SUMMARY PLAN DESCRIPTION

Augustana College

EMPLOYEE HEALTH CARE PLAN

This booklet is your Summary Plan Description. Its purpose is to summarize the provisions of the Plan, which provides and/or affects payment or reimbursement. The Plan Document takes precedence over this booklet. This Summary Plan Description supersedes any and all previous Summary Plan Descriptions issued to you by Augustana College.

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

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

We believe that each participant has the responsibility to: read and understand the benefit plan and comply with the rules and limitations stated therein; carry and present his or her identification card prior to receiving services; notify the Plan of any eligibility or address changes for any covered person(s); supply health care providers with any information needed for provision of health care services; notify health care providers in a timely manner of appointment cancellations; and follow the health care provider's instructions and guideline.

We strongly encourage each person insured under this plan to enroll with Medicare upon attaining eligibility, which is generally at age 65. You are entitled to Medicare benefits even if you are still actively working and/or are covered by another health care plan.

All health benefits described herein are being provided and maintained for you and your covered dependents by Augustana College, hereinafter referred to as the "Company." Butler Benefit Service, Inc. will process all benefit payments.

Claims should be submitted to:

Butler Benefit Service, Inc.
P.O. Box 3310
Davenport, Iowa 52808-3310
(563) 327-2200
(866) 927-2200

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PLAN DESCRIPTION

PURPOSE
The Plan Document details the benefits, rights, and privileges of Covered Individuals (as later defined), in a fund established by Augustana College and referred to as the "Plan." The Plan Document explains the times when the Plan will pay or reimburse all or a portion of covered expenses.

EFFECTIVE DATE
The effective date of the Plan is September 1, 2010.
The Plan is amended effective September 1, 2010, September 1, 2011, January 1, 2012 and July 1, 2012.

NAME OF PLAN	Augustana College Employee Health Care Plan
NAME, ADDRESS AND PHONE NUMBER OF PLAN SPONSOR	Augustana College 639 38th Street Rock Island, Illinois 61201-2296 (309) 794-7000
NAME, ADDRESS AND PHONE NUMBER OF CLAIMS PROCESSOR	Butler Benefit Service, Inc. (BBSI) P.O. Box 3310 Davenport, Iowa 52808-3310 (563) 327-2200 (866) 927-2200
EMPLOYER IDENTIFICATION NUMBER	36-2166962
GROUP NUMBER	BBS0169
PLAN NUMBER	508
TYPE OF BENEFIT PROVIDED	Medical and Prescription Drug Expense Coverage
PLAN ADMINISTRATOR AND AGENT FOR LEGAL SERVICE	Chief Business and Financial Officer Director of Human Resources Controller of the College Augustana College 639 38th Street Rock Island, Illinois 61201-2296 (309) 794-7000
FUNDING OF THE PLAN	This is a self-funded benefit plan coming within the purview of the Employee Retirement Income Security Act of 1974 (“ERISA”) and the laws of the State of Illinois. The Plan is funded with employee and/or employer contributions. Plan benefits are provided directly from the Plan through the Claims Processor.
FISCAL YEAR OF THE PLAN	Begins September 1st and ends August 31st.
BENEFIT YEAR OF THE PLAN	Calendar Year (January 1st through December 31st)
MEDIUM FOR PROVIDING BENEFITS	The Claims Processor processes claims in accordance with the Plan Document.

Plan Sponsor
Augustana College is the Plan Sponsor. The Plan Sponsor has established the Plan, and has the sole discretion to maintain, amend and/or terminate the Plan.

Named Fiduciary and Plan Administrator
The Named Fiduciary and Plan Administrator is Augustana College, who will have the authority to control and manage the operation and administration of the Plan. The Plan Administrator (or similar decision making body) has the sole authority and discretion to interpret and construe the terms of the Plan and to determine any and all questions in relation to the administration, interpretation or operation of the Plan, including, but not limited to, eligibility under the Plan, payment of benefits or claims under the Plan and any and all other matters arising under the Plan.

Claims Processor is Not a Fiduciary
The Claims Processor is not a fiduciary under the Plan by virtue of paying claims in accordance with the Plan's rules as established by the Plan Administrator.

Legal Entity
The Plan is a legal entity. Legal notice may be filed with, and legal process served upon, the Plan Administrator.

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

Discretionary Authority
The Plan Administrator shall have sole, full and final discretionary authority to interpret all Plan provisions, including the right to remedy possible ambiguities, inconsistencies or omissions in the Plan and related documents; to make determinations in regards to issues relating to eligibility for benefits; to decide disputes that may arise relative to a Plan Participants rights; and to determine all questions of fact and law arising under the Plan.

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

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

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

Claim Procedure
The College will provide adequate notice in writing to any Covered employees whose claim for benefits under this Plan has been denied, setting forth the specific reasons for such denial and written in a manner calculated to be understood by the employee. Further, the College will afford a reasonable opportunity to any employee, whose claim for benefits has been denied, for a full and fair review of the decision denying the claim by the person designated by the College for that purpose.

Protection against Creditors
No benefit payment under this Plan will be subject in any way to alienation, sale, transfer, pledge, attachment, garnishment, execution, or encumbrance of any kind, and any attempt to accomplish the same will be void. If the College will find that such an attempt has been made with respect to any payment due or to become due to any Covered employee, the College in its sole discretion may terminate the interest of such Covered employee or former Covered employee in such payment, and in such case will apply the amount of such payment to or for the benefit of such Covered employee or former Covered employee, his spouse, parent, adult child, guardian of a minor child, brother or sister, or other relative of a dependent of such Covered employee or former Covered employee, as the College may determine, and any such application will be a complete discharge of all liability with respect to such benefit payment.

Indemnification of Employees
No director, officer, or employee of the College or of the Claims Processor will incur any personal liability for the breach of any responsibility, obligation, or duty in connection with any act done or omitted to be done in good faith in the administration or management of the Plan and will be indemnified and held harmless by the College from and against any such personal liability, including all expenses reasonably incurred in his defense if the College fails to provide such defense. The College and the Plan may each purchase fiduciary liability insurance consistent with applicable law.

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

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

IMPORTANT NOTICES

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

Under federal law, group health plans and health insurance issuers offering group health insurance generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or the newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, the plan or issuer may pay for a shorter stay if the attending physician (e.g., your physician, nurse, or midwife, or a physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and insurers 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 less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification, contact your plan administrator.

AVAILABILITY OF NOTICE OF PRIVACY PRACTICES

The Augustana College Employee Health Care Plan (Plan) maintains a Notice of Privacy Practices that provides information to individuals whose protected health information (PHI) will be used or maintained by the Plan. If you would like a copy of the Plan's Notice of Privacy Practices, please contact the Director of Human Resources at Augustana College at (309) 794-7000, or in writing at 639 38th Street, Rock Island, Illinois 61201.

QUALIFIED MEDICAL CHILD SUPPORT ORDER PROCEDURES

Qualified Medical Child Support Order

A Qualified Medical Child Support Order (QMCSO) is a medical child support order which creates or recognizes an Alternate Recipient's right to, or assigns to an Alternate Recipient the right to, receive benefits for which a Covered Individual is eligible, and which the Plan Administrator has determined meets the requirements of this Section. A Medical Child Support Order to be qualified must clearly:

a. Specify the name and last known mailing address (if any) of the Covered employee and the name and mailing address of each Alternate Recipient covered by the order; and
b. Include a reasonable description of the type of coverage to be provided by the Plan to each Alternate Recipient, or the manner in which such type of coverage is to be determined; and
c. Specify each period to which such order applies; and
d. Specify each plan to which such order applies; and
e. Not require the Plan to provide any type or form of benefits or any option not otherwise provided under the Plan except to the extent necessary to meet the requirements described in Section 1908 of the Social Security Act (relating to the enforcement of state laws regarding child support and reimbursement of Medicaid).

Upon receipt of a Medical Child Support Order, the Plan Administrator shall:

1. Promptly notify in writing the Covered employee, each Alternate Recipient covered by the order, and each representative for these parties of the receipt of the Medical Child Support Order. Such notice shall include a copy of the order and the Plan's QMCSO procedures.
2. Permit the Alternate Recipient to designate a representative to receive copies of notices sent the Alternate Recipient regarding the Medical Child Support Order.
3. Within a reasonable period after receiving a Medical Child Support Order, determine whether it is a qualified order and notify the parties indicated in subsection (a) above of such determination.
4. Ensure the Alternate Recipient is treated by the Plan as a beneficiary for reporting and disclosure purposes, such as by distributing to the Alternate Recipient a copy of the Summary Plan Description and any subsequent Summaries of Material Modifications generated by a Plan Amendment.

Covered Individuals and beneficiaries may obtain without charge a copy of the Qualified Medical Child Support Order procedures from the Plan Administrator.

CLAIMS AND APPEALS: EXTERNAL REVIEW

When a Covered Individual has exhausted the internal appeals process outlined herein, the Covered Individual has a right to have that decision reviewed by independent health care professionals who has no association with the Plan, the Plan Sponsor, or the Plan Administrator. If the adverse benefit determination involved making a judgment as to the medical necessity, appropriateness, health care setting, level of care or effectiveness of the health care service or treatment you requested, you may submit a request to the Plan for external review within **4 months** after receipt of a denial of benefits; such request should be addressed to: Claims Manager, Butler Benefit Service, Inc., P.O. Box 3310, Davenport, Iowa, 52808-3310. For standard external review, a decision will be made within **45 days** of receiving your request. If you have a medical condition that would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function if treatment is delayed, you may be entitled to request an **expedited external review** of the denial. If our denial to provide or pay for health care service or course of treatment is based on a determination that the service or treatment is experimental or investigation, you also may be entitled to file a request for external review of our denial.

Please contact your Plan Administrator with any questions on your rights to external review.

PRIOR WRITTEN APPROVAL

Before you receive certain services, supplies or procedures, you should have written authorization. This procedure is called Prior Written Approval. This program helps determine if a proposed treatment plan is medically necessary and is a benefit of this Plan. It is in your best interest to receive Prior Written Approval ***before*** you receive any of the services listed below. Without Prior Written Approval for any of the following services, the Plan cannot confirm benefits:

- Communication System (Touch Talker).
- Cosmetic procedure, including but not limited to: scar revisions, reconstruction of nose (rhinoplasty), port wine stain surgery, surgery on eyelids (blepharoplasty), surgery to correct overbite or underbite (orthognathic surgery) and breast surgery (including reconstruction, reduction or gynecomastia).
- Charges for dental services not specifically included in benefits described in this Plan; or for hospital charges in relation to dental care, except those services which are certified by a medical doctor to be medically necessary to safeguard the life and health of the Covered Individual due to the existence of a non-dental physical condition.
- Electrical stimulation of the spine (dorsal column stimulator).
- Electronic Limbs (myo-electric and other electronic prosthetic devices).
- Bone Growth Stimulator.
- Growth Hormones.
- Insulin infusion pump.
- Motorized wheelchair including chairs with three or four wheels.
- Reduction mammoplasty.
- Replacement of prosthetic appliance.
- Surgery to correct funneled or hollowed chest (pectus excavatum surgery).
- All transplants and joint replacements, including but not limited to cornea, artery or vein, bone marrow, heart, heart and lung, lung, valve, kidney, implantable prosthetic lenses in connection with cataracts, joint replacement, liver, prosthetic bypass or replacement vessels.
- Uvulopalatopharyngoplasty to reduce sleep apnea.

This is not meant to be an all-inclusive list. Always consult with Butler Benefit Service, Inc. when purchasing health care services, supplies or equipment if you are in any doubt of eligible charges.

Certain factors may alter or impact the Prior Written Approval decision by the Plan, including Plan coverage, the date services are incurred, the amount approved for payment and the provider of such services.

Written request for authorization should be sent to the Plan care of:

Butler Benefit Service, Inc.
P.O. Box 3310
Davenport, Iowa 52808-3310
Phone: (563) 327-2200 or (866) 927-2200
Fax: (563) 327-2250 or (866) 927-2250

Once the Plan reviews the request, written notice of the decision will be mailed to the Covered Individual and the provider to the most current address on record for each.

Please note: Even if you receive written prior approval for a service, certain services are still subject to pre-certification; please refer to the “Pre-Certification” provision in the MANAGED CARE section of this document.

PREFERRED PROVIDER NETWORK

This Plan is a plan which contains a Preferred Provider Organization. This Plan has entered into an agreement with certain hospitals, physicians and other health care providers, which are called Participating Providers, or In-Network Providers. Because these Participating Providers have agreed to charge reduced fees to persons covered under the Plan, the Plan can afford to reimburse a higher percentage of their fees for eligible expenses covered under the Plan. If a Covered Individual uses a Participating Provider, that Covered Individual may receive a higher benefit percentage from the Plan than when a Non-Participating, or Out-of-Network, Provider is used.

The term "Eligible Expenses" is defined elsewhere in the Plan. Any charges which exceed the Usual and Customary charges, as determined by the Plan, or which are determined by the Plan to be Not Reasonable, or which are determined by the Plan to be ineligible, will not be considered as, nor reimbursed as, In-Network expenses.

The Plan may decide from time to time, at its sole discretion, to reimburse a provider at the "In-Network" level of benefits if that provider agrees to discount charges for covered eligible expenses incurred by Covered Individuals, even if that provider does not participate in the Plan's Preferred Provider Organization.

Covered Individuals access the PPO network by choice and at their own discretion. Choice of a Participating Provider is not a requirement for coverage under this Plan

The PPO which is applicable to each Covered Individual is shown on the Covered Individual's health plan identification card. Information about the PPO network(s) available to this Plan's Covered Individuals, including instructions on how to access the directory of participating providers, will be provided to Covered Individuals and updated as needed.

If any of the following circumstances apply, benefits will be payable at the In-Network level of benefits for eligible expenses:

- The Covered Individual receives Anesthesia services by an Out-of-Network Provider at an In-Network facility.
- During a scheduled in-patient admission at an In-Network facility, the Covered Individual receives consulting services from an Out-of-Network physician, provided the admitting physician is In-Network.
- The service was not available through the PPO.
- The patient has obtained an Approved Referral ***prior to the service being rendered***; such referral must be:
    1. Written by a Participating physician for specific services; and
    2. Reviewed by the Utilization Review Agent for medical necessity and appropriateness; and
    3. Approved by the Plan Administrator.

  An Approved Referral will remain in force through a course of treatment or twelve (12) consecutive months, whichever is less.
- Emergency care when an In-Network provider is not available.
- Services for Covered Individuals who travel and receive services outside the area served by the Network, provided that the travel is for other than the purpose of obtaining medical care.
- Services for Covered Dependent Children who live outside of the area served by the Network.
- Ancillary services when the primary service is rendered by an In-Network provider.

Wrap Network
Also known as a "vacation" network; this is a preferred provider organization the Plan utilizes when a Covered Individual incurs expenses for emergency or urgent care services outside of their home area. There is no need to locate a participating provider when emergency or urgent care is necessary.

Tertiary/Catastrophic Network
A preferred provider organization the Plan utilizes when a Covered Individual suffers a catastrophic illness or injury. Some instances when a tertiary network may be accessed include, but are not limited to:
Organ Transplants, Cardiovascular/Heart Disease Procedures, High Risk Maternity, Neonatal Cases, Cancer, Severe Burns, Severe Trauma, High-risk Medical/Surgical Cases.
Please contact BBSI for assistance in locating appropriate providers.

DETERMINATION OF ELIGIBLE EXPENSES

The Plan Administrator retains discretionary authority to determine whether charges are considered to be eligible expenses under the Plan, based upon information presented to the Plan Administrator. The Plan refers to the terms "reasonable," "usual and customary," "medically necessary" and other similar and related terms throughout the Plan Document and Summary Plan Description. This purpose of this section is to explain these terms and their impact on the benefits provided under the Plan.

Clean Claim

A Clean Claim is one that can be processed without obtaining additional information from the provider of the service or a third party. It is a claim which has no defect or impropriety. A defect or impropriety shall include a lack of required sustaining documentation or a particular circumstance requiring special treatment which prevents timely payment from being made. A Clean Claim does not include claims under investigation for fraud and abuse or claims under review for medical necessity.

Filing a Clean Claim. A provider submits a Clean Claim by providing the required data elements on the standard claims forms, along with any attachments and additional elements or revisions to data elements, attachments and additional elements, of which the provider has knowledge. The Plan Administrator may require attachments or other information in addition to these standard forms (as noted elsewhere in this document and at other times prior to claim submittal). The paper claim form or electronic file record must include all required data elements and must be complete, legible, and accurate. A claim will not be considered to be a Clean Claim if the Covered Individual has failed to submit required forms or additional information to the Plan as well.

Medically Necessary and Medical Necessity

Medical Necessity and similar language refers to health care services ordered by a Physician exercising prudent clinical judgment provided to a Covered Individual for the purposes of evaluation, diagnosis or treatment of that Covered Individual's Sickness or Injury. Such services, to be considered Medically Necessary, must be clinically appropriate in terms of type, frequency, extent, site and duration for the diagnosis or treatment of the Covered Individual's Sickness or Injury. The Medically Necessary setting and level of service is that setting and level of service which, considering the Covered Individual's medical symptoms and conditions, cannot be provided in a less intensive medical setting. Such services, to be considered Medically Necessary must be no more costly than alternative interventions, including no intervention and are at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the Covered Individual's Sickness or Injury without adversely affecting the Covered Individual's medical condition.

a. It must not be maintenance therapy or maintenance treatment.
b. Its purpose must be to restore health.
c. It must not be primarily custodial in nature.
d. It must not be a listed item or treatment not allowed for reimbursement by CMS (Medicare).

The Plan reserves the right to incorporate CMS (Medicare) guidelines in effect on the date of treatment as additional criteria for determination of Medical Necessity and/or an Allowable Expense.

Reasonableness

The Plan will only pay fee(s) that, in the Plan Administrator's discretion, are for services or supplies which are necessary for the care and treatment of an illness or injury not caused by the treating provider. Determination that charges are reasonable will be made by the Plan Administrator, taking into consideration unusual circumstances or complications; industry standards and practices as they relate to similar scenarios; and the cause of injury or illness necessitating the charge(s).

This determination will consider, but will not be limited to, the findings and assessments of the following entities: (a) The National Medical Associations, Societies, and Organizations; and (b) The Food and Drug Administration. Services, supplies, care and/or treatment that results from errors in medical care that are clearly identifiable, preventable, and serious in their consequence for patients, are not reasonable. The Plan Administrator retains discretionary authority to determine whether charges(s) are reasonable based upon information presented to the Plan Administrator. A finding of provider negligence and/or malpractice is not required for charge(s) to be considered not reasonable.

Usual and Customary (U&C)

Only Usual and Customary charges are covered expenses. When determining whether an expense is Usual and Customary, the Plan Administrator will take into consideration the fee(s) which the provider most frequently charges the majority of patients for the service or supply, and the prevailing range of fees charged in the same "area" by providers of similar training and experience for the service or supply. The term(s) "same geographic locale" and/or "area" shall be defined as a metropolitan area, county, or such greater area as is necessary to obtain a representative cross-section of providers, persons or organizations rendering such treatment, services, or supplies for which a specific charge is made. To be Usual and Customary, fee(s) must be in compliance with generally accepted billing practices for unbundling or multiple procedures.

The term "Usual" refers to the amount of a charge made for medical services, care, or supplies, to the extent that the charge does not exceed the common level of charges made by other medical professionals with similar credentials, or health care facilities, pharmacies, or equipment suppliers of similar standing, which are located in the same geographic locale in which the charge is incurred.

The term "Customary" refers to the form and substance of a service, supply, or treatment provided in accordance with generally accepted standards of medical practice to one individual, which is appropriate for the care or treatment of the same sex, comparable age and who receive such services or supplies within the same geographic locale.

The term "Usual and Customary" does not necessarily mean the actual charge made nor the specific service or supply furnished to a Plan Participant by a provider of services or supplies, such as a physician, therapist, nurse, hospital, or pharmacist. The Plan Administrator will determine what the Usual and Customary charge is, for any procedure, service, or supply, and whether a specific procedure, service or supply is Usual and Customary.

Usual and Customary charges may alternatively be determined and established by the Plan using normative data such as Medicare cost to charge ratios, average wholesale price (AWP) for prescriptions and/or manufacturer's retail pricing (MRP) for supplies and devices.

Medical Record Review

In the event that the Plan, based upon a medical record review and audit, determines that a different treatment or different quantity of a drug or supply was provided which is not supported in the billing, then the Plan Administrator may determine the Maximum Allowable Charge according to the medical record review and audit results.

Maximum Allowable Charge

The Maximum Allowable Charge(s) will be the lesser of:

- The Usual and Customary amount,
- The allowable charge specified under the terms of the Plan,
- The negotiated rate established in a contractual arrangement with a provider, or
- The actual billed charges for the covered services

The Plan will reimburse the actual charge billed if it is less than the Usual and Customary amount. The Plan has the discretionary authority to decide if a charge is Reasonable, Usual and Customary.

Errors

The Maximum Allowable Charge will not include any identifiable billing mistakes including, but not limited to, upcoding, duplicate charges, and charges for services not performed.

Multiple Surgical Procedures

Eligible expenses for services provided by physicians and/or facilities for multiple surgical procedures (not including the primary surgical procedure) performed at the same time will be determined by the Plan, provided that such services are deemed by the Plan to be medically necessary, reasonable, usual and customary.

- If the multiple surgical procedure is determined incidental, benefits will be denied.
- If multiple unrelated surgical procedures are performed by two (2) or more surgeons on separate operative fields, benefits will be based on the amount allowed for each surgeon's primary procedure.
- If two (2) or more surgeons perform a procedure that is normally performed by one (1) surgeon, eligible expenses for all surgeons will not exceed the allowed amount for that procedure.
- An assistant surgeon's services will only be covered if medically necessary and only up to the allowed charge.

MANAGED CARE

Utilization Review Agent
This Plan is a plan which contains a Utilization Review Agent. The Utilization Review Agent is shown on the Covered Individual's health plan identification card. Information about the Utilization Review Agent will be provided to Covered Individuals and updated as needed.

Utilization Review
Utilization review is a program designed to help insure that all Covered Individuals receive necessary and appropriate health care while providing the most cost-effective alternatives and avoiding unnecessary expenses. The program consists of:

- Pre-certification of certain non-emergency services before such services are provided (at least two (2) business days in advance, whenever possible). A list of services which require pre-certification is provided later in this section.
- Retrospective review of the medical necessity of in-patient facility admissions which commence on an emergency basis.
- Concurrent review, based on the admitting diagnosis, of the listed services requested by the attending physician; and
- Certification of services and planning for discharge from a medical care facility or cessation of medical treatment.

These services are described in greater detail below. The name and phone number for the Utilization Review Agent is listed on the reverse side of your health plan identification card.

Pre-Certification

CAREFULLY REVIEW THE FOLLOWING PRE-CERTIFICATION REQUIREMENTS AND PROCEDURES; FAILURE TO FOLLOW PRE-CERTIFICATION PROCEDURES MAY INCREASE YOUR FINANCIAL RESPONSIBILITY. Pre-Certification is intended to confirm that any in-patient admission is medically necessary, the stay is only as long as the patient's condition requires, and that discharge planning is adequate to meet the patient's needs. Note: If this Plan is secondary to another medical plan that also covers the Covered Individual, pre-certification will not be required.

The Plan requires that all in-patient hospital admissions be pre-certified by the Utilization Review Agent:

- All non-emergency in-patient admissions must be reported ***prior*** to the admission (at least two (2) business days in advance, whenever possible);
- All emergency in-patient hospital admissions must be reported within two (2) business days of admission.

Additionally, the Plan strongly recommends Pre-Certification of the following services:

- All non-emergency, scheduled surgical procedures.
- All non-emergency, scheduled MRIs, MRAs, CT scans, and PET scans.
- Durable medical equipment purchases in excess of $300 and ***any*** rental of durable medical equipment.
- Any course of radiation therapy, chemotherapy, home health care or dialysis

Pre-Certification of In-Patient Admission creates Pre-Service Claim
A Pre-service Claim is considered to be filed when the request for approval of an in-patient admission is made and received by the Utilization Review Agent in accordance with the Plan's procedures. The Utilization Review Agent shall notify the Covered Individual of determination of medical necessity for an in-patient admission in a reasonable period of time appropriate to the medical circumstances, according to the time limits set forth for Pre-Service Claims in the Claims Procedures section of this Plan Document.

When the Utilization Review Agent provides pre-certification of an in-patient admission to the Covered Individual, the Utilization Review Agent will assign a certain number of in-patient hospital days for the stay. If any days are not medically necessary, and the Covered Individual chooses to remain beyond the medically necessary length of stay, the Covered Individual shall be liable for all hospital charges beyond the medically necessary length of stay.

How to Pre-Certify Services

The Covered Individual must inform the provider that he participates in a program which has pre-certification requirements. The Covered Individual must notify the appropriate Utilization Review Agent of the upcoming non-emergency service prior to the admission to the hospital or Facility (at least two (2) business days in advance, whenever possible). For emergency services, the Utilization Review Agent must be notified within two (2) business days after the admission. If there is any question as to whether or not a service should be pre-certified, please call Butler Benefit Service, Inc. or simply go ahead and call the Utilization Review Agent and pre-certify the service; it is better to call and not need to have the service pre-certified than to not pre-certify a service for which it is required, and suffer the Penalty for Non-Pre-certification.

Notice can be given by the Covered Individual or a family member of the Covered Individual, by the hospital or by the Admitting physician, but it is ultimately the responsibility of the Covered Individual to make sure a hospital admission, surgery, procedure, service, supply or equipment has been pre-certified. The following information will be requested by the Utilization Review Agent for pre-certification:

- Employer: Augustana College;
- Group Number: BBS0169;
- Covered employee's Name, Address and health plan identification number;
- Patient's Name, Date of Birth, Gender and relationship to Covered employee;
- Admitting hospital Name, Address and Phone Number;
- Admitting Diagnosis and Procedure, if known;
- Date of Admission and/or Surgery;
- Admitting physician's Name, Address and Phone Number.

Penalty for Non-Certification (Cost Containment Penalty)

Failure to pre-certify in-patient hospital admissions with the Utilization Review Agent as required will result in the **eligible expenses for those services to be reduced by $300 per Covered Individual per incident**. The Cost Containment Penalty does not apply toward the Out-of-Pocket Expense Limit, and will be figured before the Deductible and Coinsurance are applied. The penalty is not considered a covered expense. PRE-CERTIFICATION DOES NOT GUARANTEE BENEFITS. ALL CHARGES ARE SUBJECT TO REVIEW AND ELIGIBILITY.

Newborns' and Mothers' Health Protection Act of 1996

Group health plans and health insurance issuers 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 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, plans and issuers may not, under Federal law, require that a provider obtain authorization from the Plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Continued Stay Review

If the Utilization Review Agent determines at any time during an admission, home health care treatment program, hospice care program or other course of treatment, that care or treatment is no longer medically necessary, there will be no coverage for expenses incurred thereafter because the patient elects to remain in-patient or continue with care. Notification of termination of benefits for such continued care will be given to a Covered Individual within 24 hours of the termination. If the attending physician feels that it is medically necessary for a Covered Individual to receive additional services or to stay in the medical care facility for a greater length of time than has been pre-certified, the attending physician must request the additional services or days.

Additional Surgical Opinion Provision

Certain surgical procedures are performed either inappropriately or unnecessarily. In some cases, surgery is only one of several treatment options. In other cases, surgery will not help the condition. In order to prevent unnecessary or potentially harmful surgical treatments, the second and/or third opinion program fulfills the dual purpose of protecting the health of the Plan's Covered Individuals and protecting the financial integrity of the Plan.

Benefits will be provided for a second (and third, if necessary) opinion consultation, at 100% of allowable charge, Deductible waived, no Co-Payment applies, to determine the medical necessity of an elective surgical procedure. An elective surgical procedure is one that can be scheduled in advance; that is, it is not an emergency or of a life-threatening nature. The patient may choose any board-certified specialist who is not an associate of the attending physician and who is affiliated in the appropriate specialty.

The Plan will not pay for expenses for an opinion on a proposed surgical procedure that is not a covered procedure under this Plan. While any covered surgical treatment is allowed a second opinion, the following procedures are ones for which surgery is often performed when other treatments are available:

- Appendectomy
- Cataract surgery
- Surgery of ear
- Gall bladder surgery
- Hemorrhoid surgery
- Hernia surgery
- Hysterectomy
- Knee, shoulder, elbow or toe surgery
- Mastectomy
- Nasal surgery
- Prostate surgery
- Removal of fallopian tubes and/or ovaries
- Spinal surgery
- Tonsillectomy, Adenoidectomy
- Varicose vein ligation

Case Management

When a catastrophic condition, such as spinal cord injury, cancer, AIDS or a premature birth occurs, a person may require long-term, perhaps lifetime care. After the person's condition is diagnosed, he or she might need extensive services or might be able to be moved into another type of care setting – even to his or her home. Case Management is a voluntary service. There are no reductions of benefits or penalties if the patient and family choose not to participate.

Case Management is a program whereby a case manager monitors these patients and explores, discusses and recommends coordinated and/or alternative types of appropriate medically necessary care. The case manager consults with the patient, the family and the attending physician in order to develop a plan of care for approval by the patient's attending physician and the patient. This plan of care may include some or all of the following:

- Personal support to the patient;
- Contacting the family to offer assistance and support;
- Monitoring hospital or skilled nursing facility;
- Determining alternative care options; and
- Assisting in obtaining any necessary equipment and services.

The Case Manager will coordinate and implement the Case Management program by providing guidance and information on available resources.

Alternative Treatment Benefit

If there is more than one type of service or supply which can be used for the treatment of an injury or illness, the Plan Administrator shall have the right to alter or waive the normal provisions of this Plan when it is reasonable to expect a cost effective result without a sacrifice to the quality of patient care.

The Plan Administrator, attending physician, patient and patient's family must all agree to the alternate treatment plan. Once agreement has been reached, the Plan Administrator will direct the Plan to reimburse for medically necessary expenses as stated in the alternate treatment plan, even if these expenses normally would not be paid by the Plan. Each treatment plan is individually tailored to a specific patient and should not be seen as appropriate or recommended for any other patient, even one with the same diagnosis.

If a proposed plan of treatment is offered by a Covered Individual's physician and accepted by the Plan Administrator, the proposed alternate treatment plan will be considered as an eligible expense. Services and supplies, otherwise ineligible, that are suggested and used according to the proposed alternate treatment plan, will be paid as an eligible Alternative Treatment Benefit.

MEDICAL EXPENSE BENEFITS

Medical Expense Benefit Summary

Pre-Certification

In-patient hospital and skilled nursing facility admissions MUST be pre-certified with the Utilization Review Agent. Failure to pre-certify an admission will result in application of a *Cost Containment Penalty* to expenses incurred during that admission. Please refer to the "PRE-CERTIFICATION" provision in the MANAGED CARE section of this document.

Annual Deductible

- Accrues on Calendar Year basis.
- In-Network and Out-of-Network Deductible expenses are separate.

	IN-NETWORK SERVICES	OUT-OF-NETWORK SERVICES
Individual Deductible	$1,000	$2,000
Family Deductible Limit	$2,000	$4,000

Annual Out-of-Pocket Expense Limit

- Accrues on Calendar Year basis.
- Includes Coinsurance expenses.
- In-Network and Out-of-Network Out-of-Pocket Expenses are separate.
- The following expenses do not accrue toward the Out-of-Pocket Expense Limit and are never paid at 100%:
  - Charges for services that are not Reasonable, not Medically Necessary, are not Usual and Customary, and/or are in excess of the Maximum Allowable Charge;
  - Amounts exceeding Plan limitations;
  - Cost containment penalties;
  - Co-Payments;
  - Deductible expenses;
  - Coinsurance for Specialty Medications;
  - Ineligible charges.

	IN-NETWORK SERVICES	OUT-OF-NETWORK SERVICES
Individual Out-of-Pocket Expense Limit	$1,500	$2,500
Family Out-of-Pocket Expense Limit	$3,000	$5,000

Medical Expense Benefit Limitations and Maximums

- Maximums listed below are the total for In-Network and Out-of-Network expenses combined.

Maximum Annual Benefit for All Essential Health Benefits

- Includes all medical and prescription drug benefit maximums listed in this Plan.

For the period beginning on September 1, 2011 and ending on August 31, 2012:	For the period beginning on September 1, 2012 and ending on August 31, 2013:	For the period beginning on September 1, 2013 and ending on August 31, 2014:	Effective September 1, 2014:
$2,000,000	$2,000,000	$2,000,000	No limit

Medical Expense Benefit Limitations and Maximums *(continued)*	
Allowable Charge	The Plan Administrator retains discretionary authority to determine whether charges are considered to be eligible expenses under the Plan. The Plan will only pay fee(s) that, in the Plan Administrator's discretion, are for services or supplies which are reasonable, usual and customary.
Chiropractic Services	$500 per Calendar Year
Dialysis, Out-patient	3 months per Calendar Year; such 3-month period will begin on the first day out-patient dialysis treatment is received during that Calendar Year
Durable Medical Equipment	Rental limited to purchase price.
Home Health Care	100 visits per Calendar Year
Hospital Room and Board	Semi-private rate; if a facility has only private rooms, the maximum eligible charge will be the negotiated private room rate. If a private room is medically necessary, the negotiated private room rate will be allowed.
Naprapathic Services	$1,000 per Calendar Year
Infertility Services	$15,000 per Lifetime, including expenses paid under both Medical and Prescription Drug Expense Benefits; Limited to Covered Individuals age 19 and older
Orthotic Foot Devices	$500 per Lifetime
Preventive Care	Benefits for preventive services will be limited to the frequencies recommended by the U.S. Preventive Services Task Force.
Rehabilitative Therapies, Out-patient ➢ Includes Physical, Occupational and Speech Therapy. ➢ Does not include in-patient therapies.	60 Visits per Calendar Year, all therapies combined
Skilled Nursing Facility	90 days per Calendar Year; room and board limited to semi-private rate; if a facility has only private rooms, the maximum eligible charge will be the negotiated private room rate. If a private room is medically necessary, the negotiated private room rate will be allowed.
TMJ (Temporomandibular Joint) Dysfunction, Treatment of	$2,500 per Lifetime
Wig after Chemotherapy Treatment	$500 per Lifetime

Benefit Percentages ➢ All services are subject to the Annual Deductible unless otherwise specified.	**IN-NETWORK SERVICES**	**OUT-OF-NETWORK SERVICES**
Ambulance Services ➢ Subject to In-Network Deductible only.	80%	
Anesthesia Services	80%	50%
Chemotherapy and Radiation Therapy ➢ *Pre-Certification of Chemotherapy and Radiation Therapy is strongly recommended.*	80%	50%
Chiropractic Services ➢ Limited to maximum benefit of $500 per Calendar Year.	80%	50%
Diagnostic X-ray, Laboratory and Testing ➢ *Pre-Certification of any MRI, CT Scan or PET Scan is strongly recommended.*	80%	50%
Dialysis ➢ Out-patient dialysis is limited to maximum 3 months per Calendar Year; such 3-month period will begin on the first day out-patient dialysis treatment is received during that Calendar Year. ➢ *Pre-Certification of any dialysis is strongly recommended*	80%	50%
Durable Medical Equipment ➢ Rental limited to purchase price. ➢ *Pre-Certification of Durable Medical Equipment is strongly recommended.*	80%	50%
Home Health Care ➢ Limited to 100 visits per Calendar Year. ➢ *Pre-Certification of Home Health Care is strongly recommended.*	80%	50%
Hospice Care	80%	50%
Hospital Services ➢ Includes in-patient and out-patient services, Emergency Room services, Ancillary services and all other eligible expenses. ➢ Room and board is limited to the semi-private rate. ➢ Emergency Room Co-Pay waived if Covered Individual is admitted as Hospital In-Patient directly from Emergency Room. ➢ In-patient admissions must be pre-certified; *failure to pre-certify an in-patient admission will result in a reduction of benefits.*	**Emergency Room Charge:** 100% after $50 Co-Pay, Deductible waived **All other eligible Hospital Services:** 80%	**Emergency Room Charge:** 100% after $50 Co-Pay, Deductible waived **All other eligible Hospital Services:** 50%
Maternity Care	80%	50%
Medical Travel Benefit ➢ Deductible is waived for Travel Network providers. ➢ Refer to the Medical Travel Benefit provision in the Description of Medical Benefits subsection for details. ➢ Pre-Certification is mandatory for medical procedures covered under this provision.	**Travel Network providers only:** 100%, Deductible waived	Not applicable.

Benefit Percentages *(continued)*		
	IN-NETWORK SERVICES	**OUT-OF-NETWORK SERVICES**
Mental Health and Substance Abuse Care ➢ In-patient admissions must be pre-certified; *failure to pre-certify an in-patient admission will result in a reduction of benefits.*	**Office Visits:** 100% after $20 Co-Pay, Deductible waived **All other eligible Mental Health and Substance Abuse Services:** 80%	50%
Naprapathic Services ➢ Limited to maximum benefit of $1,000 per Calendar Year.	80%	50%
Orthotic Foot Devices ➢ Limited to custom molded devices prescribed by a physician. ➢ Limited to maximum benefit of $500 per Lifetime.	80%	50%
Physician Services ➢ Includes office visits and consultations, diagnostic x-ray and lab, injections, allergy testing and treatment, in-patient hospital visits, surgical services (in-patient and out-patient), emergency room care, additional surgical opinion and all other eligible physician services. ➢ *Pre-Certification of any surgical procedure is strongly recommended.*	**Emergency Room Care:** 100%, Deductible waived **Office Visit:** 100% after $20 Co-Pay, Deductible waived **All other eligible Physician Services:** 80%	50%
Preventive Care ➢ Includes office visits, routine physical examination, gynecological examination, pap smear, mammogram, prostate screening, well child care, developmental assessments, x-rays and laboratory blood tests, immunizations (except mass immunizations) and routine colonoscopies. Immunizations required for travel are covered under this provision. Benefits for preventive services will be limited to the frequencies recommended by the U.S. Preventive Services Task Force. *(continued on next page)*	100%, Deductible waived	50%

Benefit Percentages *(continued)*		
	IN-NETWORK SERVICES	**OUT-OF-NETWORK SERVICES**
Preventive Care *(continued)* ➢ Women's Preventive Services, including: well woman visits, to include preconception and prenatal visits; contraceptive methods and counseling, to include all FDA-approved contraceptive methods, sterilization procedures, patient education and counseling; screening for gestational diabetes; high-risk HPV (human papilloma virus) DNA testing; counseling for sexually transmitted infections; counseling and screening for HIV (human immunodeficiency virus); breastfeeding support and counseling by trained provider and costs for renting breastfeeding equipment; screening and counseling for interpersonal and domestic violence. Benefits for Women's Preventive Services will be limited to the frequencies recommended by the U.S. Dept. of Health and Human Services Health Resources and Services Administration.	100%, Deductible waived	50%
Out-patient Rehabilitative Therapies ➢ Includes Physical, Occupational and Speech Therapy. ➢ Does not include in-patient therapies. ➢ Limited to 60 visits per Calendar Year, all therapies combined	80%	50%
Skilled Nursing Facility ➢ Limited to 90 Days per Calendar Year; ➢ Room and board limited to semi-private rate; ➢ In-patient admissions must be pre-certified; *failure to pre-certify an in-patient admission will result in a reduction of benefits.*	80%	50%
Specialty Medications ➢ Must be reviewed and approved by the Pharmacy Benefit Manager *prior to purchase*. ➢ Limited to maximum 30-day supply per each fill of a prescription and each refill of a prescription. ➢ Coinsurance does not accrue toward Annual Out-of-Pocket Expense Limit.	90%, Deductible waived Covered Individual's coinsurance will not exceed $100 per fill	Not covered
Transplant Services ➢ In-patient admissions must be pre-certified; *failure to pre-certify an in-patient admission will result in a reduction of benefits*.	80%	50%
Well Newborn Care ➢ Limited to the initial hospital confinement following birth. ➢ Be sure to notify the Plan in writing within 31 days of the child's birth to be eligible for timely coverage.	80%	50%
Wig after Chemotherapy Treatment ➢ Subject to In-Network Deductible only. ➢ Limited to maximum benefit of $500 per Lifetime	80%	

Benefit Percentages *(continued)*		
	IN-NETWORK SERVICES	**OUT-OF-NETWORK SERVICES**
All Other Covered Expenses	80%	50%

Description of Medical Benefits

Upon receipt of proof of loss, the Plan will pay the benefit percentage listed in the Medical Expense Benefit Summary for eligible expenses incurred in each Benefit Period. The amount payable in no event shall exceed the Maximum Annual Benefit stated in the Medical Expense Benefit Summary. All benefits described in the Medical Expense Benefit Summary are subject to the exclusions and limitations described more fully herein including, but not limited to, the Plan Administrator's determination that: care and treatment is medically necessary; that charges are reasonable, usual and customary, and that services, supplies and care are not experimental and/or investigational.

The Deductible
The Deductible is the amount of covered medical expenses which must be incurred before Medical Expense Benefits are payable. The amount of the Deductible is shown in the Medical Expense Benefit Summary. Each family member is subject to the Deductible up to the family maximum as shown in the Medical Expense Benefit Summary. This amount does not accrue toward the Annual Out-of-Pocket Expense Limit. Deductible Expenses for both In-Network and Out-of-Network services are separate.

The Family Deductible Limit
When Deductible expenses for any combination of covered family members reaches the family Deductible limit during the Calendar Year, as shown in the Medical Expense Benefit Summary, no further Deductibles will be required on any family member for the remainder of that Calendar Year.

Benefit Percentage
The Benefit Percentage is the percentage paid by the Plan for covered expenses that are in excess of the Deductible and any Coinsurance or Co-Payments.

Coinsurance
Coinsurance is the percentage of covered expenses a Covered Individual is responsible for each time he receives certain covered services. The Coinsurance for most services accrues toward the Out-of-Pocket Expense Limit.

Co-Payment
A Co-Payment (Co-Pay) is the fixed dollar amount a Covered Individual is responsible for each time he receives certain covered services. The Co-Payment does not apply toward the Covered Individual's Out-of-Pocket Expense Limit and continues to be taken after the Out-of-Pocket Expense Limit is met.

Out-of-Pocket Expense Limit
Covered charges are payable at the percentages shown in the Medical Expense Benefit Summary each Calendar Year until the Out-of-Pocket Expense Limit shown in the Medical Expense Benefit Summary is reached. Then, covered charges incurred by a Covered Individual, or family unit, will be payable at 100% (except for charges excluded) for the rest of the Calendar Year. The Annual Out-of-Pocket Expense Limit includes only Coinsurance expenses. Out-of-Pocket Expenses for both In-Network and Out-of-Network services are separate. See the Medical Expense Benefit Summary for a list of expenses that are not applied to the Out-of-Pocket Expense Limit, and are never paid at 100%.

Benefit Payment
Each Calendar Year, benefits will be paid for the covered charges of a Covered Individual that are in excess of the Deductible and any Coinsurance or Co-Payments. Payment will be made at the rate shown in the Medical Expense Benefit Summary. No benefits will be paid in excess of the Maximum Benefit Amount or any listed limit of the Plan.

Maximum Annual Benefit
The Maximum Annual Benefit is shown in the Medical Expense Benefit Summary. It is the total amount of benefits that will be paid under the medical and prescription drug portion of the Plan during a Benefit Period for all covered charges incurred by a Covered Individual. The Maximum Annual Benefit includes all medical and prescription drug benefit maximums listed in this Plan.

Allocation and Apportionment of Benefits
The College reserves the right to allocate the Deductible amount to any eligible charges and to apportion the benefits to the Covered Individual and any assignees. Such allocation and apportionment shall be conclusive and shall be binding upon the Covered Individual and all assignees.

Eligible Medical Expenses

The Plan Administrator retains discretionary authority to determine whether charges are considered to be eligible expenses under the Plan. The Plan will only pay fee(s) that, in the Plan Administrator's discretion, are for services or supplies which are reasonable, usual and customary. Eligible medical expenses are the following expenses that are incurred while coverage is in force for the Covered Individual. If, however, any of the listed expenses are excluded from coverage because of a reason described in the Medical Exclusions section, those expenses will not be considered eligible medical expenses. A charge is incurred on the date that the service or supply is performed or furnished.

The Plan will make payment for eligible medical expenses subject to the applicable Deductible and Coinsurance percentage, and maximum amounts shown in the Medical Expense Benefit Summary.

Medical Travel Benefit
The Medical Travel Benefit is an option for a Covered Individual whose treating physician recommends certain covered medical procedures which are available through the Plan's Travel Network. A Covered Individual may elect to receive treatment from medical providers participating in the Travel Network, pursuant to an executed Medical Travel Benefit Agreement. The Medical Travel Benefit is included toward and subject to the provisions and limitations as stated in the Medical Expense Benefit Summary. Information regarding the Medical Travel Benefit and the Travel Network is available from the Claims Processor.

In addition to covered medical costs related to the procedure defined in the Plan, covered medical costs incurred under the Medical Travel Benefit are defined to include necessary Travel Services for the Covered Individual and one companion, an administrative fee for the Travel Network Coordinator, an administrative fee for the Claims Processor, and a Recovery Benefit. The Plan will also pay for any emergency or life-saving health services required as a result of any covered medical procedures or health services received by the Covered Individual.

Any medical services performed by a person or entity that is not a Travel Network Provider, or that is outside of the Medical Travel Network Agreement, shall be subject to the general terms and limitations of the Plan and shall not be subject to the terms otherwise applicable to treatment received through the Travel Network.

All Travel Services must be reserved and scheduled through the Travel Network Coordinator. The Plan shall remain responsible for Travel Services costs if a change is required once travel and other accommodations have been made.

The Recovery Benefit includes a payment to the Covered Individual which recognizes the potential financial savings and is meant as compensation for incidental and "out of pocket" expenses related to the procedure and is paid upon completion of the procedure. The Recovery Benefit provided under the Medical Travel Benefit program will be subject to taxation as income to the Covered Individual. The Travel Network Coordinator will provide appropriate documentation for benefits paid under the Medical Travel Benefit.

Definitions
1. The "Travel Network" is a network of participating medical service providers of medical, surgical, diagnostic, treatment and care services, selected by the Plan specifically for the purpose of the Medical Travel Benefit.
2. A "Travel Network Provider" is a provider of healthcare services participating in the Travel Network.

3. The "Travel Network Coordinator" maintains the Travel Network, prepares and executes the Medical Travel Benefit Agreement, coordinates the delivery of such services as described in the Medical Travel Benefit Agreement, and coordinates and facilitates payments of benefits described in the Medical Travel Benefit Agreement.
4. A "Medical Travel Benefit Agreement" is an agreement prepared on a case-by-case basis by the Travel Network Coordinator, and which is between the Plan, the Covered Individual, the Travel Network and the Travel Network Provider, and which describes the services to be provided to the Covered Individual by the Provider, the amount, method and timing of payment by the Plan to the Travel Network Provider.
5. "Travel Services" include (a) round trip transportation between the Covered Individual's home location and the location of the Travel Network Provider where treatment is to be performed; (b) hotel accommodations near the Travel Network Provider; and (c) necessary local transportation among the airport, hotel, and Travel Network Provider.
6. "Recovery Benefit" is a pre-determined flat payment amount that is specified in the Medical Travel Benefit Agreement, and which is paid to the Covered Individual in connection with his/her treatment. The Recovery Benefit is payable upon completion of the travel associated with such treatment as agreed upon in the Medical Travel Benefit Agreement.

Home Health Care Expenses
Home health care expenses are the charges made by a home health care agency, for the following services and supplies which are furnished to a Covered Individual in his home within the scope of the home health care agency's license in accordance with a home health care plan:

- Part-time or intermittent nursing care provided by a registered nurse (RN), a licensed practical nurse (LPN), a licensed vocational nurse, or a public health nurse.
- Part-time or intermittent home health aide services which consist primarily of caring for the patient.
- Medical supplies, drugs, and medicines prescribed by a physician, and laboratory services provided by or on behalf of a hospital, but only to the extent that such charges would have been covered if the Covered Individual had remained in the hospital or a skilled nursing facility.
- Charges for physical, speech or occupational therapy.
- Charges for parenteral or enteral nutrition.
- Charges for inhalation therapy
- Medical social services.

Home Health Care Expenses will not be covered if they are for:

- Custodial care, housekeeping services, or meals or nutritional services.
- Services by a member of the employee's or dependent's family or household.
- Services of a non-medical social worker.
- Transportation services.

Each Home Health Care visit, up to four (4) hours, by a registered nurse (RN) or licensed practical nurse (LPN) to provide nursing care, by a therapist to provide physical, occupational or speech therapy, and each visit of up to four (4) hours by a home health aide shall be considered as one (1) home health care visit.

Pre-Certification of any Home Health Care is strongly recommended.

Hospice Expenses
A hospice means a health care program providing services to terminally ill patients. The following services and supplies provided by a hospice are covered:

- Hospice care in a free-standing hospice facility, hospital -based hospice, extended care hospice facility, or nursing home hospice;
- Nursing care by a registered nurse (RN), or by a licensed practical nurse (LPN), a vocational nurse, or a public health nurse within the scope of his or her license.
- Physical therapy, occupational therapy and speech therapy, when rendered by a licensed therapist.
- Medical supplies, including drugs and biologicals, and the use of medical appliances.
- Physician services.
- Services, supplies, and treatments deemed medically necessary and ordered by a licensed physician.

The Plan will not pay for:

- Expenses or services of a person who resides in the patient's home or is a close relative of the patient.
- Expenses solely in connection with research.
- Expenses for services that do not meet medically acceptable standards of quality and sound principles of health care.
- Expenses related to the organization or dispensation of non-medical personal, legal or financial affairs, such as preparation of a will, liquidation of an estate, or other similar activities.
- Expenses excluded by any general limitation or provision set forth in this Plan.

Hospital Expenses
Hospital expenses are the charges made by a hospital in its own behalf. *In-patient admissions must be pre-certified*. Such charges include:

- Semi-private room and board rate. If a facility only has private rooms available, the room rate will be limited to the negotiated private room rate. If a private room is medically necessary, the negotiated private room rate will be allowed. After 23 observation hours, a confinement will be considered an in-patient confinement.
- Necessary ancillary hospital services other than room and board as furnished by the hospital.
- Special care units, including burn care units, cardiac care units, delivery rooms, intensive care units, isolation rooms, operating rooms and recovery rooms.
- Out-patient hospital services.
- Emergency room services for treatment of a condition which is of an urgent or emergency nature.

Mental Health/Substance Abuse Treatment Expenses
The Plan will allow physician and facility charges determined by the Plan to be reasonable, usual and customary, for Mental Health and/or Substance Abuse treatments, including office or home visits, hospital in-patient or out-patient care and clinic care, subject to the maximums listed in the Medical Expense Benefit Summary. *In-patient admissions must be pre-certified*. The Mental Health Parity Act applies to all persons covered under this Plan.

Physician Services
The Plan will allow physician charges determined by the Plan to be reasonable, usual and customary for medical care and/or surgical treatments, including office or home visits, hospital in-patient or out-patient care, clinic care, and surgical opinion consultations. *Surgical procedures should be pre-certified.*

Skilled Nursing/Extended Care Facility Expenses
Eligible skilled nursing/extended care facility expenses will be payable if and when:

1. The patient is confined as a bed patient in the facility; and
2. The attending physician certifies that the confinement is needed for care of a condition that would otherwise cause a hospital confinement; and
3. The attending physician completes a treatment plan which includes the diagnosis, the proposed course of treatment and the projected date of discharge from the skilled nursing facility.

Eligible skilled nursing/extended care facility expenses under this benefit will be limited up to the maximums listed in the Medical Expense Benefit Summary and will include:

1. Room and board, including any charges made by the facility as a condition of occupancy or on a regular daily or weekly basis, such as general nursing services. The daily room and board charges allowed will not exceed the average semi-private rate. If a facility only has private rooms available, the room rate will be limited to the negotiated private room rate. If a private room is medically necessary, the negotiated private room rate will be allowed.
2. Medical services customarily provided by the skilled nursing facility, with the exception of private-duty or special nursing services and physician fees.
3. Drugs, biologicals, solutions, dressings and casts furnished for use during the convalescent period, but no other supplies.

Skilled Nursing Facility admissions must be pre-certified.

Specialty Medications
This Plan provides coverage for certain "Specialty Medications" under the Medical Expense Benefits. Specialty Medications are drugs which require a physician's prescription, but which are not covered under the Prescription Drug Benefit of this Plan. Specialty Medications are drugs that have typically been provided by and administered in the physician office, clinic or outpatient hospital setting. Ongoing developments in drug delivery and patient education have made it possible for some of these medications to be self-administered by the patient. Many Specialty Medications may be obtained through the Plan's pharmacy benefit manager's network at a greatly reduced cost and, if properly reviewed and approved (as indicated below), will be eligible for benefits under the Medical Expense Benefit, instead of the Prescription Drug Expense Benefit of this Plan.

The Plan will allow the Pharmacy Benefit Manager's maximum allowable cost or the dispensing pharmacy's charge, whichever is less, for specialty medications covered under this provision. This provision does not allow coverage for experimental drugs or "off-label" use of legend drugs (drugs which are prescribed for conditions other than those approved by the U.S. Food and Drug Administration). Medications covered under this provision include, but are not limited to, immunosuppressants, antiretrovirals, cancer therapies, recombinant biological pharmaceuticals, interferons, growth hormones, drugs to treat other rare disorders, and most injectable medications (except those specifically covered under the Prescription Drug Expense Benefit provision of this Plan). Following are some examples:

Actimmune	Betaseron	Hemofil M	Lupron	Rebetron
Amicar	Copaxone	Humate-P	Neupogen	Rebif
Aranesp	Enbrel	Humira	Pegasys	Recombinate
Arava	Epogen	Intron-A	Peg-Intron	Remicade
Avonex	Forteo	Kogenate	Procrit	Sandostatin
Benefix	Fragmin	Lovenox		

To be eligible for benefits under this provision, the medication must be reviewed and approved by the Pharmacy Benefit Manager **prior to purchase**. The following information is needed to facilitate the approval process:

- Patient's name, address and date of birth;
- Diagnosis;
- Covered Employee's name, identification number and date of birth;
- Medication name, dosage, frequency and route of administration;
- Prescribing physician's name, phone number and fax number.

The Plan will advise the patient and/or covered Employee of such decision within the time limits set forth in the Claims Procedures section of this Plan Document.

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

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

- Except for transplant of a cornea, the recipient must be in danger of death in the event the organ transplant is not performed.
- There must be a reasonable expectation of survival if he were to receive the transplant.
- If the donor is not covered under this Plan, charges incurred by the donor are only payable if the donor has no other coverage available, i.e. Group health plan, a government program, or a research program. In this case, charges of the donor will be considered charges of the recipient.
- If both recipient and donor are covered under this Plan, the expenses for each will be considered separately.

- Eligible charges for the procurement of an organ will be considered under the recipient's coverage, to include the following:
  - Harvesting, removal, preserving, storage and transportation of the actual organ.
  - Surgeon's fee for removing the organ.
  - Procurement of an organ from a cadaver or tissue bank.
  - Hospital's fee for storage of the organ.
- Subject to Plan maximums as stated in the Medical Expense Benefit Summary.
- ***Pre-certification is required for all transplant surgeries.***

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

- Charges in connection with mechanical organs or a transplant involving a mechanical organ or a transplant involving an animal organ; except charges in relation to mechanical organs which may be necessary on a temporary short-term basis until a suitable donor organ is available will be eligible under the Plan.
- Services or supplies furnished in connection with the transportation of a living donor.
- Services or supplies related to donation of any organ under the coverage of a donor.

Covered Expenses In or Out of the Hospital

1. ***Medically Necessary Abortion:*** Charges for abortion performed to safeguard the life of the mother.
2. ***Acupuncture:*** Charges for acupuncture.
3. ***Acne:*** Charges for non-cosmetic treatment of acne. Accutane and any laboratory tests specifically related to treatment with Accutane are not covered. Treatment of acne may be subject to review by the Utilization Review Agent and deemed medically necessary to be eligible for benefits under this Plan.
4. ***Allergy Treatment:*** Charges for allergy testing, allergens and allergy injections.
5. ***Ambulance:*** Charges for medically necessary local ground or air ambulance service to and from the nearest, local adequate hospital or nursing facility where emergency care or treatment is rendered, or to the nearest facility equipped to furnish necessary medical treatment if not available at a local hospital. This Plan will only cover ambulance transportation when:
   a. No other method of transportation is appropriate;
   b. The services necessary to treat the illness or injury are not available in the hospital or nursing facility where the Covered Individual is an in-patient; and/or
   c. The hospital or nursing facility where the ambulance takes the Covered Individual is the nearest with adequate facilities.
6. ***Ambulatory Surgical Center:*** Charges made by an ambulatory surgical center when treatment has been rendered.
7. ***Anesthesia:*** Charges for the cost and administration of anesthetic in conjunction with a covered surgical or medical procedure.
8. ***Blood:*** Charges for the processing and administration of blood or blood components, including charges for the processing and storage of autologous blood.
9. ***Cardiac Rehabilitation Programs:*** Out-patient, second phase cardiac rehabilitation programs to provide supervised monitored exercise sessions following an acute cardiac episode or surgery.
10. ***Cataract and Retinal Repair Surgery:*** Charges for cataract or retinal repair surgery, including the initial set of contact lenses or eyeglasses (but not both) required following cataract or retinal repair surgery. *Pre-Certification of any surgical procedure is strongly recommended.*
11. ***Chemotherapy:*** Charges for chemotherapy, including the services of technicians. *Pre-Certification of any Chemotherapy is strongly recommended.*
12. ***Childbirth at Home:*** Charges for childbirth at home.
13. ***Chiropractic Services:*** Charges for chiropractic services by a D.C., subject to the chiropractic services limit shown in the Medical Expense Benefit Summary.
14. ***Contraceptive Services:*** Charges for contraceptive services, including examinations, procedures, contraceptive injections, implants and devices. Prescription contraceptive drugs are covered under the Prescription Drug Expense Benefit of this Plan.
15. ***Dental Services, Medically Necessary:*** Charges for medically necessary, emergent, non-restorative dental services provided by a dentist when medically necessary and limited to services provided for the repair of damage to the jaw or sound natural teeth as the direct result of an accidental injury. Injury as a result of chewing or biting will not be considered an accidental injury. This will not in any event be deemed to include charges for treatment for the repair or replacement of a denture.

16. ***Diabetic Self Management Education:*** Charges for Diabetic Self Management Education. Such services must:
    - Be medically necessary and prescribed by a physician.
    - Be instructed by a qualified health care professional, including but not limited to physicians, nurses or licensed pharmacists.
    - Meet the standards developed by the appropriate State Department of Public Health
17. ***Diagnostic Tests:*** Charges for x-rays, microscopic tests, laboratory tests, electrocardiograms, electroencephalograms, pneumoencephalogram, basal metabolism tests, allergy tests, or similar well-established diagnostic tests generally approved by physicians throughout the United States not connected with a routine physical exam, which:
    - Are performed as a result of definite symptoms of an injury or illness; or
    - Reveal the need for medical treatment.

    Pre-Certification of any MRI, CT Scan or PET Scan is strongly recommended.
18. ***Dialysis:*** Charges for dialysis as an in-patient or at a Medicare-approved out-patient dialysis center, subject to the limitations stated in the Medical Expense Benefit Summary. *Pre-Certification of any dialysis is strongly recommended.*
19. ***Drugs and Biologicals:*** Charges for drugs and biologicals which are approved by the Food and Drug Administration, including (but not limited to) globulin, serum, vaccine, antitoxin or antigen, used in the prevention or treatment of disease.
20. ***Durable Medical Equipment:*** Charges for the rental, up to the purchase price, of a wheelchair, hospital bed, iron lung, or other durable medical equipment required for medically necessary temporary therapeutic use, or the purchase of this equipment if economically justified, whichever is less. Maintenance and repair of durable medical equipment is the responsibility of the Covered Individual and is not covered under this Plan. Replacement of durable medical equipment will only be allowed if:
    a. The replacement is necessary due to usual wear and tear and not due to external damage of any sort; or
    b. The replacement is necessary due to Covered Individual having undergone pathologic change or due to growth to the extent the equipment is no longer usable by the Covered Individual; and
    c. The Utilization Review Agent certifies the equipment as not repairable or alterable, or is no longer the appropriate size for the Covered Individual.
    d. For C-pap and bi-pap machines: unit has been in continuous use by the Covered Individual for five (5) years or longer.

    Pre-Certification of any rental or purchase of Durable Medical Equipment is strongly recommended.
21. ***Eye Examinations, Eyeglasses or Contact Lenses, Medically Necessary:*** Charges for eye examination due to a medical condition, and for eyeglasses or contact lenses for aphakic (absence of natural lens of the eye) patient and for soft contact lenses or sclera shells intended for use in the treatment of disease or injury.
22. ***Growth Development Delays:*** Charges for testing and treatment of growth development delays, including growth hormones when medically necessary as determined by a physician.
23. ***Handling and Conveyance Fees:*** Charges for handling and conveyance fees; however shipping charges are not covered.
24. ***Home Infusion Therapy:*** Charges for home infusion therapy, including the administration of nutrients, antibiotics, and other drugs and fluids intravenously or through a feeding tube.
25. ***Infertility:*** Charges for the diagnosis and treatment of infertility, up to the limits stated in the Medical Expense Benefit Summary. Covered services include, but are not limited to: testing, artificial insemination, in vitro fertilization, uterine embryo lavage, gamete intrafallopian tube transfer, zygote intrafallopian tube transfer and low tubal ovum transfer. Prescription drug treatment for infertility is covered under the Prescription Drug Expense Benefit of the Plan. The following services are NOT covered: reversal of voluntary sterilization, services of a surrogate parent, cryo-preservation, storage of sperm or eggs or embryos for use at an undetermined future time, selected termination of embryo (unless the life of the mother would be in danger were all embryos to be carried to full term), travel costs, experimental or investigational treatments, and infertility treatments rendered to Covered Individuals under the age of 19.
26. ***Insulin:*** Charges for insulin, insulin supplies, syringes and blood glucose monitoring equipment and supplies.
27. ***Intravenous Injections and Solutions:*** Charges for intravenous injections and solutions; administration of these items is included.

28. ***Mammogram, Routine:*** Charges for routine mammograms, up to the limits outlined in the Medical Expense Benefit Summary.
29. ***Mammoplasty:*** Charges for medically necessary mammoplasty following a medically necessary mastectomy. Services include reconstruction of the breast on which the mastectomy has been performed and reconstruction of the other breast to produce symmetrical appearance. Breast prostheses and physical complications of all stages of mastectomy, including lymphedemas, are also eligible under the Plan. This further includes removal of breast implants, including implants that involved cosmetic procedure performed for reasons of reconstruction performed as a result of illness or injury. Removal of breast implants solely for cosmetic purposes is not covered. Charges for medically necessary reduction mammoplasty will only be covered under this Plan when medical necessity is established by the Utilization Review Agent.
30. ***Medical Supplies:*** Charges for dressings, sutures, casts, splints, crutches, braces, or other necessary medical supplies, with the exception of dental braces, orthopedic shoes, arch supports, elastic stockings, trusses, lumbar braces, garter belts and similar items which can be purchased without a prescription.
31. ***Mental Health/Substance Abuse Treatment:*** Charges in relation to individual or group psychiatric care (treatment of a psychiatric condition, alcoholism, substance abuse or drug addiction) are limited to the Coinsurance percentage of covered expenses in excess of the Deductible up to the maximums as shown in the Medical Expense Benefit Summary. A psychiatric condition includes but is not limited to anorexia nervosa and bulimia, schizophrenia, and depressive disorders including but not limited to manic-depressive. Acute in-patient detoxification is covered if determined that out-patient management is not medically appropriate; treatment is considered medical and does not apply to the substance abuse benefit or limitations until the patient is discharged from the hospital or transferred to a Substance Abuse Unit. *Pre-Certification of any in-patient admission is required.*
32. ***Minor Emergency Medical Clinic:*** Charges made by a minor emergency medical clinic when treatment has been rendered.
33. ***Naprapathic Services:*** Charges for naprapathic services, when rendered by licensed Naprapath, subject to the limits stated in the Medical Expense Benefit Summary.
34. ***Obesity, Treatment of:*** Charges for diagnosis and treatment of obesity, limited to office visits and consultations, laboratory services and nutrition counseling. Surgical procedures and medications are specifically excluded under this provision.
35. ***Occupational Therapy:*** Charges for restorative or rehabilitative occupational therapy, up to the limits shown in the Medical Expense Benefit Summary, due to an illness or injury, or due to surgery performed because of an illness or injury; however, occupational therapy supplies related to these services are not covered.
36. ***Oral Surgery:*** Charges for the following oral surgery whether performed by a dentist or a medical doctor will be considered as eligible medical expenses:
    a. Correction of congenital abnormalities of the jaw.
    b. Removal of bony growths of the jaw and hard palate (except as preparation for dentures or other prostheses).
    c. Surgical procedures of the jaw and gums for treatment of fractures and dislocations of the jaw and facial bones or to repair the mouth or lips necessary to correct accident injury.
    d. Excision of lesions of the jaws, cheeks, lips, tongue or roof and floor of the mouth.
    e. Incision of the accessory sinuses, mouth, salivary glands or ducts.
    f. Surgical extraction of impacted teeth.
    g. General anesthesia for covered oral surgery.
    h. Intra-oral x-rays in connection with covered oral surgery.
37. ***Orthotic Foot Devices:*** Charges for custom molded orthotic foot devices (such as special shoe inserts for arch or foot support) which are prescribed by a physician.
38. ***Orthotic Appliances:*** Charges for the initial purchase, fitting and repair of orthotic appliances such as braces, splints, or other appliances which are required for support for an injured or deformed part of the body as a result of a disabling congenital condition or an injury or illness. Charges for any braces or devices predominantly used for support during athletic activities are not covered.
39. ***Oxygen:*** Charges for oxygen and other gases, and their administration.
40. ***Pap Smear:*** Exam and laboratory charges in relation to a routine annual pap smear test.
41. ***Podiatric Care:*** Charges for non-routine podiatric care, including charges for open cutting procedures, partial or complete removal of nail roots, or for services reasonably necessary in the treatment of a metabolic or peripheral vascular disease.

42. ***Physical Therapy:*** Treatment or services rendered by a licensed physical therapist in a home setting or at a facility or institution, which has the primary purpose of providing medical care for an illness or injury. Charges for restorative or rehabilitative physical therapy, up to the limits shown in the Medical Expense Benefit Summary, due to an illness or injury, or due to surgery performed because of an illness or injury will be eligible.
43. ***Pre-Admission Testing:*** Charges for laboratory and x-ray tests performed as out-patient. Tests must be related to the condition which is the cause of the Admission, and must be performed in place of tests while hospital -confined.
44. ***Pregnancy:*** Eligible pregnancy related expenses for a Covered Individual, including medically necessary amniocentesis tests, are considered the same as any other medical condition under the Plan. For the purpose of this provision only, a birthing center shall be treated the same as a hospital.
45. ***Prescription Drugs:*** Charges for drugs requiring the written prescription of a licensed physician, except as specifically excluded elsewhere in this Plan.
46. ***Preventive Care:*** Charges for routine Preventive care for Covered Individuals, up to the limits as stated in the Medical Expense Benefit Summary. Eligible expenses include, but are not limited to, those for routine or periodic examinations, screening examinations, evaluation procedures, Preventive medical care, school, camp or school sports examinations, or treatment or services not directly related to the diagnosis or treatment of a specific injury, illness or pregnancy -related condition.
47. ***Private Duty Nursing:*** Charges for in-patient private duty nursing care are covered only when medically necessary and the hospital's intensive care unit is filled or the hospital has no intensive care unit.
48. ***Prostate Specific Antigen (PSA) Test:*** Exam and laboratory charges in relation to a routine prostate specific antigen test.
49. ***Prosthetic Appliances:*** Charges for prosthetic appliances used to replace a missing natural body part, except penile prosthesis or implant. Repair or replacement of damaged, lost or stolen devices is not covered. Replacement of a prosthetic appliance will be covered when due to a pathological change or normal growth. Prior Written Approval of a replacement is recommended.
50. ***Radiation Therapy:*** Charges for radiation therapy or treatment, including the services of technicians. *Pre-Certification of any Radiation Therapy is strongly recommended.*
51. ***Reconstructive Surgery:*** Charges for reconstructive surgery to correct a condition that resulted from an injury or illness, or for the correction of a congenital anomaly or birth defect.
52. ***Respiratory Therapy:*** Charges for medically necessary respiratory (pulmonary) therapy or treatment.
53. ***Smoking Cessation:*** Charges for physician office visits for evaluation and treatment of smoking and/or tobacco use. Medications for treatment of smoking cessation are covered under the Prescription Drug Expense Benefit of this Plan.
54. ***Speech Therapy:*** Charges for restorative or rehabilitative speech therapy, up to the limits shown in the Medical Expense Benefit Summary, by a licensed speech therapist due to an illness or injury, or due to surgery performed because of an illness or injury.
55. ***Sterilization, Elective:*** Charges in relation to an elective sterilization procedure (such as tubal ligation, Essure procedure or vasectomy), but only for the initial surgery. Benefits do not include the reversal of an elective sterilization.
56. ***TMJ:*** Charges for treatment of TMJ (temporomandibular joint) disorder, up to the limits stated in the Medical Expense Benefit Summary.
57. ***Urgent/Immediate Care Clinic:*** Charges made by an urgent/immediate care clinic when treatment has been rendered.
58. ***Well Newborn Care:*** hospital and physician charges in relation to the routine well care of a newborn, including circumcision.

Medical Exclusions

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

1. ***Abortion, Elective:*** Charges for elective abortion unless medically necessary to safeguard the life of the mother; this exclusion does not include medical complications arising from and after such an abortion.
2. ***Administrative Fees:*** Charges for completion of any form, for failure to keep a scheduled appointment, charges for medical information or finance charges.
3. ***Bereavement:*** Charges for bereavement counseling or services of volunteers or clergy.
4. ***Billed by Employee of Facility:*** Charges for professional services billed by a physician or nurse who is an employee of a hospital or skilled nursing facility and paid by the hospital or facility for the service.
5. ***Chelation Therapy:*** Charges in relation to chelation therapy except in the treatment of heavy metal poisoning.
6. ***Close Relative, Services Rendered by:*** Charges for services rendered by a physician, nurse, or licensed therapist if such physician, nurse, or licensed therapist is a close relative, including the spouse, parent (including step-parent), sibling (including step-sibling), child (including legally adopted and step-child), grandparent, mother-in-law, father-in-law, sister-in-law, brother-in-law, daughter-in-law or son-in-law of the Covered Individual, whether the relationship is by blood or exists in law, or person who resides in the same household of the Covered Individual.
7. ***Concurrent Services:*** Charges for in-patient concurrent services of physicians, unless there is a clinical necessity for supplemental skills and the two or more physicians attend the patient for separate conditions during the same hospital admission.
8. ***Convalescent or Rest Care:*** Charges for hospitalization when such confinement occurs primarily for physiotherapy, hydrotherapy, convalescent or rest care, or any routine care or tests not connected with the actual illness or injury.
9. ***Cosmetic:*** Charges in connection with the care or treatment of or surgery performed for a cosmetic procedure. This exclusion will not apply when such treatment is rendered to correct a condition resulting from an accidental injury, or when rendered to correct a congenital anomaly or birth defect, or for breast reconstruction following a mastectomy. **Written prior approval is recommended**.
10. ***Court Mandated:*** Services that are provided due to a court order, except:
    a. When determined to be medically necessary; and
    b. No third party liability has been established.
11. ***Custodial Care:*** Charges in connection with custodial care.
12. ***Dental Services:*** Charges for dental services not specifically included in the Medical Expense Benefits described in this Plan; or for hospital charges in relation to dental care, except those services which are certified by a medical doctor to be medically necessary to safeguard the life and health of the Covered Individual due to the existence of a non-dental physical condition. **Written prior approval is recommended**.
13. ***Educational or Vocational:*** Charges for educational or vocational testing or training, except as specifically shown as a covered expense elsewhere in the Plan.
14. ***Employer, Provided by:*** Services provided through a medical clinic or similar facility provided or maintained by an employer.
15. ***Employment Related:*** No benefits or expenses will be paid or reimbursed to or for any Covered Individual for any injury, illness, occupational disease, or other loss which arises out of and in the course of employment, and for which the Covered Individual is reimbursed or entitled to reimbursement under any federal or state law, including a workers' compensation law or similar law. This exclusion applies to each Covered Individual:
    a. Who is actively engaged in a business, occupation, or profession on substantially a full-time basis and who may elect coverage under a workers' compensation law or similar law, but either fails to secure such coverage or voluntarily elects not to secure such coverage; or
    b. Whose employer may elect coverage under workers' compensation law or similar law, but either fails to secure such coverage or voluntarily elects not to secure workers' compensation coverage.
16. ***Excess Charges:*** Charges for services that are not Reasonable, not Medically Necessary, are not Usual and Customary, and/or are in excess of the Maximum Allowable Charge.
17. ***Exercise Programs or Equipment:*** Charges for exercise programs or equipment and other such equipment, or health club memberships.

18. ***Experimental:*** Charges for experimental procedures, drugs, or research studies, or for any investigational charges, services, supplies, procedures, drugs, or for any services or supplies not considered legal in the United States or not recognized by the American Medical Association, the American Dental Association or the American College of Surgeons and/or the United States Food & Drug Administration. Experimental or investigational services includes:
    a) care, procedures, treatment protocol or technology which:
        i. Is not widely accepted as safe, effective and appropriate for the injury or sickness throughout the recognized medical and dental professions and established medical and dental societies in the United States; or
        ii. Is experimental, in the research or investigational stage or conducted as part of research protocol, or has not been proved by statistically significant randomized clinical trials to establish increase survival or improvement in the quality of life over other conventional therapies.
    b) drugs, tests, and technology which:
        I. The FDA has not approved for general use;
        II. Are considered experimental;
        III. Are for investigational use; or
        IV. Are approved for a specific medical or dental condition but are applied to another condition.

    The Plan will rely on the Data project of the American Medical Association, the American Dental Association, the National Institute of Health, the U.S. Food and Drug Administration, the National Cancer Institute, Office of Health Technology Assessment, the Health Care Financing Administration of the U.S. Department of Health and Human Services, and Congressional Office of Technology Assessment in determining investigational or experimental services.
19. ***Eye Examination, Routine:*** Charges for routine eye examinations (except eye examinations due to a medical condition).
20. ***Foot Care, Routine:*** Charges for routine foot care, such as removal of corns, calluses, or trimming of toenails, except the services necessary for the partial or complete removal of nail roots or for services reasonably necessary in the treatment of a metabolic or peripheral vascular disease when recommended by a medical doctor or doctor of osteopathy.
21. ***Foreign Travel:*** If a Covered Individual receives medical treatment outside of the United States or its territories, benefits shall be provided for those charges to the extent that the services rendered are included as covered expenses in the Plan, and provided the Covered Individual did not travel to such a location for the sole purpose of obtaining medical services, drugs, or supplies. Additionally, charges for such treatment may not exceed the limits specified herein as reasonable and customary in the area of residence of the Covered Individual in the United States. Fees and charges exceeding reasonable and customary shall be disallowed as ineligible charges. Charges equal to or less than reasonable and customary shall be considered. In no event shall benefit payment exceed that actual amount charged. (For more efficient claims processing, claims should be submitted in English and converted to American dollars).
22. ***Gender Identification:*** Charges related to transsexualism, gender dysphoria, or sexual reassignment or services or supplies related to the performance of gender transformation procedures, including medical or psychiatric treatment, medications, implants, hormone therapy and surgery.
23. ***Genetic Testing and Counseling:*** Charges in relation to genetic testing for other than diagnostic purposes, and charges for genetic counseling.
24. ***Governmental Program:*** Charges for services or supplies that the Covered Individual is entitled to claim from any governmental program even if he waived or failed to claim rights to such services, benefits, or damages.
25. ***Hair Loss:*** Charges for care and treatment of hair loss, including wigs, artificial hairpieces and drugs, except the purchase of a wig after chemotherapy (subject to the limits stated in the Medical Expense Benefit Summary.
26. ***Hearing Impairments:*** Charges in connection with any service, supply, testing or treatment for hearing impairments, including hearing exams, hearing aids, earmolds, cochlear implants or any such devices and the fitting thereof.
27. ***Holistic Medicine:*** Charges related to holistic medicine or healing, or other programs with an objective to provide personal fulfillment, or for Christian Science services.
28. ***Home Remodeling:*** Charges for ramps or home remodeling,
29. ***Hypnotherapy:*** Charges for hypnotherapy, except as listed as a covered expense elsewhere in this Plan.

30. ***Illegal Act:*** Charges incurred due to an illness or injury resulting from the Covered Individual's voluntary commission of an illegal act (including but not limited to driving a motor vehicle while under the influence of alcohol or drugs, voluntary intake of any illegal drug, voluntary intake of a prescription drug not prescribed by a physician for that person specifically, burglary, robbery, assault, criminal trespass, participation in a riot or civil disturbance), or while the Covered Individual is engaged in an illegal occupation. An act is illegal if it is violative of a law, and that neither a citation nor conviction is required for the Plan to deny a claim in accordance with this exclusion. Such exclusion does not apply to injuries and/or illnesses sustained due to a medical condition (physical or mental) or victims of domestic violence.
31. ***Incurred by Other Persons:*** Expenses actually incurred by other persons.
32. ***Mammoplasty:*** Charges for mammoplasty or purchase of breast prostheses, except as specifically shown as a covered expense elsewhere in the Plan.
33. ***Marital or Family Counseling:*** Charges for services or supplies for marital and/or family counseling or training services.
34. ***Mass Immunizations:*** Charges for unexpected mass immunizations directed by federal, state or local public officials or schools for general population groups.
35. ***Massage Therapy:*** Charges for massage therapy when not in conjunction with a program of physical therapy treatment.
36. ***Maxillary/Mandibular Implants:*** Charges related to maxillary or mandibular implants.
37. ***Milieu Therapy:*** Charges for milieu therapy or any confinement in an institution primarily to change or control one's environment.
38. ***Motor Vehicles:*** Charges for the rental or purchase of motor vehicles such as cars or vans, or for the equipment or costs associated with converting a motor vehicle to accommodate a disability.
39. ***No Legal Obligation to Pay:*** Charges for which the Covered Individual is not (in the absence of this coverage) legally obligated to pay, or for which a charge would not ordinarily be made in the absence of this coverage.
40. ***Non-Covered Procedures:*** Charges in relation to complications of a non-covered procedure, except for charges incurred due to complications of an abortion, such as excessive hemorrhaging.
41. ***Not Medically Necessary:*** Charges incurred in connection with services and supplies which are not necessary for treatment of the injury or illness, or are in excess of reasonable, usual and customary charges, or are not recommended and approved by a physician, or are not recognized by the American Medical Association or American Dental Association as generally accepted and medically or dentally necessary for the diagnosis and/or treatment of an active illness or injury; or charges for procedures, surgical or otherwise, which are specifically listed by the American Medical Association or American Dental Association as having no medical or dental value.
42. ***Not Specifically Listed:*** Charges for services not specifically listed under "Eligible Medical Expenses."
43. ***Nutritional Supplements/Vitamins:*** Charges for nutritional supplements or vitamins, except prenatal vitamins.
44. ***Orthopedic Shoes:*** Charges for orthopedic shoes even if prescribed by a physician.
45. ***Over-the-Counter Drugs and Medications:*** Drugs and medications that can be obtained without a physician's prescription (except insulin and syringes), even if the physician provides a prescription for such drug or medication, except as specifically shown as a covered expense elsewhere in the Plan.
46. ***Penile Prostheses/Implants:*** Charges for penile prostheses/implants and any charges relating thereto.
47. ***Personal Comfort:*** Charges for the purchase or rental of air conditioners, humidifiers, dehumidifiers, air purifiers, saunas, whirlpool bath equipment, or any non-durable medical equipment, services or supplies which constitute personal comfort or beautification items; for television or telephone use, or for any equipment that is useful in the absence of illness or injury.
48. ***Phone Consultation:*** Charges for consultation by telephone with any healthcare provider.
49. ***Prior to Effective Date or After Termination Date:*** Charges incurred prior to the effective date of coverage under the Plan or after coverage is terminated, unless Extension of Benefits applies.
50. ***Private Duty Nursing:*** Charges for special nurses and attendants, except to the extent provided under Home Health Care Services, or as specifically provided for elsewhere in this Plan.
51. ***Prohibited by Law:*** Charges for services, supplies or treatment prohibited by the laws of the jurisdiction where the person resides at the time expenses are incurred.
52. ***Radioactive Contamination:*** Charges incurred as a result of radioactive contamination or the hazardous properties of nuclear material.
53. ***Recreational or Self-Help:*** Charges for services or supplies for recreational educational therapy or forms of non-medical self-help or self-cure, and any related diagnostic testing.
54. ***Reversal of Sterilization:*** Charges related to or in connection with the reversal of a sterilization procedure.

55. ***Routine Health Care:*** Charges for routine health examinations, physician check-ups, screening tests, developmental assessments or immunizations not associated with any sickness, injury or condition requiring professional service or treatment, except as stated in the Medical Expense Benefit Summary.
56. ***Self-Inflicted/Self-Induced:*** Charges in relation to intentionally self-inflicted injury or self-induced illness, unless related to a medical condition (such as depression) as specified in the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
57. ***Services Not Rendered by Nurse:*** Charges for professional nursing services if rendered by other than a registered nurse (RN) or licensed practical nurse (LPN). In addition, the Plan will not cover certified registered nurse s in independent practice (other than a nurse-anesthetist).
58. ***Services Not Rendered by Physician:*** physician's fees for any treatment or service which is not rendered by and in the physical presence of a physician.
59. ***Services Rendered by School:*** Charges for services rendered or billed by a school or halfway house or a member of its staff.
60. ***Shipping:*** Charges for shipping; however, handling and conveyance fees will not be excluded.
61. ***Surrogate Parent:*** Charges for services rendered to or by a surrogate for purposes of childbirth.
62. ***Third Party Examination:*** Charges for routine medical examinations or care, routine health checkups, health assessments, immunizations (except immunizations for travel, which are covered under this Plan), hospitalizations or preparation of reports for third party examinations such as to travel, secure insurance, meet employment requirements, obtain government licenses or examinations to comply with a court order.
63. ***Third Party Responsible:*** The Plan is not required to pay whenever another party is responsible for payment. However, the Plan may pay benefits in accordance with the Subrogation and Reimbursement section of the Plan Document, and such claims or expenses shall be paid on the condition and with the agreement and understanding that the Plan will be reimbursed by the Covered Individual to the extent of the value of covered services provided and shall be treated as an "advancement" of Plan benefits until there is a determination whether a third party or other source of coverage is responsible for paying the claims or expenses and that such claims or expenses are not otherwise "covered" by the Plan.
64. ***Travel or Lodging:*** Charges for travel or lodging costs whether or not recommended by a physician, except as specifically shown as a covered expense elsewhere in the Plan.
65. ***Visual Impairments, Surgical Correction of:*** Charges for radial keratotomy, corneal modulation, refractive keratoplasty or any similar procedure.
66. ***Vocational Rehabilitation:*** Charges for vocational rehabilitation.
67. ***War or any Act of War:*** Charges as a result of war or any act of war, whether declared or undeclared, or caused during service in the armed forces of any country or international organization, or in any auxiliary or civilian noncombatant unit serving with such forces, political terrorist actions, or atomic or thermonuclear explosion or resulting radiation.
68. ***Weight Loss:*** Charges for surgical procedures or medications rendered as treatment for an overweight condition or a condition of obesity whether or not determined to be medically necessary, or for any complication of such treatment.

PRESCRIPTION DRUG EXPENSE BENEFITS

Prescription Drug Expense Benefit Summary

Prescription Drug Co-Pays

- One (1) Co-Pay applies to each prescription and each refill of a prescription.
- Mail order is highly recommended for medications that are taken on a continual basis.
- For the purposes of this Plan, the formulary brand name medications will be determined based upon the Pharmacy Benefit Manager's Formulary list.

		Retail Pharmacy up to 90-day supply per fill	**Mail Order Pharmacy** up to 90-day supply per fill
IN-NETWORK ➢ Covered Individual will only be charged the Co-Pay at the pharmacy. ➢ Claims are submitted to the Plan electronically.	**Generic Drug**	$10 Up to 34 day supply	$20 Up to 90 day supply
		$20 35-60 day supply	
		$30 61-90 day supply	
	Preferred Brand Drug	$30 Up to 34 day supply	$60 Up to 90 day supply
		$60 35-60 day supply	
		$90 61-90 day supply	
	Non-preferred Brand Drug	$50 Up to 34 day supply	$100 Up to 90 day supply
		$100 35-60 day supply	
		$150 61-90 day supply	

OUT-OF-NETWORK

- Covered Individual must pay 100% of cost to pharmacy at the time of purchase.
- Covered Individual must submit receipts to the Claims Processor for reimbursement.
- Covered Individual will be reimbursed the cost of the prescription less the applicable In-Network Co-Pay and the difference in cost between the Out-of-Network pharmacy and an In-Network pharmacy.

Over-the-Counter (OTC) Medication Program

- Allows certain OTC medications as determined by the Pharmacy Benefit Manager (such as Prilosec, Zantac, Claritin and their generic equivalents), at the Co-Pay listed below provided a physician's prescription is presented to the pharmacy at the time of purchase. Please contact the Pharmacy Benefit Manager for a list of eligible OTC medications – the phone number is on your identification card.
- Available at In-Network pharmacies only.

	Retail Pharmacy up to 90-day supply per fill	**Mail Order Pharmacy** up to 90-day supply per fill
OTC Co-Pays - One (1) Co-Pay applies to each prescription and each refill of a prescription.	$10 Up to 34 day supply	$20 Up to 90 day supply
	$20 35-60 day supply	
	$30 61-90 day supply	

Tablet Splitting Program

- 'Tablet splitting' means using a higher strength tablet to cut in half to give the prescribed dose of medication. For example, your doctor prescribes Lipitor 10 mg tablets. You could talk to your doctor and pharmacist about buying Lipitor 20 mg tablets and then cutting them in half to get your 10 mg dose. This allows you to get the same dose by purchasing fewer tablets.
- Available at In-Network pharmacies only.

		Retail Pharmacy up to 90-day supply (45 tablets) per fill	**Mail Order Pharmacy** up to 90-day supply (45 tablets) per fill
Tablet Splitting Co-Pays - One (1) Co-Pay applies to each prescription and each refill of a prescription.	**Generic Drug**	$5 Up to 34 day supply	$10 Up to 90 day supply
		$10 35-60 day supply	
		$15 61-90 day supply	
	Preferred Brand Drug	$15 Up to 34 day supply	$30 Up to 90 day supply
		$30 35-60 day supply	
		$45 61-90 day supply	
	Non-preferred Brand Drug	$25 Up to 34 day supply	$50 Up to 90 day supply
		$50 35-60 day supply	
		$75 61-90 day supply	

Description of Prescription Drug Benefits

The Plan will pay the reasonable, usual and customary charge of prescription drugs, after the Co-Pay has been satisfied at the benefit percentage listed in the Prescription Drug Expense Benefit Summary for each prescription and each refill of a prescription. The prescription drug Co-Payment is not eligible for benefits under the medical benefits portion of this Plan. The Prescription Drug Program will not cover the cost of administration of any drug.

Note: When a generic is available to fill the brand drug prescription, and the brand drug is still dispensed, the Covered Individual will be responsible for the Coinsurance as stated in the Prescription Drug Expense Benefit Summary PLUS the difference in price between the available generic drug and brand drug purchased (except in the case where the physician writes "Dispense as Written" on the brand name prescription, the difference in price will not be charged to the Covered Individual).

For the purposes of this Plan, the formulary brand name medications will be determined based upon the Pharmacy Benefit Manager's Formulary list.

Pharmacy Benefit Manager
The pharmacy benefit manager for this Plan processes electronic claims filed by network pharmacies. The pharmacy benefit manager also reviews new and current drugs for FDA compliance and Formulary status. The pharmacy benefit manager's name and customer service telephone number are listed on your health plan identification card.

Mail Order Program
The Plan provides benefits for prescription drugs obtained through its specified mail order service. Please contact your Human Resources Department or BBSI for order forms.

Covered Prescription Drugs

1. All medications which, under federal or state law, require the written prescription of a licensed physician except as noted under Exclusions.
2. Insulin and glucagon and syringes used to administer insulin or glucagon, and diabetic diagnostic agents including test strips and lancets.
3. Epi-Pen and Imitrex.
4. Contraceptives.

Drugs Which Require Prior Approval
Certain prescription drugs must be reviewed for medical necessity and appropriateness and approved by the Plan Administrator to be considered for coverage under this Plan – such approval should be obtained **prior to purchase**. Requests for prior approval must be made to the Claims Processor – such request may be made in person, by phone or in writing. Some examples include (but are not limited to):

- Prescriptions which exceed the Food and Drug Administration's dosing guidelines.
- Injectable medications (except insulin, glucagon, Epi-Pen and Imitrex) including syringes, needles and/or administration.
- Antiretrovirals, immunosuppresants, interferons, growth hormones, recombinant biological pharmaceuticals, and drugs to treat other rare disorders.

Certain approved drugs ***may*** be covered under the Medical Expense Benefit portion of this Plan - please refer to the Specialty Medications provision in the MEDICAL EXPENSE BENEFITS section of this document.

Prescription Drug Exclusions

The following exclusions and limitations apply to all Covered Individuals who are covered under the Prescription Drug Expense Benefit of this Plan. Note: Certain items excluded under the Prescription Drug Benefit of this Plan ***may*** be covered under the Medical Expense Benefits portion of the Plan; please check the Medical Expense Benefit section for details.

1. ***Accutane:*** Accutane, or for any laboratory testing related to the use of Accutane.
2. ***Administrative Fees:*** Charges for the administration of any drug, or for the completion of any form, or charges for medical information.
3. ***Allergy Injections:*** Allergy injections.
4. ***Anesthetic Agents:*** Anesthetic agents.
5. ***Asthma and Respiratory Supplies:*** Asthma and respiratory supplies (exception: the Plan will allow one (1) aerochamber per benefit period).
6. ***Blood Components and Products:*** Blood components and blood products.
7. ***Bulk Chemicals:*** Bulk chemicals.
8. ***Cosmetic:*** Drugs used for cosmetic alteration.
9. ***Court Mandated:*** Services that are provided due to a court order, except:
    a. When determined to be medically necessary; and
    b. No third party liability has been established.
10. ***Days Supply:*** The charge for more than a ninety (90) day supply shall not be covered by the Plan.
11. ***Devices or Appliances:*** Devices or appliances (except for needles and syringes necessary for the administration of insulin and other covered injectable medications).
12. ***Diagnostic Agents:*** Charges for diagnostic agents including urine and other test strips (except blood glucose test strips).
13. ***Dialysis Supplies:*** Charges for dialysis supplies.
14. ***Durable Medical Equipment:*** Charges for durable medical equipment.
15. ***Employer, Provided by:*** Services provided through a medical clinic or similar facility provided or maintained by an employer.
16. ***Employment Related:*** No benefits or expenses will be paid or reimbursed to or for any Covered Individual for any injury, illness, occupational disease, or other loss which arises out of and in the course of employment, and for which the Covered Individual is reimbursed or entitled to reimbursement under any federal or state law, including a workers' compensation law or similar law. This exclusion applies to each Covered Individual:
    a. Who is actively engaged in a business, occupation, or profession on substantially a full-time basis and who may elect coverage under a workers' compensation law or similar law, but either fails to secure such coverage or voluntarily elects not to secure such coverage; or
    b. Whose employer may elect coverage under workers' compensation law or similar law, but either fails to secure such coverage or voluntarily elects not to secure workers' compensation coverage.
17. ***Excess Charges:*** Charges for services that are not Reasonable, not Medically Necessary, are not Usual and Customary, and/or are in excess of the Maximum Allowable Charge.
18. ***Excess Refills:*** Refills of a prescription that is more than one (1) year old or refills of a prescription in excess of the number of times specified by a physician.
19. ***Experimental:*** Charges for experimental drugs not considered legal in the United States or for any drug not approved by the Food and Drug Administration (FDA) or for FDA-approved drugs that are prescribed for non-FDA-approved uses. Experimental or investigational services includes:
    a. care, procedures, treatment protocol or technology which:
        i. Is not widely accepted as safe, effective and appropriate for the injury or sickness throughout the recognized medical and dental professions and established medical and dental societies in the United States; or
        ii. Is experimental, in the research or investigational stage or conducted as part of research protocol, or has not been proved by statistically significant randomized clinical trials to establish increase survival or improvement in the quality of life over other conventional therapies.

b. drugs, tests, and technology which:
   i. The FDA has not approved for general use;
   ii. Are considered experimental;
   iii. Are for investigational use; or
   iv. Are approved for a specific medical or dental condition but are applied to another condition.

The Plan will rely on the Data project of the American Medical Association, the American Dental Association, the National Institute of Health, the U.S. Food and Drug Administration, the National Cancer Institute, Office of Health Technology Assessment, the Health Care Financing Administration of the U.S. Department of Health and Human Services, and Congressional Office of Technology Assessment in determining investigational or experimental services.

20. ***Foreign Travel:*** If a Covered Individual purchases prescription drugs outside of the United States or its territories, benefits shall be provided for those charges to the extent that the services rendered are included as covered expenses in the Plan, and provided the Covered Individual did not travel to such a location for the sole purpose of purchasing such drugs. Additionally, charges for such drugs may not exceed the limits specified herein as reasonable and customary in the area of residence of the Covered Individual in the United States. Fees and charges exceeding reasonable and customary shall be disallowed as ineligible charges. Charges equal to or less than reasonable and customary shall be considered. In no event shall benefit payment exceed that actual amount charged. (For more efficient claims processing, claims should be submitted in English and converted to American dollars).
21. ***Gender Identification:*** Charges related to transsexualism, gender dysphoria, or sexual reassignment or services or supplies related to the performance of gender transformation procedures, including medications and hormone therapy.
22. ***Governmental Program:*** Charges for services or supplies that the Covered Individual is entitled to claim from any governmental program even if he waived or failed to claim rights to such services, benefits, or damages.
23. ***Hair Loss:*** Cosmetic hair products or drugs for treatment of hair loss.
24. ***Holistic Medicine:*** Charges related to holistic medicine or healing, or other programs with an objective to provide personal fulfillment.
25. ***Illegal Act:*** Charges incurred due to an illness or injury resulting from the Covered Individual's voluntary commission of an illegal act (including but not limited to driving a motor vehicle while under the influence of alcohol or drugs, voluntary intake of any illegal drug, voluntary intake of a prescription drug not prescribed by a physician for that person specifically, burglary, robbery, assault, criminal trespass, participation in a riot or civil disturbance), or while the Covered Individual is engaged in an illegal occupation. An act is illegal if it is violative of a law, and that neither a citation nor conviction is required for the Plan to deny a claim in accordance with this exclusion. Such exclusion does not apply to injuries and/or illnesses sustained due to a medical condition (physical or mental) or victims of domestic violence.
26. ***Immunizations:*** Immunization agents, vaccines, biological sera, toxoids or allergens.
27. ***Incurred by Other Persons:*** Expenses actually incurred by other persons.
28. ***Mass Immunizations:*** Charges for unexpected mass immunizations directed by federal, state or local public officials or schools for general population groups.
29. ***Medical or Surgical Supplies:*** Charges for medical or surgical supplies, such as ostomy bags and devices.
30. ***No Legal Obligation to Pay:*** Charges for which the Covered Individual is not (in the absence of this coverage) legally obligated to pay, or for which a charge would not ordinarily be made in the absence of this coverage.
31. ***Not Dispensed by Retail Pharmacy:*** Drugs dispensed by other than retail pharmacy (except through the approved Mail Order Program) or dispensed from or by any hospital, extended care facility, or other institution.
32. ***Not Medically Necessary:*** Charges incurred in connection with services and supplies which are not necessary for treatment of the injury or illness, or are in excess of reasonable and customary charges, or are not recommended and approved by a physician, or are not recognized by the American Medical Association or American Dental Association as generally accepted and medically or dentally necessary for the diagnosis and/or treatment of an active illness or injury; or charges for procedures, surgical or otherwise, which are specifically listed by the American Medical Association or American Dental Association as having no medical or dental value.
33. ***Nutritional Supplements and Vitamins:*** Charges for nutritional and diet supplements (enteral and parenteral) or vitamins, except prenatal vitamins.
34. ***Other Insurance:*** Any drug for which reimbursement is available under any other group health plan.

35. ***Over-the-Counter Drugs and Medications:*** Drugs and medications that can be obtained without a physician's prescription (except insulin and syringes), even if the physician provides a prescription for such drug or medication, except as specifically shown as a covered expense elsewhere in the Plan.
36. ***Phone Consultation:*** Charges for consultation by telephone with any healthcare provider.
37. ***Prior to Effective Date or After Termination Date:*** Charges incurred prior to the effective date of coverage under the Plan or after coverage is terminated, unless Extension of Benefits applies.
38. ***Prohibited by Law:*** Charges for services, supplies or treatment prohibited by the laws of the jurisdiction where the person resides at the time expenses are incurred.
39. ***Radioactive Contamination:*** Charges incurred as a result of radioactive contamination or the hazardous properties of nuclear material.
40. ***Services Rendered by School:*** Charges for services rendered or billed by a school or halfway house or a member of its staff.
41. ***Shipping:*** Charges for shipping.
42. ***Third Party Responsible:*** The Plan is not required to pay whenever another party is responsible for payment. However, the Plan may pay benefits in accordance with the Subrogation and Reimbursement section of the Plan Document, and such claims or expenses shall be paid on the condition and with the agreement and understanding that the Plan will be reimbursed by the Covered Individual to the extent of the value of covered services provided and shall be treated as an "advancement" of Plan benefits until there is a determination whether a third party or other source of coverage is responsible for paying the claims or expenses and that such claims or expenses are not otherwise "covered" by the Plan.
43. ***War or any Act of War:*** Charges as a result of war or any act of war, whether declared or undeclared, or caused during service in the armed forces of any country or international organization, or in any auxiliary or civilian noncombatant unit serving with such forces, political terrorist actions, or atomic or thermonuclear explosion or resulting radiation.
44. ***Weight Loss:*** Drugs used as treatment for an overweight condition or a condition of obesity.

PRE-EXISTING CONDITIONS

This Plan complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This Plan cannot deny coverage based on an individual's health status. This Plan has not established eligibility rules based on any of the following health status-related factors: medical conditions (including physical and mental illnesses), claim experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of domestic violence) and disability. This does not prevent this Plan from establishing limitations or restrictions on the amount, level, extent, or nature of the benefits offered, provided all rules are applied on a non-discriminatory basis to all Covered Individuals.

A pre-existing condition is a condition for which medical advice, diagnosis, care or treatment was recommended or received within six (6) months prior to the Covered Individual's enrollment date under this Plan (which is the earlier of the first day of health coverage or the first day of any waiting period for coverage). Genetic information is not a condition. Treatment includes receiving services and supplies, consultations, diagnostic test or prescribed medicines. In order to be taken into account, the medical advice, diagnosis, care or treatment must have been recommended by, or received from, a physician.

Covered charges incurred under Medical benefits for pre-existing conditions are not payable unless incurred twelve (12) consecutive months (or eighteen (18) months if a late enrollee) after the Covered Individual's enrollment date. This time may be offset if the person has creditable coverage from his or her previous health plan. The Pre-Existing Condition Limitation does not apply to a Covered Individual that has not yet reached age nineteen (19).

The pre-existing condition Limitation will be waived wholly or in part in the event an individual was insured previously by creditable coverage, and providing there was no break in such coverage of sixty-three (63) days or longer immediately prior to the Covered Individual's enrollment date. If, after creditable coverage has been taken into account, there will still be a pre-existing conditions Limitation imposed on a Covered Individual, that individual will be so notified. For the purposes of this Plan, "creditable coverage" means, with respect to an individual, coverage of the individual provided under any of the following:

a) Part A or Part B of Title XVIII of the Social Security Act (Medicare);
b) A group health plan;
c) An individual health insurance policy that provides benefits similar to or exceeding benefits provided under a basic health benefit plan;
d) Title XIX of the Social Security Act, other than coverage consisting solely of benefits under section 1928 (Medicaid);
e) Chapter 55 of Title 10, United States Code (military-sponsored health care);
f) A State health benefits risk pool;
g) A health plan offered under chapter 89 of Title 5, United States Code (FEHBP);
h) A public health plan (as defined in the regulations); or A medical care program of the Indian Health Service or of a tribal organization; or
i) A health benefit plan under section 5(e) of the Peace Corps Act (22 U.S.C. 2504(e)); or
j) A plan recognized as "creditable" under HIPAA.

An eligible person may request a Certificate of Creditable Coverage from his or her prior plan within twenty-four (24) months after losing coverage and the employer will assist any eligible person in obtaining a Certificate of Creditable Coverage from a prior plan.

Exceptions to the Pre-Existing Condition Limitation:
The pre-existing condition Limitation does not apply to pregnancy, or to a Covered Individual that has not yet reached age nineteen (19).

Any child of a Covered Individual who is an Alternate Recipient under a Qualified Medical Child Support Order shall be considered as having a right to dependent coverage under this Plan with no pre-existing conditions provisions applied.

ELIGIBILITY FOR COVERAGE

ELIGIBLE CLASSIFICATIONS

The following classifications of Employees are eligible for coverage under this Plan, if the Eligibility and Period of Service requirements are met:

- All Active Faculty, Staff and Administration Employees.
- All Retired Faculty, Staff or Administration Employees who:
    1. Are at least fifty-five (55) years of age; and
    2. Are under age sixty-five (65); and
    3. Retired from employment with the College on or before December 31, 2009.

ELIGIBILITY REQUIREMENTS

To be eligible for coverage under this Plan, an Employee within an Eligible Classification who meets the Period of Service Requirements must:

- For Active Employees: Work for the College at least twenty (20) hours per week on a regular basis.
- For Retired Employees: Have been covered under this Plan on the day immediately prior to the date of retirement.

PERIOD OF SERVICE REQUIREMENTS

An Employee within an Eligible Classification who meets the Eligibility Requirements of this Plan will be eligible for coverage under this Plan on:

- For Active Employees: The first day of the calendar month next following the first day of employment with the College.
- For Retired Employees: The first day of retirement following ten (10) years or more of continuous employment with the College.

All applicable terms and provisions of the Personnel Policy shall apply to the Eligibility and Termination provisions contained within this Plan Document. The Personnel Policy shall be made readily available by the Employer/Plan Sponsor at the request of the Claims Processor in order to determine eligibility and termination under the plan.

Active Employee Eligibility and Effective Date

An employee is eligible for coverage under the Plan from the first day that he or she:

1. Is employed by the College on a regular, full-time basis as specified above; and
2. Is actively at work; and
3. Has satisfied the Required Period of Service as specified above; and
4. Is within one of the classifications shown above.

A “waiting period” is the time between the first day of employment and the first day of coverage under the Plan. The waiting period is counted in the pre-existing conditions exclusion time.

If the employee has met the above eligibility requirements on or before the effective date of this Plan, the date of eligibility shall be the effective date of the Plan. If the employee meets the above eligibility requirements after the effective date of the Plan, the date of eligibility shall be as indicated above. Employee coverage under the Plan shall become effective on the date of the employee’s eligibility, provided he has made written application for such coverage on or before such date. If an employee applies for coverage within thirty-one (31) days after his date of eligibility, his coverage shall become effective on the date he makes his written application.

All employee coverage under the Plan shall commence at 12:01 A.M. Standard Time, on the date such coverage is effective, provided such employee is able to be actively at work at such time. If the employee is not actively at work on the date this employee coverage would otherwise take effect, but would have been able to actively work at 12:01 A.M. Standard Time had such work commenced at that time, such employee shall be eligible for coverage on that date. If an eligible employee is not able to be actively at work on the date this employee coverage would otherwise become effective, for reasons other than those related to a health condition, his coverage shall become effective on the day he returns to active work.

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

Each employee will become eligible for dependent coverage on the latest of the following:

1. The date he becomes eligible for coverage.
2. The date on which he first acquires a dependent.
3. The date he first comes within the classification (if any) eligible for dependent coverage, as stated above.

If both husband and wife are employed by the College and both are eligible for coverage under this Plan, each may carry single coverage in lieu of family coverage. However, if either have eligible dependents, only one may carry family coverage on the entire family unit. A person may not be covered as both an employee and as a dependent.

Rehiring a Terminated Employee
A terminated employee who is rehired will be treated as a new hire and be required to satisfy all Eligibility and Enrollment requirements.

Retiree Eligibility and Effective Date
A Retired employee shall be eligible to continue coverage under this Plan for himself and his covered dependents providing:

1. He is covered under the Plan on the day immediately preceding his date of retirement; and
2. Is within one of the classifications shown above.
3. Has satisfied the Required Period of Service as specified above.

If the Retired Employee has met the above eligibility requirements on or before the effective date of this Plan, the date of eligibility shall be the effective date of the Plan. If the Retired Employee meets the above eligibility requirements after the effective date of the Plan, the date of eligibility shall be as indicated above. Retiree coverage under the Plan shall become effective on the date of the Retiree's eligibility, provided he has made written application for such coverage on or before such date.

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

1. If the employee makes such written request on or before the date he becomes eligible for dependent coverage, he shall become covered, with respect to those persons who are then his dependents, on the date he becomes eligible for dependent coverage.
2. A dependent is any one of the following persons:
   a.) A covered Employee's spouse (unless legally separated) or the Employee's Domestic Partner or the Employee's Civil Union Partner (unless legally separated), and children from birth to the limiting age of twenty-six (26) years. However, a Dependent child will be covered after age 26, provided the child is a military veteran, is a resident of Illinois, is unmarried and under the limiting age of thirty (30); to be eligible, veterans must have:
      i. Served in the active or reserve components of the U.S. Armed Forces, including the National Guard;
      ii. Received a release or discharge other than a dishonorable discharge; and
      iii. Submitted proof of service using a DD2-14 (Member 4 or 6) form, otherwise known as a "Certificate of Release or Discharge from Active Duty." This form is issued by the federal government to all veterans. For more information on how to obtain a copy of a DD2-14, the veteran can call the Illinois Department of Veterans' Affairs at 1-800-437-9824 or the U.S. Department of Veterans' Affairs at 1-800-827-1000.
   b.) When the child reaches either limiting age, coverage will end on the last day of the month in which the child's birthday occurs. **The Employee is responsible for notifying the Plan when a Dependent Child is no longer an eligible Dependent under the Plan.**
   c.) The term "spouse" shall mean the person recognized as the covered employee's husband or wife under the laws of the state where the covered employee lives. The Plan Administrator may require documentation proving a legal relationship.
   d.) The term "Domestic Partner" shall mean the person with whom (1) the Employee has entered into a "Domestic Partnership" and (2) the Employee resides on a permanent basis. The Employee must provide a copy of the properly executed "Statement of Domestic Partnership" to the Plan Administrator, which has been duly notarized. (The Statement of Domestic Partnership form may be obtained from the Employer.) The date of eligibility for a Domestic Partner shall be earlier of:

i. The date the Domestic Partnership Agreement is executed; or
ii. The date the Employee becomes eligible for Dependent coverage.

e.) The term "children" shall include natural children, adopted children, step-children, children placed with a covered employee in anticipation of adoption or children for whom the covered employee is the legal guardian. Grandchildren are eligible for coverage only if the employee or the employee's spouse has been appointed legal guardian in an appropriate legal proceeding and the Plan has been presented with the Order Appointing Guardianship.

f.) The term "Civil Union Partner" shall mean the person recognized as the covered employee's civil union partner under the laws of the state where the covered employee lives. The Plan Administrator may require documentation proving a legal relationship.

3. A newborn child of an employee will be covered from the moment of birth providing dependent coverage is in effect at that time and the employee notifies the employer in writing of the newborn child's name and date of birth within thirty-one (31) days of the birth. If dependent coverage is not in effect, the employee will have thirty-one (31) days from the date of the birth to make application for dependent coverage and coverage will be retroactive to the date of the birth. If the employee does not notify the Plan of the child's birth within thirty-one (31) days after the birth, the child will not be eligible for enrollment in this Plan until the next Open Enrollment Period or Special Enrollment Period, and coverage for the newborn child will not be effective until the date of enrollment.
4. An adoptive child of an employee, who has not attained the age of twenty-six (26), will be covered from the date the child is placed in the physical custody of the employee and the employee is legally responsible for medical expenses incurred by said child, whether or not the adoption has become final, if dependent coverage is in effect on that date and the employee notifies the employer in writing of the adoptive child's name and date of birth within thirty-one (31) days of the birth. If dependent coverage is not in effect, the employee has thirty-one (31) days from the date the child is placed in the physical custody of the employee to make application for dependent coverage and coverage will be retroactive to the date of physical custody. If the employee makes notification later than thirty-one (31) days after the adoptive child is placed in the physical custody of the employee, the child will not be eligible for enrollment in this Plan until the next Open Enrollment Period or Special Enrollment Period, and coverage for the adoptive child will not be effective until the date of enrollment.
5. If a dependent is acquired other than at the time of his birth due to a court order, decree, or marriage, domestic partnership or civil union, coverage for this new dependent will be effective on the date of such court order, decree, or marriage, domestic partnership or civil union if dependent coverage is in effect under the Plan at that time and the employee notifies the employer in writing of the dependent's name and date of birth within thirty-one (31) days of the acquisition. If the employee does not have dependent coverage in effect under the Plan at the time of the court order, decree, or marriage, domestic partnership or civil union and requests such coverage and properly enrolls this new dependent within the thirty-one (31) day period immediately following the date of the court order, decree, or marriage, domestic partnership or civil union, dependent coverage will be retroactive to the date of the court order, decree, or marriage, domestic partnership or civil union. If the employee does not notify the Plan of the acquisition of the dependent within thirty-one (31) days after the acquisition, the dependent will not be eligible for enrollment in this Plan until the next Open Enrollment Period or Special Enrollment Period, and coverage for the dependent will not be effective until the date of enrollment.
6. A covered dependent child who becomes totally disabled prior to reaching the limiting age of twenty-six (26) may remain covered under this Plan, provided that the child remains mentally or physically incapable of sustaining his or her own living, is dependent upon the covered employee for more than 50% of his support, and is unmarried. The Plan Administrator may require, at reasonable intervals during the two (2) years following the dependent's reaching the limiting age, subsequent proof of the child's total disability and dependency. After such two year period, the Plan Administrator may require subsequent proof not more than once each year. The Plan Administrator reserves the right to have such dependent examined by a physician of the Plan Administrator's choice, at the Plan's expense, to determine the existence of such incapacity.
7. As required by the Federal Omnibus Budget Reconciliation Act of 1993, any child of a Covered Individual who is an Alternate Recipient under a Qualified Medical Child Support Order shall be considered as having a right to dependent coverage under this Plan with no pre-existing conditions provisions applied. Covered Individuals and beneficiaries may obtain without charge a copy of the Qualified Medical Child Support Order procedures from the Plan Administrator.
8. These persons are excluded as dependents: other individuals living in the covered employee's home, but who are not eligible as defined; the legally separated or divorced former spouse of the employee; any spouse who is a resident of a Country outside the United States; any person who is on active duty in any military service of any country (except as provided elsewhere in this Plan); or any spouse who is covered under the Plan as an employee.

9. If a person covered under this Plan changes status from employee to dependent or dependent to employee, and the person is covered continuously under this Plan before, during and after the change in status, credit will be given for Deductibles and all amounts applied to maximums.
10. If both husband and wife are employees, their children will be covered as dependents of the husband or wife, but not of both.

Qualified Medical Child Support Order

A Qualified Medical Child Support Order is a medical child support order which creates or recognizes an Alternate Recipient's right to, or assigns to an Alternate Recipient the right to, receive benefits for which a Covered Individual is eligible, and which the Plan Administrator has determined meets the requirements of this Section. A Medical Child Support Order to be qualified must clearly:

f. Specify the name and last known mailing address (if any) of the Covered employee and the name and mailing address of each Alternate Recipient covered by the order; and
g. Include a reasonable description of the type of coverage to be provided by the Plan to each Alternate Recipient, or the manner in which such type of coverage is to be determined; and
h. Specify each period to which such order applies; and
i. Specify each plan to which such order applies; and
j. Not require the Plan to provide any type or form of benefits or any option not otherwise provided under the Plan except to the extent necessary to meet the requirements described in Section 1908 of the Social Security Act (relating to the enforcement of state laws regarding child support and reimbursement of Medicaid).

Upon receipt of a Medical Child Support Order, the Plan Administrator shall:

5. Promptly notify in writing the Covered employee, each Alternate Recipient covered by the order, and each representative for these parties of the receipt of the Medical Child Support Order. Such notice shall include a copy of the order and these QMCSO procedures.
6. Permit the Alternate Recipient to designate a representative to receive copies of notices sent the Alternate Recipient regarding the Medical Child Support Order.
7. Within a reasonable period after receiving a Medical Child Support Order, determine whether it is a qualified order and notify the parties indicated in subsection (a) above of such determination.
8. Ensure the Alternate Recipient is treated by the Plan as a beneficiary for reporting and disclosure purposes, such as by distributing to the Alternate Recipient a copy of the Summary Plan Description and any subsequent Summaries of Material Modifications generated by a Plan Amendment.

ENROLLMENT

Annual Open Enrollment Period
Each year, during the Open Enrollment Period, eligible employees and their eligible dependents will be able to change their benefit elections. Benefit choices made during the Open Enrollment Period will become effective on September 1st following the Open Enrollment Period in which the benefit election change is made, and remain in effect until the next September 1st, unless there is a change in family status during the intervening time (birth, death, marriage, domestic partnership, civil union, divorce, adoption) or loss of coverage due to loss of a spouse's employment. To the extent previously satisfied, coverage waiting periods and pre-existing conditions limits will be considered satisfied when changing from one benefit election to another. A Covered Individual who fails to make an election during open enrollment will automatically retain his or her present benefit election. Covered Individuals will receive detailed information regarding open enrollment from the College.

Enrollment Requirements
An employee must enroll for coverage by filling out and signing an enrollment application. If the covered employee does not enroll in the Plan within thirty-one (31) days of his initial date of eligibility, his enrollment will be considered a Late Enrollment (see the Late Enrollment provision below).

Enrollment Requirements for Newborn Children
A newborn child of a covered employee must be enrolled in the Plan within thirty-one (31) days of the child's birth in order for coverage to take effect on the date of birth. Eligible expenses will be applied toward the Plan of the newborn child. If the newborn child is not enrolled within thirty-one (31) days of birth, there will be no payment from the Plan and the covered parent will be responsible for all costs until the newborn child is enrolled in the Plan, and the enrollment will be considered a Late Enrollment (see the Late Enrollment provision below).

Timely Enrollment
The enrollment will be "timely" if the completed form is received by the Plan Administrator no later than thirty-one (31) days after the person becomes eligible for the coverage, either initially or under a Special Enrollment Period. If two employees (husband and wife) are covered under the Plan and the employee who is covering the dependent children terminates coverage, the dependent coverage may be continued by the other covered employee with no waiting period as long as coverage has been continuous.

Late Enrollment

Enrollment for coverage is required within thirty-one (31) days of the date an individual would otherwise be eligible. If enrollment is not completed within that time, or if a covered employee's and/or dependent's coverage terminates because of failure to make a contribution when due, such person will be considered a late enrollee. Some late enrollments may be made under the following Special Enrollment provision, however, if the Special Enrollment provisions do not apply, a late enrollee will only be eligible to enroll during the Open Enrollment Period designated by the College.

If an individual loses eligibility for coverage as a result of terminating employment or a general suspension of coverage under the Plan, then upon becoming eligible again due to resumption of employment or due to resumption of Plan coverage, only the most recent period of eligibility will be considered for purposes of determining whether the individual is a late enrollee.

Special Enrollment

Special Enrollment rights may be triggered upon the occurrence of certain types of events: loss of other health coverage, addition of a new dependent and upon becoming eligible for a state premium assistance subsidy. When a triggering event occurs, an eligible individual will have certain rights to enroll in this Plan, provided that enrollment requirements are satisfied. A description of triggering events, special enrollment rights and enrollment requirement for each type of event are listed below. An individual who does not enroll in the Plan within the deadlines explained below will lose Special Enrollment rights for that event.

The enrollment date for anyone who enrolls under a Special Enrollment Period is the first date of coverage. Thus, the time between the date a special enrollee first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a Waiting Period.

Loss of Other Health Plan Coverage: Eligible Employees and their Dependents who, at the time they were offered coverage under the Plan were eligible for the coverage and declined it because of other health coverage, are entitled to enroll in the plan when the other coverage ends. If the Employee or Dependent lost the other coverage as a result of the individual's failure to pay premiums or required contributions or for cause (such as making a fraudulent claim), that individual does not have a Special Enrollment right.

- **Other Coverage is COBRA Coverage.** If the other coverage is COBRA coverage, the eligible Employee must exhaust COBRA coverage to be eligible for special enrollment in the Plan. Exhaustion of COBRA coverage means that COBRA coverage ends for any reason other than failure to pay contributions on time or for cause.
- **Other Coverage is Not COBRA Coverage.** If the other coverage is not COBRA coverage, the Employee must lose the other coverage as a result of loss of eligibility for the coverage, termination of employment or employer contribution toward the other coverage terminates.
- **Other Coverage is Medicaid or state Children's Health Insurance Program.** If the other coverage is Medicaid or a state's Children's Health Insurance Program (CHIP), the Employee or his eligible Dependent(s) must lose such coverage due to a loss of eligibility for Medicaid or CHIP.
- **Deadline for Special Enrollment Period. T**he eligible Employee is required to request special enrollment in the Plan not later than thirty (30) days (in the case of loss of eligibility for Medicaid or CHIP, sixty (60) days) after:
  1. The exhaustion of the other coverage; or
  2. The termination of the other coverage as a result of the loss of eligibility for the other coverage; or
  3. The termination of employer contributions toward that other coverage.

  If the Plan Administrator does not receive the eligible Employee's completed request for enrollment within this deadline, the eligible Employee and his or her Dependents lose special enrollment rights for that event.
- **Effective Date of Enrollment.** Enrollment in the Plan under this Special Enrollment provision will be effective not later than the first day of the calendar month beginning after the date the Plan Administrator receives the completed request for enrollment.

Addition of a Dependent: Eligible Employees and their Dependents who, at the time they were offered coverage under the Plan were eligible for the coverage and declined it, are entitled to enroll in the plan upon the eligible Employee's marriage, domestic partnership, civil union, or the birth or adoption of his or her child.

- **Non-Participating Employee May Also Enroll.** The addition of a new dependent triggers enrollment rights for an eligible Employee even if he or she does not participate in the Plan at the time of the event. For example, upon the birth of an eligible Employee's child, the eligible Employee (assuming that he or she did not previously enroll), his or her spouse, and his or her newborn child may all enroll because of the child's birth. The same rule applies to the eligible Employee's marriage, domestic partnership, civil union, or adoption of a child if the eligible Employee had not previously enrolled in the Plan.
- **Deadline for Special Enrollment Period.** An eligible Employee must request special enrollment within thirty (30) days of marriage, domestic partnership, civil union, or birth, adoption or placement for adoption of his or her child. If the Plan Administrator does not receive the eligible Employee's completed request for enrollment within this deadline, he or his Dependents lose special enrollment rights for that event.
- **Effective Date of Enrollment.** The date of enrollment for coverage will be the date of the event.

Attainment of Eligibility for Premium Assistant under Medicaid or state Children's Health Insurance Program: Eligible Employees and their Dependents who, at the time they were offered coverage under the Plan were eligible for the coverage and declined it, are entitled to enroll in the plan when that Employee and/or dependent(s) becomes eligible for a state's premium assistance subsidy, with respect to coverage under the plan, under either a Medicaid plan under Title XIX of the Social Security Act, or the state Children's Health Insurance Program under Title XXI of the Social Security Act. (States may choose to voluntarily offer a premium assistance subsidy to eligible low-income children and their families for "qualified employer-sponsored coverage." This subsidy may be provided as a reimbursement to the employee or as a direct payment to the employer (unless the employer opts out of receiving direct payments)).

- **Non-Participating Employee May Also Enroll.** A dependent's eligibility for a state's premium assistance subsidy triggers enrollment rights for an eligible Employee even if he or she does not participate in the Plan at the time of the event.

- **Deadline for Special Enrollment Period.** An eligible Employee must request special enrollment within sixty (60) days of becoming eligible for such state premium assistance. If the Plan Administrator does not receive the eligible Employee's completed request for enrollment within this deadline, he or his Dependents lose special enrollment rights for that event.
- **Effective Date of Enrollment.** Enrollment in the Plan under this Special Enrollment provision will be effective not later than the first day of the calendar month beginning after the date the Plan Administrator receives the completed request for enrollment.

Pre-existing Condition Exclusion and Special Enrollees. Special Enrollees and their dependents will not be treated as late enrollees. The Plan will not apply a pre-existing condition exclusion to pregnancy, or to a Covered Individual that has not yet reached age nineteen (19).

Effect of Re-Enrollment on Deductibles, Out-of-Pocket Expense Limits and Benefit Limitations
Annual Deductibles, Out-of-Pocket Expense Limits and Benefit Limitations for a Covered Individual whose coverage under this Plan terminates for any reason and who is subsequently re-enrolled in this Plan within the same Calendar Year as termination occurs will be calculated and accrued as if no termination occurred.

The Maximum Annual Benefit for a Covered Individual whose coverage under this Plan terminates for any reason and who is subsequently re-enrolled in this Plan will be calculated and accrued as if no termination occurred, regardless of the number of times a Covered Individual terminates coverage and re-enrolls under this Plan.

Special Enrollment for Previously Enrolled Participants
Dependents who had ceased to be eligible to enroll in the Plan prior to the passage of the Patient Protection and Affordable Care Act shall be provided with a 30 day Special Enrollment opportunity. This Special Enrollment opportunity will begin September 1, 2011. All Dependents whose coverage under this Plan had previously ended, or who were denied coverage (or were not eligible for coverage) because the availability of Dependent coverage of Children ended before age 26, are eligible to enroll, or re-enroll in the plan or coverage under this Special Enrollment period. Coverage for Dependents who enroll through this Special Enrollment opportunity must take effect no later than September 1, 2011.

Participants who were previously enrolled, but were terminated from Plan participation because of a prior lifetime limitation provision shall be provided with a 30 day Special Enrollment opportunity. This Special Enrollment opportunity will begin September 1, 2011. All participants whose coverage under this Plan had previously ended due to reaching the lifetime benefit limitation under this Plan, are eligible to enroll, or re-enroll in the plan or coverage under this Special Enrollment period. Coverage for participants who enroll through this Special Enrollment opportunity must take effect no later than September 1, 2011.

TERMINATION OF COVERAGE

When coverage under this Plan stops, Covered Individual's will receive a certificate that will show the period of coverage under this Plan. Please contact the Plan Administrator for further details.

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

1) The date the Plan is terminated; or with respect to any benefit of the Plan, the date of termination of such benefit.
2) The date of the employee's termination of employment.
3) The date the employee requests termination of coverage under this Plan. However, voluntary termination of coverage for an active employee will only be allowed during the Plan's Annual Open Enrollment Period or when a triggering event occurs. Triggering events include:
   - Becoming eligible under another employer-sponsored health plan;
   - Entitlement to Medicare or Medicaid;
   - A significant increase in the employee's cost of coverage under this Plan.

   Termination of coverage due to a triggering event must be requested within thirty (30) days of the triggering event.
4) The date the employee ceases to be in a class of employees eligible for coverage, unless the employee meets the requirements for continuation of coverage (see section entitled "Extension of Benefits").
5) The thirty-first (31st) day after the employee enters military duty on a full-time basis.
6) The date FMLA leave ends, if the employee has not returned to work as an active, regular full-time employee.
7) The date ending the period for which the last contribution is made if the employee fails to make any required contributions when due, unless coverage ends earlier for other reasons.
8) The date of the employee's death.

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

1) The date the Plan is terminated; or with respect to any benefit of the Plan, the date of termination of such benefit.
2) The last day of the month in which the retiree ceases to be in a class of retirees eligible for coverage.
3) The thirty-first (31st) day after the retiree enters military duty of on a full-time basis.
4) The date ending the period for which the last contribution is made if the retiree fails to make any required contributions when due, unless coverage ends earlier for other reasons.
5) The date the retiree becomes eligible for Medicare coverage.
6) The date of the retiree's death.

Dependent Termination – Dependent of Active Employee or Retiree
Dependent coverage will automatically terminate immediately upon the earliest of the following dates, except as provided in any Extension of Benefits provision:

1) The date the Plan is terminated; or with respect to any dependents benefit of the Plan, the date of termination of such benefit.
2) The date of termination of the employee's/retiree's coverage under the Plan.
3) The date the employee/retiree ceases to be in a class of employees/retirees eligible for dependent coverage.
4) The last day of the month in which the dependent ceases to be an eligible dependent as defined in the Plan. In the case of a Child age 26 or older for whom coverage is being continued due to mental or physical inability to earn his or her own living, the earliest to occur of:
   a. Cessation of such inability;
   b. Failure to furnish any required proof of the uninterrupted continuance of such inability or to submit to any required examination;
   c. Upon the Child's no longer being dependent upon the Covered Employee for his or her support.
5) The date the dependent spouse becomes covered under this Plan as an eligible employee.

6) The date the employee/retiree requests termination of coverage for the dependent. However, voluntary termination of coverage for dependents of active employees will only be allowed during the Plan's Annual Open Enrollment Period or when a triggering event occurs. Triggering events include:
   - Become eligible under another employer-sponsored health plan;
   - Entitlement to Medicare or Medicaid;
   - A significant increase in the employee's cost of coverage under this Plan.

   Termination of coverage due to a triggering event must be requested within thirty (30) days of the triggering event.
7) The date ending the period for which the last contribution is made if the employee/retiree fails to make any required contributions when due, unless coverage ends earlier for other reasons.
8) The thirty-first (31st) day after the dependent enters military duty on a full-time basis.
9) The last day of the month in which the employee's/retiree's death occurs.

EXTENSION OF BENEFITS

Family and Medical Leave Act Provision

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

When a qualifying leave has been taken by the employee, coverage will continue under the Family and Medical Leave Act of 1993, until the earliest of the following dates:

a. The Covered Individual fails to return from such leave;
b. The Covered Individual exhausts his or her leave entitlement under said Act;
c. The Covered Individual informs the College of the intent not to return from such leave; or
d. The Covered Individual fails to pay to the Plan any contribution required during the qualifying leave period within thirty-one (31) days after the due date of such contribution.

Uniformed Services Employment and Reemployment Rights Act (USERRA)

It is the intent of the Plan to adhere to the provisions of The Uniformed Services Employment and Reemployment Rights Act (USERRA), which prohibits discrimination against persons because of their service in the Armed Forces Reserve, the National Guard, or other uniformed services. The USERRA prohibits the employer from denying any benefit of employment on the basis of an individual's membership, application for membership, performance of service, application for service, or obligation for service in the uniformed services. USERRA also protects the right of veterans, reservists, National Guard members, and certain other members of the uniformed services to reclaim their civilian employment after being absent due to military service or training. An individual who would like complete information regarding his rights under USERRA should contact the College, or visit the Department of Labor's website at http://www.dol.gov/vets/welcome.html.

Employees going into or returning from military service may elect to continue Plan coverage as mandated by the USERRA under the following circumstances. Employees performing military duty of more than thirty-one (31) days may elect to continue employer sponsored health care for up to twenty-four (24) months. For military service of less than thirty-one (31) days, health care coverage is provided as if the service member had remained employed, provided that the individual makes the required contributions, if any. These rights apply only to employees and their dependents covered under the Plan before leaving for military service. The maximum period of coverage of a person under such an election shall be the lesser of:

- The twenty-four (24) month period beginning on the thirty-first day following the date on which the person's absence begins, or
- The day after the date on which the person was required to apply for or return to a position or employment and fails to do so.

A person who elects to continue health plan coverage may be required to pay up to 102% of the full contribution under the Plan, except a person on active duty for thirty-one (31) days or less cannot be required to pay more than the employee's share, if any, for the coverage. Failure to pay the required monthly contribution within thirty-one (31) days of the due date will result in termination of coverage under this Plan.

Continuing coverage under this Plan will be terminated for a person serving military duty for more than thirty-one (31) days but who fails to elect continuation coverage under this provision within sixty (60) days following the last day of active employment prior to entering military service.

In order to be eligible for coverage under this Plan upon return to work after military leave, the period of time a service member has to make application for reemployment or report back to work after military service is based on time spent on military duty:

- For service of less than thirty-one (31) days, the service member must return at the beginning of the next regularly scheduled work period on the first full day after release from service, taking into account safe travel home plus an eight (8) hour rest period.

- For service of more than thirty (30) days but less than one hundred eighty-one (181) days, the service member must submit an application for reemployment within fourteen (14) days of release from service.
- For service of more than one hundred eighty (180) days, an application for reemployment must be submitted within ninety (90) days of release from service.

An exclusion or waiting period may not be imposed in connection with the reinstatement of coverage upon reemployment if one would not have been imposed had coverage not been terminated because of service. However, an exclusion or waiting period may be imposed for coverage of any illness or injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of uniformed service.

Continuation during Periods of Employer-Certified Disability, Leave of Absence or Layoff
A person may remain eligible for a limited time if active, regular full-time or part-time work ceases due to disability, leave of absence or layoff, but not beyond the periods defined in the College's policies. Coverage may be continued as follows:

- For employer-certified disability leave: an employee may continue coverage under this Plan for a maximum of six (6) months, provided that the employee pays the required premium. If the employee is unable to return to work at the end of the six month continuation period, he may be eligible for COBRA continuation coverage (see COBRA Extension of Benefits provision, which follows later in this section).
- For employer-certified leave of absence (non-disability): an employee may continue coverage under this Plan for a maximum of twelve (12) months, provided that the employee pays the required premium. If the employee is unable to return to work at the end of the twelve month continuation period, he may be eligible for COBRA continuation coverage (see COBRA Extension of Benefits provision, which follows later in this section).
- For layoff: an employee may not continue coverage under this Plan during any period of layoff, although he may be eligible for COBRA continuation coverage (see COBRA Extension of Benefits provision, which follows later in this section).

While continued, coverage will be that which was in force on the last day worked as an Active Employee. However, if benefits reduce for others in the class, they will also reduce for the continued person.

COBRA Extension of Benefits

A federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), requires that most employers sponsoring a group health plan offer employees and their families covered under their health plan the opportunity for a temporary extension of health coverage (called "COBRA continuation coverage") in certain instances where coverage under the Plan would otherwise end. This notice is intended to inform Covered Individuals and beneficiaries, in summary fashion, of the rights and obligations under the continuation coverage provisions of COBRA, as amended and reflected in final and proposed regulations published by the Department of the Treasury. This notice is intended to reflect the law and does not grant or take away any rights under the law. Complete instructions on COBRA, as well as election forms and other information, will be provided by the Plan Administrator to Covered Individuals who become Qualified Beneficiaries under COBRA.

What is COBRA continuation coverage?
COBRA continuation coverage is group health plan coverage that an employer must offer to certain Covered Individuals and their eligible family members (called "Qualified Beneficiaries") at group rates for up to a statutory-mandated maximum period of time or until they become ineligible for COBRA continuation coverage, whichever occurs first. The right to COBRA continuation coverage is triggered by the occurrence of one of certain enumerated events that result in the loss of coverage under the terms of the employer's Plan (the "Qualifying Event"). The coverage must be identical to the Plan coverage that the Qualified Beneficiary had immediately before the Qualifying Event, or if the coverage has been changed, the coverage must be identical to the coverage provided to similarly situated active employees who have not experienced a Qualifying Event (in other words, similarly situated non-COBRA beneficiaries).

Who is a Qualified Beneficiary?
In general, a Qualified Beneficiary is:

- Any individual who, on the day before a Qualifying Event, is covered under a plan by virtue of being on that day either a covered employee, the spouse of a covered employee, or a dependent child of a covered employee. If, however, an individual is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.
- Any child who is born to or placed for adoption with a covered employee during a period of COBRA continuation coverage. If, however, an individual is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

The term "covered employee" includes not only common-law employees (whether part-time or full-time) but also any individual who is provided coverage under the Plan due to his or her performance of services for the employer sponsoring the Plan (e.g., self-employed individuals, independent contractor, or corporate director).

An individual is not a Qualified Beneficiary if the individual's status as a covered employee is attributable to a period in which the individual was a non-resident alien who received from the individual's employer no earned income that constituted income from sources within the United States. If, on account of the preceding reason, an individual is not a Qualified Beneficiary, then a spouse or dependent child of the individual is not considered a Qualified Beneficiary by virtue of the relationship to the individual.

Each Qualified Beneficiary (including a child who is born to or placed for adoption with a covered employee during a period of COBRA continuation coverage) must be offered the opportunity to make an in dependent election to receive COBRA continuation coverage.

What is a Qualifying Event?
A Qualifying Event is any of the following if the Plan provides that the Covered Individual would lose coverage (i.e., cease to be covered under the same terms and conditions as in effect immediately before a Qualifying Event) in the absence of COBRA continuation coverage:

- The death of a covered employee.
- The termination (other than by reason of the employee's gross misconduct), or reduction of hours, of a covered employee's employment.
- The divorce or legal separation of a covered employee from the employee's spouse.
- A covered employee's enrollment in the Medicare program.
- A dependent child's ceasing to satisfy the Plan's requirements for a dependent child (e.g., attainment of the maximum age for dependency under the Plan).

If the Qualifying Event causes the covered employee, or the spouse or a dependent child of the covered employee, to cease to be covered under the Plan under the same terms and conditions as in effect immediately before the Qualifying Event, the persons losing such coverage become Qualified Beneficiaries under COBRA if all the other conditions of the COBRA law are also met.

The taking of leave under the Family and Medical Leave Act of 1993 ("FMLA") does not constitute a Qualifying Event. A Qualifying Event occurs, however, if an employee does not return to employment at the end of the FMLA leave and all other COBRA continuation coverage conditions are present. If a Qualifying Event occurs, it occurs on the last day of FMLA leave and the applicable maximum coverage period is measured from this date (unless coverage is lost at a later date and the Plan provides for the extension of the required periods, in which case the maximum coverage date is measured from the date when the coverage is lost). Note that the covered employee and family members will be entitled to COBRA continuation coverage even if they failed to pay the employee portion of premiums for coverage under the Plan during the FMLA leave.

Retirement as a Qualifying Event
This Plan offers alternative retiree continuation of coverage to certain eligible employees who retire from employment with the College. An eligible retiree may choose continuing coverage under either the COBRA provision or the alternative retiree coverage, but not both. A retiree who chooses the alternative retiree coverage under this Plan will not be eligible for COBRA continuation coverage if he does not elect COBRA within the COBRA election period, even if he exhausts his alternative retiree coverage.

What is the election period and how long must it last?
An election period is the time period within which the Qualified Beneficiary can elect COBRA continuation coverage under the employer's Plan. A plan can condition availability of COBRA continuation coverage upon the timely election of such coverage. An election of COBRA continuation coverage is a timely election if it is made during the election period. The election period must begin not later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event and must not end before the date that is sixty (60) days after the later of the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event or the date notice is provided to the Qualified Beneficiary of her or his right to elect COBRA continuation coverage.

Is a covered Employee or Qualified Beneficiary responsible for informing the Plan Administrator of the occurrence of a Qualifying Event?
In the event the Qualifying Event is the termination of employment (for reasons other than gross misconduct) or reduction in hours of employment, the death of the employee or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer is responsible for notifying the Plan Administrator that a Qualifying Event has occurred.

However, under the law, the Qualified Beneficiary has the responsibility to inform the Plan Administrator of a divorce, legal separation, or a child losing dependent status under the Plan. These events cause spouses and dependents to lose coverage under the Plan. The Plan will offer COBRA continuation coverage to Qualified Beneficiaries only after the Plan Administrator has been notified that a Qualifying Event has occurred. Notice must be given to the Plan Administrator **in writing** (along with any other documentation required by the Plan Administrator, e.g., divorce papers, benefits determination letter from the Social Security Administration) within sixty (60) days after the later of:

1. The date of the Qualifying Event, or
2. The date the Qualified Beneficiary would lose coverage on account of the Qualifying Event.

The Qualifying Beneficiary must provide such written notice to:

Director of Human Resources
Augustana College
639 38th Street
Rock Island, Illinois 61201-2296
(309) 794-7000

Once the Plan Administrator receives notice that a Qualifying Event has occurred, COBRA continuation coverage will be offered to each of the Qualified Beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

Failure to notify the Plan Administrator as described above will cause the Qualified Beneficiary (and any Covered Individual) to lose their rights to COBRA continuation coverage.

Is a waiver before the end of the election period effective to end a Qualified Beneficiary's election rights?
If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of COBRA continuation coverage. However, if a waiver is later revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent to the employer or Plan Administrator, as applicable.

When will a Qualified Beneficiary's COBRA continuation coverage be terminated?
During the election period, a Qualified Beneficiary may waive COBRA continuation coverage. Except for an interruption of coverage in connection with a waiver, COBRA continuation coverage that has been elected for a Qualified Beneficiary must extend for at least the period beginning on the date of the Qualifying Event and ending on the earliest of the following dates:

- The last day of the applicable maximum coverage period.
- The first day for which timely payment is not made to the Plan with respect to the Qualified Beneficiary.
- The date upon which the employer ceases to provide any group health plan (including successor plans) to any employee.
- The date, after the date of the election, that the Qualified Beneficiary first becomes covered under any other plan that does not contain any exclusion or limitation with respect to any pre-existing condition, other than such an exclusion or limitation that does not apply to, or is satisfied by, the Qualified Beneficiary.
- The date, after the date of the election, which the Qualified Beneficiary first becomes entitled to Medicare benefits (either Part A or Part B, whichever occurs earlier).

In the case of a Qualified Beneficiary entitled to a disability extension, the later of:

- Twenty-nine (29) months after the date of the Qualifying Event; or
- The first day of the month that is more than thirty-one (31) days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier; or
- The end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension.

The Plan can terminate for cause the coverage of a Qualified Beneficiary on the same basis that the Plan terminates for cause the coverage of similarly situated non-COBRA beneficiaries, for example, for the submission of a fraudulent claim.

In the case of an individual who is not a Qualified Beneficiary and who is receiving coverage under the Plan solely because of the individual's relationship to a Qualified Beneficiary, if the Plan's obligation to make COBRA continuation coverage available to the Qualified Beneficiary ceases, the Plan is not obligated to make coverage available to the individual who is not a Qualified Beneficiary.

What are the maximum coverage periods for COBRA continuation coverage?
The maximum coverage periods are based on the type of Qualifying Event and the status of the Qualified Beneficiary, as shown below.

- In the case of a Qualifying Event that is a termination of employment (for reasons other than gross misconduct) or reduction of hours of employment, the maximum coverage period ends eighteen (18) months after the Qualifying Event if there is not a disability extension and twenty-nine (29) months after the Qualifying Event if there is a disability extension.
- In the case of a covered employee's enrollment in the Medicare program before experiencing a Qualifying Event that is a termination of employment (for reasons other than gross misconduct) or reduction of hours of employment, the maximum coverage period for Qualified Beneficiaries other than the covered employee ends on the later of:
    1) Thirty-six (36) months after the date the covered employee becomes enrolled in the Medicare program; or
    2) Eighteen (18) months (or twenty-nine (29) months, if there is a disability extension) after the date of the covered employee's termination of employment (for reasons other than gross misconduct) or reduction of hours of employment.
- In the case of a Qualified Beneficiary who is a child born to or placed for adoption with a covered employee during a period of COBRA continuation coverage, the maximum coverage period is the maximum coverage period applicable to the Qualifying Event giving rise to the period of COBRA continuation coverage during which the child was born or placed for adoption.
- In the case of any other Qualifying Event than that described above, the maximum coverage period ends thirty-six (36) months after the Qualifying Event.

Under what circumstances can the maximum coverage period be expanded?
If a Qualified Beneficiary's family experiences another Qualifying Event while receiving eighteen (18) months of COBRA continuation coverage, the spouse and dependent children of the Qualified Beneficiary's family can get up to eighteen (18) additional months of COBRA continuation coverage, for a maximum of thirty-six (36) months, if notice of the second Qualifying Event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event that caused the spouse or dependent child to lose coverage under the Plan had the first Qualifying Event not occurred. In no circumstances can the COBRA maximum coverage period be expanded to more than 36 months after the date of the first Qualifying Event or the Medicare enrollment date. Failure to notify the Plan Administrator as described above will cause the Qualified Beneficiary (and any Covered Individual) to lose their rights to COBRA continuation coverage.

How does a Qualified Beneficiary become entitled to a disability extension?
If a Qualified Beneficiary is determined to be disabled by the Social Security Administration at any time within the first sixty (60) days of COBRA continuation coverage, the Qualified Beneficiary must notify the Plan Administrator and provide the Plan Administrator with a copy of the benefits determination letter within sixty (60) days of the receipt of the determination (but not after the expiration of the eighteen (18) month maximum coverage period) in order to be eligible for the eleven (11) month extension described above in the Maximum Period of Coverage section. The disability extension also will be granted to any non-disabled family member who is a Qualified Beneficiary. The disability would have to have started at some time before the sixtieth (60^{th}) day of COBRA continuation coverage and must last at least until the end of the eighteen (18) month period of continuation coverage. Under the law, you must notify the Plan Administrator within thirty-one (31) days of any final determination that the individual is no longer disabled (for Social Security disability purposes). Failure to Notify the Plan Administrator as described above will cause the Qualified Beneficiary (and any Covered Individual) to lose their rights to COBRA continuation coverage.

Second COBRA Election Period for Certain Individuals Eligible for Trade Adjustment Assistance
If your employment is adversely affected by international trade, such as increased imports or a shift in production to another country, you may become eligible for federal trade adjustment assistance (TAA) under the Trade Act of 1974. Part of this assistance is a 65 percent federal tax credit toward the purchase of COBRA continuation coverage if loss of health coverage is trade-related. If you become eligible for TAA after a termination of employment (for any reason other than gross misconduct) or a reduction of hours with the College, and if you are eligible to, but do not elect COBRA continuation coverage under the Plan during the initial 60-day COBRA election period that is a direct consequence of the TAA-related loss of coverage (for example, loss of Plan coverage due to loss of employment with the College caused by a shift of production to another country), you will be eligible for a second COBRA election period during which you may elect COBRA continuation coverage for both yourself and your dependents who are eligible for COBRA continuation coverage. This second COBRA election period begins on the first day of the month in which you are determined to be a TAA-eligible individual, provided your election of COBRA continuation coverage is made within six months after the date of the TAA-related loss of coverage under the Plan. If you elect COBRA continuation coverage during this second election period, COBRA continuation coverage is effective on the first day of the second election period and not on the date Plan coverage originally ended.

Can a Plan require payment for COBRA continuation coverage?
Yes. For any period of COBRA continuation coverage, a plan can require the payment of an amount that does not exceed one hundred two percent (102%) of the applicable premium except the Plan may require the payment of an amount that does not exceed one hundred fifty percent (150%) of the applicable premium for any period of COBRA continuation coverage covering a disabled Qualified Beneficiary that would not be required to be made available in the absence of disability extension. A group health plan can terminate a Qualified Beneficiary's COBRA continuation coverage as of the first day of any period for which timely payment is not made to the Plan with respect to that Qualified Beneficiary.

Must the Plan allow payment for COBRA continuation coverage to be made in monthly installments?
Yes. The Plan is also permitted to allow for payment at other intervals.

What is Timely Payment for payment for COBRA continuation coverage?
Timely Payment means payment that is made to the Plan by the date that is thirty-one (31) days after the first day of that period. Payment that is made to the Plan by a later date is also considered Timely Payment if either under the terms of the Plan, covered employees or Qualified Beneficiaries are allowed until that later date to pay for their coverage for the period or under the terms of an arrangement between the employer and the entity that provides Plan benefits on the employer's behalf, the employer is allowed until that later date to pay for coverage of similarly situated non-COBRA beneficiaries for the period.

Notwithstanding the above paragraph, a plan cannot require payment for any period of COBRA continuation coverage for a Qualified Beneficiary earlier than forty-five (45) days after the date on which the election of COBRA continuation coverage is made for that Qualified Beneficiary. Payment is considered made on the date on which it is sent to the Plan.

Must a Qualified Beneficiary be given the right to enroll in a conversion health plan at the end of the maximum coverage period for COBRA continuation coverage?
If a Qualified Beneficiary's COBRA continuation coverage under a group health plan ends as a result of the expiration of the applicable maximum coverage period, the Plan must, during the one hundred eighty (180) day period that ends on that expiration date, provide the Qualified Beneficiary with the option of enrolling under a conversion health plan, if such an option is otherwise generally available to similarly situated non-COBRA beneficiaries under the Plan. If such a conversion option is not otherwise generally available, it need not be made available to Qualified Beneficiaries.

Questions concerning this Plan or COBRA continuation coverage rights should be addressed to:

Director of Human Resources
Augustana College
639 38th Street
Rock Island, Illinois 61201-2296
(309) 794-7000

For more information about a Covered Individual's rights under COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact your State Insurance Department or the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area, or visit the EBSA website at www.dol.gov/ebsa. (See the "RIGHTS UNDER ERISA AND STATE LAW" section of this document for address and phone number information. Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep the Plan informed of address changes
In order to protect their rights, Covered Individuals should keep the Plan Administrator informed of any changes in the addresses for themselves and covered family members. Covered Individual should always keep a copy, for their records, of any notices they send to the Plan Administrator.

PRIVACY STANDARDS

Standards for Privacy of Individually Identifiable Health Information (the "Privacy Standards") issued pursuant to The Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA").

The Augustana College Employee Health Care Plan (the "Plan") Plan Document and Summary Plan Description (the "Plan Documents") are hereby stated to comply with HIPAA's Privacy Standards, as follows:

1. Disclosure of Summary Health Information to the Plan Sponsor

In accordance with the Privacy Standards, the Plan may disclose Summary Health Information to the Plan Sponsor, if the Plan Sponsor requests the Summary Health Information for the purpose of (a) obtaining premium bids from health plans for providing health insurance coverage under this Plan or (b) modifying, amending or terminating the Plan.

"Summary Health Information" may be individually identifiable health information and it summarizes the claims history, claims expenses or the type of claims experienced by individuals in the Plan, but it excludes all identifiers that must be removed for the information to be de-identified, except that it may contain geographic information to the extent that it is aggregated by five-digit zip code.

2. Disclosure of Protected Health Information ("PHI") to the Plan Sponsor for Plan Administration Purposes

In order that the Plan Sponsor may receive and use PHI for Plan Administration purposes, the Plan Sponsor agrees to:

a. Not use or further disclose PHI other than as permitted or required by the Plan Document s or as Required by Law (as defined in the Privacy Standards);
b. Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;
c. Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor, except pursuant to an authorization which meets the requirements of the Privacy Standards;
d. Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor becomes aware;
e. Make available PHI in accordance with Section 164.524 of the Privacy Standards (45 CFR 164.524);
f. Make available PHI for amendment and incorporate any amendments to PHI in accordance with Section 164.526 of the Privacy Standards (45 CFR 164.526);
g. Make available the information required to provide an accounting of disclosures in accordance with Section 164.528 of the Privacy Standards (45 CFR 164.528);
h. Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services ("HHS"), or any other officer or employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the Plan with Part 164, Subpart E, of the Privacy Standards (45 CFR 164.500 et seq);
i. If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible; and
j. Ensure that adequate separation between the Plan and the Plan Sponsor, as required in Section 164.504(f)(2)(iii) of the Privacy Standards (45 CFR 164.504(f)(2)(iii)), is established as follows:
    i. The following employees, or classes of employees, or other persons under control of the Plan Sponsor, shall be given access to the PHI to be disclosed:
        - VP of Business and Finance
        - Director of Human Resources
        - Assistant Director of Human Resources
        - Human Resources Assistant
        - Controller of the College
        - Staff Accountant

ii. The access to and use of PHI by the individuals described in subsection (i) above shall be restricted to the Plan Administration functions that the Plan Sponsor performs for the Plan.

iii. In the event any of the individuals described in subsection (i) above do not comply with the provisions of the Plan Document s relating to use and disclosure of PHI, the Plan Administrator shall impose reasonable sanctions as necessary, in its discretion, to ensure that no further non-compliance occurs. Such sanctions shall be imposed progressively (for example, an oral warning, a written warning, time off without pay and termination), if appropriate, and shall be imposed so that they are commensurate with the severity of the violation.

"Plan Administration" activities are limited to activities that would meet the definition of payment or health care operations, but do not include functions to modify, amend or terminate the Plan or solicit bids from prospective issuers. "Plan Administration" functions include quality assurance, claims processing, auditing, monitoring and management of carve-out plans, such as vision and dental. It does not include any employment-related functions or functions in connection with any other benefit or benefit plans.

The Plan shall disclose PHI to the Plan Sponsor only upon receipt of a certification by the Plan Sponsor that (a) the Plan Documents have been amended to incorporate the above provisions and (b) the Plan Sponsor agrees to comply with such provisions.

3. Disclosure of Certain Enrollment Information to the Plan Sponsor

Pursuant to Section 164.504(f)(1)(iii) of the Privacy Standards (45 CFR 164.504(f)(1)(iii)), the Plan may disclose to the Plan Sponsor information on whether an individual is participating in the Plan or is enrolled in or has disenrolled from a health insurance issuer or health maintenance organization offered by the Plan to the Plan Sponsor.

4. Disclosure of PHI to Obtain Stop-loss or Excess Loss Coverage

The Plan Sponsor hereby authorizes and directs the Plan, through the Plan Administrator or the Butler Benefit Service, Inc., to disclose PHI to stop-loss carriers, excess loss carriers or managing general underwriters (MGUs) for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage related to benefit claims under the Plan. Such disclosures shall be made in accordance with the Privacy Standards.

5. Other Disclosures and Uses of PHI

With respect to all other uses and disclosures of PHI, the Plan shall comply with the Privacy Standards.

6. Provisions for Security in Transmission of PHI

This Plan will adhere to the national security standards, as defined by HIPAA, for safeguards to protect the confidentiality, integrity, and availability of electronic protected health information that is collected, maintained, used, or transmitted by the Plan. These standards require measures to be taken to secure this information while in the custody of entities covered by HIPAA (covered entities) as well as in transit between covered entities and from covered entities to others.

7. Electronic PHI

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

a. The Plan Sponsor shall implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the electronic PHI that the Plan Sponsor creates, maintains or transmits on behalf of the Plan;

b. The Plan Sponsor shall ensure that any agents, including a subcontractor, to whom it provides electronic PHI agree to implement reasonable and appropriate security measures to protect such information;

c. The Plan Sponsor shall ensure that the adequate separation required by 45 CFR 164.504(f)(2)(iii) is supported by reasonable and appropriate security measures; and

d. The Plan Sponsor shall report to the Plan any security incident (as defined in 45 CFR 164.304) of which it becomes aware.

RIGHTS UNDER ERISA AND STATE LAW

As a Covered Individual in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA) and the laws of the State of Illinois. ERISA provides that all Covered Individuals shall be entitled to:

Receive Information about Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing the Plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series), if any, filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and copies of the latest annual report (Form 5500 Series) and updated summary plan description (SPD). The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual Form 5500, if any is required by ERISA to be prepared, in which case Augustana College, as Plan Administrator, is required by law to furnish each Covered Individual with a copy of this summary annual report.

COBRA and HIPAA Rights

- Continue health care coverage for yourself, your spouse, or your dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this SPD and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.
- 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 with 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 (18 months for late enrollees) after your enrollment date in your coverage. The Pre-Existing Condition Limitation does not apply to a Covered Individual that has not yet reached age nineteen (19).

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps that you can take to enforce the above rights. For instance, if you request a copy of Plan Documents or the latest annual report (Form 5500), if any, from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require Augustana College, as Plan Administrator, to provide the materials and pay you up to $110 per day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored in whole or in part, and if you have exhausted the claims procedures available to you under the Plan, you may file suit in a state or federal court.

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

Assistance with Your Questions
If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor (listed in your telephone directory) or contact 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 publications hotline of the Employee Benefits Security Administration.

Questions and complaints may also be directed to the:

Illinois Division of Insurance
Office of Consumer Health Insurance
Health Insurance and HMO Inquiries - Consumers Call Toll-Free (within Illinois):
(877) 527-9431
E-Mail Address: Director@ins.state.il.us

Office Locations:

Springfield
320 W. Washington Street
Springfield, IL 62767-0001
MAIN: (217) 782-4515
FAX: (217) 782-5020 (Main)
FAX: (217) 558-2083 (Consumer Complaints)
TDD: (217) 524-4872

Chicago
James R. Thompson Center
100 W. Randolph St., Suite 9-301
Chicago, IL 60601-3395
MAIN: (312) 814-2420
FAX: (312) 814-5416
TDD: (312) 814-2603

COORDINATION OF BENEFITS

If you are covered by more than one group health plan, it is important to understand Coordination of Benefits (COB). The purpose of this section is to determine the proper order of payers. COB ensures that Covered Individuals who are covered by more than one group health plan receive the proper benefits while avoiding overpayment by either health plan. This Plan will always pay either its benefits in full, or a reduced amount which when added to the benefits payable by the other plan(s) will not exceed 100% of allowable expenses. Only the amount paid by this Plan will be charged against this Plan's maximums. The Coordination of Benefits provision applies whether or not a claim is filed under the other plan(s). If needed, authorization must be given this Plan to obtain information as to benefits or services available from the other plan(s), or to recover overpayment. All benefits contained in the Plan are subject to this provision.

Effect of Medicare
Each plan makes its claim payment according to where it falls in the order explained below, if Medicare is not involved. It is the intent of the Plan to adhere to the laws of DEFRA, TEFRA, and COBRA as currently constituted and as amended from time to time. The Plan will pay claims in accordance with the Medicare Secondary Payer rules set forth by the U.S. Department of Health and Human Services and the Centers for Medicare and Medicaid Services.

Any employee or dependent eligible for Medicare should contact the Claims Processor for current rulings. If any Covered Individual eligible for Medicare fails to enroll therefore, benefits will be paid by the Plan as though he had enrolled.

Order of Benefit Determination

When a Covered Individual is covered under two different group health plans, one is considered 'primary' and the other is considered 'secondary.' The primary plan is usually responsible for the majority of the claim and provides reimbursement according to plan allowances. The secondary plan often (but not always) provides reimbursement covering the remaining allowable expenses.

If a person is covered by this health Plan and another group health plan, and . . .

- The other plan does not have a COB provision:
  - The other plan (without COB) is primary; and
  - This Plan (which has COB) is secondary.
- The person is covered as the "Insured" by one plan and as a dependent by the other plan:
  - The plan which covers the person as the "Insured" is primary; and
  - The plan which covers the person as a dependent is secondary.
- The person is covered as the "Insured" by both plans:
  - The plan that has been in effect longer is primary; and
  - The plan that has been in effect for a shorter period of time is secondary.
- The person is covered under one plan as an active employee or dependent of an active employee, and covered under another plan as a COBRA enrollee or dependent of a COBRA enrollee:
  - The plan which covers the active employee is primary; and
  - The COBRA plan is secondary.
- If the person is a dependent child and his/her parents are not divorced or legally separated:
  - The plan of the parent whose birthday occurs earlier in the Calendar Year is primary; and
  - The plan of the parent whose birthday occurs later in the Calendar Year is secondary; but
  - If both parents have the same birthday, the plan that has been in effect longer is primary.
- However, if a dependent child's parents ARE divorced or legally separated, and:
  - Health coverage is stipulated in a court decree, then:
    - The plan of the parent deemed primarily responsible for health coverage under the court decree is primary; and
    - The plan of the step-parent married to the custodial parent (if applicable) is secondary; and
    - The plan of the other parent pays next; and
    - The plan of the step-parent married to the non-custodial parent (if applicable) pays last.

- Health coverage is NOT stipulated in a court decree, then:
  - The plan of the parent with custody is primary; and
  - The plan of the step-parent married to the custodial parent (if applicable) is secondary; and
  - The non-custodial parent's plan pays next; and
  - The plan of the step-parent married to the non-custodial parent (if applicable) pays last.
- If the parents share joint custody and are equally responsible for health expenses, then:
  - The plan of the parent whose birthday occurs earlier in the Calendar Year is primary; and
  - The plan of the parent whose birthday occurs later in the Calendar Year is secondary; but
  - If both parents have the same birthday, the plan that has been in effect longer is primary and the plan that has been in effect for the shorter period of time is secondary; and
  - The plan of the step-parent married to the parent whose plan is primary (if applicable) pays next; and
  - The plan of the step-parent married to the parent whose plan is secondary (if applicable) pays last.

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

The above information is designed to help identify the primary and secondary plans in various situations. If clarification on coverage is needed related to COB, call BBSI at (563) 327-2200, or toll-free at (866) 927-2200.

The College has the right:

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

Coordination Procedures

Notwithstanding the other provisions of this Plan, benefits that would be payable under this Plan will be reduced so that the sum of benefits and all benefits payable under all other plans will not exceed 100% of allowable expenses incurred during any claim determination period with respect to a Covered Individual eligible for:

1. Benefits either as an insured person or as a dependent under any other plan which has no provision similar in effect to this provision, or
2. Dependent benefits under this Plan for a Covered Individual who is also eligible for benefits:
   a. As an insured person under any other plan; or
   b. As a dependent covered under another group plan; or
3. Employee benefits under this Plan for an employee who is also eligible for benefits as an insured person under any other plan and has been covered continuously for a longer period of time under such other plan.

Definitions

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

1. Workers' compensation insurance.
2. Group insurance or any other arrangement for coverage for Covered Individual in a group whether on an insured or uninsured basis, including but not limited to:
   a. Hospital indemnity benefits.
   b. Hospital reimbursement-type plans which permit the covered individuals to elect indemnity at the time of claims.
3. Hospital or medical service organizations on a group basis, group practice, and other group pre-payment plans.
4. Hospital or medical service organizations on an individual basis having a provision similar in effect to this provision.
5. A licensed Health Maintenance Organization (HMO).
6. Any coverage for students which is sponsored by or provided through a school or other educational institution.

7. Any coverage under a governmental program and any coverage required or provided by any statute.
8. Group automobile insurance.
9. Individual automobile insurance coverage on an automobile leased or owned by the College.
10. Individual automobile insurance coverage based upon the principles of "no-fault" coverage, including medical payments coverage and personal injury protection.
11. Homeowners' insurance.

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

The term "allowable expenses" means any necessary item of expense, the charge for which is reasonable, usual, and customary, at least a portion of which is covered under at least one of the plans covering the person for whom claim is made. When a plan provides benefits in the form of services rather than cash payments, then the reasonable cash value of each service rendered will be deemed to be both an allowable expense and a benefit paid.

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

Excess Insurance

If at the time of injury, sickness, disease or disability there is available, or potentially available any Coverage (including but not limited to Coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of Coverage. The Plan's benefits shall be excess to:

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

Automobile Limitations

When medical payments are available under any vehicle insurance, the Plan shall pay excess benefits only, without reimbursement for vehicle plan and/or policy deductibles. This Plan shall always be considered secondary to such plans and/or policies. This applies to all forms of medical payments under vehicle plans and/or policies regardless of its name, title or classification.

Facility of Payment

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

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

Rights of Recovery

The Plan (and parties retained by the Plan) will have the right, exercisable alone and in its sole discretion, to pursue overpayments and refunds, allowing the Plan to:

1. Pursue the provider(s) for duplicate payments when payments have been made by both the Plan and another payer for the same claim; and
2. Obtain refunds from other payer(s) when the Plan pays a claim for which the other payer is responsible; or
3. Withhold payment of any future benefits to offset for such excess payment(s).

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

SUBROGATION, REIMBURSEMENT AND/OR THIRD PARTY RESPONSIBILITY

A. Payment Condition

1. The Plan, in its sole discretion, may elect to conditionally advance payment of benefits in those situations where an injury, sickness, disease or disability is caused in whole or in part by, or results from the acts or omissions of Covered Persons, Plan Beneficiaries, and/or their dependants, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this section as "Covered Person(s)") or a third party, where another party may be responsible for expenses arising from an incident, and/or other funds are available, including but not limited to no-fault, uninsured motorist, underinsured motorist, medical payment provisions, third party assets, third party insurance, and/or grantor(s) of a third party (collectively "Coverage").
2. Covered Person(s), his or her attorney, and/or legal guardian of a minor or incapacitated individual agrees that acceptance of the Plan's conditional payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain one hundred percent (100%) of the Plan's conditional payment of benefits or the full extent of payment from any one or combination of first and third party sources in trust, without disruption except for reimbursement to the Plan or the Plan's assignee. By accepting benefits the Covered Person(s) agrees the Plan shall have an equitable lien on any funds received by the Covered Person(s) and/or their attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The Covered Person(s) agrees to include the Plan's name as a co-payee on any and all settlement drafts.
3. In the event a Covered Person(s) settles, recovers, or is reimbursed by any Coverage, the Covered Person(s) agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the Covered Person(s). If the Covered Person(s) fails to reimburse the Plan out of any judgment or settlement received, the Covered Person(s) will be responsible for any and all expenses (fees and costs) associated with the Plan's attempt to recover such money.

B. Subrogation

1. As a condition to participating in and receiving benefits under this Plan, the Covered Person(s) agrees to assign to the Plan the right to subrogate and pursue any and all claims, causes of action or rights that may arise against any person, corporation and/or entity and to any Coverage to which the Covered Person(s) is entitled, regardless of how classified or characterized, at the Plan's discretion.
2. If a Covered Person(s) receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the Plan to any claim, which any Covered Person(s) may have against any Coverage and/or party causing the sickness or injury to the extent of such conditional payment by the Plan plus reasonable costs of collection.
3. The Plan may, at its discretion, in its own name or in the name of the Covered Person(s) commence a proceeding or pursue a claim against any party or Coverage for the recovery of all damages to the full extent of the value of any such benefits or conditional payments advanced by the Plan.
4. If the Covered Person(s) fails to file a claim or pursue damages against:
   a) the responsible party, its insurer, or any other source on behalf of that party;
   b) any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
   c) any policy of insurance from any insurance company or guarantor of a third party;
   d) worker's compensation or other liability insurance company; or,
   e) any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage;

   the Covered Person(s) authorizes the Plan to pursue, sue, compromise and/or settle any such claims in the Covered Person(s)' and/or the Plan's name and agrees to fully cooperate with the Plan in the prosecution of any such claims. The Covered Person(s) assigns all rights to the Plan or its assignee to pursue a claim and the recovery of all expenses from any and all sources listed above.

C. Right of Reimbursement

1. The Plan shall be entitled to recover 100% of the benefits paid, without deduction for attorneys' fees and costs or application of the common fund doctrine, make whole doctrine, or any other similar legal theory, without regard to whether the Covered Person(s) is fully compensated by his/her recovery from all sources. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any state prohibiting assignment of rights which interferes with or compromises in any way the Plan's equitable lien and right to reimbursement. The obligation to reimburse the Plan in full exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses. If the Covered Person(s)' recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved.
2. No court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of litigation may be deducted from the Plan's recovery without the prior, expressed written consent of the Plan.
3. The Plan's right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of the Covered Person(s), whether under the doctrines of causation, comparative fault or contributory negligence, or other similar doctrine in law. Accordingly, any lien reduction statutes, which attempt to apply such laws and reduce a subrogating Plan's recovery will not be applicable to the Plan and will not reduce the Plan's reimbursement rights.
4. These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgment of these rights is required by the Plan and signed by the Covered Person(s).
5. This provision shall not limit any other remedies of the Plan provided by law. These rights of subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable sickness, injury, disease or disability.

D. Excess Insurance

1. If at the time of injury, sickness, disease or disability there is available, or potentially available any Coverage (including but not limited to Coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of Coverage, except as otherwise provided for under the Plan's Coordination of Benefits section. The Plan's benefits shall be excess to:
   a) the responsible party, its insurer, or any other source on behalf of that party;
   b) any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
   c) any policy of insurance from any insurance company or guarantor of a third party;
   d) worker's compensation or other liability insurance company; or
   e) any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

E. Separation of Funds

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

F. Wrongful Death

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

G. Obligations

1. It is the Covered Person(s)' obligation at all times, both prior to and after payment of medical benefits by the Plan:
   a) to cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the Plan's rights;
   b) to provide the Plan with pertinent information regarding the sickness, disease, disability, or injury, including accident reports, settlement information and any other requested additional information;
   c) to take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights;
   d) to do nothing to prejudice the Plan's rights of subrogation and reimbursement;
   e) to promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received; and
   f) to not settle or release, without the prior consent of the Plan, any claim to the extent that the Plan Beneficiary may have against any responsible party or Coverage.
2. If the Covered Person(s) and/or his or her attorney fails to reimburse the Plan for all benefits paid or to be paid, as a result of said injury or condition, out of any proceeds, judgment or settlement received, the Covered Person(s) will be responsible for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Covered Person(s).
3. The Plan's rights to reimbursement and/or subrogation are in no way dependant upon the Covered Person(s)' cooperation or adherence to these terms.

H. Offset

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

I. Minor Status

1. In the event the Covered Person(s) is a minor as that term is defined by applicable law, the minor's parents or court-appointed guardian shall cooperate in any and all actions by the Plan to seek and obtain requisite court approval to bind the minor and his or her estate insofar as these subrogation and reimbursement provisions are concerned.
2. If the minor's parents or court-appointed guardian fail to take such action, the Plan shall have no obligation to advance payment of medical benefits on behalf of the minor. Any court costs or legal fees associated with obtaining such approval shall be paid by the minor's parents or court-appointed guardian.

J. Language Interpretation

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

K. Severability

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

CLAIMS PROCEDURES

Under the Plan, there are four types of claims: Pre-service (Urgent and Non-urgent), Concurrent Care and Post-service.

- Pre-service Claims. A "pre-service claim" is a claim for a benefit under the Plan where the Plan conditions receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

  A "pre-service urgent care claim" is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the Covered Individual or the Covered Individual's ability to regain maximum function, or, in the opinion of a physician with knowledge of the Covered Individual's medical condition, would subject the Covered Individual to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

  If the Plan does not require the Covered Individual to obtain approval of a specific medical service prior to getting treatment, then there is no pre-service claim. The Covered Individual simply follows the Plan's procedures with respect to any notice which may be required after receipt of treatment, and files the claim as a post-service claim.

- Concurrent Claims. A "concurrent claim" arises when the Plan has approved an on-going course of treatment to be provided over a period of time or number of treatments, and either:

  - The Plan Administrator determines that the course of treatment should be reduced or terminated; or
  - The Covered Individual requests extension of the course of treatment beyond that which the Plan Administrator has approved.

  If the Plan does not require the Covered Individual to obtain approval of a medical service prior to getting treatment, then there is no need to contact the Plan Administrator to request an extension of a course of treatment. The Covered Individual simply follows the Plan's procedures with respect to any notice which may be required after receipt of treatment, and files the claim as a post-service claim.

- Post-service Claims: A "post-service claim" is a claim for a benefit under the Plan after the services have been rendered.

When Health Claims Must Be Filed

Post-service health claims must be filed with the third party administrator within twelve (12) months of the date charges for the service were incurred. Failure to file a claim within this time limit will not invalidate the claim provided that the Covered Individual submits evidence satisfactory to the Plan Administrator that it was not reasonably possible to file the claim within the time limit. In no event will the time limit be extended beyond [one year] from the date the charges were incurred except in the case of legal incapacity of the Covered Individual. Benefits are based upon the Plan's provisions at the time the charges were incurred. **Claims filed later than that date shall be denied.**

A pre-service claim (including a concurrent claim that also is a pre-service claim) is considered to be filed when the request for approval of treatment or services is made and received by the third party administrator in accordance with the Plan's procedures.

Upon receipt of the required information, the claim will be deemed to be filed with the Plan. The third party administrator will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested as provided herein. This additional information must be received by the third party administrator within 45 days from receipt by the Covered Individual of the request for additional information. **Failure to do so may result in claims being declined or reduced.**

Timing of Claim Decisions

The Plan Administrator shall notify the Covered Individual, in accordance with the provisions set forth below, of any adverse benefit determination (and, in the case of pre-service claims and concurrent claims, of decisions that a claim is payable in full) within the following timeframes:

- Pre-service Urgent Care Claims:
  - If the Covered Individual has provided all of the necessary information, as soon as possible, taking into account the medical exigencies, but not later than 24 hours after receipt of the claim.
  - If the Covered Individual has not provided all of the information needed to process the claim, then the Covered Individual will be notified as to what specific information is needed as soon as possible, but not later than 24 hours after receipt of the claim. The Covered Individual will be notified of a determination of benefits as soon as possible, but not later than 24 hours, taking into account the medical exigencies, after the earliest of:
    - The Plan's receipt of the specified information; or
    - The end of the period afforded the Covered Individual to provide the information.
- Pre-service Non-urgent Care Claims:
  - If the Covered Individual has provided all of the information needed to process the claim, in a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15-day extension period.
  - If the Covered Individual has not provided all of the information needed to process the claim, then the Covered Individual will be notified as to what specific information is needed as soon as possible, but not later than 5 days after receipt of the claim. The Covered Individual will be notified of a determination of benefits in a reasonable period of time appropriate to the medical circumstances, either prior to the end of the extension period (if additional information was requested during the initial processing period), or by the date agreed to by the Plan Administrator and the Covered Individual (if additional information was requested during the extension period).
- Concurrent Claims:
  - Plan Notice of Reduction or Termination. If the Plan Administrator is notifying the Covered Individual of a reduction or termination of a course of treatment (other than by Plan amendment or termination), before the end of such period of time or number of treatments. The Covered Individual will be notified sufficiently in advance of the reduction or termination to allow the Covered Individual to appeal and obtain a determination on review of that adverse benefit determination before the benefit is reduced or terminated.
  - Request by Covered Individual Involving Urgent Care. If the Plan Administrator receives a request from a Covered Individual to extend the course of treatment beyond the period of time or number of treatments that is a claim involving urgent care, as soon as possible, taking into account the medical exigencies, but not later than 24 hours after receipt of the claim, as long as the Covered Individual makes the request at least 24 hours prior to the expiration of the prescribed period of time or number of treatments. If the Covered Individual submits the request with less than 24 hours prior to the expiration of the prescribed period of time or number of treatments, the request will be treated as a claim involving urgent care and decided within the urgent care timeframe.
  - Request by Covered Individual Involving Non-urgent Care. If the Plan Administrator receives a request from the Covered Individual to extend the course of treatment beyond the period of time or number of treatments that is a claim not involving urgent care, the request will be treated as a new benefit claim and decided within the timeframe appropriate to the type of claim (either as a pre-service non-urgent claim or a post-service claim).
- Post-service Claims:
  - If the Covered Individual has provided all of the information needed to process the claim, in a reasonable period of time, but not later than 30 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15-day extension period.

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

- Extensions – Pre-service Urgent Care Claims. No extensions are available in connection with Pre-service urgent care claims.

- Extensions – Pre-service Non-urgent Care Claims. This period may be extended by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Covered Individual, prior to the expiration of the initial 15-day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

- Extensions – Post-service Claims. This period may be extended by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Covered Individual, prior to the expiration of the initial 30-day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

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

Notification of an Adverse Benefit Determination

The Plan Administrator shall provide a Covered Individual with a notice, either in writing or electronically (or, in the case of pre-service urgent care claims, by telephone, facsimile or similar method, with written or electronic notice), containing the following information:

- A reference to the specific portion(s) of the summary plan description upon which a denial is based;

- Specific reason(s) for a denial;

- A description of any additional information necessary for the Covered Individual to perfect the claim and an explanation of why such information is necessary;

- A description of the Plan's review procedures and the time limits applicable to the procedures, including a statement of the Covered Individual's right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on final review;

- A statement that the Covered Individual is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the Covered Individual's claim for benefits;

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

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

- In the case of denials based upon a medical judgment (such as whether the treatment is medically necessary or experimental), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Covered Individual's medical circumstances, or a statement that such explanation will be provided to the Covered Individual, free of charge, upon request; and

- In a claim involving urgent care, a description of the Plan's expedited review process.

Appeals of Adverse Benefit Determinations

Full and Fair Review of All Claims

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

- Covered Individuals at least one hundred eighty (180) days following receipt of a notification of an initial adverse benefit determination within which to appeal the determination and sixty (60) days to appeal a second adverse benefit determination;
- Covered Individuals the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;
- For a review that does not afford deference to the previous adverse benefit determination and that is conducted by an appropriate named fiduciary of the Plan, who shall be neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;
- For a review that takes into account all comments, documents, records, and other information submitted by the Covered Individual relating to the claim, without regard to whether such information was submitted or considered in any prior benefit determination;
- That, in deciding an appeal of any adverse benefit determination that is based in whole or in part upon a medical judgment, the Plan fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual;
- For the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claim, even if the Plan did not rely upon their advice;
- That a Covered Individual will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Covered Individual's claim for benefits in possession of the Plan Administrator or the third party administrator; information regarding any voluntary appeals procedures offered by the Plan; any internal rule, guideline, protocol or other similar criterion relied upon in making the adverse determination; and an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Covered Individual's medical circumstances; and
- In an urgent care claim, for an expedited review process pursuant to which:
  - A request for an expedited appeal of an adverse benefit determination may be submitted orally or in writing by the Covered Individual; and
  - All necessary information, including the Plan's benefit determination on review, shall be transmitted between the Plan and the Covered Individual by telephone, facsimile or other available similarly expeditious method.

First Appeal Level

Requirements for First Appeal

The Covered Individual must file the first appeal in writing (although oral appeals are permitted for pre-service urgent care claims) within 180 days following receipt of the notice of an adverse benefit determination. For pre-service urgent care claims, if the Covered Individual chooses to orally appeal, the Covered Individual may telephone:

Claims Manager, Butler Benefit Service, Inc.
Phone: (563) 327-2200 or (toll-free) (866) 927-2200

To file an appeal in writing, the Covered Individual's appeal must be addressed as follows and mailed or faxed as follows:

Butler Benefit Service, Inc.
Attn: Claims Manager
P.O. Box 3310
Davenport, Iowa 52808-3310
Fax: (563) 327-2250 or (toll-free) (866) 927-2250

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

- The name of the employee/Covered Individual;
- The employee/Covered Individual's social security number;
- The group name or identification number;
- All facts and theories supporting the claim for benefits. **Failure to include any theories or facts in the appeal will result in their being deemed waived. In other words, the Covered Individual will lose the right to raise factual arguments and theories which support this claim if the Covered Individual fails to include them in the appeal**;
- A statement in clear and concise terms of the reason or reasons for disagreement with the handling of the claim; and
- Any material or information that the Covered Individual has which indicates that the Covered Individual is entitled to benefits under the Plan.

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

Timing of Notification of Benefit Determination on First Appeal

The Plan Administrator shall notify the Covered Individual of the Plan's benefit determination on review within the following timeframes:

- Pre-service Urgent Care Claims: As soon as possible, taking into account the medical exigencies, but not later than 24 hours after receipt of the appeal.
- Pre-service Non-urgent Care Claims: Within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the appeal.
- Concurrent Claims: The response will be made in the appropriate time period based upon the type of claim – pre-service urgent, pre-service non-urgent or post-service.
- Post-service Claims: Within a reasonable period of time, but not later than 30 days after receipt of the appeal.
- Calculating Time Periods. The period of time within which the Plan's determination is required to be made shall begin at the time an appeal is filed in accordance with the procedures of this Plan, without regard to whether all information necessary to make the determination accompanies the filing.

Manner and Content of Notification of Adverse Benefit Determination on First Appeal

The Plan Administrator shall provide a Covered Individual with notification, with respect to pre-service urgent care claims, by telephone, facsimile or similar method, and with respect to all other types of claims, in writing or electronically, of a Plan's adverse benefit determination on review, setting forth:

- The specific reason or reasons for the denial;
- Reference to the specific portion(s) of the summary plan description on which the denial is based;
- The identity of any medical or vocational experts consulted in connection with the claim, even if the Plan did not rely upon their advice;
- A statement that the Covered Individual is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Covered Individual's claim for benefits;

- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the Covered Individual upon request;
- If the adverse benefit determination is based upon a medical judgment, a statement that an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Covered Individual's medical circumstances, will be provided free of charge upon request;
- A description of any additional information necessary for the Covered Individual to perfect the claim and an explanation of why such information is necessary;
- A description of the Plan's review procedures and the time limits applicable to the procedures;
- For pre-service urgent care claims, a description of the expedited review process applicable to such claims;
- A statement of the Covered Individual's right to bring an action under section 502(a) of ERISA, following an adverse benefit determination on final review; and
- The following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency."

Furnishing Documents in the Event of an Adverse Determination

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

Second Appeal Level

Adverse Decision on First Appeal; Requirements for Second Appeal

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

Timing of Notification of Benefit Determination on Second Appeal

The Plan Administrator shall notify the Covered Individual of the Plan's benefit determination on review within the following timeframes:

- Pre-service Urgent Care Claims: As soon as possible, taking into account the medical exigencies, but not later than 24 hours after receipt of the second appeal.
- Pre-service Non-urgent Care Claims: Within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the second appeal.
- Concurrent Claims: The response will be made in the appropriate time period based upon the type of claim – pre-service urgent, pre-service non-urgent or post-service.
- Post-service Claims: Within a reasonable period of time, but not later than 30 days after receipt of the second appeal.
- Calculating Time Periods. The period of time within which the Plan's determination is required to be made shall begin at the time the second appeal is filed in accordance with the procedures of this Plan, without regard to whether all information necessary to make the determination accompanies the filing.

Manner and Content of Notification of Adverse Benefit Determination on Second Appeal

The same information must be included in the Plan's response to a second appeal as a first appeal, except for:

- A description of any additional information necessary for the Covered Individual to perfect the claim and an explanation of why such information is needed;
- A description of the Plan's review procedures and the time limits applicable to the procedures; and
- For pre-service urgent care claims, a description of the expedited review process applicable to such claim. See the section entitled "Manner and Content of Notification of Adverse Benefit Determination on First Appeal."

Furnishing Documents in the Event of an Adverse Determination

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

Decision on Review

If, for any reason, the Covered Individual does not receive a written response to the appeal within the appropriate time period set forth above, the Covered Individual may assume that the appeal has been denied. Note that: **all claim review procedures provided for in the Plan must be exhausted before any legal action is brought. Any legal action for the recovery of any benefits must be commenced within two (2) years after the Plan's claim review procedures have been exhausted.**

External Review

When a Covered Individual has exhausted the internal appeals process outlined above, the Covered Individual has a right to have that decision reviewed by independent health care professionals who has no association with the Plan, the Augustana College, or the plan administrator. If the adverse benefit determination involved making a judgment as to the medical necessity, appropriateness, health care setting, level of care or effectiveness of the health care service or treatment you requested, you may submit a request to the Plan for external review within **4 months** after receipt of a denial of benefits; such request should be addressed to: Claims Manager, Butler Benefit Service, Inc., P.O. Box 3310, Davenport, Iowa, 52808-3310. For standard external review, a decision will be made within **45 days** of receiving your request. If you have a medical condition that would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function if treatment is delayed, you may be entitled to request an **expedited external review** of the denial. If our denial to provide or pay for health care service or course of treatment is based on a determination that the service or treatment is experimental or investigation, you also may be entitled to file a request for external review of our denial.

Please contact your Plan Administrator with any questions on your rights to external review.

GENERAL PROVISIONS

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

Free Choice of Physician
The Covered Individual will have free choice of any legally qualified physician or surgeon, and the physician-patient relationship will be maintained. However, services provided by an Out-of-Network physician may reduce benefits payable for covered services.

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

Assignment
Benefits may not be assigned except by consent of the College, other than to providers of medical services and according to the provisions set forth in the Plan Document.

Rights of Recovery
Whenever payments have been made by the College with respect to allowable expenses in excess of the maximum amount of payment necessary to satisfy the intent of this Plan, the College will have the right, exercisable alone and in its sole discretion, to recover such excess payments or to withhold payment of any future benefits to offset for such excess payment.

Fraud
The following actions by any Covered Individual, or a Covered Individual's knowledge of such actions being taken by another, constitute fraud and will result in immediate termination of all coverage under this Plan for the entire Family Unit of which the Covered Individual is a member:

1. Attempting to submit a claim for benefits (which includes attempting to fill a prescription) for a person who is not a participant of the Plan;
2. Attempting to file a claim for a Covered Individual for services which were not rendered or Drugs or other items which were not provided;
3. Providing false or misleading information in connection with enrollment in the Plan; or
4. Providing any false or misleading information to the Plan.

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

Legal Proceedings
No action at law or in equity will be brought to recover on the Plan prior to the expiration of sixty (60) days after proof of loss has been filed in accordance with the requirements of the Plan, nor will such action be brought at all unless brought within two (2) years from the expiration of the time within which proof of loss is required by the Plan.

Conformity with Governing Law
This is a self-funded benefit plan coming within the purview of the Employee Retirement Income Security Act of 1974 ("ERISA") and the laws of the State of Illinois. If any provision of this Plan is contrary to any law to which it is subject, such provision is hereby amended to conform thereto.

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

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

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

GINA
"GINA" shall mean the Genetic Information Nondiscrimination Act of 2008 (Public Law No. 110-233), which prohibits group health plans, issuers of individual health care policies, and employers from discriminating on the basis of genetic information.

The term "genetic information" means, with respect to any individual, information about:
1. Such individual's genetic tests;
2. The genetic tests of family members of such individual; and
3. The manifestation of a disease or disorder in family members of such individual.

While the Plan may collect genetic information after initial enrollment, it may not do so in connection with any annual renewal process where the collection of information affects subsequent enrollment. The Plan will not adjust premiums or increase group contributions based upon genetic information, request or require genetic testing or collect genetic information either prior to or in connection with enrollment or for underwriting purposes.

"Family members" include dependents, plus all relatives to the fourth degree, without regard to whether they are related by blood, marriage, or adoption.

The term "genetic information" includes participating in clinical research involving genetic services. Genetic tests would include analysis of human DNA, RNA, chromosomes, proteins, or metabolite that detect genotypes, mutations, or chromosomal changes. Genetic information is a form of Protected Health Information (PHI) as defined by and in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and is subject to applicable Privacy and Security Standards.

"Underwriting" includes any rules for determining eligibility, computing premiums or contributions, and applying preexisting conditions. Offering reduced premiums or other rewards for providing genetic information would be impermissible underwriting.

GINA will not prohibit a health care provider who is treating an individual from requesting that the patient undergo genetic testing.

The rules permit the Plan to obtain genetic test results and use them to make claims payment determinations when it is necessary to do so to determine whether the treatment provided to the patient was medically advisable and/or necessary.

The Plan may request, but not require, genetic testing in certain very limited circumstances involving research, so long as the results are not used for underwriting, and then only with written notice to the individual that participation is voluntary and will not affect eligibility for benefits, premiums or contributions. In addition, the Plan will notify and describe its activity to the Health and Human Services secretary of its activities falling within this exception.

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

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

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

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

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

DEFINITIONS

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

ACTIVELY AT WORK/ACTIVE SERVICE
An employee is considered to be actively at work when performing, in the customary manner, all of the regular duties of his occupation with the College and is not confined to a hospital or other health care facility. An employee shall be deemed actively at work on each day of a regular paid vacation; on a regular non-working day, provided he was actively at work on the last preceding regular working day; or if he is absent solely due to injury or illness.

ADOPTED CHILD
Any child legally placed in an employee's home by an adoption agency who meets the eligibility requirements of this Plan, whether or not the adoption is final. Placement is defined as the assumption and retention of a legal obligation for total or partial support of a child in anticipation of adoption of such child.

ALTERNATE RECIPIENT
Any child of a Covered Individual who is recognized under a Qualified Medical Child Support Order (QMCSO) as having a right to enrollment in this Plan with respect to such Covered Individual.

AMBULANCE
Medically necessary transportation to and from a hospital or from a hospital to a nursing facility in the surrounding area where the ambulance transportation originated. To determine if the ambulance transportation is covered, this Plan considers if no other method of transportation is appropriate, that the services necessary to treat the injury or illness are not available in the hospital, nursing facility or chemical dependency facility in which the Covered Individual is an in-patient or out-patient and the point of destination is the nearest one with adequate and appropriate methods of care.

AMBULATORY SURGICAL CENTER
An institution or facility, either free-standing or as part of a hospital, with permanent facilities, equipped and operated for the primary purpose of performing surgical procedures and to which a patient is admitted to and discharged from within a twenty-four (24) hour period. An office maintained by a physician for the practice of medicine or dentistry or for the primary purpose of performing terminations of pregnancy shall not be considered to be an ambulatory surgical center.

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

ANNUAL
Periodic, based on a Calendar Year.

ASSIGNMENT OF/ASSIGNED BENEFITS
Assignment of Benefits occurs when the Covered Individual authorizes the Plan to pay benefits directly to the provider of services.

BASELINE
The initial test results to which the results in future years will be compared in order to detect abnormalities.

BENEFITS
Those medically necessary services and supplies that qualify for payment under this Plan.

BENEFIT PERCENTAGE
That portion of eligible expenses to be paid by the Plan in accordance with the coverage provisions as stated in the Plan. It is the basis used to determine any Out-of-Pocket Expenses in excess of the Annual Deductible which are to be paid by the employee.

BENEFIT PERIOD
A time period of one (1) Calendar Year. Such Benefit Period will terminate on the earliest of the following dates:

- The last day of the one-year period so established;
- The day the Covered Individual ceases to be covered for Medical Expense Benefits.

BIRTHING CENTER
Any freestanding health facility, place, professional office or institution which is not a hospital or in a hospital, where births occur in a home-like atmosphere. This facility must be licensed and operated in accordance with the laws pertaining to birthing centers in the jurisdiction where the facility is located. The birthing center must provide facilities for obstetrical delivery and short-term recovery after delivery; and have a written agreement with a hospital in the same locality for immediate acceptance of patients who develop complications or require pre- or post-delivery confinement.

CALENDAR YEAR
A period of time commencing at 12:01 a.m. on January 1st and ending at 12:00 a.m. on the next succeeding December 31st of the same given year.

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

CERTIFICATE OF CREDITABLE COVERAGE
The term “Certificate of Creditable Coverage” is defined as a written document provided by a prior plan which will allow an individual to establish prior creditable coverage to offset a pre-existing exclusion imposed by a subsequent group health plan. The certificate must indicate the date any waiting period or affiliation period began as well as the dates coverage began and ended.

CHILD
“Child” shall mean, in addition to the Employee’s own blood descendant of the first degree or lawfully adopted Child, a Child placed with a covered Employee in anticipation of adoption, a covered Employee’s Child who is an alternate recipient under a Qualified Medical Child Support Order as required by the federal Omnibus Budget Reconciliation Act of 1993, any stepchild or any other Child for whom the Employee has obtained legal guardianship.

CHIROPRACTIC SERVICES
Services performed by a person trained and licensed to practice chiropractic medicine, provided those services are for the remedy of diseases or conditions which the chiropractor is licensed to treat. Eligible expenses include spinal manipulations and other therapeutic treatments, x-rays, supplies and equipment.

CIVIL UNION PARTNER
A person with whom the covered employee has entered into a legal civil union, as determined and defined by the laws of the state of the covered employee’s residence.

CLAIMANT
An individual for whom a service has been rendered or furnished and on whose behalf expenses for such services have been submitted to the Plan for consideration of benefits.

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

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

CLEAN CLAIM
A clean claim is one that can be processed without obtaining additional information from the provider of the service or a third party. It is a claim which has no defect or impropriety. A defect or impropriety shall include a lack of required sustaining documentation or a particular circumstance requiring special treatment which prevents timely payment from being made. A Clean Claim does not include claims under investigation for fraud and abuse or claims under review for medical necessity.

CLOSE RELATIVE
The spouse, parent (including step-parent), sibling (including step-sibling), child (including legally adopted and step-child), grandparent, mother-in-law, father-in-law, sister-in-law, brother-in-law, daughter-in-law or son-in-law of the Covered Individual, whether the relationship is by blood or exists in law, or person who resides in the same household of the Covered Individual.

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

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

COLLEGE
Augustana College.

CONFINEMENT
A continuous stay in the hospital(s) or extended care facility(ies) or combination thereof, due to a sickness or injury diagnosed by a physician.

CO-PAYMENT
A Co-Payment (Co-Pay) is the fixed dollar amount a Covered Individual pays each time he receives certain covered services.

COSMETIC
Primarily directed at improving an individual's appearance rather than for restoration or improvement of a bodily function.

COVERED CHARGES/EXPENSES/SERVICES
Those expenses covered by this Plan, including the hospital, surgical, medical and dental care expenses described in this booklet. The Plan Administrator retains discretionary authority to determine whether charges are considered to be covered expenses under the Plan. However, expenses are not covered if they are expressly excluded, are not medically necessary, are experimental or investigational in nature, exceed the maximum amount considered by this Plan, or if the charges are in excess of the usual and customary and reasonable amounts as determined by the Plan. See also the definitions of eligible expenses expense.

COVERED INDIVIDUAL
Any employee, COBRA Qualified Beneficiary, eligible dependent, or person who qualifies under other classifications as stated in the Eligibility section, meeting the eligibility requirements for coverage as specified in this Plan, and properly enrolled in the Plan.

CREDITABLE COVERAGE
Includes an individual's coverage under a group health plan, Medicare, Medicaid, a public health plan, a medical or dental plan for members of the uniformed services and their dependents an Indian or tribal organization medical program, a State health benefits risk pool, the Federal Employees Health Benefits program or a Peace Corps health benefits plan, or any other plan or program recognized under the Health Insurance Portability and Accountability Act of 1996, as amended. Creditable coverage is used to reduce an individual's pre-existing condition exclusion period under a new plan as long as there is no break in coverage of sixty-three (63) or more consecutive days.

CRIMINAL ACT
A crime or offense which carries with it a punishment as determined by common law or statute within the presiding jurisdiction of law enforcement.

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

DEDUCTIBLE
A specified dollar amount of covered expenses which must be incurred during a Benefit Period before any other covered expenses can be considered for payment according to the applicable benefit percentage.

DEFRA
The Deficit Reduction Act of 1984, as amended.

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

DEPENDENT
The term "DEPENDENT" means:

- The employee's legal spouse who is a resident of the same country in which the employee resides. Such spouse must have met all requirements of a valid marriage contract of the State in which the employee resides. The Plan Administrator may require documentation proving a legal marital relationship.
- The Employee's legal Domestic Partner who resides with the Employee. Such Domestic Partner must have entered into a Domestic Partnership with the Employee (a Statement of Domestic Partnership form may be obtained from the Employer). A duly witnessed and notarized Statement of Domestic Partnership must be provided to the Plan Administrator to establish eligibility for the Domestic Partner.
- The employee's legal civil union partner who is a resident of the same country in which the employee resides. Such civil union partner must have met all requirements of a valid civil union contract of the State in which the employee resides. The Plan Administrator may require documentation proving a legal civil union relationship.
- The employee's child who meets all the following requirements:
    1) Is the Employee's own blood descendant of the first degree or lawfully adopted Child, a Child placed with a covered Employee in anticipation of adoption, a covered Employee's Child who is an alternate recipient under a Qualified Medical Child Support Order as required by the federal Omnibus Budget Reconciliation Act of 1993, any stepchild (as long as a natural parent remains married to the employee and also resides in the employee's household) or any other Child for whom the Employee has obtained legal guardianship.
    2) Is less than twenty-six (26) years of age. This requirement may be waived if:
        a. The child is mentally or physically handicapped and became handicapped prior to age twenty-six (26), provided that the child is incapable of self-sustaining employment and is dependent upon the employee and/or the employee's spouse (or former spouse) or Domestic Partner or civil union partner for support and maintenance; or
        b. The child is a military veteran, is a resident of Illinois, is unmarried and under the limiting age of thirty (30); to be eligible, veterans must have:
            i. Served in the active or reserve components of the U.S. Armed Forces, including the National Guard;
            ii. Received a release or discharge other than a dishonorable discharge; and
            iii. Submitted proof of service using a DD2-14 (Member 4 or 6) form, otherwise known as a "Certificate of Release or Discharge from Active Duty." This form is issued by the federal government to all veterans. For more information on how to obtain a copy of a DD2-14, the veteran can call the Illinois Department of Veterans' Affairs at 1-800-437-9824 or the U.S. Department of Veterans' Affairs at 1-800-827-1000.

At any time, the Plan may require proof that a spouse, domestic partner or child qualifies or continues to qualify as a dependent as defined by this Plan.

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

- A spouse or civil union partner who is legally separated or divorced from the employee.
- A domestic partner whose Domestic Partnership with the Employee has been terminated, or who no longer resides with the Employee.
- Any person on active military duty more than thirty (30) days.
- Any spouse covered under this Plan as an individual employee.

DEPENDENT COVERAGE
Eligibility under the terms of the Plan for benefits payable as a consequence of eligible expenses incurred for an illness or injury of a dependent.

DOMESTIC PARTNER
A person with whom the covered Employee has entered into a Domestic Partnership.

DOMESTIC PARTNERSHIP
A Domestic Partnership is a legal and personal relationship between two individuals who live together and share a common domestic life but are not joined by a traditional or common-law marriage nor a civil union, but which meets the following criteria:

1. The Employee and Domestic Partner have an exclusive mutual commitment similar to marriage and have lived together for at least six (6) months and intend to live together indefinitely.
2. The Employee and Domestic Partner are jointly responsible for each other's common welfare and share financial obligations.
3. Neither the Employee nor the Domestic Partner is married to anyone else or has another domestic partner.
4. The Domestic Partner is at least eighteen (18) years of age and mentally competent to consent to contract.

DURABLE MEDICAL EQUIPMENT
Equipment which is able to withstand repeated uses, primarily and customarily used to serve a medical purpose, and not generally useful to a person in the absence of illness or injury.

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

ELIGIBLE EXPENSE/ALLOWABLE EXPENSE
Any Medically Necessary and Reasonable treatment, services, or supplies that are not specifically excluded from coverage elsewhere in this Plan, and for which charges are Usual and Customary.

ELIGIBLE PROVIDER
Eligible providers shall include legally licensed or duly certified health care providers to the extent that same, within the scope of their license, are permitted to perform services which are considered eligible expenses under the Plan. "Eligible Provider" shall not include the Covered Individual or any close relative of the Covered Individual.

EMERGENCY MEDICAL CONDITION
A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (i), or (iii) of section 1867(e)(1)(A) of the Social Security Act (42 U.S.C. 1395dd(e)(1)(A)). In that provision of the Social Security Act, clause (i) refers to placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; clause (ii) refers to serious impairment to bodily functions; and clause (iii) refers to serious dysfunction of any bodily organ or part.

EMERGENCY SERVICES
With respect to an Emergency Medical Condition:

1. A medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd) that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition; and
2. Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital, as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd) to stabilize the patient.

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

EMPLOYEE COVERAGE
Coverage hereunder providing benefits payable as a consequence of an injury or illness of an employee.

EMPLOYER
Augustana College.

ENROLLMENT DATE
The earlier of the first date of coverage or the first date of the waiting period, if any, for coverage. The enrollment date for Special Enrollees or late enrollees is the actual date of coverage.

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

ESSENTIAL HEALTH BENEFITS
"Essential Health Benefits" shall mean, under section 1302(b) of the Patient Protection and Affordable Care Act, those health benefits to include at least the following general categories and the items and services covered within the categories: ambulatory patient services; Emergency Services; hospitalization; maternity and newborn care; mental health and substance abuse disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

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

FAMILY
A covered employee and his eligible dependents.

FOSTER CHILD
A child whom the employee is raising as his/her own, who resides in the employee's home and for whom the employee has full parental responsibility and control. A foster children must have been placed in the employee's home by the appropriate governing authority.

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

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

HOME HEALTH CARE AGENCY
A public or private agency or organization that specializes in providing medical care and treatment in the home. Such a provider must be primarily engaged in and duly licensed by the appropriate licensing authority (if such licensing is required) to provide skilled nursing services and other therapeutic services. Its staff must maintain a complete medical record on each individual and it must have a full-time administrator.

HOME HEALTH CARE PLAN
A program for continued care and treatment of the Covered Individual established and approved in writing by the Covered Individual's attending physician. The attending physician must certify that the proper treatment of the illness or injury would require continued confinement as a resident in-patient in a hospital or extended care facility in the absence of the services and supplies provided as part of the home health care plan.

HOSPICE
A health care program providing a coordinated set of services rendered at home, in out-patient or clinic settings, or in institutional settings for Covered Individuals suffering from a condition that has a terminal prognosis. A hospice must have an interdisciplinary group of personnel which includes at least one physician and one registered graduate nurse, and its staff must maintain central clinical records on all patients. A hospice must meet the standards of the National Hospice Organization (NHO) and applicable state licensing.

HOSPITAL
An institution which meets all of the following conditions:

- It is constituted, licensed, and operated in accordance with the laws of jurisdiction in which it is located which pertain to hospitals.
- It maintains on its premises facilities necessary to provide for the diagnosis and medical and surgical treatment of an illness or an injury.
- It is accredited by the Joint Commission on the Accreditation of Health Care Organizations (JCAHCO). The JCAHCO accreditation limitation may be waived at the discretion of the Plan if the only hospital in the immediate area is not JCAHCO approved.
- It is a provider of services under Medicare.
- It is not, other than incidentally, a place for rest, a place for the aged, or a nursing home.

The definition of "HOSPITAL " will also include an institution qualified for the treatment of psychiatric problems, substance abuse, or tuberculosis that does not have surgical facilities and/or is not approved by Medicare, provided that such institution satisfies the definition of hospital in all other respects.

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

ILLNESS
A bodily disorder, disease, physical sickness, mental infirmity, or functional nervous disorder of a Covered Individual. A recurrent illness will be considered one illness. Concurrent illnesses will be considered one illness unless the concurrent illnesses are totally unrelated. All such disorders existing simultaneously which are due to the same or related causes shall be considered one illness.

IMPACTED TOOTH
A tooth that is positioned or wedged against another tooth, or covered by bone or soft tissue, so that it cannot erupt.

IMMUNIZATION
An injection or oral preparation with a specific antigen to promote antibody formation to make a person immune to disease or less susceptible to a contagious disease.

INCURRED
The point in time when a service is performed, or a supply is provided, or a purchase is made.

INFERTILITY
The inability or diminished ability to produce offspring.

INJURY
The term “INJURY" shall mean only accidental bodily injury caused by an external force, occurring while the Plan is in effect. All injuries to one person from one accident shall be considered an “INJURY."

IN-PATIENT
The classification of a Covered Individual when that Covered Individual receives medical care, treatment, services, or supplies at a hospital while registered as a bed patient at that hospital, skilled nursing facility or extended care facility.

IN-PATIENT CARE
Hospital room and board and general nursing care for a person confined in a hospital or extended care facility as a bed patient for twenty-four (24) consecutive hours or more.

INTENSIVE CARE UNIT (ICU)
An area within a hospital which is reserved, equipped, and staffed by the hospital for the treatment and care of critically ill patients who require extraordinary, continuous, and intensive nursing care for the preservation of life.

INTENSIVE OUT-PATIENT TREATMENT/PARTIAL HOSPITALIZATION
A distinct and organized intensive ambulatory treatment service, less than 24-hour daily care specifically designed for the diagnosis and active treatment of a mental health and/or substance abuse disorder when there is a reasonable expectation for improvement or to maintain the Covered Individual’s functional level and to prevent relapse or hospitalization. Such program must provide: diagnostic services; psychiatric nurses and staff trained to work with psychiatric patients; services of social workers; individual, group and family therapies; activities and occupational therapies; patient education; and chemotherapy and biological treatment interventions for therapeutic purposes.

LATE ENROLLEE
A Covered Individual who enrolls under the Plan other than during the first thirty-one (31) day period in which the individual is eligible to enroll under the Plan or during a Special Enrollment Period.

LEGAL GUARDIAN
A person recognized by a court of law as having the duty of taking care of the person and managing the property and rights of a minor child.

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

LIFETIME
The term “Lifetime" (which is used in connection with benefit maximums and limitations) means the period during which a Covered Individual is covered under this Plan, whether or not coverage is continuous. Under no circumstances does “Lifetime " mean during the actual lifetime of the Covered Individual.

MANDIBLE/MANDIBULAR
The lower jaw, pertaining to the lower jaw.

MAXILLA
The bone forming one-half of the upper jaw. The upper jaw consists of two maxillae; however, it is commonly referred to as the maxilla.

MAXIMUM ANNUAL BENEFIT
The highest dollar amount of eligible expenses that could be paid to or on behalf of any Covered Individual during a single Benefit Period (as defined by the Plan), subject to the terms of this Plan.

MEDICAL CARE FACILITY
A hospital, a facility that treats one or more specific ailments or any type of skilled nursing facility.

MEDICALLY NECESSARY, MEDICAL NECESSITY AND MEDICAL CARE NECESSITY
Medical Necessity and similar language refers to health care services ordered by a Physician exercising prudent dinical judgment provided to a Covered Person for the purposes of evaluation, diagnosis or treatment of that Covered Person’s Sickness or Injury. Such services, to be considered Medically Necessary, must be clinically appropriate in terms of type, frequency, extent, site and duration for the diagnosis or treatment of the Covered Person’s Sickness or Injury. The Medically Necessary setting and level of service is that setting and level of service which, considering the Covered Person’s medical symptoms and conditions, cannot be provided in a less intensive medical setting. Such services, to be considered Medically Necessary must be no more costly than alternative interventions, including no intervention and are at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the Covered Person’s Sickness or Injury without adversely affecting the Covered Person’s medical condition.

A) It must not be maintenance therapy or maintenance treatment.
B) Its purpose must be to restore health.
C) It must not be primarily custodial in nature.
D) It must not be a listed item or treatment not allowed for reimbursement by CMS (Medicare).

The Plan reserves the right to incorporate CMS (Medicare) guidelines in effect on the date of treatment as additional criteria for determination of Medical Necessity and/or an Allowable Expense. All of these criteria must be met; merely because a physician recommends or approves certain care does not mean that it is medically necessary. The Plan Administrator has the discretionary authority to decide whether care or treatment is medically necessary

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

MENTAL HEALTH ILLNESS/DISORDER
Any disease or condition, regardless of whether the cause is organic, this is classified as a Mental Disorder in the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services or is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association.

MENTAL HEALTH CLINIC
A facility established for the purpose of providing consultation, diagnosis and treatment in connection with mental health disorder, and approved as such by a state department or agency having authority over such facilities.

MINOR EMERGENCY MEDICAL CLINIC
A freestanding facility which is engaged primarily in providing minor emergency and episodic medical care to a Covered Individual. A board-certified physician, a registered nurse, and a registered x-ray technician must be in attendance at all times that the clinic is open. The clinic's facilities must include x-ray and laboratory equipment and a life support system. For the purposes of this Plan, a clinic meeting these requirements will be considered to be a minor emergency medical clinic, by whatever actual name it may be called; however, a clinic located on or in conjunction with or in any way made a part of a regular hospital shall be excluded from the terms of this definition.

MORBID OBESITY
Morbid obesity is a condition of persistent and uncontrollable weight gain that is a potential threat to life. It is characterized by a weight that is at least 100 pounds over or twice the ideal weight for the frame, age, height, and gender specified in the most recently published Metropolitan Life Insurance table. Morbid obesity may also be defined by comparable body mass index (BMI) measures.

NAMED FIDUCIARY
Augustana College, which has the authority to control and manage the operation and administration of the Plan.

NEGOTIATED
In most cases, a simple discount arrangement.

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

NO-FAULT AUTO INSURANCE
The basic reparations provision of a law providing for payments without determining fault in connection with automobile accidents.

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

ORTHOTIC APPLIANCE
An external device intended to correct any defect in form or function of the human body.

OUT-OF-POCKET EXPENSE
The amount of covered charges that are payable by the Covered Individual or family unit.

OUT-PATIENT
The classification of a Covered Individual when that Covered Individual receives medical care, treatment, services, or supplies at a clinic, a physician’s office, a hospital if not a registered bed patient at that hospital, an out-patient psychiatric facility, or an out-patient alcoholism treatment facility.

OUT-PATIENT PSYCHIATRIC TREATMENT FACILITY
An administratively distinct governmental, public, private or independent unit or part of such unit that provides out-patient mental health services and which provides for a psychiatrist who has regularly scheduled hours in the facility, and who assumes the overall responsibility for coordinating the care of all patients.

OUT-PATIENT SUBSTANCE ABUSE TREATMENT FACILITY
An institution which provides a program for diagnosis, evaluation, and effective treatment of alcoholism and/or substance abuse; provides detoxification services needed with its effective treatment program; provides infirmary-level medical services that may be required; is at all times supervised by a staff of physicians; prepares and maintains a written plan of treatment for each patient, based on the patient’s medical, psychological, and social needs and supervised by a physician; and meets licensing standards.

OUT-PATIENT SURGERY
Out-patient surgery includes, but is not limited to, the following types of procedures performed in a hospital, surgi-center or clinic:

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

PARTICIPATING PROVIDER
A provider that has entered into an agreement with the Plan or preferred provider organization to accept agreed-upon discounted rates for covered services.

PATIENT
The Covered Individual who is awaiting or receiving medical or dental care and treatment.

PHARMACY
A licensed establishment where covered prescription drugs are filled and dispensed by a pharmacist licensed under the laws of the state where he or she practices.

PHARMACY BENEFIT MANAGER
The organization contracting with the College to provide cost containment services related to the prescription drug benefits provided by this Plan

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

PHYSICIAN
A legally licensed medical or dental doctor or surgeon, osteopath, podiatrist, optometrist, chiropractor or registered clinical psychologist, physician assistant, nurse practitioner or licensed nurse midwife to the extent that same, within the scope of his license, is permitted to perform services provided in this Plan. A physician shall not include the Covered Individual or any close relative of the Covered Individual.

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

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

PLAN DOCUMENT
The legal document according to which this Plan is administered.

PLAN SPONSOR
Augustana College.

PLAN YEAR
The reporting year for ERISA purposes. The Plan Year will commence each September 1st and end on the next following August 31st.

PRE-ADMISSION TEST
Any diagnostic test or study required as part of a hospital's admission policy or which is necessary for a scheduled surgical procedure, and which is performed prior to a hospital confinement.

PRE-EXISTING CONDITION
A disease, injury, or illness of a Covered Individual for which the Covered Individual has been under the care of a licensed physician or has received medical care, services, or supplies within the six (6) month period immediately preceding his effective date of coverage. Medical care, services, or supplies shall include, but shall not be limited to, medication, therapy, x-ray or lab tests, counseling, or any other treatment recommended by a licensed provider of medical care or services. The Pre-Existing Condition Limitation does not apply to a Covered Individual that has not yet reached age nineteen (19).

PREFERRED PROVIDER ORGANIZATION/NETWORK (PPO)
An organization composed of a group of health care providers who offer their services at a discount rate to the employer if a Covered Individual uses such PPO member's services in accordance with the formal agreement between the College and the preferred provider organization.

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

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

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

PRIVATE DUTY NURSING
A continuous bedside nursing service, rendered by one nurse to one patient, either in a hospital, nursing facility, hospice facility or the patient's home, as opposed to general duty nursing, which renders services to a number of patients in an in-patient setting.

PROCUREMENT COSTS
Those charges for services associated with the procurement of a human organ for transplant, including, but not limited to, surgical removal of an organ from a living donor, pathology and radiology services and services necessary to preserve the viability of the organ to be transplanted.

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

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

PSYCHOLOGIST
A registered clinical psychologist. A psychologist who specializes in the evaluation and treatment of mental illness who is registered with the appropriate state registering body or, in a state where statutory licensure exists, holds a valid credential for such practice or, if practicing in a state where statutory licensure does not exist, meets the following qualifications: has a doctoral degree from an accredited university, college, or professional school and has two years of supervised experience in health services of which at least one year is post-doctoral and one year in an organized health services program; or, holds a graduate degree from an accredited university or college and has not less than six years as a psychologist with at least two years of supervised experience in health services.

QUALIFIED BENEFICIARY
A Covered Individual who qualifies for continuation of coverage under the provisions of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, as then constituted or later amended.

QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)
A Qualified Medical Child Support Order is a medical child support order which creates or recognizes an Alternate Recipient's right to, or assigns to an Alternate Recipient the right to, receive benefits for which a Covered Individual is eligible, and which the Plan Administrator has determined meets the requirements as outlined in this Plan.

REASONABLENESS
The Plan will only pay fee(s) that, in the administrator's discretion, are for services or supplies which are necessary for the care and treatment of an illness or injury not caused by the treating provider. Determination that charges are reasonable will be made by the Plan Administrator, taking into consideration unusual circumstances or complications; industry standards and practices as they relate to similar scenarios; and the cause of injury or illness necessitating the charge(s). This determination will consider, but will not be limited to, the findings and assessments of the following entities: (a) The National Medical Associations, Societies, and Organizations; and (b) The Food and Drug Administration. Services, supplies, care and/or treatment that results from errors in medical care that are clearly identifiable, preventable, and serious in their consequence for patients, are not reasonable. The Plan Administrator retains discretionary authority to determine whether charges(s) are reasonable based upon information presented to the Plan Administrator. A finding of provider negligence and/or malpractice is not required for charge(s) to be considered not reasonable.

RECOVERY (subrogation)
Shall mean any and all sums of money and/or any promise to pay sums of money in the future, received by you from persons or entities, or their insurers, who may by responsible to you or your dependent on account of an injury or illness for which the Plan has paid you benefits, regardless of how such sums are characterized or labeled, including, without limitation, sums paid or promised to be paid as compensation for actual medical expenses, pain and suffering, aggravation, wrongful death, loss of consortium to you or your covered dependent's wife or children, punitive or exemplary damages, attorney fees, costs, expenses, or any other direct or derivative compensatory damages that arise out of or are to any extent based upon the injury or illness suffered by you or your covered dependent.

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

REHABILITATION INSTITUTION
A legally constituted and operated institution (other than a hospital) established to provide medical treatment for patients who require in-patient care for chemical dependency, but do not currently require continuous hospital services for such condition, and which has permanent facilities for in-patient medical care on the premises, including 24-hour nursing service, and maintains daily medical records on all patients. In no event will the term "rehabilitation institution" include any institution, or part thereof, which is used principally as a rest facility or nursing facility, a facility for the ages, or one providing primarily custodial care.

RESIDENTIAL TREATMENT PROGRAM
A program provided by a facility established for the purpose of residential treatment of chemical dependency and approved as such by a state department or agency having authority over such programs.

RETIREE/RETIRED EMPLOYEE
An employee of the College who has retired from active service with the College.

ROOM AND BOARD
All charges, by whatever name called, which are made by a hospital, hospice, or extended care facility as a condition of occupancy. Such charges do not include the professional services of physicians nor intensive nursing care (by whatever name called).

SEMI-PRIVATE
A class of accommodations in a hospital or extended care facility in which at least two patient beds are available per room.

SICKNESS
Physical sickness; disease; mental, emotional or nervous disorders; and pregnancy. Recurrent, related or concurrent sicknesses are considered as one “SICKNESS," unless a concurrent sickness is totally unrelated to the other sickness.

SKILLED NURSING/EXTENDED CARE FACILITY
An institution, or distinct part thereof, which meets all of the following conditions:

- It is constituted, licensed, and operated in accordance with the laws of jurisdiction in which it is located which pertain to skilled nursing facilities.
- It is engaged in providing, on an in-patient basis for persons convalescing from injury or illness, professional nursing services and physical restoration services to assist patients to reach a degree of body functioning to permit self-care in essential daily living activities.
- Its staff maintains a complete medical record on each patient.
- It has an effective utilization review plan.
- It is approved and licensed by Medicare.

This term shall apply to expenses incurred in an institution referring to itself as a skilled nursing facility, extended care facility, or any such other similar facility. The definition of “SKILLED NURSING FACILITY" will also include an institution that is not approved by Medicare, provided that such institution satisfies the definition of skilled nursing facility in all other respects.

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

SPECIAL CARE UNIT
A section, ward, or wing within the hospital which is separated from other hospital facilities and a) is operated exclusively for the purpose of providing professional care and treatment for critical injuries or illness; b) has special supplies and equipment, necessary for such care and treatment, available on a standby basis for immediate use; and c) provides room and board and constant observation and care by a registered nurse (RN) or any other specially trained hospital personnel.

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

SPOUSE
A person to whom a covered employee is legally married, as determined and defined by the laws of the state of the covered employee’s residence. The term “SPOUSE” as used in this Plan Document shall also mean the covered employee’s domestic partner (as defined by the Plan) or civil union partner.

STEP-CHILD
Any biological or adopted child of the spouse, Domestic Partner or civil union partner of an employee who has not yet reached the age of twenty-six (26).

SUBSTANCE ABUSE
Regular excessive compulsive drinking of alcohol and/or physical habitual dependence on drugs. This does not include dependence on ordinary caffeine-containing drinks.

SURGICAL OPINION, ADDITIONAL
A consultation with another physician which the Plan may require to determine the appropriateness of a surgical procedure as the preferred course of treatment as recommended by the attending physician.

SURGICAL PROCEDURES
Cutting, suturing, treatment of burns, correction of fractures, reduction of dislocation, manipulation of joints under general anesthesia, electrocauterization, tapping (paracentesis), application of plaster casts, administration of anesthetic agent into joint or spine; decompression of pneumothorax, endoscopy, or injection of sclerosing solution by a licensed physician.

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

TERMINALLY ILL
Having a life expectancy of six months or less due to an illness from which the Covered Individual is not expected to recover. This is usually a chronic illness or condition for which there is no known cure.

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

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

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

TOTAL DISABILITY (TOTALLY DISABLED)
A physical state of a Covered Individual resulting from an illness or injury which wholly prevents:

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

TREATMENT PLAN
A health care provider's report, provided on a form satisfactory to the Claims Administrator, which itemizes the services recommended by the provider for the necessary dental care of a Covered Individual. For dental/orthodontic treatment plans, the report shows the dentist's charge for each dental service, and is accompanied by supporting x-rays or other diagnostic records where required or requested by the Claims Administrator.

USUAL AND CUSTOMARY (U&C)
Only Usual and Customary charges are covered expenses. When determining whether an expense is Usual and Customary, the Plan Administrator will take into consideration the fee(s) which the provider most frequently charges the majority of patients for the service or supply, the cost to the provider for providing services, the prevailing range of fees charged in the same "area" by providers of similar training and experience for the service or supply, and the Medicare reimbursement rates. The term(s) "same geographic locale" and/or "area" shall be defined as a metropolitan area, county, or such greater area as is necessary to obtain a representative cross-section of providers, persons or organizations rendering such treatment, services, or supplies for which a specific charge is made. To be Usual and Customary, fee(s) must be in compliance with generally accepted billing practices for unbundling or multiple procedures.

The term "Usual" refers to the amount of a charge made for medical services, care, or supplies, to the extent that the charge does not exceed the common level of charges made by other medical professionals with similar credentials, or health care facilities, pharmacies, or equipment suppliers of similar standing, which are located in the same geographic locale in which the charge is incurred.

The term “Customary” refers to the form and substance of a service, supply, or treatment provided in accordance with generally accepted standards of medical practice to one individual, which is appropriate for the care or treatment of the same sex, comparable age and who receive such services or supplies within the same geographic locale.

The term “Usual and Customary” does not necessarily mean the actual charge made nor the specific service or supply furnished to a Plan Participant by a provider of services or supplies, such as a physician, therapist, nurse, hospital, or pharmacist. The Plan Administrator will determine what the Usual and Customary charge is, for any procedure, service, or supply, and whether a specific procedure, service or supply is Usual and Customary.

Usual and Customary charges may alternatively be determined and established by the Plan using normative data such as Medicare cost to charge ratios, average wholesale price (AWP) for prescriptions and/or manufacturer’s retail pricing (MRP) for supplies and devices.

UTILIZATION REVIEW AGENT
The organization contracting with the College to perform cost containment services.

VISIT
Each attendance to the Covered Individual by a physician or medical practitioner, including a registered nurse (RN), regardless of the type of professional service provided, whether termed a consultation, treatment or given some other name.

WAITING PERIOD
The amount of time that must pass before an individual is eligible to be covered for benefits under the terms of the group health plan.

WELL CARE/WELL CHILD CARE
The term "well-care" means medical treatment, services, or supplies rendered solely for the purpose of health maintenance and not for the treatment of an illness or injury.

WELL NEWBORN CARE
Medical treatment, services or supplies rendered to newborn child solely for the purpose of health maintenance and NOT for the treatment of an illness or injury prior to its discharge from the hospital following birth.