth in this section, the Employees or workforce members will be subject to disciplinary action and sanctions, including the possibility of termination of employment. If the Plan Sponsor becomes aware of any such violations, the Plan Sponsor will promptly report the violation to this Plan and will cooperate with the Plan to correct the violation, to impose the appropriate sanctions and to mitigate any harmful effects to You.

DEFINITIONS

Administrative Simplification is the section of the law that addresses electronic transactions, privacy and security. The goals are to:

- Improve efficiency and effectiveness of the health care system;
- Standardize electronic data interchange of certain administrative transactions;
- Safeguard security and privacy of Protected Health Information;
- Improve efficiency to compile/analyze data, audit, and detect fraud; and
- Improve the Medicare and Medicaid programs.

Business Associate (BA) in relationship to a Covered Entity (CE) means a BA is a person to whom the CE discloses Protected Health Information (PHI) so that a person can carry out, assist with the performance of, or perform on behalf of, a function or activity for the CE. This includes contractors or other persons who receive PHI from the CE (or from another business partner of the CE) for the purposes described in the previous sentence, including lawyers, auditors, consultants, Third Party Administrators, health care clearinghouses, data processing firms, billing firms and other Covered Entities. This excludes persons who are within the CE's workforce.

Covered Entity (CE) is one of the following: a health plan, a health care clearinghouse or a health care provider who transmits any health information in connection with a transaction covered by this law.

Designated Record Set means a set of records maintained by or for a Covered Entity that includes a Covered Persons' PHI. This includes medical records, billing records, enrollment, Payment, claims adjudication and case management record systems maintained by or for this Plan. This also includes records used to make decisions about Covered Persons. This record set must be maintained for a minimum of 6 years.

Disclose or Disclosure is the release or divulgence of information by an entity to persons or organizations outside that entity.

Electronic Protected Health Information (Electronic PHI) is Individually Identifiable Health Information that is transmitted by electronic media or maintained in electronic media. It is a subset of Protected Health Information.

Health Care Operations are general administrative and business functions necessary for the CE to remain a viable business. These activities include:

- Conducting quality assessment and improvement activities;
- Reviewing the competence or qualifications and accrediting/licensing of health care professional plans;
- Evaluating health care professional and health plan performance;
- Training future health care professionals;
- Insurance activities relating to the renewal of a contract for insurance;
- Conducting or arranging for medical review and auditing services;
- Compiling and analyzing information in anticipation of or for use in a civil or criminal legal proceeding;
- Population-based activities related to improving health or reducing health care costs, protocol development, case management and care coordination;

- Contacting of health care providers and patients with information about Treatment alternatives and related functions that do not entail direct patient care; and
- Activities related to the creation, renewal or replacement of a contract for health insurance or health benefits, as well as ceding, securing, or placing a contract for reinsurance of risk relating to claims for health care (including stop-loss and excess of loss insurance).

Individually Identifiable Health Information is information that is a subset of health information, including demographic information collected from a Covered Person, and that:

- Is created by or received from a Covered Entity;
- Relates to the past, present or future physical or mental health or condition of a Covered Person, the provision of health care or the past, present or future Payment for the provision of health care; and
- Identifies the Covered Person or with respect to which there is reasonable basis to believe the information can be used to identify the Covered Person.

Payment means the activities of the health plan or a Business Associate, including the actual Payment under the policy or contract; and a health care provider or its Business Associate that obtains reimbursement for the provision of health care.

Plan Sponsor means Your employer.

Plan Administrative Functions means administrative functions of Payment or Health Care Operations performed by the Plan Sponsor on behalf of the Plan including quality assurance, claims processing, auditing and monitoring.

Privacy Official is the individual who provides oversight of compliance with all policies and procedures related to the protection of PHI and federal and state regulations related to a Covered Person's privacy.

Protected Health Information (PHI) is Individually Identifiable Health Information transmitted or maintained by a Covered Entity in written, electronic or oral form. PHI includes Electronic PHI.

Treatment is the provision of health care by, or the coordination of health care (including health care management of the individual through risk assessment, case management and disease management) among, health care providers; the referral of a patient from one provider to another; or the coordination of health care or other services among health care providers and third parties authorized by the health plan or the individual.

Use means, with respect to Individually Identifiable Health Information, the sharing, employment, application, utilization, examination or analysis of such information within an entity that maintains such information.

STATEMENT OF ERISA RIGHTS

As a Covered Person under this group health Plan, You are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Covered Persons 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 at work sites) all documents governing the Plan, including insurance contracts, collective bargaining agreements if applicable, and a copy of the latest annual report (Form 5500 series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration. No charge will be made for examining the documents at the Plan Administrator's principal office.
- Obtain, upon written request to the Plan Administrator, copies of documents that govern the operation of the Plan, including insurance contracts and collective bargaining agreements if applicable, and copies of the latest annual report and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report (Form 5500 series). The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

CONTINUE GROUP HEALTH COVERAGE

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

PRE-EXISTING CONDITIONS EXCLUSION PERIOD

There will be a reduction or elimination of exclusionary periods of coverage for Pre-Existing Conditions under Your group health Plan if You have Creditable Coverage from another plan. You should be provided a Certificate of Creditable Coverage free of charge, from Your group health Plan or health insurance issuer when You lose coverage under the Plan, when You become entitled to elect COBRA continuation coverage, when Your COBRA continuation coverage ceases, if You request it before losing coverage, or if You request it up to 24 months after losing coverage. Without evidence of Creditable Coverage, You may be subject to a Pre-Existing Condition exclusion for 12 months if You apply when first eligible, or 18 months for Late Enrollees, after Your Enrollment Date in Your coverage.

PRUDENT ACTIONS BY PLAN FIDUCIARIES

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

NO DISCRIMINATION

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

ENFORCE YOUR RIGHTS

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

Under ERISA, there are steps an Employee can take to enforce the above rights. For instance, if You request a copy of the Plan document or the latest annual report from the Plan and You do not receive them within thirty (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 Plan Administrator.

If a claim for benefits is denied or ignored, in whole or in part, the Covered Person may file suit in a state or federal court. In addition, if You disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, You may file suit in federal court. If it should happen that the Plan fiduciaries misuse the Plan's money or if You are discriminated against for asserting Your rights, You may seek assistance from the U.S. Department of Labor, or 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 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 the claim to be frivolous).

ASSISTANCE WITH YOUR QUESTIONS

If there are any questions about this Plan, the Plan Administrator should be contacted. If You have any questions about this statement or about Your rights under ERISA, or if You need assistance in obtaining documents from the Plan Administrator, You should contact the nearest office of the 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, D.C. 20210. You may also obtain certain publications about Your rights and responsibilities under ERISA by calling the publication hotline of the Employee Benefits Security Administration.

PLAN AMENDMENT AND TERMINATION INFORMATION

Effective: 07-01-2006

The Plan Sponsor fully intends to maintain this Plan indefinitely, however the employer reserves the right to terminate, suspend or amend this Plan at any time, in whole or in part, including making modifications to the benefits under this Plan. No person or entity has any authority to make any oral change or amendments to this Plan. The Plan Administrator will provide written notice to Covered Persons within 60 days following the adopted formal action that makes material changes to the Plan.

YOUR RIGHTS IF PLAN IS AMENDED OR TERMINATED

If this Plan is amended, Your rights are limited to Plan benefits in force at the time expenses are Incurred, whether or not You have received written notification from the Plan Administrator that the Plan has been amended.

If this Plan is terminated, the rights of a Covered Person are limited to Covered Expenses Incurred before You receive notice of termination.

The Plan will assume that You received the written amendment or termination letter from the Plan Administrator five days after the letter is mailed to You regarding the changes.

No person will become entitled to any vested rights under this Plan.

DISTRIBUTION OF ASSETS UPON TERMINATION OF PLAN

Plan assets will be held for the exclusive purpose of providing benefits and defraying reasonable expenses, and will not inure to the benefit of the employer, except:

- If Plan assets consist of both participant contributions and employer contributions, the employer will determine which portion of the remaining assets is from the employer contributions and which portion is from participant contributions. The assets that are from participant contributions will be used to cover the cost of Incurred Covered Expenses and reasonable expenses to administer the Plan. The portion of assets that are from employer contributions can be reverted to the employer.
- If all Plan assets are from employer contributions, the assets at the time of termination can revert to the employer, once Incurred Plan expenses have been paid.

NO CONTRACT OF EMPLOYMENT

This Plan is not intended to be, and may not be construed as a contract of employment between You and the employer.

GLOSSARY OF TERMS

Effective: 07-01-2006

Accident means an unexpected, unforeseen and unintended event that causes bodily harm or damage to the body.

Activities of Daily Living (ADL) means the following, with or without assistance: Bathing, dressing, toileting and associated personal hygiene; transferring (which is to move in and out of a bed, chair, wheelchair, tub or shower); mobility, eating (which is getting nourishment into the body by any means other than intravenous), and continence (which is voluntarily maintaining control of bowel and/or bladder function; in the event of incontinence, maintaining a reasonable level of personal hygiene).

Adverse Benefit Determination means a denial, reduction or termination of a benefit or a failure to provide or make payment, in whole or in part, for a benefit. It also includes any such denial, reduction, termination or failure to provide or make payment that is based on a determination that You are no longer eligible to participate in the Plan.

Ambulance Transportation means professional ground or air Ambulance Transportation in an Emergency situation or when deemed Medically Necessary, which is:

- To the closest facility most able to provide the specialized treatment required; and
- The most appropriate mode of transportation consistent with the well being of You or Your Dependent.

Birth Center means a legally operating institution or facility which is licensed and equipped to provide immediate prenatal care, delivery and postpartum care to the pregnant individual under the direction and supervision of one or more Physicians specializing in obstetrics or gynecology or a certified nurse midwife. It must provide for 24 hour nursing care provided by registered nurses or certified nurse midwives.

Certificate of Creditable Coverage means a certificate or other documentation that is provided to a person upon losing health care coverage. The certificate or other documentation specifies how much Creditable Coverage a person has and is used to reduce the length of a Pre-Existing Condition exclusion period under a Plan.

Close Relative means a member of the immediate family. Immediate family includes You, Your spouse, mother, father, grandmother, grandfather, step parents, step grandparents, siblings, step siblings, half siblings, children, step children and grandchildren.

COBRA means Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended from time to time, and applicable regulations. This law gives Covered Persons the right, under certain circumstances, to elect continuation coverage under the Plan when active coverage ends due to a Qualifying Event.

Co-pay is the amount a Covered Person must pay each time certain covered services are provided, as outlined on the Schedule of Benefits.

Common-Law Marriage is a partnership whereby a man and woman who have lived together for a certain period of time and who hold themselves to be husband and wife may be considered, in the State of Texas, to be married even without a license and a formal ceremony.

Cosmetic Treatment means medical or surgical procedures which are primarily used to improve, alter or enhance appearance, whether or not for psychological or emotional reasons.

Covered Expenses means any expense, or portion thereof, which is Incurred as a result of receiving an eligible benefit under this Plan.

Covered Person means You and Your Dependent(s) who are enrolled under this Plan.

Effective: 07-01-2006

Creditable Coverage means coverage an individual has under the following, as defined by federal law and applicable regulations:

- A group health plan;
- Health insurance coverage (through a group or individual policy);
- Medicare;
- Medicaid;
- A medical care program of the Uniformed Services;
- A medical care program of the Indian Health Services or of a tribal organization;
- A State health benefits risk pool;
- A State Children's Health Insurance Program;
- A health plan offered under the Federal Employee Health Benefits Program;
- A public health plan, including any plan established or maintained by a State, the US government, a foreign country or any political subdivision of the same; or
- A health benefit plan under Section 5(e) of the Peace Corps Act.

Creditable Coverage shall not include coverages for liability, disability income, limited scope dental or vision benefits, specified disease, supplemental benefits and other excepted benefits as defined by federal law and applicable regulations. A period of Creditable Coverage shall not be counted, with respect to enrollment under a group health plan, if there is a 63-day lapse in coverage between the end of the prior coverage and the beginning of the person's enrollment under this Plan.

Custodial Care means nonmedical care given to a Covered Person to administer medication and to assist with personal hygiene or other Activities of Daily Living rather than providing therapeutic treatment and services. Custodial Care services can be safely and adequately provided by persons who do not have the technical skills of a covered healthcare provider. Custodial Care also includes care when active medical treatment cannot be reasonably expected to reduce the disability or condition.

Deductible is the amount of Covered Expenses which must be paid by the Covered Person or the covered family before benefits are payable. The Schedule of Benefits shows the amount of the applicable Deductible (if any) and the health care benefits to which it applies.

Dependent – see Eligibility and Enrollment section of this document.

Developmental Delays is characterized by severe and pervasive impairment in various areas of development such as social interaction skills, adaptive behavior and communication skills. Developmental Delays may not always have a history of birth trauma or other Illness that could be causing the impairment such as a hearing problem, mental Illness or other neurological symptoms or Illness.

Durable Medical Equipment means equipment which:

- Can withstand repeated use.
- Is primarily used to serve a medical purpose with respect to an Illness or Injury.
- Generally is not useful to a person in the absence of an Illness or Injury.
- Is appropriate for use in the Covered Person's home.

Effective Date means the first day of coverage under this Plan as defined in this document.

Emergency means a serious medical condition, which arises suddenly and requires immediate care and treatment in order to avoid jeopardy to the life and health of the person.

Employee – see Eligibility and Enrollment section of this document.

Effective: 07-01-2006

Enrollment Date means:

- For anyone who applies for coverage when first eligible, the Enrollment Date is the date that coverage begins, or if there is a Waiting Period, the first day of the Waiting Period, whichever is earlier.
- For anyone who enrolls under the Special Enrollment Provision, the Enrollment Date is the first day of coverage.
- For Late Enrollees, the Enrollment Date is the first day of coverage.

ERISA means the Employee Retirement Income Security Act of 1974, as amended from time to time and the applicable regulations.

Experimental or Investigational means any supply, medicine, facility, equipment, service or treatment that:

- Is not currently or at the time the charges were Incurred recognized as acceptable medical practice by the Plan. (FDA approval does not necessarily constitute accepted medical practice)
- Is subject of ongoing Phase I, II or III clinical trials.
- Requires the Covered Person to sign a release or other document indicating that the treatment is Experimental or Investigational or other similar terms.
- Has not been approved by the appropriate government regulatory bodies.
- A drug or device that must have Food and Drug Administration (FDA) approval for those specific indications and methods of use for which such drug or device is sought to be provided, subject to medical judgment by Fiserv Health's medical staff or Qualified outside medical reviewers.

Any drug, device, procedure, service or treatment, which at the time sought to be provided is not approved by the Center for Medicare and Medicaid Services (CMS) for reimbursement under Medicare, is considered an Experimental procedure.

Drugs are considered Experimental if they are not commercially available for purchase, and are not approved by the FDA for general use. General use refers to permission for commercial distribution. Any other approvals that are granted as an interim step in the FDA regulatory process are considered Experimental procedures.

Any drug or device approved by the FDA for a specific disease, Injury, Illness or condition, but which is sought to be provided for another disease, Injury, Illness or condition, is considered Experimental, subject to medical judgment by Fiserv Health's medical staff or Qualified outside medical reviewers.

- Based on prevailing peer reviewed medical literature in the United States, there is failure to demonstrate that the treatment is safe and effective for the condition, and that there is not enough scientific evidence to support conclusions concerning the effect of the drug, device, procedure, service or treatment on health outcomes.

The evidence must consist of well-designed and well-conducted investigations published in peer-review journals. The quality of the body of studies and the consistency of the results are considered in evaluating the evidence.

The evidence must demonstrate that the drug, device, procedure, service or treatment can measure or alter the sought after changes to the disease, Injury, Illness or condition. In addition, there must be evidence or a convincing argument based on established medical research that such measurement or alteration affects that health outcome.

Opinions and evaluations by national medical associations, consensus panels, other technology evaluation bodies or outside independent review organizations are evaluated according to the scientific quality of the supporting evidence and rationale.

References used in the evaluation include, but are not limited to, The American Cancer Society, The American Medical Association, FDA, US Department of Health & Human Services, Merck Manual, Mosby Advanced Catalog Search, National Library of Medicine Search, National Institutes of Health, Pubmed (Medicine), The Hayes Directory of New Medical Technologies and/or the American Academies or Colleges of various Physician specialties.

A service, supply, treatment or facility may be considered Experimental or Investigational, even if the provider has performed, prescribed, recommended, ordered or approved it, or if it is the only available procedure or treatment for the Illness or Injury.

Extended Care Facility includes, but is not limited to a skilled nursing, convalescent or subacute facility. It is an institution or a designated part of one that is operating pursuant to the law for such an institution and is under the full time supervision of a Physician or registered nurse. In addition, the Plan requires that the facility: Provide 24 hour-a-day service to include skilled nursing care and Medically Necessary therapies for the recovery of health or physical strength; is not a place primarily for Custodial Care; requires compensation from its patients; admits patients only upon Physician orders; has an agreement to have a Physician's services available when needed; maintains adequate medical records for all patients; has a written transfer agreement with at least one Hospital and is licensed by the state in which it operates and provides the services under which the licensure applies.

Full-Time Student means a student attending an accredited 2- or 4-year college or university and which is accredited in the current publication of accredited institutions of higher education or a licensed trade school. Attendance is based on what the accredited school considers to be full-time.

HIPAA means the Health Insurance Portability and Accountability Act of 1996, as amended from time to time, and the applicable regulations. This law gives special enrollment rights, prohibits discrimination, and protects privacy of protected health information among other things.

Home Health Care means a formal program of care and intermittent treatment that is: Performed in the home; and prescribed by a Physician; and intermittent care and treatment for the recovery of health or physical strength under an established plan of care; and prescribed in place of a Hospital or an Extended Care Facility or results in a shorter Hospital or Extended Care Facility stay; and organized, administered, and supervised by a Hospital or Qualified licensed providers under the medical direction of a Physician; and appropriate when it is not reasonable to expect the Covered Person to obtain medically indicated services or supplies outside the home.

For purposes of Home Health Care, Nurse Services means Intermittent home nursing care by professional registered nurses or by licensed practical nurses. Intermittent means occasional or segmented care, i.e., care that is not provided on a continuous, non-interrupted basis.

Hospice Care means a health care program providing a coordinated set of services rendered at home, in Outpatient settings, or in Inpatient settings for Covered Persons suffering from a condition that has a terminal prognosis. Non-curative supportive care is provided through an interdisciplinary group of personnel. A hospice must meet the standards of the National Hospice Organization and applicable state licensing.

Hospice Care Provider means an agency or organization that has Hospice Care available 24 hours a day, seven days a week; is certified by Medicare as a Hospice Care Agency, and, if required, is licensed as such by the jurisdiction in which it is located. The provider may offer skilled nursing services; medical social worker services; psychological and dietary counseling; services of a Physician, physical or occupational therapist; home health aide services; pharmacy services; and Durable Medical Equipment.

Effective: 07-01-2006

Hospital means:

- A facility that is licensed as an acute Hospital; and
- Provides diagnostic and therapeutic facilities for the surgical or medical diagnosis, treatment, and care of injured and sick persons as Inpatients; and
- Has a staff of licensed Physicians available at all times; and
- It is accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or is recognized by the American Hospital Association (AHA) and is qualified to receive payments under the Medicare program; and
- Always provides 24 hour nursing services by registered graduate nurses; and
- Is not a place primarily for Custodial or Maintenance Care.

For purposes of this Plan, Hospital also includes Surgical Centers and Birthing Centers licensed by the state in which it operates. Hospital does not include services provided in facilities operating as residential treatment centers.

Illness means sickness, disease or disorders, whether physical or mental. Pregnancy and complications of pregnancy are considered an Illness under this Plan.

Incurred means the date the service or treatment is given, the supply is received or the facility is used, without regard to when the service, treatment, supply or facility is billed, charged or paid.

Independent Contractor means an entity or individual who performs services to or on behalf of the employer who is not an Employee or an officer of the employer and who retains control over how the work gets done. The employer who hires the Independent Contractor controls only the outcome of the work and not the performance of the hired service. Determination as to whether an individual or entity is an Independent Contractor shall be made consistent with Section § 530 of the Internal Revenue Code.

Infertility Treatment means services, tests, supplies, devices, or drugs which are intended to promote fertility, achieve a condition of pregnancy, or treat an Illness causing an infertility condition when such treatment is done in an attempt to bring about a pregnancy.

For purposes of this definition, Infertility Treatment includes, but is not limited to fertility tests and drugs; tests and exams done to prepare for induced conception; surgical reversal of a sterilized state which was a result of a previous surgery; sperm enhancement procedures; direct attempts to cause pregnancy by any means including, but not limited to: hormone therapy or drugs; artificial insemination; In vitro fertilization; Gamete Intrafallopian Transfer (GIFT), or Zygote Intrafallopian Transfer (ZIFT); embryo transfer; and freezing or storage of embryo, eggs, or semen.

Injury means an act causing harm or damage to the body.

Inpatient means a registered bed patient using and being charged for room and board at the Hospital or in a Hospital for 24 hours or more. A person is not an Inpatient on any day on which he or she is on leave or otherwise gone from the Hospital, whether or not a room and board charge is made.

Late Enrollee means a person who enrolls under this Plan other than on:

- The earliest date on which coverage can become effective under the terms of this Plan; or
- A special Enrollment Date for the person as defined by HIPAA.

Learning Disability means a group of disorders that results in significant difficulties in one or more of seven areas including: basic reading skills, reading comprehension, oral expression, listening comprehension, written expression, mathematical calculation and mathematical reasoning. Specific learning disabilities are diagnosed when the individual's achievement on standardized tests in a given area is substantially below that expected for age, schooling and level of intelligence.

Effective: 07-01-2006

Maximum Benefit means the maximum amount to be paid by the Plan on behalf of the Covered Person for Covered Expenses which are Incurred while the person is covered under the Plan.

Medically Necessary or Medical Necessity means treatment, services, supplies, medicines, or facilities necessary and appropriate for the diagnosis, care, or treatment of an Illness or Injury and which meet all of the following criteria as determined by the Plan:

- The health intervention is for the purpose of treating a medical condition; and
- Is the most appropriate supply or level of service, considering potential benefits and harms to the patient; and
- Is known to be effective in improving health outcomes. For new interventions, effectiveness is determined by scientific evidence. For existing interventions, effectiveness is determined first by scientific evidence, then by professional standards, and finally by expert opinion; and
- Is cost effective for this condition, compared to alternative interventions, including no intervention. Cost effective does not necessarily mean the lowest price; and
- Not primarily for the convenience or preference of the Covered Person, his or her family or any provider; and
- It is not Experimental, Investigational, Cosmetic or Custodial in nature; and
- Is currently or at the time the charges were Incurred recognized as acceptable medical practice by the Plan.

The fact that a Physician has performed, prescribed, recommended, ordered, or approved a service, treatment plan, supply, medicine, equipment or facility, or that it is the only available procedure or treatment for a condition, does not, in itself, make the utilization of the service, treatment plan, supply, medicine, equipment or facility Medically Necessary.

Mental Health Disorder means disorders that are clinically significant psychological syndromes associated with distress, dysfunction or Illness. The syndrome must represent a dysfunctional response to a situation or event that exposes the Covered Person to an increased risk of pain, suffering, conflict, Illness or death.

Mentally Disabled means an individual who has been diagnosed to have a psychiatric or behavior disorder that severely limits the individual's ability to function without daily supervision or assistance.

Orthotic Appliances means braces, splints and other appliances used to support or restrain a weak or deformed part of the body and is designed for repeated use, intended to treat or stabilize a Covered Person's Illness or Injury or improve function; and generally is not useful to a person in the absence of an Illness or Injury.

Outpatient means other than an Inpatient.

Participating Pharmacy means a licensed entity, acting within the scope of their license in the state in which they dispense, that has entered into a written agreement with Fiserv Health Pharmacy Benefits Administrator and has agreed to provide services to covered individuals for the fees negotiated in the agreement.

Participation means that You and the Plan each pay a percentage of the Covered Expenses as listed on the Schedule of Benefits, after You pay the Deductible(s).

Physician means any of the following licensed practitioners, acting within the scope of their license in the state in which they practice, who perform services payable under this Plan: a doctor of medicine (MD), doctor of dental medicine including oral surgeons (DMD), osteopathy (DO), podiatry (DPM), dentistry (DDS), chiropractic (DC), optometry (OPT), a physician's assistant (PA), a nurse practitioner (NP), a certified nurse midwife (CNM), or a certified registered nurse anesthetist (CRNA).

Effective: 07-01-2006

Placed or Placement for Adoption means the assumption and retention of a legal obligation for total or partial support of a child in anticipation of adoption of such child. The child's placement with the person terminates upon the termination of such legal obligation.

Plan means UNIVERSITY OF ST THOMAS Group Health Benefit Plan.

Plan Sponsor means an employer who sponsors a group health plan.

Pre-Existing Condition means an Illness or Injury for which medical advice, diagnosis, care or treatment was recommended or received within the timeframe specified in the Pre-Existing Condition Provision section of this document.

Preventive/Routine Care means a prescribed standard procedure that is ordered by a Physician to evaluate or assess Your health and well being, screen for possible detection of unrevealed Illness or Injury, improve Your health, or extend Your life expectancy. Benefits included as Preventive/Routine Care are listed in the Schedule of Benefits and will be paid subject to any listed limits or maximums. Preventive/Routine Care does not include benefits specifically excluded by this Plan, or treatment after the diagnosis of an Illness or Injury.

Qualified means licensed, registered or certified by the state in which the provider practices.

Reconstructive Surgery means surgical procedures performed on abnormal structures of the body caused by congenital Illness or anomaly, Accident, or Illness. It is generally performed to achieve a normal appearance and may also be performed to improve or restore function.

Significant Break in Coverage means a period of 63 consecutive days during which a person does not have any Creditable Coverage.

Surgical Center means a licensed facility that is under the direction of an organized medical staff of Physicians; has facilities that are equipped and operated primarily for the purpose of performing surgical procedures; has continuous Physician services and registered professional nursing services available whenever a patient is in the facility; generally does not provide Inpatient services or other accommodations; and offers the following services whenever the patient is in the center:

- Provides drug services as needed for medical operations and procedures performed;
- Provides for the physical and emotional well being of the patients;
- Provides Emergency services;
- Has organized administration structure and maintains statistical and medical records.

Telemedicine means the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data and education using interactive audio, video, or data communications.

Temporomandibular Joint Disorder (TMJ) shall mean a disorder of the jaw joint(s) and/or associated parts resulting in pain or inability of the jaw to function properly.

Terminal Illness or Terminally Ill means a life expectancy of about six months.

Third Party Administrator (TPA) is a service provider hired by the Plan to process claims and perform other administrative services. The TPA does not assume liability for payment of benefits under this Plan.

Usual and Customary means the amount the Plan determines to be the reasonable charge for comparable services, treatment, or materials in a Geographical Area. **Geographical Area** means a zip code area, or a greater area if the Plan determines it is needed to find an appropriate cross section of accurate data.

You, Your means the Employee.