PLAN DOCUMENT AND
SUMMARY PLAN DESCRIPTION
FOR

ASBURY UNIVERSITY
EMPLOYEE MEDICAL BENEFIT PLAN

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INTRODUCTION

This document is a description of the Asbury University Employee Medical Benefit Plan (the Plan). No oral interpretations can change this Plan. The Plan described is designed to protect Plan Participants against certain catastrophic health expenses.

Coverage under the Plan will take effect for an eligible Employee and designated Dependents when the Employee and such Dependents satisfy all the eligibility requirements of the Plan.

The Employer reserves the right to terminate, suspend, discontinue or amend the Plan at any time and for any reason.

Changes in the Plan may occur in any or all parts of the Plan including benefit coverage, deductibles, maximums, copayments, exclusions, limitations, definitions, eligibility and the like.

The Plan believes that it is a "grandfathered" health plan under the Patient Protection and Affordable Care Act ("Health Care Reform"). As permitted by Health Care Reform, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that the Plan may not include certain consumer protections of Health Care Reform that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections under Health Care Reform such as the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Administrator. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

Failure to follow the eligibility or enrollment requirements of this Plan may result in delay of coverage or no coverage at all. Reimbursement from the Plan can be reduced or denied because of certain provisions in the Plan, such as coordination of benefits, subrogation, exclusions, timeliness of COBRA elections, utilization review or other cost management requirements, lack of Medical Necessity, lack of timely filing of claims or lack of coverage. These provisions are explained in summary fashion in this document; additional information is available from the Plan Administrator at no extra cost.

The Plan will pay benefits only for the expenses incurred while this coverage is in force. No benefits are payable for expenses incurred before coverage began or after coverage terminated. An expense for a service or supply is incurred on the date the service or supply is furnished.

No action at law or in equity shall be brought to recover under any section of this Plan until the appeal rights provided have been exercised and the Plan benefits requested in such appeals have been denied in whole or in part.

If the Plan is terminated, amended, or benefits are eliminated, the rights of Covered Persons are limited to Covered Charges incurred before termination, amendment or elimination.

This document summarizes the Plan rights and benefits for covered Employees and their Dependents and is divided into the following parts:

Schedule of Benefits. Provides an outline of the Plan reimbursement formulas as well as payment limits on certain services.

Eligibility, Funding, Effective Date and Termination. Explains eligibility for coverage under the Plan, funding of the Plan and when the coverage takes effect and terminates.

Benefit Descriptions. Explains when the benefit applies and the types of charges covered.

Cost Management Services. Explains the methods used to curb unnecessary and excessive charges.

This part should be read carefully since each Participant is required to take action to assure that the maximum payment levels under the Plan are paid.

Defined Terms. Defines those Plan terms that have a specific meaning.

Plan Exclusions. Shows what charges are **not** covered.

Claim Provisions. Explains the rules for filing claims and the claim appeal process.

Coordination of Benefits. Shows the Plan payment order when a person is covered under more than one plan.

Third Party Recovery Provision. Explains the Plan's rights to recover payment of charges when a Covered Person has a claim against another person because of injuries sustained.

Continuation Coverage Rights Under COBRA. Explains when a person's coverage under the Plan ceases and the continuation options which are available.

ERISA Information. Explains the Plan's structure and the Participants' rights under the Plan.

SCHEDULE OF BENEFITS

Verification of Eligibility (877) 309-2955

Call this number to verify eligibility for Plan benefits **before** the charge is incurred.

MEDICAL BENEFITS

All benefits described in this Schedule 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 Usual and Reasonable; that services, supplies and care are not Experimental and/or Investigational. The meanings of these capitalized terms are in the Defined Terms section of this document.

This document is intended to describe the benefits provided under the Plan but, due to the number and wide variety of different medical procedures and rapid changes in treatment standards, it is impossible to describe all covered benefits and/or exclusions with specificity. Please contact the Plan Administrator if you have questions about specific supplies, treatments or procedures.

Note: For services that are not pre-certified, claims will be denied for no pre-certification. Once information is received claims can be re-opened based on medical information provided. Any services or days found not to be medically necessary will not be covered.

Inpatient Services that require precertification:

Cervical Spine Surgery
Computer Navigation for Orthopedic Surgery
Elective Admissions
Hospice
LTAC Admissions
Lumbar Spine Surgery
Rehabilitation Facility Admissions
Sacroiliac Joint Fusion
Skilled Nursing Facility Admissions
Transplants

Outpatient Services that require precertification:

Coronary CT Angiography (CCTA)
Coronary MRA
Cardiac MRI
MRA of the Head and/or Neck
MRI of the Brain
MRI of the Spine – Cervical, Thoracic, Lumbar, Sacral
PET Scan
Blepharoplasty/Blepharoptosis
Bone-Anchored Hearing Aids
Breast Procedures
Cardiac Resynchronization Therapy (CRT) with or without Implantable Cardioverter
Cartilage Transplant Knee
Cervical Spine Surgery
Cochlear Implant
Computer Navigation for Orthopedic Surgery
Cosmetic and Reconstructive Services of Head, Neck, Trunk and Groin
Elective Total Hip Arthroplasty
Elective Total Knee Arthroplasty

IDET Procedure
Implantable Cardioverter-Defibrillator (ICD)
Lumbar Spine Surgery
Mandibular/Maxillary Surgery (Orthognathic)
Mastectomy for Gynecomastia
Nasal Septoplasty
Panniculectomy and Lipectomy/Diastasis Recti Repair
Reduction Mammoplasty
Rhinoplasty
Sacroiliac Joint Fusion
Sinus Endoscopy
Sleep Apnea Surgery - LAUP/UPPP, Nasal, and Uvulopalatoplasty
Treatment of Varicose Veins (Lower Extremities)

Manager Care that require precertification:

Behavioral Health Services
Inpatient Behavioral Health and Substance Abuse

ABA Therapy
Autism Spectrum Disorder

Ancillary Services
Air Ambulance - Non-Emergent
Botulinum Toxin – Review for Migraine use only
Home Health Services
Genetic Testing for Breast and/or Ovarian Cancer Syndrome
Genetic Testing for Inherited Peripheral Neuropathies
Genetic Testing for PTEN Hamartoma Tumor Syndrome
Home Hospice
Home Infusion Services
Hyperbaric Oxygen Therapy (Systemic/Topical)
Occupational Therapy
Physical Therapy
Private Duty Nursing
Speech Therapy

Durable Medical Equipment
Bone Stimulator
Cardio/External Defibrillator
Cooling Devices
CPAP/BIPAP
Electric Scooters
Infusion Pumps
Insulin Pumps
Limb Prosthetics
Left Ventricular Assist Devices (LVAD) – Reviewed by Transplant
Myoelectric Prosthetics
Neuromuscular Stimulators
TENS Unit
Wheelchairs (Custom)
Wheelchairs (Power)
Wound Vacs

Specialty Infusion Drugs
Azacitidine (Vidaza)

Bevacizumab (Avastin) – Review for Non-Eye Only
Bortezomib (Velcade)
Etanercept (Enbrel)
Fulvestrant (Faslodex)
Immune Globulin (Intravenous)
Infliximab (Remicade)
Ipilimumab (Yervoy)
Nivolumab (Opdivo)
Paclitaxel (Abraxane Only)
Panitumubab (Vectibix)
Pembrolizumab (Keytruda)
Pemetrexed (Alimta)
Rituximab (Rituxan) – Review for Non-Oncology Diagnosis/Treatment Only

The attending Physician does not have to obtain precertification from the Plan for prescribing a maternity length of stay that is 48 hours or less for a vaginal delivery or 96 hours or less for a cesarean delivery.

Please see the Cost Management section in this booklet for details.

The Plan is a plan which contains a Network Provider Organization.

PPO name: Anthem Blue Cross & Blue Shield
Address: 13550 Triton Park Boulevard
Louisville, Kentucky 40223

Telephone: (800) 810-2583
Fax: (502) 889-2414

This Plan has entered into an agreement with certain Hospitals, Physicians and other health care providers, which are called Network Providers. Because these Network 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.

Therefore, when a Covered Person uses a Network Provider, that Covered Person will receive better benefits from the Plan than when a Non-Network Provider is used. It is the Covered Person's choice as to which Provider to use.

Under the following circumstances, the higher In-Network payment will be made for certain Non-Network services:

If a Covered Person has no choice of Network Providers in the specialty that the Covered Person is seeking within the PPO service area.

If a Covered Person is out of the PPO service area and has a Medical Emergency requiring immediate care.

If a Covered Person receives Physician or anesthesia services by a Non-Network Provider at an In-Network facility.

Additional information about this option, including any rules that apply to designation of a primary care provider, as well as a list of Network Providers, will be given to Plan Participants, at no cost, and updated as needed. This list will include providers who specialize in obstetrics or gynecology.

Deductibles/Copayments Payable by Plan Participants

Deductibles/Copayments are dollar amounts that the Covered Person must pay before the Plan pays.

A deductible is an amount of money that is paid once a Calendar Year per Covered Person. Typically, there is one deductible amount per Plan and it must be paid before any money is paid by the Plan for any Covered Charges. Each January 1st, a new deductible amount is required.

A copayment is the amount of money that is paid each time a particular service is used. Typically, there may be copayments on some services and other services will not have any copayments. Copayments do not accrue towards the 100% Maximum Out-Of-Pocket payment.

BlueCard Program

Like all Blue Cross & Blue Shield plans throughout the country, Anthem participates in a program called "BlueCard." This program lets the Member get Covered Charges at the Network cost-share when he/she is traveling out of state and needs health care, as long as the Member uses a BlueCard Provider. All the Member has to do is show their Identification Card to a participating Blue Cross & Blue Shield Provider, and they will send the claims to the Claims Administrator.

If a Member is out of state and an Emergency or urgent situation arises, the Member should get care right away. In a non-Emergency situation, the Member can find the nearest contracted Provider by visiting the BlueCard Doctor and Hospital Finder website (www.BCBS.com) or call the number on the back of their Identification Card. Members can also access Doctors and Hospitals outside of the U.S. The BlueCard program is recognized in more than 200 countries throughout the world.

Care outside the United States – BlueCard Worldwide

Prior to travel outside the United States, Members should check with the Plan Sponsor or call Customer Service at the number on their Identification Card to find out if their Plan has BlueCard Worldwide benefits.
Coverage outside the United States may be different, and it is recommended:

- Before leaving home, Members should call the Customer Service number on their Identification Card for coverage details.
- Members should always carry the current Identification Card.
- In an emergency, a Member should go directly to the nearest Hospital.
- The BlueCard Worldwide Service Center is available 24 hours a day, seven days a week toll-free at (800) 810-BLUE (2583) or by calling collect at (804) 673-1177. An assistance coordinator, along with a medical professional, will arrange a Physician appointment or hospitalization, if needed.

Call the Service Center in these non-emergent situations:

- A Member needs to find a Physician or Hospital or needs medical assistance services. An assistance coordinator, along with a medical professional, will arrange a Physician appointment or hospitalization, if needed.
- A Member needs to be hospitalized or needs Inpatient care. After calling the Service Center, the Member must also call the Claims Administrator to obtain approval for benefits at the phone
number on their Identification Card. Note: this number is different than the phone numbers listed above for BlueCard Worldwide.

Payment Information

- Participating BlueCard Worldwide Hospitals. In most cases, when a Member makes arrangements for hospitalization through BlueCard Worldwide, he/she should not need to pay up front for Inpatient care at participating BlueCard Worldwide hospitals except for the Out-of-Pocket costs
  (non-Covered Charges, Deductible, Copayments and Coinsurance) you normally pay. The Hospital
  should submit the claim on the Member's behalf.
- Doctors and/or non-participating Hospitals. Members will need to pay up front for outpatient services, care received from a Doctor, and Inpatient care not arranged through the BlueCard Worldwide Service Center. Then the Member can complete a BlueCard Worldwide claim form and send it with the original bill(s) to the BlueCard Worldwide Service Center (the address is on the form).

Claim Filing

- The Hospital will file a Member's claim if the BlueCard Worldwide Service Center arranged the Member's hospitalization. The Member will need to pay the Hospital for the Out-of-Pocket costs he/she would normally pay.
- The Member must file the claim for outpatient and Physician care, or Inpatient care not arranged through the BlueCard Worldwide Service Center. The Member will need to pay the Provider and subsequently send an international claim form with the original bills to the Claims Administrator.

Claim Forms

International claim forms are available from the Claims Administrator, the BlueCard Worldwide Service Center, or online at www.bcbs.com/bluecardworldwide. The address for submitting claims is on the form.

ASBURY UNIVERSITY

ASBURY UNIVERSITY MEDICAL BENEFIT SCHEDULE – CORE PLAN

	NETWORK	NON-NETWORK
Lifetime Maximum Benefit	Unlimited	Unlimited
Annual Deductible (Single/Family) The Family Amount Can Be Any Combination Of Family Members But An Individual Would Never Satisfy More Than Their Own Individual Amount. Deductibles Apply to Out-of-Pocket Maximum	$1,000/$2,000	$2,000/$4,000
Maximum Out-Of-Pocket (Single/Family) The Family Amount Can Be Any Combination Of Family Members But An Individual Would Never Satisfy More Than Their Own Individual Amount. Maximum Excludes: • Cost Containment Penalties • Exclusions and Limitations • Pharmacy Charges • Non-Network Transplant Services • Copayments	$4,000/$8,000	$8,000/$16,000
COVERED BENEFITS		
PHYSICIAN SERVICES	**YOUR COST SHARE RESPONSIBILITY**	
Physician Office Services • Office Visit Copayment (PCP/SCP) • Allergy Injection[1] • Allergy Serum • Allergy Testing • Imaging Services (MRI, MRA, PETS, C- SCAN) • Diagnostic Test (Lab and X-Ray)	 $30/$30 Copayment $5 Copayment 20% Deductible waived 20% After Deductible 20% After Deductible No Cost Share	 40% After Deductible 40% After Deductible 40% After Deductible 40% After Deductible 40% After Deductible 40% After Deductible
Preventive Care Services Office Visit Copayment Services include, but are not limited to: • Routine Exams (PCP/SCP) • Pelvic Exams • Colonoscopy • Bone Density Scans • Mammogram[2] • PAP/PSA Testing • Immunizations • Annual Diabetic Eye Exam • Diabetic Education • PCP Vision/Hearing Screening • Breast Pumps – NOT COVERED Other Outpatient Services at a Hospital or Alternative	$30/$30 Copayment	40% After Deductible
Live Health Online	$20 Copayment	

COVERED BENEFITS		
FACILITY SERVICES	**YOUR COST SHARE RESPONSIBILITY**	
Behavioral Health & Substance Abuse Covered As Outlined In The Medical Benefits Section • Inpatient Facility Services • Inpatient Professional Services • Other Outpatient Services	 20% After Deductible 20% After Deductible 20% After Deductible	 40% After Deductible 40% After Deductible 40% After Deductible
Emergency Room Covered As Outlined In The Medical Benefits Section **Copayment Waived If Admitted To Hospital** • Emergency Room Services • Emergency Room Physician • Non-Emergent Emergency Room Services	 $75 Copayment No Cost Share Not A Covered Benefit	 $75 Copayment No Cost Share Not A Covered Benefit
Hospice Care Covered As Outlined In The Medical Benefits Section	No Cost Share	No Cost Share
Hospital Inpatient Services **Precertification Required** Covered As Outlined In The Medical Benefits Section • Room & Board (Semiprivate or ICU/CCU) • Hospital Services & Supplies **Inpatient Hospital Professional Services** • Surgeon • Anesthesiologist • Radiologist • Pathologist	 20% After Deductible 20% After Deductible 20% After Deductible 20% After Deductible 20% After Deductible 20% After Deductible	 40% After Deductible 40% After Deductible 40% After Deductible 40% After Deductible 40% After Deductible 40% After Deductible
NOTE: The In-Network Benefit Applies To Non-Network Providers In The Following Situations: • Professional Services (Radiologist, Pathologist or Anesthesiologist) When Services Are Rendered At An In-Network Facility • Services Are Not Available At An In-Network Facility/Provider • Covered Individuals Traveling Outside The United States • Medical Emergency Treatment • Diagnostic Procedures Performed In An In-Network Physician's Office & Sent To An Outside Diagnostic Facility For Evaluation		
Inpatient Facility Services (Other Than Hospital) Covered As Outlined In The Medical Benefits Section • Skilled Nursing Facility 90 Day Annual Limit Combined In-Network/Non-Network	20% After Deductible	40% After Deductible
Outpatient Surgery/Alternative Care Facility Covered As Outlined In The Medical Benefits Section Services Include, But Not Limited To: • Surgery • Administration of General Anesthesia	20% After Deductible	40% After Deductible
NOTE: The In-Network Benefit Applies To Non-Network Providers In The Following Situations: • Professional Services (Radiologist, Pathologist or Anesthesiologist) When Services Are Rendered At An In-Network Facility • Services Are Not Available At An In-Network Facility/Provider • Covered Individuals Traveling Outside The United States • Medical Emergency Treatment • Diagnostic Procedures Performed In An In-Network Physician's Office & Sent To An Outside Diagnostic Facility For Evaluation		
Urgent Treatment Center • Urgent Treatment Center Services	$35 Copayment	$35 Copayment

COVERED BENEFITS		
SPECIALIZED SERVICES	**YOUR COST SHARE RESPONSIBILITY**	
Accidental Dental Injury Covered As Outlined In The Medical Benefits Section • Physician Office Visit Copayment (PCP/SPC) • Other Place of Service	$30/$30 Copayment 20% After Deductible	40% After Deductible 40% After Deductible
Ambulance Services (Land / Air) Covered As Outlined In The Medical Benefits Section	20% After Deductible	20% After Deductible
Attention Deficit Disorder (ADD) **Attention Deficit Hyperactivity Disorder (ADHD)** Covered As Outlined In The Medical Benefits Section • Physician Office Visit Copayment (PCP/SPC) • Other Place of Service	$30/$30 Copayment 20% After Deductible	40% After Deductible 40% After Deductible
Autism (ages 1-21) Covered As Outlined In The Medical Benefits Section • Physician Office Visit Copayment (PCP/SPC) • Other Place Of Service	$30/$30 Copayment 20% After Deductible	40% After Deductible 40% After Deductible
Bariatric Surgery/Morbid Obesity Covered As Outlined In The Medical Benefits Section • Physician Office Visit Copayment (PCP/SPC) • Other Place Of Service	Not A Covered Benefit Not A Covered Benefit	Not A Covered Benefit Not A Covered Benefit
Behavioral Health & Substance Abuse Covered As Outlined In The Medical Benefits Section • Physician Office Visit Copayment (PCP/SPC) • Other Place Of Service	$30 Copayment 20% After Deductible	40% After Deductible 40% After Deductible
Cardiac Rehabilitation Therapy Covered As Outlined In The Medical Benefits Section Limited to 36 visits, combined in and non-network, per calendar year • Physician Office Visit Copayment (PCP/SPC) • Other Place Of Service	$30 Copayment 20% After Deductible	40% After Deductible 40% After Deductible
Chemotherapy/Infusion Therapy Covered As Outlined In The Medical Benefits Section	20% After Deductible	40% After Deductible
Chiropractic/Spinal Manipulation Covered As Outlined In The Medical Benefits Section • 12 Visit Calendar Year Maximum Benefit Combined In-Network & Non-Network	$30 Copayment	40% After Deductible

COVERED BENEFITS		
SPECIALIZED SERVICES	**YOUR COST SHARE RESPONSIBILITY**	
Clinical Trials Covered As Outlined In The Medical Benefits Section • Physician Office Visit Copayment (PCP/SPC) • Other Place Of Service	$30 Copayment 20% After Deductible	40% After Deductible 40% After Deductible
Hearing Services/Cochlear Implants Covered As Outlined In The Medical Benefits Section *Hearing Aids Are Limited To One Hearing Aid Per Hearing Impaired Ear Every 36 Months To Age 18.*	20% After Deductible	40% After Deductible
Home Health Care Covered As Outlined In The Medical Benefits Section • Limited to 90 visits per Calendar Year Maximum Combined In-Network & Non-Network	20% After Deductible	40% After Deductible
Infertility Services/Treatment • Physician Office Visit Copayment (PCP/SPC) • Other Place Of Service	Not A Covered Benefit Not A Covered Benefit	Not A Covered Benefit Not A Covered Benefit
Inpatient & Outpatient Professional Services Covered As Outlined In The Medical Benefits Section Services Include, But Not Limited To: • Medical Care Visit (One Per Day) • Intensive Medical Care • Concurrent Care • Surgery • Anesthesia Administration	20% After Deductible	40% After Deductible
NOTE: The In-Network Benefit Applies To Non-Network Providers In The Following Situations: • Professional Services (Radiologist, Pathologist or Anesthesiologist) When Services Are Rendered At An In-Network Facility • Services Are Not Available At An In-Network Facility/Provider • Covered Individuals Traveling Outside The United States • Medical Emergency Treatment • Diagnostic Procedures Performed In An In-Network Physician's Office & Sent To An Outside Diagnostic Facility For Evaluation		
Maternity/Pregnancy Covered As Outlined In The Medical Benefits Section **Dependent Daughters Are Covered** • Physician Office Visit Copayment (PCP/SPC) • Hospital/Birthing Center	$30 Copayment 20% After Deductible	40% After Deductible 40% After Deductible
Medical Supplies and Equipment Covered As Outlined In The Medical Benefits Section	20% After Deductible	40% After Deductible
Nutritional Counseling Covered As Outlined In The Medical Benefits Section • Physician Office Visit Copayment (PCP/SPC) • Other Place Of Service	$30 Copayment 20% After Deductible	40% After Deductible 40% After Deductible

COVERED BENEFITS		
SPECIALIZED SERVICES	**YOUR COST SHARE RESPONSIBILITY**	
Occupational Therapy • Physician Office Visit Copayment (PCP/SPC) • Other Place Of Service	$30 Copayment 20% Deductible Waived	40% After Deductible 40% After Deductible
NOTE: Occupational Therapy has a Maximum Of 20 Visits Per Calendar Year Combined Both In-Network & Non-Network Providers.		
Oral Surgery Covered As Outlined In The Medical Benefits Section • Physician Office Visit Copayment (PCP/SPC) • Other Place Of Service	$30 Copayment 20% After Deductible	40% After Deductible 40% After Deductible
Organ Transplant Services[3]	Covered As Outlined In The Transplant Benefit Section	
Orthotic/Pulmonary Devices Covered As Outlined In The Medical Benefits Section	20% After Deductible	40% After Deductible
Physical Therapy • Physician Office Visit Copayment (PCP/SPC) • Other Place Of Service	$30 Copayment 20% Deductible Waived	40% After Deductible 40% After Deductible
NOTE: Physical Therapy has a Maximum Of 20 Visits Per Calendar Year Combined Both In-Network & Non-Network Providers.		
Private Duty Nursing Covered Only with Home Health Care Benefit – Limited to 90 visits per year, combined network and non-network	20% After Deductible	40% After Deductible
Pulmonary Therapy Covered As Outlined In The Medical Benefits Section – Limited to 20 visits per year, combined network and non-network	20% After Deductible	40% After Deductible
Sleep Disorder Therapy Covered As Outlined In The Medical Benefits Section	20% After Deductible	40% After Deductible
Speech Therapy • Physician Office Visit Copayment (PCP/SPC) • Other Place Of Service	$30 Copayment 20% Deductible Waived	40% After Deductible 40% After Deductible
NOTE: Speech Therapy has a Maximum Of 20 Visits Per Calendar Year Combined Both In-Network & Non-Network Providers.		
Sterilization (Reversal Excluded) Covered As Outlined In The Medical Benefits Section • Physician Office Visit Copayment (PCP/SPC) • Other Place Of Service	$30 Copayment 20% After Deductible	40% After Deductible 40% After Deductible
Temporomandibular Joint Dysfunction (TMJ) Covered As Outlined In The Medical Benefits Section	20% After Deductible	40% After Deductible

COVERED BENEFITS		
PRESCRIPTION DRUGS	**YOUR COST SHARE RESPONSIBILITY**	
Retail Pharmacy (30 Day Supply) Generic Formulary Brand Name Non-Formulary Brand Name **NOTE: *$200 Deductible applies – Tiers II and III only, network and non-network**	$10 Copayment $30 Copayment $60 Copayment	50% coinsurance, minimum $60 copayment[4]
Mail Service (90 Day Supply) Generic Formulary Brand Name Non-Formulary Brand Name	$20 Copayment $75 Copayment $150 Copayment	Not covered
NOTE: Member may be responsible for additional cost when not selecting the available generic drug. Specialty medications must be obtained via Specialty Pharmacy network in order to receive network level benefits. Specialty drugs are to a 30-day supply, regardless of whether they are retail or mail order		

COVERED BENEFITS		
HUMAN ORGAN TRANSPLANTS		
Transplant Services – Human Organ & Tissue Transplant Covered As Outlined In The Transplant Benefits Section Any Medically Necessary Human Organ & Stem Cell/Bone Marrow Transplant And Transfusion As Determined By The Utilization Review Administrator, Including Necessary Acquisition Procedures, Harvest And Storage, Including Medically Necessary Preparatory Myeloablative Therapy. A Blue Distinction Center Requirement Does Not Apply To Cornea Or Kidney Transplants, Or For Any Covered Charges Related To A Covered Transplant Procedure Prior To Or After The Transplant Benefit Period. Cornea and Kidney transplants are covered the same as any other illness and subject to the medical benefits.		
NOTE: Even If A Hospital Is A Network Provider For Other Services, It May Not Be A Network Transplant Provider For These Services. Prior To Seeking Care Please Contact Healthlink At (877) 284-0102 To Determine Which Hospitals Are Network Transplant Providers.		
TRANSPLANT BENEFIT	**IN-NETWORK**	**NON-NETWORK**
	YOUR COST SHARE RESPONSIBILITY	
Transplant Benefit-Non-Blue Distinction Center Facility	Plan Covers 100% of Charges	50% After Deductible
Transplant Benefit – Blue Distinction Center Facility	Plan Covers 100% of Charges	Not A Covered Benefit
Transportation & Lodging	There Is A $200 Maximum Per Day And A $10,000 Maximum Benefit Per Transplant For Travel & Lodging Expenses	
NOTE: The Plan Will Provide Assistance With Reasonable And Necessary Travel Expenses As Determined By The Plan When You Obtain Prior Approval And Are Required To Travel More Than 75 Miles From Your Residence To Reach The Facility Where The Covered Transplant Procedure Will Be Performed. Assistance With Travel Expenses Includes Transportation To And From The Facility And Lodging For The Transplant Recipient And One Adult Companion For An Adult Transplant Recipient Or Two Adult Companions For A Child Transplant Recipient Under Age 18. The Member Must Submit Itemized Receipts For Transportation And Lodging Expenses In A Form Acceptable To The Plan. Internal Revenue Service (IRS) Guidelines Will Be Applied In Determining Which Expenses May Be Paid By The Plan.		
Donor Searches Maximum Benefit $30,000 unrelated donor search Per Transplant. Donor Benefits Are Limited To Benefits Not Available To The Donor From Any Other Source.	Plan Covers 100% of Charges	Not A Covered Benefit
NOTE: Medically Necessary Charges For Procurement Of An Organ From A Live Donor Are Covered To The Maximum Allowable Amount Including Complications From The Donor Procedure For Up To Six Weeks From The Date Of Procurement.		
All Other Transplant Services Covered As Outlined In The Transplant Benefits Section	Plan Covers 100% of Charges	Not A Covered Benefit

ASBURY UNIVERSITY

ASBURY UNIVERSITY MEDICAL BENEFIT SCHEDULE – BUY UP PLAN

	NETWORK	NON-NETWORK
Lifetime Maximum Benefit	Unlimited	Unlimited
Annual Deductible (Single/Family) The Family Amount Can Be Any Combination Of Family Members But An Individual Would Never Satisfy More Than Their Own Individual Amount. Deductibles Apply to Out-of-Pocket Maximum	$300/$600	$600/$1,200
Maximum Out-Of-Pocket (Single/Family) The Family Amount Can Be Any Combination Of Family Members But An Individual Would Never Satisfy More Than Their Own Individual Amount. Maximum Excludes: • Cost Containment Penalties • Exclusions and Limitations • Pharmacy Charges • Non-Network Transplant Services • Copayments	$2,500/$5,000	$5,000/$10,000
COVERED BENEFITS		
PHYSICIAN SERVICES	**YOUR COST SHARE RESPONSIBILITY**	
Physician Office Services		
• Office Visit Copayment (PCP/SCP)	$30/$30 Copayment	40% After Deductible
• Allergy Injection[1]	$5 Copayment	40% After Deductible
• Allergy Serum	20% Deductible waived	40% After Deductible
• Allergy Testing	20% After Deductible	40% After Deductible
• Imaging Services (MRI, MRA, PETS, C- SCAN)	20% After Deductible	40% After Deductible
• Diagnostic Test (Lab and X-Ray)	No Cost Share	40% After Deductible
Preventive Care Services Office Visit Copayment Services include, but are not limited to: • Routine Exams (PCP/SCP) • Colonoscopy • Bone Density Scans • Mammogram[2] • PAP/PSA Testing • Immunizations • Annual Diabetic Eye Exam • Diabetic Education • PCP Vision/Hearing Screening • Breast Pumps – NOT COVERED Other Outpatient Services at a Hospital or Alternative Care Facility	$30/$30 Copayment	40% After Deductible
Live Health Online	$20 Copayment	

COVERED BENEFITS		
FACILITY SERVICES	**YOUR COST SHARE RESPONSIBILITY**	
Behavioral Health & Substance Abuse Covered As Outlined In The Medical Benefits Section • Inpatient Facility Services • Inpatient Professional Services • Other Outpatient Services	 20% After Deductible 20% After Deductible 20% After Deductible	 40% After Deductible 40% After Deductible 40% After Deductible
Emergency Room Covered As Outlined In The Medical Benefits Section **Copayment Waived If Admitted To Hospital** • Emergency Room Services • Emergency Room Physician • Non-Emergent Emergency Room Services	 $75 Copayment No Cost Share Not A Covered Benefit	 $75 Copayment No Cost Share Not A Covered Benefit
Hospice Care Covered As Outlined In The Medical Benefits Section	No Cost Share	No Cost Share
Hospital Inpatient Services **Precertification Required** Covered As Outlined In The Medical Benefits Section • Room & Board (Semiprivate or ICU/CCU) • Hospital Services & Supplies **Inpatient Hospital Professional Services** • Surgeon • Anesthesiologist • Radiologist • Pathologist	 20% After Deductible 20% After Deductible 20% After Deductible 20% After Deductible 20% After Deductible 20% After Deductible	 40% After Deductible 40% After Deductible 40% After Deductible 40% After Deductible 40% After Deductible 40% After Deductible
NOTE: The In-Network Benefit Applies To Non-Network Providers In The Following Situations: • Professional Services (Radiologist, Pathologist or Anesthesiologist) When Services Are Rendered At An In-Network Facility • Services Are Not Available At An In-Network Facility/Provider • Covered Individuals Traveling Outside The United States • Medical Emergency Treatment • Diagnostic Procedures Performed In An In-Network Physician's Office & Sent To An Outside Diagnostic Facility For Evaluation		
Inpatient Facility Services (Other Than Hospital) Covered As Outlined In The Medical Benefits Section • Skilled Nursing Facility 90 Day Annual Limit Combined In-Network/Non-Network	20% After Deductible	40% After Deductible
Outpatient Surgery/Alternative Care Facility Covered As Outlined In The Medical Benefits Section Services Include, But Not Limited To: • Surgery • Administration of General Anesthesia	20% After Deductible	40% After Deductible
NOTE: The In-Network Benefit Applies To Non-Network Providers In The Following Situations: • Professional Services (Radiologist, Pathologist or Anesthesiologist) When Services Are Rendered At An In-Network Facility • Services Are Not Available At An In-Network Facility/Provider • Covered Individuals Traveling Outside The United States • Medical Emergency Treatment • Diagnostic Procedures Performed In An In-Network Physician's Office & Sent To An Outside Diagnostic Facility For Evaluation		
Urgent Treatment Center • Urgent Treatment Center Services	$35 Copayment	$35 Copayment

COVERED BENEFITS		
SPECIALIZED SERVICES	**YOUR COST SHARE RESPONSIBILITY**	
Accidental Dental Injury Covered As Outlined In The Medical Benefits Section • Physician Office Visit Copayment (PCP/SPC) • Other Place Of Service	 $30/$30 Copayment 20% After Deductible	 40% After Deductible 40% After Deductible
Ambulance Services (Land / Air) Covered As Outlined In The Medical Benefits Section	20% After Deductible	20% After Deductible
Attention Deficit Disorder (ADD) **Attention Deficit Hyperactivity Disorder (ADHD)** Covered As Outlined In The Medical Benefits Section • Physician Office Visit Copayment (PCP/SPC) • Other Place Of Service	 $30/$30 Copayment 20% After Deductible	 40% After Deductible 40% After Deductible
Autism (ages 1-21) Covered As Outlined In The Medical Benefits Section • Physician Office Visit Copayment (PCP/SPC) • Other Place Of Service	 $30/$30 Copayment 20% After Deductible	 40% After Deductible 40% After Deductible
Bariatric Surgery/Morbid Obesity Covered As Outlined In The Medical Benefits Section • Physician Office Visit Copayment (PCP/SPC) • Other Place Of Service	 Not A Covered Benefit Not A Covered Benefit	 Not A Covered Benefit Not A Covered Benefit
Behavioral Health & Substance Abuse Covered As Outlined In The Medical Benefits Section • Physician Office Visit Copayment (PCP/SPC) • Other Place Of Service	 $30 Copayment 20% After Deductible	 40% After Deductible 40% After Deductible
Cardiac Rehabilitation Therapy Covered As Outlined In The Medical Benefits Section Limited to 36 visits, combined in and non-network, per calendar year • Physician Office Visit Copayment (PCP/SPC) • Other Place Of Service	 $30 Copayment 20% After Deductible	 40% After Deductible 40% After Deductible
Chemotherapy/Infusion Therapy Covered As Outlined In The Medical Benefits Section	20% After Deductible	40% After Deductible
Chiropractic/Spinal Manipulation Covered As Outlined In The Medical Benefits Section • 12 Visit Calendar Year Maximum Benefit Combined In-Network & Non-Network	$30 Copayment	40% After Deductible

COVERED BENEFITS		
SPECIALIZED SERVICES	**YOUR COST SHARE RESPONSIBILITY**	
Clinical Trials Covered As Outlined In The Medical Benefits Section • Physician Office Visit Copayment (PCP/SPC) • Other Place Of Service	$30 Copayment 20% After Deductible	40% After Deductible 40% After Deductible
Hearing Services/Cochlear Implants Covered As Outlined In The Medical Benefits Section *Hearing Aids Are Limited To One Hearing Aid Per Hearing Impaired Ear Every 36 Months To Age 18.*	20% After Deductible	40% After Deductible
Home Health Care Covered As Outlined In The Medical Benefits Section • Limited to 90 visits per Calendar Year Maximum Combined In-Network & Non-Network	20% After Deductible	40% After Deductible
Infertility Services/Treatment • Physician Office Visit Copayment (PCP/SPC) • Other Place Of Service	Not A Covered Benefit Not A Covered Benefit	Not A Covered Benefit Not A Covered Benefit
Inpatient & Outpatient Professional Services Covered As Outlined In The Medical Benefits Section Services Include, But Not Limited To: • Medical Care Visit (One Per Day) • Intensive Medical Care • Concurrent Care • Surgery • Anesthesia Administration	20% After Deductible	40% After Deductible
NOTE: The In-Network Benefit Applies To Non-Network Providers In The Following Situations: • Professional Services (Radiologist, Pathologist or Anesthesiologist) When Services Are Rendered At An In-Network Facility • Services Are Not Available At An In-Network Facility/Provider • Covered Individuals Traveling Outside The United States • Medical Emergency Treatment • Diagnostic Procedures Performed In An In-Network Physician's Office & Sent To An Outside Diagnostic Facility For Evaluation		
Maternity/Pregnancy Covered As Outlined In The Medical Benefits Section **Dependent Daughters Are Covered** • Physician Office Visit Copayment (PCP/SPC) • Hospital/Birthing Center	$30 Copayment 20% After Deductible	40% After Deductible 40% After Deductible
Medical Supplies and Equipment Covered As Outlined In The Medical Benefits Section	20% After Deductible	40% After Deductible
Nutritional Counseling Covered As Outlined In The Medical Benefits Section • Physician Office Visit Copayment (PCP/SPC) • Other Place Of Service	$30 Copayment 20% After Deductible	40% After Deductible 40% After Deductible

COVERED BENEFITS		
SPECIALIZED SERVICES	**YOUR COST SHARE RESPONSIBILITY**	
Occupational Therapy • Physician Office Visit Copayment (PCP/SPC) • Other Place Of Service	$30 Copayment 20% Deductible Waived	40% After Deductible 40% After Deductible
NOTE: Occupational Therapy has a Maximum Of 20 Visits Per Calendar Year Combined Both In-Network & Non-Network Providers.		
Oral Surgery Covered As Outlined In The Medical Benefits Section • Physician Office Visit Copayment (PCP/SPC) • Other Place Of Service	$30 Copayment 20% After Deductible	40% After Deductible 40% After Deductible
Organ Transplant Services[3]	Covered As Outlined In The Transplant Benefit Section	
Orthotic/Pulmonary Devices Covered As Outlined In The Medical Benefits Section	20% After Deductible	40% After Deductible
Physical Therapy • Physician Office Visit Copayment (PCP/SPC) • Other Place Of Service	$30 Copayment 20% Deductible Waived	40% After Deductible 40% After Deductible
NOTE: Physical Therapy has a Maximum Of 20 Visits Per Calendar Year Combined Both In-Network & Non-Network Providers.		
Private Duty Nursing Covered Only with Home Health Care Benefit – Limited to 90 visits per year, combined network and non-network	20% After Deductible	40% After Deductible
Pulmonary Therapy Covered As Outlined In The Medical Benefits Section – Limited to 20 visits per year, combined network and non-network	20% After Deductible	40% After Deductible
Sleep Disorder Therapy Covered As Outlined In The Medical Benefits Section	20% After Deductible	40% After Deductible
Speech Therapy • Physician Office Visit Copayment (PCP/SPC) • Other Place Of Service	$30 Copayment 20% Deductible Waived	40% After Deductible 40% After Deductible
NOTE: Speech Therapy has a Maximum Of 20 Visits Per Calendar Year Combined Both In-Network & Non-Network Providers.		
Sterilization (Reversal Excluded) Covered As Outlined In The Medical Benefits Section • Physician Office Visit Copayment (PCP/SPC) • Other Place Of Service	$30 Copayment 20% After Deductible	40% After Deductible 40% After Deductible
Temporomandibular Joint Dysfunction (TMJ) Covered As Outlined In The Medical Benefits Section	20% After Deductible	40% After Deductible

COVERED BENEFITS		
PRESCRIPTION DRUGS	**YOUR COST SHARE RESPONSIBILITY**	
Retail Pharmacy (30 Day Supply) Generic Formulary Brand Name Non-Formulary Brand Name	 $10 Copayment $30 Copayment $60 Copayment	 50% coinsurance, minimum $60 copayment[4]
Mail Service (90 Day Supply) Generic Formulary Brand Name Non-Formulary Brand Name	 $20 Copayment $75 Copayment $150 Copayment	 Not covered
NOTE: Member may be responsible for additional cost when not selecting the available generic drug. Specialty medications must be obtained via Specialty Pharmacy network in order to receive network level benefits. Specialty drugs are to a 30-day supply, regardless of whether they are retail or mail order		

COVERED BENEFITS		
HUMAN ORGAN TRANSPLANTS		
Transplant Services – Human Organ & Tissue Transplant Covered As Outlined In The Transplant Benefits Section Any Medically Necessary Human Organ & Stem Cell/Bone Marrow Transplant And Transfusion As Determined By The Utilization Review Administrator, Including Necessary Acquisition Procedures, Harvest And Storage, Including Medically Necessary Preparatory Myeloablative Therapy. A Blue Distinction Center Requirement Does Not Apply To Cornea Or Kidney Transplants, Or For Any Covered Charges Related To A Covered Transplant Procedure Prior To Or After The Transplant Benefit Period. Cornea and Kidney transplants are covered the same as any other illness and subject to the medical benefits.		
NOTE: Even If A Hospital Is A Network Provider For Other Services, It May Not Be A Network Transplant Provider For These Services. Prior To Seeking Care Please Contact Healthlink At (877) 284-0102 To Determine Which Hospitals Are Network Transplant Providers.		
TRANSPLANT BENEFIT	**IN-NETWORK**	**NON-NETWORK**
	YOUR COST SHARE RESPONSIBILITY	
Transplant Benefit – Non-Blue Distinction Center Facility	Plan Covers 100% of Charges	50% After Deductible
Transplant Benefit – Blue Distinction Center Facility	Plan Covers 100% of Charges	Not A Covered Benefit
Transportation & Lodging	There Is A $200 Maximum Per Day And A $10,000 Maximum Benefit Per Transplant For Travel & Lodging Expenses	
NOTE: The Plan Will Provide Assistance With Reasonable And Necessary Travel Expenses As Determined By The Plan When You Obtain Prior Approval And Are Required To Travel More Than 75 Miles From Your Residence To Reach The Facility Where The Covered Transplant Procedure Will Be Performed. Assistance With Travel Expenses Includes Transportation To And From The Facility And Lodging For The Transplant Recipient And One Adult Companion For An Adult Transplant Recipient Or Two Adult Companions For A Child Transplant Recipient Under Age 18. The Member Must Submit Itemized Receipts For Transportation And Lodging Expenses In A Form Acceptable To The Plan. Internal Revenue Service (IRS) Guidelines Will Be Applied In Determining Which Expenses May Be Paid By The Plan.		
Donor Searches Maximum Benefit $30,000 unrelated donor search Per Transplant. Donor Benefits Are Limited To Benefits Not Available To The Donor From Any Other Source.	Plan Covers 100% of Charges	Not A Covered Benefit
NOTE: Medically Necessary Charges For Procurement Of An Organ From A Live Donor Are Covered To The Maximum Allowable Amount Including Complications From The Donor Procedure For Up To Six Weeks From The Date Of Procurement.		
All Other Transplant Services Covered As Outlined In The Transplant Benefits Section	Plan Covers 100% of Charges	Not A Covered Benefit

Benefit Schedule Notes:

Flat dollar copayments are excluded from the out-of-pocket limits. Also Prescription Drug deductibles / copayments / coinsurance and Non-network Human Organ and Tissue Transplants are excluded from the out- of-pocket limits.

Deductible(s) apply only to covered medical services listed with a percentage (%) coinsurance, including 0%. However, the deductible does not apply to Emergency Room Services where a copayment and percentage (%) coinsurance applies and may not apply to some Behavioral Health services where coinsurance applies.

Network and Non-network deductibles, copayments, coinsurance and out-of-pocket maximums are separate and do not accumulate toward each other.

Dependent Age: to end of the month which the child attains age 26.

Specialist copayment is applicable to all Specialists excluding General Physicians, Internist, Pediatricians, OB/GYNs and Geriatrics or any other Network Provider as allowed by the plan.

When allergy injections are rendered with a Physicians Home and Office Visit, only the Office Visit cost share applies. When the Office Visit cost share is a % coinsurance, deductible and coinsurance apply to allergy injections.

Certain diabetic and asthmatic supplies have no deductible/copayment/coinsurance up to the maximum allowable amount at network pharmacies except diabetic test strips.

Benefit period = calendar year

Mammograms (routine and diagnostic), Diabetic Education and Medical Nutrition Therapy are subject to the PCP/OV cost share in Network office and outpatient facility settings.

Behavioral Health Services: Mental Health and Substance Abuse benefits provided in accordance with Federal Mental Health Parity.

Physical and Occupational Therapy in the office setting are subject to the Primary Physician cost share.

[1]We encourage you to refer to the Schedule of Benefits for limitations.

[2]Diagnostic Mammograms and Preventive Mammograms are covered subject to the PCP/OV cost share.

[3] Kidney and Cornea transplants are treated the same as any other illness and subject to the medical benefits.

[4]Rx non-network diabetic/asthmatic supplies not covered except diabetic test strips.

Predetermination:
Members are encouraged to always obtain predetermination of benefits when using non-network providers. Predetermination will help the member know if the services are considered not medically necessary.

Grandfathered Health Plan:

We believe this coverage is a “grandfathered health plan” under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator or your Employer.

You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans. You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.

This summary of benefits is intended to be a brief outline of coverage. The entire provisions of benefits and exclusions are contained in the Group Contract, Certificate and Schedule of Benefits. In the event of a conflict between the Group Contract and this description, the terms of the Group Contract will prevail.

ELIGIBILITY, FUNDING, EFFECTIVE DATE AND TERMINATION PROVISIONS

A Plan Participant should contact the Plan Administrator to obtain additional information, free of charge, about Plan coverage of a specific benefit, particular drug, treatment, test or any other aspect of Plan benefits or requirements.

ELIGIBILITY

Eligible Classes of Employees. All Active Employees of the Employer. The following Classes of Employees:

(1) Works 1,560 hours annually or Faculty members who are issued a full-time contract

Eligibility Requirements for Employee Coverage. A person is eligible for Employee coverage from the first day that he or she:

(1) Is a Full-Time, Active Employee of the Employer. An Employee is considered to be Full-Time if he or she normally works at least 1,560 hours per year and is on the regular payroll of the Employer for that work. For Plan Years beginning on or after January 1, 2015, an Employee is considered to be Full-Time if he or she normally works at least 30 hours per week and is on the regular payroll of the Employer for that work.

For Plan Years beginning on or after January 1, 2015, an Employee's status as a Full-Time Employee will be determined on the basis of the average number of hours worked during an initial or standard look back measurement period, as applicable, as established by the Plan in accordance with applicable law. The Employee's eligibility (or lack of eligibility) for Plan coverage on the basis of his or her Full-Time or Part-Time status will extend through the stability period established by the Plan in accordance with applicable law. In calculating the average hours worked, the Plan will count hours paid and hours for which the Employee is entitled to payment (such as paid holidays, vacation, pay, etc.). For Plan Years beginning before January 1, 2015, an Employee's status as a Full-Time or Part-Time Employee will be determined on the basis of the Employer's standard employment practices.

(2) Is in a class eligible for coverage.

Eligible Classes of Dependents. A Dependent is any one of the following persons:

(1) A covered Employee's Spouse.

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 or was married, and shall not include common law marriages. The term "Spouse" shall not include partners of the same sex who were legally married under the laws of the State in which they were married. The Plan Administrator may require documentation proving a legal marital relationship.

(2) A covered Employee's Child(ren).

An Employee's "Child" includes his natural child, stepchild, legally adopted child, or a child placed with the Employee for adoption. An Employee's Child will be an eligible Dependent until reaching the limiting age of 26, without regard to student status, marital status, financial dependency or residency status with the Employee or any other person. When the child reaches the applicable limiting age, coverage will end on the last day of the child's birthday month.

The phrase "placed for adoption" refers to a child whom a person intends to adopt, whether or not the adoption has become final, who has not attained the age of 18 as of the date of such placement for adoption. The term "placed" means the assumption and retention by such person of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child must be available for adoption and the legal process must have commenced.

(3) A covered Employee's Qualified Dependents.

The term "Qualified Dependents" shall include children for whom the Employee is a Legal Guardian.

To be eligible for Dependent coverage under the Plan, a Qualified Dependent must be under the limiting age of 26 years. Coverage will end on the last day of the month in which the Qualified Dependent ceases to meet the applicable eligibility requirements.

Any child of a Plan Participant 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.

A participant of this Plan may obtain, without charge, a copy of the procedures governing qualified medical child support order (QMCSO) determinations from the Plan Administrator.

The Plan Administrator may require documentation proving eligibility for Dependent coverage, including birth certificates, tax records or initiation of legal proceedings severing parental rights.

(4) A covered Dependent Child or Qualified Dependent who reaches the limiting age and is Totally Disabled, incapable of self-sustaining employment by reason of mental or physical handicap, primarily dependent upon the covered Employee for support and maintenance and unmarried. The Plan Administrator may require, at reasonable intervals, continuing proof of the Total Disability and dependency.

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.

Any foster child who is eligible for benefits provided by any governmental program or law will not be eligible for coverage under the Plan unless required by the laws of this state.

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 person who is on active duty in any military service of any country; or any person who is covered under the Plan as an Employee.

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.

If both mother and father are Employees, their children will be covered as Dependents of the mother or father, but not of both.

Eligibility Requirements for Dependent Coverage. A family member of an Employee will become eligible for Dependent coverage on the first day that the Employee is eligible for Employee coverage and the family member satisfies the requirements for Dependent coverage.

At any time, the Plan may require proof that a Spouse, Qualified Dependent or a Child qualifies or continues to qualify as a Dependent as defined by this Plan.

FUNDING

Cost of the Plan. Asbury University shares the cost of Employee and Dependent coverage under this Plan with the covered Employees.

The level of any Employee contributions is set by the Plan Administrator. The Plan Administrator reserves the right to change the level of Employee contributions.

ENROLLMENT

Enrollment Requirements. An Employee must enroll for coverage by filling out the appropriate application and paperwork.

Enrollment Requirements for Newborn Children.

Newborn children of the Employee or the Employee's spouse will be covered for illness or injury for an initial period of 31 days from the date of the birth. Coverage for newborns will continue beyond the 31 days only if the Employee submits through the Employer, or the Plan, a request to add the child under the Employee's Plan. The request must be submitted within 31 days after the birth of the child. Failure to notify the Plan during this 31 day period will result in no coverage for the newborn beyond the first 31 days, except as permitted for a Late Enrollee.

A newborn of a Covered Person other than the Employee or the Employee's spouse is not eligible for coverage.

A child will be considered legally adopted from the earlier of: (1) the moment of placement in your home; or (2) the date of an entry of an order granting custody of the child to you. The child will continue to be considered legally adopted unless the child is removed from your home prior to issuance of a legal decree of adoption.

TIMELY OR LATE ENROLLMENT

(1) **Timely Enrollment** - The enrollment will be "timely" if the completed form is received by the Plan Administrator no later than 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 as long as coverage has been continuous.

(2) **Late Enrollment** - An enrollment is "late" if it is not made on a "timely basis" or during a Special Enrollment Period. Late Enrollees and their Dependents who are not eligible to join the Plan during a Special Enrollment Period may join only during open enrollment.

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.

The time between the date a Late Enrollee first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a Waiting Period. Coverage begins on January 1.

SPECIAL ENROLLMENT RIGHTS

Federal law provides Special Enrollment provisions under some circumstances. If an Employee is declining enrollment for himself or herself or his or her dependents (including his or her spouse) because of other health insurance or group health plan coverage, there may be a right to enroll in this Plan if there is a loss of eligibility for that other coverage (or if the employer stops contributing towards the other coverage). However, a request for enrollment must be made within 31 days after the coverage ends (or after the employer stops contributing towards the other coverage).

In addition, in the case of a birth, marriage, adoption or placement for adoption, there may be a right to enroll in this Plan. However, a request for enrollment must be made within 31 days of the birth, marriage, adoption or placement for adoption.

The Special Enrollment rules are described in more detail below. To request Special Enrollment or obtain more detailed information of these portability provisions, contact the Plan Administrator, Asbury University, 1 Macklem Drive, Wilmore, Kentucky, 40390, (859) 858-3511.

SPECIAL ENROLLMENT PERIODS

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.

(1) **Individuals losing other coverage creating a Special Enrollment right.** An Employee or Dependent who is eligible, but not enrolled in this Plan, may enroll if loss of eligibility for coverage meets all of the following conditions:

(a) The Employee or Dependent was covered under a group health plan or had health insurance coverage at the time coverage under this Plan was previously offered to the individual.

(b) If required by the Plan Administrator, the Employee stated in writing at the time that coverage was offered that the other health coverage was the reason for declining enrollment.

(c) The coverage of the Employee or Dependent who had lost the coverage was under COBRA and the COBRA coverage was exhausted, or was not under COBRA and either the coverage was terminated as a result of loss of eligibility for the coverage or because employer contributions towards the coverage were terminated. Coverage will begin no later than the first day of the first calendar month following the date the completed enrollment form is received.

(d) The Employee or Dependent requests enrollment in this Plan not later than 31 days after the date of exhaustion of COBRA coverage or the termination of non-COBRA coverage due to loss of eligibility or termination of employer contributions, described above. Coverage will begin no later than the first day of the first calendar month following the date the completed enrollment form is received.

(2) For purposes of these rules, a loss of eligibility occurs if one of the following occurs:

(a) The Employee or Dependent has a loss of eligibility due to the plan no longer offering any benefits to a class of similarly situated individuals (i.e.: part-time employees).

(b) The Employee or Dependent has a loss of eligibility as a result of legal separation, divorce, cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan), death, termination of employment, or reduction in the number of hours of employment or contributions towards the coverage were terminated.

(c) The Employee or Dependent has a loss of eligibility when coverage is offered through an HMO, or other arrangement, in the individual market that does not provide benefits to individuals who no longer reside, live or work in a service area, (whether or not within the choice of the individual).

(d) The Employee or Dependent has a loss of eligibility when coverage is offered through an HMO, or other arrangement, in the group market that does not provide benefits to individuals who no longer reside, live or work in a service area, (whether or not within the choice of the individual), and no other benefit package is available to the individual.

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 or an intentional misrepresentation of a material fact in connection with the plan), that individual does not have a Special Enrollment right.

(3) **Dependent beneficiaries.** If:

(a) The Employee is a participant under this Plan (or is eligible to be enrolled under this Plan but for a failure to enroll during a previous enrollment period), and

(b) A person becomes a Dependent of the Employee through marriage, birth, legal adoption or placement for legal adoption.

Then the Dependent (and if not otherwise enrolled, the Employee) may be enrolled under this Plan. In the case of the birth or adoption of a child, the Spouse of the covered Employee may be enrolled as a Dependent of the covered Employee if the Spouse is otherwise eligible for coverage. If the Employee is not enrolled at the time of the event, the Employee must enroll under this Special Enrollment Period in order for his eligible Dependents to enroll.

The Dependent Special Enrollment Period is a period of 31 days and begins on the date of the marriage, birth, legal adoption or placement for adoption. To be eligible for this Special Enrollment, the Dependent and/or Employee must request enrollment during this 31-day period.

The coverage of the Dependent and/or Employee enrolled in the Special Enrollment Period will be effective:

(a) In the case of marriage, the date of marriage;

(b) In the case of a Dependent's birth, as of the date of birth; or

(c) In the case of a Dependent's legal adoption or placement for legal adoption, the date of the legal adoption or placement for legal adoption.

(4) **Medicaid and State Child Health Insurance Programs.** An Employee or Dependent who is eligible, but not enrolled in this Plan, may enroll if:

(a) The Employee or Dependent is covered under a Medicaid plan under Title XIX of the Social Security Act or a State child health plan (CHIP) under Title XXI of such Act, and coverage of the Employee or Dependent is terminated due to loss of eligibility for such coverage, and the Employee or Dependent requests enrollment in this Plan within 60 days after such Medicaid or CHIP coverage is terminated.

(b) The Employee or Dependent becomes eligible for assistance with payment of Employee contributions to this Plan through a Medicaid or CHIP plan (including any waiver or demonstration project conducted with respect to such plan), and the Employee or Dependent requests enrollment in this Plan within 60 days after the date the Employee or Dependent is determined to be eligible for such assistance.

If a Dependent becomes eligible to enroll under this provision and the Employee is not then enrolled, the Employee must enroll in order for the Dependent to enroll.

Coverage will become effective as of the first day of the first calendar month following the date the completed enrollment form is received unless an earlier date is established by the Employer or by regulation.

EFFECTIVE DATE

Effective Date of Employee Coverage. An Employee will be covered under this Plan as of the first day that the Employee satisfies all of the following:

(1) The Eligibility Requirement.

(2) The Active Employee Requirement.

(3) The Enrollment Requirements of the Plan.

Active Employee Requirement.

An Employee must be an Active Employee (as defined by this Plan) for this coverage to take effect.

Effective Date of Dependent Coverage. A Dependent's coverage will take effect on the day that the Eligibility Requirements are met; the Employee is covered under the Plan; and all Enrollment Requirements are met.

Out of Service Area Dependent Child Coverage

Benefits for Covered Services will be provided for enrolled Dependent children who reside outside of the Service Area due to such children attending an out of Service Area educational institution or residing with the Subscriber's former spouse. Benefits are payable at the Network level and are limited to the Maximum Allowable Amount. Payment is subject to any Coinsurance, Copayment and/or Deductible. You may be responsible for any amount in excess of the Maximum Allowable Amount.
If you are eligible to enroll as a Member, you must enroll at the time agreed upon by the Plan.

TERMINATION OF COVERAGE

For Plan Years that begin before January 1, 2014, Plan Participants who lose coverage under the Plan will receive a certificate that will show the period of Creditable Coverage under this Plan. The Plan maintains written procedures that explain how to request this certificate. Please contact the Plan Administrator for a copy of these procedures and further details.

The Employer or Plan has the right to rescind any coverage of the Employee and/or Dependents for cause, making a fraudulent claim or an intentional material misrepresentation in applying for or obtaining coverage, or obtaining benefits under the Plan. The Employer or Plan may either void coverage for the Employee and/or covered Dependents for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage. The Employer will refund all contributions paid for any coverage rescinded; however, claims paid will be offset from this amount. The Employer reserves the right to collect additional monies if claims are paid in excess of the Employee's and/or Dependent's paid contributions.

When Employee Coverage Terminates. Employee coverage will terminate on the earliest of these dates (except in certain circumstances, a covered Employee may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, see the section entitled Continuation Coverage Rights under COBRA):

(1) The date the Plan is terminated.

(2) The date the covered Employee's Eligible Class is eliminated.

(3) The last day of the calendar month in which the covered Employee ceases to be in one of the Eligible Classes. This includes death or termination of Active Employment of the covered Employee. (See the section entitled Continuation Coverage Rights under COBRA.) It also includes an Employee on disability, leave of absence or other leave of absence, unless the Plan specifically provides for continuation during these periods.

(4) The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due.

(5) If an Employee commits fraud, makes an intentional misrepresentation of material fact in applying for or obtaining coverage, or obtaining benefits under the Plan, or fails to notify the Plan Administrator that he or she has become ineligible for coverage, then the Employer or Plan may either void coverage for the Employee and covered Dependents for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage. If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the Plan will provide at least 30 days' advance written notice of such action.

Continuation During Periods of Employer-Certified Disability, Leave of Absence or Layoff. A person may remain eligible for a limited time if Active, full-time work ceases due to disability, leave of absence or layoff. This continuance will end as follows:

For disability leave only: the end of the month in which the employee ceases to be employed at Asbury University.

For leave of absence or layoff only: the end of the month in which the employee ceases to be employed at Asbury University.

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.

Continuation During Family and Medical Leave. Regardless of the established leave policies mentioned above, this Plan shall at all times comply with the Family and Medical Leave Act of 1993 as promulgated in regulations issued by the Department of Labor.

During any leave taken under the Family and Medical Leave Act, the Employer will maintain coverage under this Plan on the same conditions as coverage would have been provided if the covered Employee had been continuously employed during the entire leave period.

If Plan coverage terminates during the FMLA leave, coverage will be reinstated for the Employee and his or her covered Dependents if the Employee returns to work in accordance with the terms of the FMLA leave. Coverage will be reinstated only if the person(s) had coverage under this Plan when the FMLA leave started, and will be reinstated to the same extent that it was in force when that coverage terminated.

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.

Employees on Military Leave. Employees going into or returning from military service may elect to continue Plan coverage as mandated by the Uniformed Services Employment and Reemployment Rights Act (USERRA) under the following circumstances. These rights apply only to Employees and their Dependents covered under the Plan immediately before leaving for military service.

(1) The maximum period of coverage of a person and the person's Dependents under such an election shall be the lesser of:

(a) The 24 month period beginning on the date on which the person's absence begins; or

(b) The day after the date on which the person was required to apply for or return to a position of employment and fails to do so.

(2) A person who elects to continue health plan coverage must pay up to 102% of the full contribution under the Plan, except a person on active duty for 30 days or less cannot be required to pay more than the Employee's share, if any, for the coverage.

(3) 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.

If the Employee wishes to elect this coverage or obtain more detailed information, contact the Plan Administrator Asbury University, 1 Macklem Drive, Wilmore, Kentucky, 40390, (859) 858-3511. The Employee may also have continuation rights under USERRA. In general, the Employee must meet the same requirements for electing USERRA coverage as are required under COBRA continuation coverage requirements. Coverage elected under these circumstances is concurrent not cumulative. The Employee may elect USERRA continuation coverage for the Employee and their Dependents. Only the Employee has election rights. Dependents do not have any independent right to elect USERRA health plan continuation.

When Dependent Coverage Terminates. A Dependent's coverage will terminate on the earliest of these dates (except in certain circumstances, a covered Dependent may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, see the section entitled Continuation Coverage Rights under COBRA):

(1) The date the Plan or Dependent coverage under the Plan is terminated.

(2) The date that the Employee's coverage under the Plan terminates for any reason including death. (See the section entitled Continuation Coverage Rights under COBRA.)

(3) The date a covered Spouse loses coverage due to loss of eligibility status. (See the section entitled Continuation Coverage Rights under COBRA.)

(4) Coverage on the last day of the month in which the Qualified Dependent ceases to meet the applicable eligibility requirements. (See the section entitled Continuation Coverage Rights under COBRA.)

(5) Coverage will end on the last day of the month in which the Child ceases to meet the applicable eligibility requirements. (See the section entitled Continuation Coverage Rights under COBRA.)

(6) The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due.

(7) If a Dependent commits fraud or makes an intentional misrepresentation of material fact in applying for or obtaining coverage, or obtaining benefits under the Plan, or fails to notify the Plan Administrator that he or she has become ineligible for coverage, then the Employer or Plan may either void coverage for the Dependent for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage. If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the Plan will provide at least 30 days' advance written notice of such action.

OPEN ENROLLMENT

Every year an open enrollment period will be held during November. Employees and their Dependents who are Late Enrollees will be able to enroll in the Plan.

Benefit choices for Late Enrollees made during the open enrollment period will become effective on January 1st.

Benefit choices made during the open enrollment period will become effective January 1st and remain in effect until the next January 1st unless there is a Special Enrollment event or a change in family status during the year (birth, death, marriage, divorce, adoption) or loss of coverage due to loss of a Spouse's employment.

Plan Participants will receive detailed information regarding open enrollment from their Employer.

MEDICAL BENEFITS

Medical Benefits apply when Covered Charges are incurred by a Covered Person for care of an Injury or Sickness and while the person is covered for these benefits under the Plan.

DEDUCTIBLE

Deductible Amount. This is an amount of Covered Charges for which no benefits will be paid. Before benefits can be paid in a Calendar Year a Covered Person must meet the deductible shown in the Schedule of Benefits.

Family Unit Limit. When the maximum amount shown in the Schedule of Benefits has been incurred by members of a Family Unit toward their Calendar Year deductibles, the deductibles of all members of that Family Unit will be considered satisfied for that year.

BENEFIT PAYMENT

Each Calendar Year, benefits will be paid for the Covered Charges of a Covered Person that are in excess of the deductible and any copayments. Payment will be made at the rate shown under reimbursement rate in the Schedule of Benefits. No benefits will be paid in excess of the Maximum Benefit Amount or any listed limit of the Plan.

OUT-OF-POCKET LIMIT

Covered Charges are payable at the percentages shown each Calendar Year until the out-of-pocket limit shown in the Schedule of Benefits is reached. Then, Covered Charges incurred by a Covered Person will be payable at 100% (except for any charges excluded as shown in the Schedule of Benefits) for the rest of the Calendar Year.

When a Family Unit reaches the out-of-pocket limit, Covered Charges for that Family Unit will be payable at 100% (except for any charges excluded, as shown on the Schedule of Benefits) for the rest of the Calendar Year.

MAXIMUM BENEFIT AMOUNT

The Maximum Benefit Amount is shown in the Schedule of Benefits. It is the total amount of benefits that will be paid under the Plan for all Covered Charges incurred by a Covered Person for Essential Health Benefits during the Plan Year. The Maximum Benefit applies to all plans and benefit options offered under the Asbury University Employee Medical Benefit Plan, including the ones described in this document. The Maximum Benefit Amount for Essential Health Benefits will not apply in Plan Years beginning on or after January 1, 2014.

COVERED CHARGES AND SERVICES

Covered Charges are the Usual and Reasonable Charges that are incurred for the following items of service and supply. These charges are subject to the benefit limits, exclusions and other provisions of this Plan. A charge is incurred on the date that the service or supply is performed or furnished.

Ambulance Services

See the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Ambulance Services are transportation by a vehicle (including ground, water, fixed wing and rotary wing air transportation) designed, equipped and used only to transport the sick and injured and staffed by Emergency Medical Technicians (EMT), paramedics, or other certified medical professionals:

- From your home, scene of accident or medical Emergency to a Hospital;
- Between Hospitals;
- Between a Hospital and Skilled Nursing Facility; or
- From a Hospital or Skilled Nursing Facility to your home.

Treatment of a sickness or injury by medical professionals from an Ambulance Service when you are not transported will be covered if Medically Necessary.

Other vehicles which do not meet this definition, include: ambulettes, are not Covered Services.

Ambulance services are a Covered Service only when Medically Necessary, except:

- When ordered by an employer, school, fire or public safety official and the Member is not in a position to refuse; or
- When a Member is required by the Plan to move from a Non-Network Provider to a Network Provider.

Ambulance trips must be made to the closest local facility that can give Covered Services appropriate for your condition. If none of these facilities are in your local area, you are covered for trips to the closest facility outside your local area. Ambulance usage is not covered when another type of transportation can be used without endangering the Member's health. Any ambulance usage for the Convenience of the Member, family or Physician is not a Covered Service.

Non Covered Services for Ambulance include but are not limited to, trips to:

- A Physician's office or clinic;
- A morgue or funeral home.

Autism Spectrum Disorders

See the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

The diagnosis and treatment of Autism Spectrum Disorders for Members ages one (1) through twenty-one (21) is covered. Autism Spectrum Disorders means a physical, mental, or cognitive illness or disorder which includes any of the pervasive developmental disorders as defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders ("DSM") published by the American Psychiatric Association, including Autistic Disorder, Asperger's Disorder, and Pervasive Developmental Disorder Not Otherwise Specified.

Treatment for autism spectrum disorders includes the following care for an individual diagnosed with any of the autism spectrum disorders:

- Medical care - services provided by a licensed physician, an advanced registered nurse practitioner, or other licensed health care provider;
- Habilitative or rehabilitative care - professional counseling and guidance services, therapy, and treatment programs, including applied behavior analysis, that are necessary to develop, maintain, and restore, to the maximum extent practicable, the functioning of an individual;
- Pharmacy care, if covered by the Plan - Medically Necessary medications prescribed by a licensed physician or other health-care practitioner with prescribing authority, if covered by the plan, and any medically necessary health-related services to determine the need or effectiveness of the medications;
- Psychiatric care - direct or consultative services provided by a psychiatrist licensed in the state in which the psychiatrist practices;
- Psychological care - direct or consultative services provided by an individual licensed by the Kentucky Board of Examiners of Psychology or by the appropriate licensing agency in the state in which the individual practices;
- Therapeutic care - services provided by licensed speech therapists, occupational therapists, or physical therapists; and
- Applied behavior analysis prescribed or ordered by a licensed health or allied health professional. Applied behavior analysis means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

No reimbursement is required under this section for services, supplies, or equipment:

- For which the Member has no legal obligation to pay in the absence of this or like coverage;
- Provided to the Member by a publicly funded program;

- Performed by a relative of a Member for which, in the absence of any health benefits coverage, no charge would be made; and
- For services provided by persons who are not licensed as required by law.

Behavioral Health Services

See the Schedule of Benefits for any applicable Deductible, Coinsurance/Copayment information. Coverage for Inpatient Services, Outpatient Services, and Physician Home Visits & Office Services for the treatment of Behavioral Health conditions is provided in compliance with federal law.

Behavioral Health Services coverage also includes Residential Treatment services. Residential Treatment means individualized and intensive treatment in a residential setting, including observation and assessment by a psychiatrist weekly or more frequently, an individualized program of rehabilitation, therapy, education, and recreational or social activities. Please note non-network Residential Treatment Centers must be licensed and accredited.

Cancer Clinical Trials

Benefits are available for services for routine patient care rendered as part of a cancer clinical trial if the services are otherwise Covered Services under this Plan and the clinical trial meets all of the following criteria:

- The trial is approved by one of the following:

  1. The National Institutes of Health, or any institutional review board recognized by the National Institutes of Health;
  2. The United States Food and Drug Administration;
  3. The United States Department of Defense; or
  4. The United States Veterans Administration; and

- The trial does one of the following:

  1. Tests how to administer a health care service, item, or drug for the treatment of cancer;
  2. Tests responses to a health care service, item, or drug for the treatment of cancer;
  3. Compares the effectiveness of health care services, items, or drugs for the treatment of cancer; or
  4. Studies new uses of health care services, items, or drugs for the treatment of cancer;

Benefits do not, however, include the following:

- The healthcare service, item, or investigational drug that is the subject of the cancer clinical trial;

- Any treatment modality outside the usual and customary standard of care required to administer or support the healthcare service, item, or investigational drug that is the subject of the cancer clinical trial;

- Any healthcare service, item, or drug provided solely to satisfy data collection and analysis needs that are not used in the direct clinical management of the patient;

- An investigational drug or device that has not been approved for market by the United States Food and Drug Administration;

- Transportation, lodging, food, or other expenses for the patient or a family member or companion of the patient that are associated with travel to or from a facility providing the cancer clinical trial;

- Any services, items, or drugs provided by the cancer clinical trial sponsors free of charge for any new patient; or

- Any services, items, or drugs that are eligible for reimbursement by a person other than the Plan, including the sponsor of the clinical trial.

Congenital Defects and Birth Abnormalities

Covered Services include coverage for necessary care and treatment of medically diagnosed congenital defects and birth abnormalities.

Benefits do not, however, include the treatment of congenitally missing, malpositioned, or super numerary teeth, even if part of a congenital anomaly.

Dental Services

See the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Related to Accidental Injury

Outpatient Services, Physician Home Visits and Office Services, Emergency Care and Urgent Care services for dental work and oral surgery are covered if they are for the initial repair of an injury to the jaw, sound natural teeth, mouth or face which are required as a result of an accident and are not excessive in scope, duration, or intensity to provide safe, adequate, and appropriate treatment without adversely affecting the patient's condition. Injury as a result of chewing or biting is not considered an accidental injury. "Initial" dental work to repair injuries due to an accident means performed within 12 months from the injury, or as reasonably soon thereafter as possible and includes all examinations and treatment to complete the repair. For a Dependent child below the age of nine years requiring facial reconstruction due to dental related injury, there may be several years between the accident and the final repair.

Covered Services for accidental dental include, but are not limited to:

- Oral examinations.
- X-rays.
- Tests and laboratory examinations
- Restorations.
- Prosthetic services.
- oral surgery
- Mandible/maxillary reconstruction.
- Anesthesia.

Other Dental Services

Benefits are provided for anesthesia and Hospital or facility charges for services performed in a Hospital and Ambulatory Surgical Facility. These services must be in connection with dental procedures for Dependents below the age of nine years, Members with serious mental or physical conditions, and Members with significant behavioral problems. Also, the admitting Physician or dentist must certify that, because of the patient's age, condition or problem, hospitalization or general anesthesia is required in order to safely and effectively perform the procedures. Benefits are not provided for routine dental care.

If the above paragraph does not apply to a Member, the only other dental expenses that are Covered Services are facility charges for Outpatient services for the removal of wisdom teeth or impacted teeth or for other dental processes. Benefits are payable only if the patient's medical condition or the dental procedure requires a Hospital setting to ensure the safety of the patient.

Diabetic Equipment, Education and Supplies

See the Schedule of Benefits for any applicable Deductible, Coinsurance, and Benefit Limitation information.

Diabetes Self-Management Training for an individual with insulin dependent diabetes, non-insulin dependent diabetes, or elevated blood glucose levels induced by pregnancy or another medical condition when:

- Medically Necessary;

- Ordered in writing by a Physician or a podiatrist; and

- Provided by a certified, registered, or licensed Health Care Professional with expertise in diabetes, as deemed necessary by a health care Provider.

For the purposes of this provision, a "Health Care Professional" means the Physician or podiatrist ordering the training or a Provider who has obtained certification in diabetes education by the American Diabetes Association.

Covered Services also include all Physician prescribed Medically Necessary equipment, supplies, and all medications necessary for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes, and noninsulin-using diabetes if prescribed by a health care provider legally authorized to prescribe the items. See “Medical Supplies, Durable Medical Equipment, and Appliances”, “Preventive Care Services”, “Physician Home Visits and Office Services”, and “Prescription Drug Benefits”.

Diagnostic Services

See the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Diagnostic services are tests or procedures generally performed when you have specific symptoms, to detect or monitor your condition. Coverage for Diagnostic Services, including when provided as part of Physician Home Visits and Office Services, Inpatient Services, Outpatient Services, Home Care Services, and Hospice Services includes but is not limited to:

- X-ray and other radiology services, including mammograms for any person diagnosed with breast disease
- Magnetic Resonance Angiography (MRA)
- Magnetic Resonance Imaging (MRI)
- CAT scans
- Laboratory and pathology services
- Cardiographic, encephalographic, and radioisotope tests
- Nuclear cardiology imaging studies
- Ultrasound services
- Allergy tests
- Electrocardiograms (EKG)
- Electromyograms (EMG) except that surface EMG’s are not Covered Services
- Echocardiograms
- Bone density studies
- Positron emission tomography (PET scanning)
- Diagnostic Tests as an evaluation to determine the need for a Covered Transplant Procedure
- Echographies
- Doppler studies
- Brainstem evoked potentials (BAER)
- Somatosensory evoked potentials (SSEP)
- Visual evoked potentials (VEP)
- Nerve conduction studies
- Muscle testing
- Electrocorticograms

Central supply (IV tubing) or pharmacy (dye) necessary to perform tests are covered as part of the test, whether performed in a Hospital or Physician’s office.

For Diagnostic services other than those approved to be received in a Physician’s office, you may be required to use the Administrator’s independent laboratory Network Provider called the Reference Laboratory Network (RLN).

When Diagnostic services are performed in Network within 3 days (72 hours) as part of pre-admission testing required for an Inpatient admission or an Outpatient surgery, no Copayment is required, and the deductible is waived. Any Coinsurance will still apply.

When Diagnostic radiology is performed in a Physician's Office, Copayment is required. Any Deductible or Coinsurance from a Network or a Non-Network Physician will still apply.

Emergency Care and Urgent Care Services

See the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Emergency Care (including Emergency Room Services)

If you are experiencing an Emergency, call 9-1-1 or go to the nearest Hospital. Medically Necessary services which the Administrator determines to meet the definition of Emergency Care will be covered, whether the care is rendered by a Network Provider or Non-Network Provider.

Emergency Care rendered by a Non-Network Provider will be covered as a Network service, however the Member **may** be responsible for the difference between the Non-Network Provider's charge and the Maximum Allowable Amount, in addition to any applicable Coinsurance, Copayment or Deductible.

The Maximum Allowed Amount for Emergency Care from a Non-Network Provider will be:

- The amount negotiated with Network Providers for the Emergency service furnished;
- The amount for the Emergency Service calculated using the same method the Administrator generally uses to determine payments for Non-Network services but substituting the Network cost-sharing provisions for the Non-Network cost-sharing provisions; or
- The amount that would be paid under Medicare for the Emergency Service.

In addition, if you contact your Physician and are referred to a Hospital emergency room, benefits will be provided at the level for Emergency Care. Hospitals generally are open to treat an Emergency 24 hours a day, 7 days a week. **Follow-up care is not considered Emergency Care.**

Benefits are provided for treatment of Emergency medical conditions and Emergency screening and Stabilization services without Prior Authorization for conditions that reasonably appear to a prudent layperson to constitute an Emergency medical condition based upon the patient's presenting symptoms and conditions. Benefits for Emergency Care include facility costs, Physician services, and supplies and Prescription Drugs.

Whenever you are admitted as an Inpatient directly from a Hospital emergency room, the Emergency Room Services Copayment/Coinsurance for that Emergency Room visit will be waived. For Inpatient admissions following Emergency Care, Precertification is not required. However, you must notify the Prior Authorization Administrator, on behalf of the Employer, or verify that your Physician has notified the Prior Authorization Administrator of your admission within 24 hours or as soon as possible within a reasonable period of time. When the Prior Authorization Administrator is contacted, you will be notified whether the Inpatient setting is appropriate, and if appropriate, the number of days considered Medically Necessary. By calling the Prior Authorization Administrator, you may avoid financial responsibility for any Inpatient care that is determined to be not Medically Necessary under your Plan. If your Provider does not have a contract with the Administrator you will be financially responsible for any claim the Administrator, on behalf of the Employer determines is not Medically Necessary.

The Behavioral Health Services Subcontractor also must be notified of all Emergency admissions for Behavioral Health services the next business day after admission or as soon as possible within a reasonable period of time.

Care and treatment provided once you are stabilized is no longer considered Emergency Care. Continuation of care from a Non-Network Provider beyond that needed to evaluate or stabilize your condition in an Emergency will be covered as a Non-Network service unless the Administrator authorizes the continuation of care and it is Medically Necessary.

Urgent Care Center Services

Often an urgent rather than an Emergency medical problem exists. All Covered Services obtained at Urgent Care Centers are subject to the Urgent Care Copayment/Coinsurance. Urgent Care services can be obtained from a Network or Non-Network Provider. Covered Services rendered by a Non-Network Urgent Care Center will be covered as a Network service; however the Member **may** be responsible for the difference between the Non-Network Provider's charge and the Maximum Allowable Amount, in addition to any applicable Coinsurance, Copayment or Deductible. If you experience an accidental injury or a medical problem, the Plan will determine whether your injury or condition is an Urgent Care or Emergency Care situation for coverage purposes, based on your diagnosis and symptoms.

An Urgent Care medical problem is an unexpected episode of illness or an injury requiring treatment which cannot reasonably be postponed for regularly scheduled care. It is not considered an Emergency. Urgent Care medical problems include, but are not limited to, earache, sore throat, and fever (not above 104 degrees). Treatment of an Urgent Care medical problem is not life threatening and does not require use of an emergency room at a Hospital. If you call your Physician prior to receiving care for an urgent medical problem and your Physician authorizes you to go to an emergency room, your care will be paid at the level specified in the Schedule of Benefits for Emergency Room Services. See your Schedule of Benefits for benefit limitations.

Endometriosis and Endometritis

Covered Services include coverage for diagnosis and treatment of endometriosis and endometritis.

Foot Care

Covered for the treatment of a metabolic or peripheral-vascular disease only, including diabetes.

Home Care Services

See the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Covered Services are those performed by a Home Health Care Agency or other Provider in your residence. Home Health Care includes professional, technical, health aide services, supplies, and medical equipment. The Member must be confined to the home for medical reasons, and be physically unable to obtain needed medical services on an Outpatient basis.

Covered Services include but are not limited to:

- Intermittent Skilled Nursing Services (by an R.N. or L.P.N.)
- Medical/Social Services
- Diagnostic Services
- Nutritional Guidance
- Home Health Aide Services. The Member must be receiving skilled nursing or therapy. Services must be furnished by appropriately trained personnel employed by the Home Health Care Provider. Other organizations may provide services only when approved by the Administrator, and their duties must be assigned and supervised by a professional nurse on the staff of the Home Health Care Provider
- Therapy Services (except for Manipulation Therapy as stated below which will not be covered when rendered in the home). Home Care Visit limits specified in the Schedule of Benefits for Home Care Services apply when Therapy Services are rendered in the home
- Medical/Surgical Supplies
- Durable Medical Equipment
- Prescription Drugs (only if provided and billed by a Home Health Care Agency)
- Private Duty Nursing

Non Covered Services include but are not limited to:

- Food, housing, homemaker services and home delivered meals
- Home or Outpatient hemodialysis services (these are covered under Therapy Services)
- Physician charges
- Helpful environment materials (hand rails, ramps, telephones, air conditioners, and similar services, appliances and devices)
- Private Duty Nursing Services rendered in a Hospital or Skilled Nursing Facility provided by registered nurses and other health workers who are not acting as employees or under approved arrangements with a contracting Home Health Care Provider

- Services provided by a member of the patient's immediate family
- Services provided by volunteer ambulance associations for which patient is not obligated to pay, visiting teacher, vocational guidance and other counselors, and services related to outside, occupational and social activities
- Manipulation Therapy services rendered in the home as part of Home Care Services.

Home Infusion Therapy

Will be paid only if you obtain prior approval from the Administrator's Home Infusion Therapy Administrator (if applicable). Benefits for home infusion therapy include a combination of nursing, durable medical equipment and pharmaceutical services which are delivered and administered intravenously in the home. Home IV therapy includes but is not limited to: injections (intra-muscular, subcutaneous, and continuous subcutaneous), Total Parenteral Nutrition (TPN), Enteral nutrition therapy, Antibiotic therapy, pain management and chemotherapy.

Hospice Services

See the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Hospice care may be provided in the home or at a Hospice facility where medical, social and psychological services are given to help treat patients with a terminal illness. Hospice Services include routine home care, continuous home care, Inpatient Hospice and Inpatient respite. To be eligible for Hospice benefits, the patient must have a life expectancy of six months or less, as confirmed by the attending Physician. Covered Services will continue if the Member lives longer than six months.

When approved by your Physician, Covered Services include the following:

- Skilled Nursing Services (by an R.N. or L.P.N.)
- Diagnostic Services
- Physical, speech and inhalation therapies if part of a treatment plan
- Medical supplies, equipment and appliances (benefits will not be covered for equipment when the Member is in a Facility that should provide such equipment)
- Counseling services
- Inpatient confinement at a Hospice
- Prescription Drugs given by the Hospice
- Home health aide

Non Covered Services include but are not limited to:

- Services provided by volunteers
- Housekeeping services

Inpatient Services

See the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Inpatient Services include:

- Charges from a Hospital, Skilled Nursing Facility (SNF) or other Provider for room, board and general nursing services
- Ancillary (related) services
- Professional services from a Physician while an Inpatient.

Room, Board, and General Nursing Services

- A room with two or more beds

- A private room. The private room allowance is the Hospital's average semi-private room rate unless it is Medically Necessary that you use a private room for isolation and no isolation facilities are available.
- A room in a special care unit approved by the Administrator, on behalf of the Employer. The unit must have facilities, equipment and supportive services for intensive care of critically ill patients.

Ancillary (Related) Services

- Operating, delivery and treatment rooms and equipment.
- Prescribed Drugs
- Anesthesia, anesthesia supplies and services given by an employee of the Hospital or other Provider
- Medical and surgical dressings, supplies, casts and splints
- Diagnostic Services
- Therapy Services

Professional Services

- **Medical care visits** limited to one visit per day by any one Physician.
- **Intensive medical care for** constant attendance and treatment when your condition requires it for a prolonged time.
- **Concurrent care** for a medical condition by a Physician who is not your surgeon while you are in the Hospital for Surgery. Care by two or more Physicians during one Hospital stay when the nature or severity of your condition requires the skills of separate Physicians.
- **Consultation** which is a personal bedside examination by another Physician when requested by your Physician. Staff consultations required by Hospital rules; consultations requested by the patient; routine radiological or cardiographic consultations; telephone consultations; EKG transmittal via phone are excluded.
- **Surgery and the administration of general anesthesia**
- **Newborn exam.** A Physician other than the Physician who performed the obstetrical delivery must do the examination.

Copayment Waiver

When a Member is transferred from one Hospital or other facility to another Hospital or other facility on the same day, any Copayment per admission in the Schedule of Benefits is waived for the second admission.

Maternity Services

See the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Maternity services include Inpatient Services, Outpatient Services and Physician Home Visits and Office Services. These services are used for normal or complicated pregnancy, miscarriage, therapeutic abortion (abortion recommended by a Provider), and ordinary routine nursery care for a healthy newborn. Abortion means the ending of a pregnancy before the birth of the infant. Miscarriage is a spontaneous abortion (occurs naturally and suddenly). A therapeutic abortion is one performed to save the life or health of the mother, or as a result of incest or rape.

If the Member is pregnant on her Effective Date and is in the first trimester of the pregnancy, she must change to a Network Provider to have Covered Services paid at the Network level. If the Member is pregnant on her Effective Date, benefits for obstetrical care will be paid at the Network level if the Member is in her second or third trimester of pregnancy (13 weeks or later) as of the Effective Date. Covered Services will include the obstetrical care provided by that Provider through the end of the pregnancy and the immediate post-partum period. The Member must complete a Continuation of Care Request Form and submit to the Administrator.

Charges for covered routine nursery charges are not subject to a separate deductible/coinsurance. If a newborn child is required to stay as an Inpatient past the mother's discharge date, the services for the newborn child will then be considered a separate admission from the Maternity and an ordinary routine nursery admission and will be subject to a separate Inpatient Coinsurance/Copayment.

Coverage for the Inpatient postpartum stay for you and your newborn child in a Hospital will be, at a minimum, 48 hours for a vaginal delivery and 96 hours for a cesarean section. Coverage will be for the length of stay recommended by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists in their Guidelines for Prenatal Care.

Coverage for a length of stay shorter than the minimum period mentioned above may be permitted if your attending Physician determines further Inpatient postpartum care is not necessary for you or your newborn child, provided the following are met and the mother concurs:

- In the opinion of your attending Physician, the newborn child meets the criteria for medical stability in the Guidelines for Perinatal Care prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists that determine the appropriate length of stay based upon evaluation of:

  1. the antepartum, intrapartum, and postpartum course of the mother and infant;
  2. the gestational stage, birth weight, and clinical condition of the infant;
  3. the demonstrated ability of the mother to care for the infant after discharge; and
  4. the availability of post discharge follow-up to verify the condition of the infant after discharge.

- **Covered Services include at-home post delivery care visits** at your residence by a Physician or Nurse performed no later than 72 hours following you and your newborn child's discharge from the Hospital. Coverage for this visit includes, but is not limited to:

  1. Parent education;
  2. Assistance and training in breast or bottle feeding; and
  3. Performance of any maternal or neonatal tests routinely performed during the usual course of Inpatient care for you or your newborn child, including the collection of an adequate sample for the hereditary and metabolic newborn screening.

  At your discretion, this visit may occur at the Physician's office.

  The Usual and Reasonable Charges for the care and treatment for dependent daughters are covered the same as any other Sickness for a covered employee or covered dependent daughter.

Medical Supplies, Durable Medical Equipment, and Appliances

See the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

The supplies, equipment and appliances described below are Covered Services under this benefit. If the supplies, equipment and appliances include comfort, luxury, or convenience items or features which exceed what is Medically Necessary in your situation or needed to treat your condition, reimbursement will be based on the Maximum Allowable Amount for a standard item that is a Covered Service, serves the same purpose, and is Medically Necessary. Any expense that exceeds the Maximum Allowable Amount for the standard item which is a Covered Service is your responsibility. For example, the reimbursement for a motorized wheelchair will be limited to the reimbursement for a standard wheelchair, when a standard wheelchair adequately accommodates your condition.

Repair, adjustment and replacement of purchased equipment, supplies or appliances as set forth below may be covered, as approved by the Administrator, on behalf of the Employer. The repair, adjustment or replacement of the purchased equipment, supply or appliance is covered if:

- The equipment, supply or appliance is a Covered Service;
- The continued use of the item is Medically Necessary;
- There is reasonable justification for the repair, adjustment, or replacement (warranty expiration is not reasonable justification).
- In addition, replacement of purchased equipment, supplies or appliance may be covered if:
  1. The equipment, supply or appliance is worn out or no longer functions.
  2. Repair is not possible or would equal or exceed the cost of replacement. An assessment by a rehabilitation equipment specialist or vendor should be done to estimate the cost of repair.
  3. Individual's needs have changed and the current equipment is no longer usable due to weight gain, rapid growth, or deterioration of function, etc.
  4. The equipment, supply or appliance is damaged and cannot be repaired.

The Administrator, on behalf of the Employer may establish reasonable quantity limits for certain supplies, equipment or appliance described below. A detailed listing of supplies, equipment or appliances that are not covered by the Plan including quantity limits, is available to you upon request. Please call the customer service number on your Identification Card. This list is subject to change.

Covered Services may include, but are not limited to:

- **Medical and surgical supplies** – Certain supplies and equipment for the management of disease that the Administrator approves are covered under the Prescription Drug benefit, if any. These supplies are considered as a medical supply benefit if the Member does not have Plan's Prescription Drug benefit or if the supplies, equipment or appliances are not received from the PBM's Mail Service or from a Network Pharmacy: Syringes, needles, oxygen, surgical dressings, splints and other similar items which serve only a medical purpose. Prescription Drugs and biologicals that cannot be self-administered and are provided in a Physician's office, including but not limited to, Depo-Provera. Covered Services do not include items usually stocked in the home for general use like Band-Aids, thermometers, and petroleum jelly.

Covered Services may include, but are not limited to:

1. Allergy serum extracts
2. Chem strips, Glucometer, Lancets
3. Clinitest
4. Elastic stockings or supports. These items must be purchased by prescription or through a Hospital. They must be Medically Necessary for the treatment of an injury or condition requiring stockings. The Plan may establish reasonable limits on the number of pairs allowed per Member per Benefit Period.
5. Needles/syringes
6. Ostomy bags and supplies except charges such as those made by a Pharmacy for purposes of a fitting are not Covered Services

Non Covered Services include but are not limited to:

1. Adhesive tape, band aids, cotton tipped applicators
2. Arch supports
3. Doughnut cushions
4. Hot packs, ice bags
5. Vitamins
6. Medijectors

If you have any questions regarding whether a specific medical or surgical supply is covered or want to obtain a detailed list, call the customer service number on the back of your Identification Card.

- **Durable medical equipment -** The rental (or, at the Plan's option, the purchase) of durable medical equipment prescribed by a Physician or other Provider. Durable medical equipment is equipment which can withstand repeated use; i.e., could normally be rented, and used by successive patients; is primarily and customarily used to serve a medical purpose; is not useful to a person in the absence of illness or injury; and is appropriate for use in a patient's home. Examples include but are not limited to wheelchairs, crutches, hospital beds, and oxygen equipment. Rental costs must not be more than the purchase price. The Plan will not pay for rental for a longer period of time than it would cost to purchase equipment. The cost for delivering and installing the equipment are Covered Services. Payment for related supplies is a Covered Service only when the equipment is a rental, and medically fitting supplies are included in the rental; or the equipment is owned by the Member; medically fitting supplies may be paid separately. Equipment should be purchased when it costs more to rent it than to buy it. Repair of medical equipment is covered.

Covered Services may include, but are not limited to:

1. Hemodialysis equipment
2. Crutches and replacement of pads and tips
3. Pressure machines
4. Infusion pump for IV fluids and medicine
5. Glucometer
6. Tracheotomy tube
7. Cardiac, neonatal and sleep apnea monitors
8. Augmentive communication devices are covered when the Administrator approves based on the Member's condition.

Non-covered items may include but are not limited to:

1. Air conditioners
2. Ice bags/coldpack pump

3. Raised toilet seats
4. Rental of equipment if the Member is in a Facility that is expected to provide such equipment
5. Translift chairs
6. Treadmill exerciser
7. Tub chair used in shower

If you have any questions regarding whether a specific durable medical equipment is covered or want to obtain a detailed list, call the customer service number on the back of your Identification Card.

- **Prosthetics** – Artificial substitutes for body parts and tissues and materials inserted into tissue for functional or therapeutic purposes. Covered Services include purchase, fitting, needed adjustment, repairs, and replacements of prosthetic devices and supplies that:

1. Replace all or part of a missing body part and its adjoining tissues; or
2. Replace all or part of the function of a permanently useless or malfunctioning body part.

Prosthetic devices should be purchased not rented and must be Medically Necessary. Applicable taxes, shipping and handling are also covered.

Covered Services may include, but are not limited to:

1. Aids and supports for defective parts of the body including but not limited to internal heart valves, mitral valve, internal pacemaker, pacemaker power sources, synthetic or homograft Vascular replacements, fracture fixation devices internal to the body surface, replacements for injured or diseased bone and joint substances, mandibular reconstruction appliances, bone screws, plates, and vitallium heads for joint reconstruction.
2. Left Ventricular Artificial Devices (LVAD) (reviewed by transplant).
3. Breast prostheses whether internal or external, following a mastectomy, and four surgical bras per Benefit Period, as required by the Women's Health and Cancer Rights Act.
4. Replacements for all or part of absent parts of the body or extremities, such as artificial limbs, artificial eyes, etc.
5. Intraocular lens implantation for the treatment of cataract or aphakia. Contact lenses or glasses are often prescribed following lens implantation and are Covered Services. (If cataract extraction is performed, intraocular lenses are usually inserted during the same operative session). Eyeglasses (for example bifocals) including frames or contact lenses are covered when they replace the function of the human lens for conditions caused by cataract surgery or injury; the first pair of contact lenses or eyeglasses are covered. The donor lens inserted at the time of surgery are not considered contact lenses, and are not considered the first lens following surgery. If the injury is to one eye or if cataracts are removed from only one eye and the Member selects eyeglasses and frames, then reimbursement for both lenses and frames will be covered.
6. Cochlear implant.
7. Colostomy and other ostomy (surgical construction of an artificial opening) supplies directly related to ostomy care.
8. Restoration prosthesis (composite facial prosthesis)
9. Wigs (the first one following cancer treatment, not to exceed one per Benefit Period).
10. Hearing Aids - Any device or instrument that can be worn repeatedly provided the device is provided to a Member under 18 years of age no more than one time per hearing impaired ear every thirty-six months.

Non-covered Prosthetic appliances include but are not limited to:

1. Dentures, replacing teeth or structures directly supporting teeth.
2. Dental appliances.
3. Such non-rigid appliances as elastic stockings, garter belts, arch supports and corsets.
4. Artificial heart implants.
5. Wigs (except as described above following cancer treatment).
6. Penile prosthesis in men suffering impotency resulting from disease or injury

If you have any questions regarding whether a specific prosthetic is covered or want to obtain a detailed list, call the customer service number on the back of your Identification Card

- **Orthotic devices** – Covered Services are the initial purchase, fitting, and repair of a custom made rigid or semi-rigid supportive device used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body, or which limits or stops motion of a weak or diseased body part. The cost of casting, molding, fittings, and adjustments are included. Applicable tax, shipping, postage and handling charges are also covered. The casting is covered when an orthotic appliance is billed with it, but not if billed separately. Covered orthotic devices may include, but are not limited to, the following:

1. Cervical collars.
2. Ankle foot orthosis.
3. Corsets (back and special surgical).
4. Splints (extremity).
5. Trusses and supports.
6. Slings.
7. Wristlets.
8. Built-up shoe.
9. Custom made shoe inserts.

Orthotic appliances may be replaced once per year per Member when Medically Necessary in the Member's situation. However, additional replacements will be allowed for Members under age 18 due to rapid growth, or for any Member when an appliance is damaged and cannot be repaired. Coverage for an orthotic custom fabricated brace or support designed as a component for a prosthetic limb is described in more detail below.

Non-Covered Services include but are not limited to:

1. Orthopedic shoes (except therapeutic shoes for diabetics).
2. Foot support devices, such as arch supports and corrective shoes, unless they are an integral part of a leg brace.
3. Standard elastic stockings, garter belts, and other supplies not specially made and fitted (except as specified under Medical Supplies).
4. Garter belts or similar devices.

If you have any questions regarding whether a specific orthotic is covered or want to obtain a detailed list, call the customer service number on the back of your Identification Card.

Outpatient Services

See the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Outpatient Services include both facility, ancillary, facility use, and professional charges when given as an Outpatient at a Hospital, Alternative Care Facility, Retail Health Clinic, or other Provider as determined by the Plan. These facilities may include a non-Hospital site providing Diagnostic and therapy services, surgery, or rehabilitation, or other Provider facility as determined by the Administrator, on behalf of the Employer.

When Diagnostic Services or Other Therapy Services (chemotherapy, radiation, dialysis, inhalation, or cardiac rehabilitation) is the only Outpatient Services charge, no Copayment is required if received as part of an Outpatient surgery. Any Coinsurance will still apply to these services.

For Emergency Accident or Medical Care refer to the **Emergency Care and Urgent Care section.**

Physician Home Visits and Office Services

See the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Covered Services include care provided by a Physician in their office or your home. Refer to the sections titled "Preventive Care", "Maternity Care", "Home Care Services" for services covered by the Plan.
For Emergency Care refer to the "Emergency Care and Urgent Care" section.

Office visits for medical care and consultations to examine, diagnose, and treat an illness or injury performed in the Physician's office. Office visits also include allergy testing, injections and serum. When allergy serum is the only charge from a Physician's office, no Copayment is required. Coinsurance is not waived.

Home Visits for medical care and consultations to examine, diagnose, and treat an illness or injury performed in your home.

Diagnostic Services when required to diagnose or monitor a symptom, disease or condition.

Surgery and Surgical services (including anesthesia and supplies). The surgical fee includes normal post-operative care.

Therapy Services for physical medicine therapies and other Therapy Services when given in the office of a Physician or other professional Provider.

Preventive Care Services

See the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Preventive Care services include Inpatient services, Outpatient services and Physician Home Visits and Office Services. These services may vary based on the age, sex, and personal history of the individual, and as determined appropriate by the Administrator's clinical coverage guidelines.

Screenings and other services are generally covered as Preventive Care for adults and children with no current symptoms or prior history of a medical condition associated with that screening or service.

Members who have current symptoms or have been diagnosed with a medical condition are not considered to require Preventive Care for that condition but instead benefits will be considered under the Diagnostic Services benefit.

Some examples of Preventive Care Covered Services are:

- Routine or periodic exams, including school enrollment physical exams. (Physical exams and immunizations required for travel, enrollment in any insurance program, as a condition of employment, for licensing, sports programs, or for other purposes, are not Covered Services.) Examinations include, but are not limited to:

  1. Well-baby and well-child care, including child health supervision services, based on American Academy of Pediatric Guidelines. Child health supervision services includes, but is not limited to, a review of a child's physical and emotional status performed by a Physician, by a health care professional under the supervision of a Physician, in accordance with the recommendations of the American Academy of Pediatrics and includes a history, complete physical examination, developmental assessment, anticipatory guidance, appropriate immunizations, and laboratory tests.

  2. Adult routine physical examinations.

  3. Pelvic examinations.

  4. Routine EKG, Chest XR, laboratory tests such as complete blood count, comprehensive metabolic panel, urinalysis.

  5. Annual dilated eye examination for diabetic retinopathy.

- Immunizations (including those required for school), following the current Childhood and Adolescent Immunization Schedule as approved by the Advisory Committee on Immunization Practice (ACIP), the American Academy of Pediatrics (AAP), and the American Academy of Family Physicians (AAFP). For adults, the Plan follows the Adult Immunization Schedule by age and medical condition as approved by the Advisory Committee on Immunization Practice (ACIP) and accepted by the American College of Gynecologists (ACOG) and the American Academy of Family Physicians.

  These include, but are not limited to:

  1. Hepatitis A vaccine.
  2. Hepatitis B vaccine.
  3. Hemophilus influenza b vaccine (Hib).
  4. Influenza virus vaccine.
  5. Rabies vaccine.
  6. Diphtheria, Tetanus, Pertussis vaccine.
  7. Mumps virus vaccine.
  8. Measles virus vaccine.
  9. Rubella virus vaccine.
  10. Poliovirus vaccine.

- Screening examinations:

  1. Routine vision screening performed by an optometrist for disease or abnormalities, including but not limited to diseases such as glaucoma, strabismus, amblyopia, cataracts.
  2. Routine hearing screening.
  3. Routine screening mammograms including coverage for low-dose mammography screening.
  4. Routine cytologic and chlamydia screening (including pap test).
  5. Routine bone density testing for women.
  6. Routine prostate specific antigen testing.
  7. Routine colorectal cancer examination and related laboratory tests.

  Other covered Preventive services include: women's contraceptives, (not including abortifacients), sterilization procedures, and counseling.

  The list of services included as Standard Preventive Care may change from time to time depending upon government guidelines. A current listing of required preventive care can be accessed at:

  - www.HealthCare.gov/center/regulations/prevention.html and
  - www.cdc.gov/vaccines/recs/acip/

Diabetes Self-Management Training for an individual with insulin dependent diabetes, non-insulin dependent diabetes, or elevated blood glucose levels induced by pregnancy or another medical condition when:

- Medically Necessary;
- Ordered in writing by a Physician or a podiatrist; and
- Provided by a certified, registered, or licensed Health Care Professional with expertise in diabetes, as deemed necessary by a health care Provider.

For the purposes of this provision, a "Health Care Professional" means the Physician or podiatrist ordering the training or a Provider who has obtained certification in diabetes education by the American Diabetes Association.

Medical Nutritional Therapy limited to consultations for the Medically Necessary management and treatment of obesity. Any Prescription Drug or medical supply prescribed as a part of this therapy will not be covered except as otherwise stated under this Benefit Booklet. This therapy is limited to services rendered by Network Providers. Charges for Medical Nutritional Therapy from a Non-Network Provider are not covered under the Plan.

Surgical Services

See the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Coverage for Surgical Services when provided as part of Physician Home Visits and Office Services, Inpatient Services, or Outpatient Services includes but is not limited to:

- Performance of generally accepted operative and other invasive procedures;
- The correction of fractures and dislocations;
- Anesthesia;
- Usual and related pre-operative and post-operative care;
- Cochlear implants;
- Other procedures as approved by the Administrator, on behalf of the Employer.

The surgical fee includes normal post-operative care. The Plan may combine the reimbursement when more than one surgery is performed during the same operative session. Contact the Administrator, on behalf of the Employer for more information.

- Covered Surgical Services include, but are not limited to:
- Operative and cutting procedures;
- Endoscopic examinations, such as arthroscopy, bronchoscopy, colonoscopy, laparoscopy;
- Other invasive procedures such as angiogram, arteriogram, amniocentesis, tap or puncture of brain or spine.

Reconstructive Services

Certain reconstructive services required to correct a deformity caused by disease, trauma, congenital anomalies, or previous therapeutic process are covered. Reconstructive services required due to prior therapeutic process are payable only if the original procedure would have been a Covered Service under this Plan. Covered Services are limited to the following:

- Necessary care and treatment of medically diagnosed congenital defects and birth abnormalities of a newborn child.
- Breast reconstruction resulting from a mastectomy. See "Mastectomy Notice" below for further coverage details.
- Hemangiomas, and port wine stains of the head and neck areas for children ages 18 years of age or younger;
- Limb deformities such as club hand, club foot, syndactyly (webbed digits), polydactyly (supernumerary digits), macrodactylia;
- Otoplasty when performed to improve hearing by directing sound in the ear canal, when ear or ears are absent or deformed from trauma, surgery, disease, or congenital defect;
- Tongue release for diagnosis of tongue-tied;
- Congenital disorders that cause skull deformity such as Crouzon's disease;
- Cleft lip;
- Cleft palate.

Mastectomy Notice

A Member who is receiving benefits for a covered mastectomy or for follow-up care in connection with a covered mastectomy, on or after the date the Women's Health & Cancer Rights Act became effective for this Plan, and who elects breast reconstruction, will also receive coverage for:

- reconstruction of the breast on which the mastectomy has been performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- prostheses and treatment of physical complications of all stages of mastectomy, including lymphedemas.

This coverage will be provided in consultation with the patient and the patient's attending Physician. Mammoplasties are only covered when rendered as part of breast cancer treatment and will be subject to the same annual Deductible, Coinsurance, Copayment provisions otherwise applicable under the Plan.

Sterilization

Sterilization is a Covered Service.

Telehealth Consultation Services

See the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Covered Services include a medical or health consultation, for purposes of patient diagnosis or treatment, that requires the use of advanced telecommunications technology, including, but not limited to:

- Compressed digital interactive video, audio, or data transmission;
- Clinical data transmission via computer imaging for teleradiology or telepathology; and
- Other technology that facilitates access to other covered health care services or medical specialty expertise.

Temporomandibular or Craniomandibular Joint Disorder and Craniomandibular Jaw Disorder

See the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Benefits are provided for Medically Necessary temporomandibular (joint connecting the lower jaw to the

temporal bone at the side of the head) and craniomandibular (head and neck muscle) joint disorders.

Therapy Services

See the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

When Therapy Services are given as part of Physician Home Visits and Office Services, Inpatient Services, Outpatient Services, or Home Care Services, coverage for these Therapy Services is limited to the following:

Physical Medicine Therapy Services

The expectation must exist that the therapy will result in a practical improvement in the level of functioning within a reasonable period of time

- **Physical therapy** including treatment by physical means, hydrotherapy, heat, or similar modalities, physical agents, bio-mechanical and neuro-physiological principles and devices. Such therapy is given to relieve pain, restore function, and to prevent disability following illness, injury, or loss of a body part. Massage therapy and Aquatic therapy is covered when rendered as part of a treatment plan. Non Covered Services include but are not limited to: maintenance therapy to delay or minimize muscular deterioration in patients suffering from a chronic disease or illness; repetitive exercise to improve movement, maintain strength and increase endurance (including assistance with walking for weak or unstable patients); range of motion and passive exercises that are not related to restoration of a specific loss of function, but are for maintaining a range of motion in paralyzed extremities; general exercise programs; diathermy, ultrasound and heat treatments for pulmonary conditions; diapulse; work hardening.

- **Speech therapy** for the correction of a speech impairment.

- **Occupational therapy** for the 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 tasks required by the person's particular occupational role. Occupational therapy does not include diversional, recreational, vocational therapies (e.g. hobbies, arts and crafts). Non Covered Services include but are not limited to: supplies (looms, ceramic tiles, leather, utensils); therapy to improve or restore functions that could be expected to improve as the patient resumes normal activities again; general exercises to promote overall fitness and flexibility; therapy to improve motivation; suction therapy for newborns (feeding machines); soft tissue mobilization (visceral manipulation or visceral soft tissue manipulation), augmented soft tissue mobilization, myofascial; adaptions to the home such as rampways, door widening, automobile adaptors, kitchen adaptation and other types of similar equipment.

- **Manipulation Therapy** includes Osteopathic/Chiropractic Manipulation Therapy used for treating problems associated with bones, joints and the back. The two therapies are similar, but chiropractic therapy focuses on the joints of the spine and the nervous system, while osteopathic therapy includes equal emphasis on the joints and surrounding muscles, tendons and ligaments. Manipulations whether performed and billed as the only procedure or manipulations performed in conjunction with an exam and billed as an office visit will be counted toward any maximum for Manipulation Therapy services as specified in the Schedule of Benefits. Manipulation Therapy services rendered in the home as part of Home Care Services are not covered.

Other Therapy Services

- **Cardiac rehabilitation** to restore an individual's functional status after a cardiac event. It is a program of medical evaluation, education, supervised exercise training, and psychosocial support. Home programs, on-going conditioning and maintenance are not covered.

- **Chemotherapy** for the treatment of a disease by chemical or biological antineoplastic agents, including the cost of such agents.

- **Dialysis treatments** of an acute or chronic kidney ailment which may include the supportive use of an artificial kidney machine.

- **Radiation therapy** for the treatment of disease by X-ray, radium, or radioactive isotopes. Includes treatment (teletherapy, brachytherapy and intraoperative radiation, photon or high energy particle sources); materials and supplies used in therapy; treatment planning.

- **Inhalation therapy** for the treatment of a condition by the administration of medicines, water vapors, gases, or anesthetics by inhalation. Covered Services include but are not limited to, introduction of dry or moist gases into the lungs; nonpressurized inhalation treatment; intermittent positive pressure breathing treatment, air or oxygen, with or without nebulized medication; continuous positive airway pressure ventilation (CPAP); continuous negative pressure ventilation (CNP); chest percussion; therapeutic use of medical gases or drugs in the form of aerosols, and equipment such as resuscitators, oxygen tents, and incentive spirometers; broncho-pulmonary drainage and breathing exercises.

- **Pulmonary rehabilitation** to restore an individual's functional status after an illness or injury. Covered Services include but are not limited to Outpatient short-term respiratory services for conditions which are expected to show significant improvement through short-term therapy. Also covered is inhalation therapy administered in Physician's office including but are not limited to breathing exercise, exercise not elsewhere classified, and other counseling. Pulmonary rehabilitation in the acute Inpatient rehabilitation setting is not a Covered Service.

Physical Medicine and Rehabilitation Services

A structured therapeutic program of an intensity that requires a multidisciplinary coordinated team approach to upgrade the patients ability to function as independently as possible; including skilled rehabilitative nursing care, physical therapy, occupational therapy, speech therapy and services of a social worker or psychologist. The goal is to obtain practical improvement in a reasonable length of time in the appropriate Inpatient setting.

Physical medicine and rehabilitation involves several types of therapy, not just physical therapy, and a coordinated team approach. The variety and intensity of treatments required is the major differentiation from an admission primarily for physical therapy.

Non-Covered Services for physical medicine and rehabilitation include, but are not limited to:

- admission to a Hospital mainly for physical therapy;
- long term rehabilitation in an Inpatient setting.

Day Rehabilitation Program services provided through a Day Hospital for physical medicine and rehabilitation are Covered Services. A Day Rehabilitation Program is for those patients who do not require Inpatient care but still require a rehabilitation therapy program four to eight hours a day, 2 or more days a week at a Day Hospital. Day rehabilitation program services may consist of Physical Therapy, Occupational Therapy, Speech Therapy, nursing services, and neuro psychological services. A minimum of two Therapy Services must be provided for this program to be a Covered Service.

Human Organ and Tissue Transplant Services

See the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

The human organ and tissue transplant (bone marrow/stem cell) services benefits or requirements described below do not apply to the following:

- **Cornea and kidney transplants; and**
- **Any Covered Services, related to a Covered Transplant Procedure, received prior to or after the Transplant Benefit Period. Please note that the initial evaluation and any necessary additional testing to determine your eligibility as a candidate for transplant by your Provider and the harvest and storage of bone marrow / stem cells is included in the Covered Transplant Procedure benefit regardless of the date of service.**

The above services are covered as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending where the service is performed subject to Member cost shares.

Covered Transplant Procedure

Any Medically Necessary human organ and tissue transplants or transfusions as determined by the Administrator, on behalf of the Employer including necessary acquisition procedures, harvest and storage, and including Medically Necessary preparatory myeloablative therapy.

Transplant Benefit Period

Starts one day prior to a Covered Transplant Procedure and continues for the applicable global time period (normally 34 -50 days depending on the type of transplant received) for services received at a Network Transplant Provider Facility or the later of 30 days or date of discharge following a Covered Transplant Procedure at a Non Network Transplant Provider Facility.

Prior Approval and Precertification

In order to maximize your benefits, the Administrator strongly encourages you to call its transplant department to discuss benefit coverage when it is determined a transplant may be needed. You must do this before you have an evaluation and/or work-up for a transplant. The Administrator will assist you in maximizing your benefits by providing coverage information, including details regarding what is covered and whether any clinical coverage guidelines, medical policies, Network Transplant Provider requirements, or exclusions are applicable. Contact the Customer Service telephone number on the back of your Identification Card **and ask for the transplant coordinator**. Even if the Administrator issues a prior approval for the Covered Transplant Procedure, you or your Provider must call the Administrator's Transplant Department for precertification prior to the transplant whether this is performed in an Inpatient or Outpatient setting.

Please note that there are instances where your Provider requests approval for HLA testing, donor searches and/or a harvest and storage of stem cells prior to the final determination as to what transplant procedure will be requested. Under these circumstances, the HLA testing and donor search charges are covered as routine diagnostic testing. The harvest and storage request will be reviewed for Medical Necessity and may be approved. However, such an approval for HLA testing, donor search and/or a harvest and storage is NOT an approval for the subsequent requested transplant. A separate Medical Necessity determination will be made for the transplant procedure.

Transportation and Lodging

The Plan will provide assistance with reasonable and necessary travel expenses as determined by the Administrator, on behalf of the Employer when you obtain prior approval and are required to travel more than 75 miles from your residence to reach the facility where your Covered Transplant Procedure will be performed. The Plan's assistance with travel expenses includes transportation to and from the facility and lodging for the patient and one companion. If the Member receiving treatment is a minor, then reasonable and necessary expenses for transportation and lodging may be allowed for two companions. The Member must submit itemized receipts for transportation and lodging expenses in a form satisfactory to the Administrator when claims are filed. Contact the Administrator at the Customer Service number listed on your Identification Card for detailed information.

Certain Human Organ and Tissue Transplant Services may be limited. See the Schedule of Benefits.

COST MANAGEMENT SERVICES

Cost Management Services Phone Number

HealthLink
(877) 284-0102

Please refer to the Employee ID card for the Cost Management Services phone number.

The provider, patient or family member must call this number to receive certification of certain Cost Management Services. This call must be made at least 48 hours in advance of services being rendered or within 48 hours after a Medical Emergency.

UTILIZATION REVIEW

Utilization review is a program designed to help insure that all Covered Persons receive necessary and appropriate health care while avoiding unnecessary expenses.

The program consists of:

(a) Precertification of the Medical Necessity for the following non-emergency services before Medical and/or Surgical services are provided:

(b) Retrospective review of the Medical Necessity of the listed services provided on an emergency basis;

(c) Concurrent review, based on the admitting diagnosis, of the listed services requested by the attending Physician; and

(d) Certification of services and planning for discharge from a Medical Care Facility or cessation of medical treatment.

The purpose of the program is to determine what charges may be eligible for payment by the Plan. This program is not designed to be the practice of medicine or to be a substitute for the medical judgment of the attending Physician or other health care provider.

If a particular course of treatment or medical service is not certified, it means that either the Plan will not pay for the charges or the Plan will not consider that course of treatment as appropriate for the maximum reimbursement under the Plan. The patient is urged to find out why there is a discrepancy between what was requested and what was certified before incurring charges.

The attending Physician does not have to obtain precertification from the Plan for prescribing a maternity length of stay that is 48 hours or less for a vaginal delivery or 96 hours or less for a cesarean delivery.

In order to maximize Plan reimbursements, please read the following provisions carefully.

Here's how the program works.

Precertification. Before a Covered Person enters a Medical Care Facility on a non-emergency basis or receives other listed medical services, the utilization review administrator will, in conjunction with the attending Physician, certify the care as appropriate for Plan reimbursement. A non-emergency stay in a Medical Care Facility is one that can be scheduled in advance.

The utilization review program is set in motion by a telephone call from, or on behalf of, the Covered Person. Contact the utilization review administrator at the telephone number on your ID card **at least 48 hours before** services are scheduled to be rendered with the following information:

- The name of the patient and relationship to the covered Employee
- The name, employee identification number and address of the covered Employee
- The name of the Employer

- The name and telephone number of the attending Physician
- The name of the Medical Care Facility, proposed date of admission, and proposed length of stay
- The proposed medical services
- The proposed rendering of listed medical services

If there is an **emergency** admission to the Medical Care Facility, the patient, patient's family member, Medical Care Facility or attending Physician must contact the utilization review administrator **within 48 hours** of the first business day after the admission.

The utilization review administrator will determine the number of days of Medical Care Facility confinement or use of other listed medical services authorized for payment. **Failure to follow this procedure may reduce reimbursement received from the Plan.**

If the Covered Person does not receive authorization as explained in this section, the benefit payment may be reduced and/or denied. Once information is received claims can be re-opened based on medical information provided. Any services or days found not to be medically necessary will not be covered.

Concurrent review, discharge planning. Concurrent review of a course of treatment and discharge planning from a Medical Care Facility are parts of the utilization review program. The utilization review administrator will monitor the Covered Person's Medical Care Facility stay or use of other medical services and coordinate with the attending Physician, Medical Care Facilities and Covered Person either the scheduled release or an extension of the Medical Care Facility stay or extension or cessation of the use of other medical services.

If the attending Physician feels that it is Medically Necessary for a Covered Person to receive additional services or to stay in the Medical Care Facility for a greater length of time than has been precertified, the attending Physician must request the additional services or days.

OUTPATIENT SURGERY

Certain surgical procedures can be performed safely and efficiently outside of a Hospital. Outpatient surgical facilities are equipped for many uncomplicated surgical operations, such as some biopsies, cataract surgeries, tonsillectomies and adenoidectomies, dilation and curettages, and similar procedures.

Charges for covered surgical procedures, when such procedures are performed on an outpatient rather than an inpatient basis, will be paid at the In-Network and Non-Network rates as detailed in the Medical Benefits Schedule of the Covered Person’s plan.

CASE MANAGEMENT

Case Management. The Plan may elect, in its sole discretion, when acting on a basis that precludes individual selection, to provide alternative benefits that are otherwise excluded under the Plan. The alternative benefits, called "Case Management," shall be determined on a case-by-case basis, and the Plan's determination to provide the benefits in one instance shall not obligate the Plan to provide the same or similar alternative benefits for the same or any other Covered Person, nor shall it be deemed to waive the right of the Plan to strictly enforce the provisions of the Plan.

A 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.

Case Management occurs when this alternate benefit will be beneficial to both the patient and the Plan.

The case manager will coordinate and implement the Case Management program by providing guidance and information on available resources and suggesting the most appropriate treatment plan. 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 cover Medically Necessary expenses as stated in the treatment plan, even if these expenses normally would not be paid by the Plan. Unless specifically provided to the contrary in the Plan Administrator's instructions, reimbursement for expenses incurred in connection with the treatment plan shall be subject to all Plan limits and cost sharing provisions.

Note: Case Management is a voluntary service. There are no reductions of benefits or penalties if the patient and family choose not to participate.

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

DEFINED TERMS

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

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

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

The Birthing Center must provide facilities for obstetrical delivery and short-term recovery after delivery; provide care under the full-time supervision of a Physician and either a registered nurse (R.N.) or a licensed nurse-midwife; and have a written agreement with a Hospital in the same locality for immediate acceptance of patients who develop complications or require pre- or post-delivery confinement.

Brand Name means a trade name medication.

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

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

Covered Services & Charge(s) means those Medically Necessary services or supplies that are covered under this Plan.

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

Covered Transplant Procedure is any Medically Necessary human organ and tissue transplants or transfusions as determined by the Administrator, on behalf of the Employer including necessary acquisition procedures, harvest and storage, and including Medically Necessary preparatory myeloablative therapy.

Covered Transplant Services are all Covered Transplant Procedures and all Covered Charges directly related to the disease that has necessitated the Covered Transplant Procedure or that arises as a result of the Covered Transplant Procedure within a Covered Transplant Benefit Period, including any Diagnostic evaluation for the purpose of determining a Member's appropriateness for a Covered Transplant Procedure.

Creditable Coverage includes most health coverage, such as coverage under a group health plan (including COBRA continuation coverage), HMO membership, an individual health insurance policy, Medicaid, Medicare or public health plans.

Creditable Coverage does not include coverage consisting solely of dental or vision benefits.

Creditable Coverage does not include coverage that was in place before a significant break of coverage of 63 days or more. With respect to the Trade Act of 2002, when determining whether a significant break in coverage has occurred, the period between the trade related coverage loss and the start of the special second COBRA election period under the Trade Act, does not count.

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

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

Emergency Services means a medical screening examination (as required under Section 1867 of the Social Security Act (EMTALA)) within the capability of the Hospital emergency department, including routine ancillary

services, to evaluate a Medical Emergency and such further medical examination and treatment as are within the capabilities of the staff and facilities of the Hospital and required under EMTALA to stabilize the patient.

Employee means a person who is an Active, regular Employee of the Employer, regularly scheduled to work for the Employer in an Employee/Employer relationship.

Employer is Asbury University.

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

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

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

The Plan Administrator must make an independent evaluation of the experimental/nonexperimental standings of specific technologies. The Plan Administrator shall be guided by a reasonable interpretation of Plan provisions. The decisions shall be made in good faith and rendered following a detailed factual background investigation of the claim and the proposed treatment. The decision of the Plan Administrator will be final and binding on the Plan. The Plan Administrator will be guided by the following principles:

(1) if the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or

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

(3) if Reliable Evidence shows that the drug, device, medical treatment or procedure is the subject of on-going phase I or phase II clinical trials, is the research, experimental, study or Investigational arm of on-going phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or

(4) if Reliable Evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

Reliable Evidence shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, service, medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure.

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

Family Unit is the covered Employee and the family members who are covered as Dependents under the Plan.

Formulary means a list of prescription medications compiled by the third party payor of safe, effective therapeutic drugs specifically covered by this Plan.

Generic drug means a Prescription Drug which has the equivalency of the brand name drug with the same use and metabolic disintegration. This Plan will consider as a Generic drug any Food and Drug Administration

approved generic pharmaceutical dispensed according to the professional standards of a licensed pharmacist and clearly designated by the pharmacist as being generic.

Genetic Information means information about the genetic tests of an individual or his family members, and information about the manifestations of disease or disorder in family members of the individual. A "genetic test" means an analysis of human DNA, RNA, chromosomes, proteins or metabolites, which detects genotypes, mutations or chromosomal changes. It does not mean an analysis of proteins or metabolites that is directly related to a manifested disease, disorder or pathological condition that could reasonably be detected by a health care professional with appropriate training and expertise in the field of medicine involved. Genetic information does not include information about the age or gender of an individual.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Late Enrollee means a Plan Participant who enrolls under the Plan other than during the first 30-day period in which the individual is eligible to enroll under the Plan or during a Special Enrollment Period.

Legal Guardian means 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.

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

Medical Emergency means a medical condition manifesting itself by acute symptoms of sufficient severity including severe pain such that a prudent layperson with average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in (1) serious jeopardy to the health of an individual (or, in the case of a pregnant woman, the health of the woman or her unborn child), (2) serious impairment to body functions, or (3) serious dysfunction of any body organ or part. A Medical Emergency includes such conditions as heart attacks, cardiovascular accidents, poisonings, loss of consciousness or respiration, convulsions or other such acute medical conditions.

Medical Non-Emergency Care means care which can safely and adequately be provided other than in a Hospital.

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

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

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

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

Mental Disorder means any disease or condition, regardless of whether the cause is organic, that is classified as a Mental Disorder in the current edition of International Classification of Diseases, published by the 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.

Morbid Obesity is a diagnosed condition in which the body weight exceeds the medically recommended weight by either 100 pounds or is twice the medically recommended weight for a person of the same height, age and mobility as the Covered Person.

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

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

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

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

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

Plan means Asbury University Employee Medical Benefit Plan, which is a benefits plan for certain Employees of Asbury University and is described in this document.

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

Plan Year is the 12-month period beginning on January 1st and ending on the following December 31st.

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

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

Sickness is:

For a covered Employee, covered Spouse, covered Dependent: Illness, disease or Pregnancy.

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

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

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

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

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

(5) It has an effective utilization review plan.

(6) It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, mentally disabled, Custodial or educational care or care of Mental Disorders.

(7) It is approved and licensed by Medicare.

This term also applies to charges incurred in a facility referring to itself as an extended care facility, convalescent nursing home, rehabilitation hospital, long-term acute care facility or any other similar nomenclature.

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

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

Temporomandibular Joint (TMJ) syndrome is the treatment of jaw joint disorders including conditions of structures linking the jaw bone and skull and the complex of muscles, nerves and other tissues related to the temporomandibular joint.

Total Disability (Totally Disabled) means: In the case of a Dependent, the complete inability as a result of Injury or Sickness to perform the normal activities of a person of like age and sex in good health.

Urgent Care Services means care and treatment for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room services.

Usual and Reasonable Charge is a charge which is not higher than the usual charge made by the provider of the care or supply and does not exceed the usual charge made by most providers of like service in the same area. This test will consider the nature and severity of the condition being treated. It will also consider medical complications or unusual circumstances that require more time, skill or experience. For Network Provider charges, the Usual and Reasonable Charge will be the contracted rate.

The Plan will pay benefits on the basis of the actual charge billed if it is less than the Usual and Reasonable Charge.

The Plan Administrator has the discretionary authority to decide whether a charge is Usual and Reasonable.

PLAN EXCLUSIONS

The following section details items which are excluded from benefit consideration and will not be considered Covered Services. The following items will not be covered. This information is provided as an aid to help identify certain common items: this list is in no way a limitation or a complete list of items that will not be considered Covered Services.

The Plan does not provide benefits for the following procedures, equipment, services, supplies or charges:

(1) Which the Administrator, on behalf of the Employer, determines are not Medically Necessary or do not meet the Administrator's medical policy, clinical coverage guidelines, or benefit policy guidelines.

(2) Received from an individual or entity that is not a Provider, as defined in this Plan Document, or recognized by the Plan.

(3) Which are Experimental/Investigative or related to such, whether incurred prior to, in connection with, or subsequent to the Experimental/Investigative service or supply, as determined by the Administrator, on behalf of the Employer.

(4) For any condition, disease, defect, ailment, or injury arising out of and in the course of employment if benefits are available under any Workers' Compensation Act or other similar law. If Workers' Compensation Act benefits are not available to you, then this Exclusion does not apply. This exclusion applies if you receive the benefits in whole or in part. This exclusion also applies whether or not you claim the benefits or compensation. It also applies whether or not you recover from any third party.

(5) To the extent that they are provided as benefits by any governmental unit, unless otherwise required by law or regulation.

(6) For illness or injury that occurs as a result of any act of war, declared or undeclared while serving in the armed forces.

(7) For a condition resulting from direct participation in a riot, civil disobedience, nuclear explosion, or nuclear accident.

(8) For care required while incarcerated in a federal, state or local penal institution or required while in custody of federal, state or local law enforcement authorities, including work release programs if the covered person has been convicted as a felon. This exclusion does not apply to a covered person while incarcerated in a local penal institution or in the custody of a local law enforcement officer prior to conviction for a felony.

(9) For court ordered testing or care unless Medically Necessary.

(10) For which you have no legal obligation to pay in the absence of this or like coverage.

(11) For membership, administrative, or access fees charged by Physicians or other Providers. Examples of administrative fees include, but are not limited to, fees charged for educational brochures or calling a patient to provide their test results.

(12) Received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust or similar person or group.

(13) Prescribed, ordered or referred by or received from a member of your immediate family, including your spouse, child, brother, sister, parent, in-law, or self.

(14) For completion of claim forms or charges for medical records or reports unless otherwise required by law.

(15) For missed or canceled appointments.

(16) For mileage, lodging and meals costs, and other travel related expenses, except as authorized by the Administrator, on behalf of the Employer, or specifically stated as a Covered Charge.

(17) For which benefits are payable under Medicare Parts A, B, and/or D or would have been payable if a Covered person had applied for Parts A, B and/or D, except, as specified elsewhere in this Plan Document or as otherwise prohibited by federal law, as addressed in the section titled "Medicare" in General Provisions. For the purposes of the calculation of benefits, if the Member has not enrolled in Medicare Part B, the Administrator will calculate benefits as if they had enrolled.

(18) Charges in excess of the Plan's Maximum Allowable Amounts.

(19) Incurred prior to your Effective Date.

(20) Incurred after the termination date of this coverage except as specified as covered.

(21) For any procedures, services, equipment or supplies provided in connection with cosmetic services. Cosmetic services are primarily intended to preserve, change or improve your appearance or are furnished for psychiatric or psychological reasons. No benefits are available for surgery or treatments to change the texture or appearance of your skin or to change the size, shape or appearance of facial or body features (such as your nose, eyes, ears, cheeks, chin, chest or breasts). Complications directly related to cosmetic services treatment or surgery, as determined by the Administrator, on behalf of the Employer, are not covered. This exclusion applies even if the original cosmetic services treatment or surgery was performed while the Member was covered by another carrier/self-funded plan prior to coverage under this Plan. Directly related means that the treatment or surgery occurred as a direct result of the cosmetic services treatment or surgery and would not have taken place in the absence of the cosmetic services treatment or surgery. This exclusion does not apply to conditions including but not limited to: myocardial infarction; pulmonary embolism; thrombophlebitis; and exacerbation of co-morbid conditions.

(22) Services which are performed to preserve the present level of function or prevent regression of functions for an illness, injury or condition which is resolved or stable.

(23) For the following:

- Custodial Care, convalescent care or rest cures.
- Domiciliary care provided in a residential institution, treatment center, supervised living or halfway house, or school because a Member's own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.
- Care provided or billed by a hotel, health resort, convalescent home, rest home, nursing home or other extended care facility home for the aged, infirmary, school infirmary, institution providing education in special environments, supervised living or halfway house, or any similar facility or institution.
- Services or care provided or billed by a school, Custodial Care center for the developmentally disabled, halfway house, or outward bound programs, even if psychotherapy is included.
- Wilderness camps

(24) For routine foot care (including the cutting or removal of corns and calluses); Nail trimming, cutting or debriding; Hygienic and preventive maintenance foot care, including but not limited to:

- Cleaning and soaking the feet.
- Applying skin creams in order to maintain skin tone.
- Other services that are performed when there is not a localized illness, injury or symptom involving the foot.

(25) For surgical treatment of flat feet; subluxation of the foot; weak, strained, unstable feet; tarsalgia; metatarsalgia; hyperkeratoses.

(26) For dental treatment, regardless of origin or cause, except as specified elsewhere in this Benefit Booklet. “Dental treatment” includes but is not limited to: Preventive care, diagnosis, treatment of or related to the teeth, jawbones (except that TMJ is a Covered Charge) or gums, including but not limited to:

- Extraction, restoration and replacement of teeth.
- Medical or surgical treatments of dental conditions.
- Services to improve dental clinical outcomes.

(27) For treatment of the teeth, jawbone or gums that is required as a result of a medical condition except as expressly required by law or specifically stated as a Covered Charge.

(28) For Dental implants.

(29) For Dental braces

(30) For Dental x rays, supplies & appliances and all associated expenses, including hospitalization and anesthesia, except as required by law. The only exceptions to this are for any of the following:

- Transplant preparation.
- Initiation of immunosuppressives.
- Direct treatment of acute traumatic injury, cancer or cleft palate.

(31) Treatment of congenitally missing, malpositioned, or super numerary teeth, even if part of a congenital anomaly.

(32) Weight loss programs whether or not they are under medical or Physician supervision except as specifically listed as covered in the "Covered Charges" section. Weight loss programs for medical reasons are also excluded. Weight loss programs include but are not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, L.A. Weight Loss) or fasting programs.

(33) For bariatric surgery, regardless of the purpose it is proposed or performed. This includes but is not limited to Roux-en-Y (RNY), Laparoscopic gastric bypass surgery or other gastric bypass surgery (surgical procedures that reduce stomach capacity and divert partially digested food from the duodenum to the jejunum, the section of the small intestine extending from the duodenum), or Gastroplasty, (surgical procedures that decrease the size of the stomach), or gastric banding procedures. Complications directly related to bariatric surgery that result in an Inpatient stay or an extended Inpatient stay for the bariatric surgery, as determined by the Administrator, on behalf of the Employer, are not covered. This exclusion applies when the bariatric surgery was not a Covered Service under this Plan or any previous plan, and it applies if the surgery was performed while the Member was covered by a previous carrier/self-funded plan prior to coverage under this Plan. Directly related means that the Inpatient stay or extended Inpatient stay occurred as a direct result of the bariatric procedure and would not have taken place in the absence of the bariatric procedure. This exclusion does not apply to conditions including but not limited to: myocardial infarction; excessive nausea/vomiting; pneumonia; and exacerbation of co-morbid medical conditions during the procedure or in the immediate post-operative time frame.

(34) For marital counseling.

(35) For prescription, fitting, or purchase of eyeglasses or contact lenses except as otherwise specifically stated as a Covered Charge. This Exclusion does not apply for initial prosthetic lenses or sclera shells following intra-ocular surgery, or for soft contact lenses due to a medical condition.

(36) For vision orthoptic training.

(37) For services or supplies primarily for educational, vocational, or training purposes, except as otherwise specified herein.

(38) For reversal of sterilization.

(39) For diagnostic testing or treatment related to infertility.

(40) For personal hygiene environmental control, or convenience items including but not limited to: air conditioners, humidifiers, physical fitness equipment; personal comfort and convenience items during an Inpatient stay, including but not limited to daily television rental, telephone services, cots or visitor's meals; charges for failure to keep a scheduled visit; for non-medical self-care except as otherwise stated; purchase or rental of supplies for common household use, such as exercise cycles, air purifiers, central or unit air conditioners, water purifiers, allergenic pillows or mattresses or waterbeds, treadmill or special exercise testing or equipment solely to evaluate exercise competency or assist in an exercise program; for a health spa or similar facility.

(41) For telephone consultations or consultations via electronic mail or internet/web site, except as authorized by the Administrator or allowed under the Telehealth services benefit in Covered Services

(42) For care received in an emergency room which is not Emergency Care, except as specified in this Plan Document. This includes, but is not limited to suture removal in an emergency room.

(43) For eye surgery to correct errors of refraction, such as near-sightedness, including without limitation radial keratotomy or keratomileusis or excimer laser refractive keratectomy.

(44) For expenses incurred at a health spa or similar facility.

(45) For self-help training and other forms of non-medical self-care, except as otherwise provided herein.

(46) For examinations relating to research screenings.

(47) For stand-by charges of a Physician.

(48) Physical exams and immunizations required for enrollment in any insurance program, as a condition of employment, for licensing, or for other purposes.

(49) Related to radial keratotomy or keratomileusis or excimer laser photo refractive keratectomy.

(50) Related to artificial and/or mechanical hearts or ventricular and/or atrial assist devices related to a heart condition or for subsequent services and supplies for a heart condition as long as any of the above devices remain in place. This Exclusion includes services for implantation, removal and complications. This Exclusion does not apply to left ventricular assist devices when used as a bridge to a heart transplant.

(51) For Private Duty Nursing Services rendered in a Hospital or Skilled Nursing Facility; Private Duty Nursing Services are Covered Charges only when provided through the Home Care Services benefit as specifically stated in the "Covered Charges" section.

(52) For Manipulation Therapy services rendered in the home as part of Home Care Services.

(53) Services and supplies related to sex transformation and/or the reversal thereof, or male or female sexual or erectile dysfunctions or inadequacies, regardless of origin or cause. This Exclusion includes sexual therapy and counseling. This exclusion also includes penile prostheses or implants and vascular or artificial reconstruction, Prescription Drugs, and all other procedures and equipment developed for or used in the treatment of impotency, and all related Diagnostic Testing.

(54) For elective abortions and/or fetal reduction surgery. An elective (voluntary) abortion is one performed for reasons other than described in Maternity Services in the "Covered Charges" section.

(55) For Drugs prescribed to treat a type of cancer, but which have not yet been approved by the United States Food and Drug Administration (FDA). Experimental/Investigative services or supplies are not covered, unless otherwise required by law. These include any treatment, procedures, Drugs, biological products, medical devices or any hospitalization.

(56) For preventive services, except as specifically stated in this Plan Document.

(57) For (services or supplies related to) alternative or complementary medicine. Services in this category include, but are not limited to, acupuncture, holistic medicine, homeopathy, hypnosis, aroma therapy, massage therapy (unless rendered as part of a physical therapy treatment plan), reike therapy, herbal, vitamin or dietary products or therapies, naturopathy, thermograph, orthomolecular therapy, contact reflex analysis, bioenergial synchronization technique (BEST) and iridology-study of the iris.

(58) For hiring, or the services of, a surrogate mother.

(59) For surgical treatment of gynecomastia.

(60) For treatment of hyperhidrosis (excessive sweating).

(61) For any service for which you are responsible under the terms of this Plan Document to pay a Copayment, Coinsurance or Deductible, and the Copayment, Coinsurance or Deductible is waived by a Non-Network Provider.

(62) Human Growth Hormone for children born small for gestational age. It is only a Covered Charge in other situations when allowed by the Administrator, on behalf of the Employer, through prior Authorization.

(63) Complications directly related to a service or treatment that is a non-Covered Charge under the Plan because it was determined by the Administrator, on behalf of the Employer, to be Experimental/ Investigational or non-Medically Necessary. Directly related means that the service or treatment occurred as a direct result of the Experimental/Investigational or non-Medically Necessary service and would not have taken place in the absence of the Experimental/Investigational or non- Medically Necessary service.

(64) For Drugs, devices, products, or supplies with over the counter equivalents and any Drugs, devices, products, or supplies that are therapeutically comparable to an over the counter Drug, device, product, or supply.

(65) Sclerotherapy for the treatment of varicose veins of the lower extremities including ultrasonic guidance for needle and/or catheter placement and subsequent sequential ultrasound studies to assess the results of ongoing treatment of varicose veins of the lower extremities with sclerotherapy.

(66) Treatment of telangiectatic dermal veins (spider veins) by any method.

(67) Reconstructive services except as specifically stated in the Covered Charges section of this Plan Document, or as required by law.

(68) For nutritional and dietary supplements, except as provided in the Covered Charges section of this Plan Document or as required by law. This exclusion includes, but is not limited to, those supplements that by law do not require either the written prescription of a Physician or dispensing by a licensed pharmacist. It also includes vitamins and food replacements, such as infant formulas and enteral formulas.

(69) For room and board charges unless the treatment provided meets the Administrator's Medical Necessity criteria for Inpatient admission for your condition.

(70) For supervised living or halfway houses.

(71) For services or care provided or billed by a school, halfway house, Custodial Care center for the developmentally disabled, or outward bound programs, even if psychotherapy is included.

PRESCRIPTION DRUG BENEFITS

Pharmacy Drug Charge

Participating pharmacies have contracted with the Plan to charge Covered Persons reduced fees for covered Prescription Drugs. CVS/Caremark is the administrator of the pharmacy drug plan.

Copayments

The copayment is applied to each covered pharmacy drug or mail order drug charge and is shown in the schedule of benefits. The copayment amount is not a Covered Charge under the medical Plan. Any one pharmacy prescription is limited to a 30-day supply. Any one mail order prescription is limited to a 90-day supply.

If a drug is purchased from a non-participating pharmacy, or a participating pharmacy when the Covered Person's ID card is not used, the amount payable in excess of the amounts shown in the schedule of benefits will be the ingredient cost and dispensing fee.

Percentages Payable

The percentage payable amount is applied to each covered pharmacy drug or mail order drug charge and is shown in the schedule of benefits.

Per-Prescription Maximum

The per-prescription maximum is the maximum amount this Plan will pay toward any one covered prescription.

Mail Order Drug Benefit Option

The mail order drug benefit option is available for maintenance medications (those that are taken for long periods of time, such as drugs sometimes prescribed for heart disease, high blood pressure, asthma, etc.). Because of volume buying, CVS/Caremark, is the mail order pharmacy, is able to offer Covered Persons significant savings on their prescriptions.

Covered Prescription Drugs

(1) All drugs prescribed by a Physician that require a prescription either by federal or state law. This includes oral contraceptives, but excludes any drugs stated as not covered under this Plan.

(2) All compounded prescriptions containing at least one prescription ingredient in a therapeutic quantity.

(3) Insulin and other diabetic supplies when prescribed by a Physician.

(4) Injectable drugs or any prescription directing administration by injection.

Limits to This Benefit

This benefit applies only when a Covered Person incurs a covered Prescription Drug charge. The covered drug charge for any one prescription will be limited to:

(1) Refills only up to the number of times specified by a Physician.

(2) Refills up to one year from the date of order by a Physician.

Expenses Not Covered

This benefit will not cover a charge for any of the following:

(1) **Administration.** Any charge for the administration of a covered Prescription Drug.

(2) **Appetite suppressants.** A charge for appetite suppressants, dietary supplements or vitamin supplements, except for prenatal vitamins requiring a prescription or prescription vitamin supplements containing fluoride.

(3) **Consumed on premises.** Any drug or medicine that is consumed or administered at the place where it is dispensed.

(4) **Devices.** Devices of any type, even though such devices may require a prescription. These include (but are not limited to) therapeutic devices, artificial appliances, braces, support garments, or any similar device.

(5) **Drugs used for cosmetic purposes.** Charges for drugs used for cosmetic purposes, such as anabolic steroids, Retin A or medications for hair growth or removal.

(6) **Experimental.** Experimental drugs and medicines, even though a charge is made to the Covered Person.

(7) **FDA.** Any drug not approved by the Food and Drug Administration.

(8) **Growth hormones.** Charges for drugs to enhance physical growth or athletic performance or appearance.

(9) **Immunization.** Immunization agents or biological sera.

(10) **Impotence.** A charge for impotence medication.

(11) **Infertility.** A charge for infertility medication.

(12) **Inpatient medication.** A drug or medicine that is to be taken by the Covered Person, in whole or in part, while Hospital confined. This includes being confined in any institution that has a facility for the dispensing of drugs and medicines on its premises.

(13) **Investigational.** A drug or medicine labeled: "Caution - limited by federal law to investigational use".

(14) **Medical exclusions.** A charge excluded under Medical Plan Exclusions.

(15) **No charge.** A charge for Prescription Drugs which may be properly received without charge under local, state or federal programs.

(16) **Non-legend drugs.** A charge for FDA-approved drugs that are prescribed for non-FDA-approved uses.

(17) **No prescription.** A drug or medicine that can legally be bought without a written prescription. This does not apply to injectable insulin.

(18) **Refills.** Any refill that is requested more than one year after the prescription was written or any refill that is more than the number of refills ordered by the Physician.

(19) **Smoking cessation.** A charge for Prescription Drugs, such as nicotine gum or smoking deterrent products, for smoking cessation.

HOW TO SUBMIT A CLAIM

Benefits under this Plan shall be paid only if the Plan Administrator decides in its discretion that a Covered Person is entitled to them.

When a Covered Person has a Claim to submit for payment that person must:

(1) Obtain a Claim form from the Personnel Office, Human Resources Office or the Plan Administrator.

(2) Complete the Employee portion of the form. ALL QUESTIONS MUST BE ANSWERED.

(3) Have the Physician complete the provider's portion of the form.

(4) For Plan reimbursements, attach bills for services rendered. ALL BILLS MUST SHOW:

- Name of Plan
- Employee's name
- Name of patient
- Name, address, telephone number of the provider of care
- Diagnosis
- Type of services rendered, with diagnosis and/or procedure codes
- Date of services
- Charges

(5) Send the above to the Claims Administrator at this address:

ARC Administrators
P.O. Box 12290
Lexington, Kentucky 40582
(877) 309-2955

WHEN CLAIMS SHOULD BE FILED

Claims from Network and Non-Network providers should be filed with the Claims Administrator within 180 days of the date charges for the service were incurred. Benefits are based on the Plan's provisions at the time the charges were incurred. Claims filed later than that date may be declined or reduced unless:

(a) It’s not reasonably possible to submit the claim in that time; and

(b) The claim is submitted within one year from the date incurred. This one year period will not apply when the person is not legally capable of submitting the claim.

The Claims Administrator will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested from the claimant. The Plan reserves the right to have a Plan Participant seek a second medical opinion.

CLAIMS PROCEDURE

Following is a description of how the Plan processes claims for benefits and reviews the appeal of any claim that is denied. The terms used in this section are defined below.

A "Claim" is defined as any request for a Plan benefit, made by a claimant or by a representative of a claimant, which complies with the Plan's reasonable procedure for filing claims and making benefit claims determinations.

A "Claim" does not include a request for a determination of an individual's eligibility to participate in the Plan.

If a Claim is denied, in whole or in part, the denial is known as an "Adverse Benefit Determination."

A claimant has the right to request a review of an Adverse Benefit Determination. This request is an "Appeal." If the Claim is denied at the end of the Appeal process, as described below, the Plan's final decision is known as a "Final Adverse Benefit Determination."

Both the Claims and the Appeal procedures are intended to provide a full and fair review.

A claimant must follow all Claims and Appeal procedures before he or she can file a lawsuit. If a lawsuit is brought, it must be filed within two years after the final determination of an Appeal.

Any of the authority and responsibilities of the Plan Administrator under the Claims and Appeal Procedures, including the discretionary authority to interpret the terms of the Plan, may be delegated to a third party. If you have any questions regarding these procedures, please contact the Plan Administrator.

There are different kinds of Claims and each one has a specific timetable for each step in the review process. Upon receipt of the Claim, the Claims Administrator will advise the Plan Administrator regarding the approval or denial of the Claim. The Claims Administrator's notification to the claimant of the Plan Administrator's decision must be made as soon as practical and not later than the time shown in the timetable. However, if the Claim has not been filed properly, or if it is incomplete, or if there are other matters beyond the control of the Plan Administrator, the claimant may be notified that the period for providing the notification will need to be extended.

If the period is extended because the Claims Administrator or the Plan Administrator needs more information from the claimant, the claimant must provide the requested information within the time shown on the timetable. Once the Claim is complete, the Plan Administrator must make its decision as shown in the timetable. If the Claim is denied, in whole or in part, the claimant has the right to file an Appeal. Then the Plan Administrator must decide the Appeal and, if the Appeal is denied, provide notice to the claimant within the time periods shown on the timetable. The time periods shown in the timetable begin at the time the Claim or Appeal is filed in accordance with the Plan's procedures. Decisions will be made within a reasonable period of time appropriate to the circumstances, but within the maximum time periods listed in the timetables below. Unless otherwise noted, "days" means calendar days.

The definitions of the types of Claims are:

Urgent Care Claim

A Claim involving Urgent Care is any Claim for medical care or treatment where the Plan conditions receipt of benefits, in whole or in part, on approval in advance of obtaining the care or treatment, and using the timetable for a non-urgent care determination could seriously jeopardize the life or health of the claimant; or the ability of the claimant to regain maximum function; or in the opinion of the attending or consulting Physician, would subject the claimant to severe pain that could not be adequately managed without the care or treatment that is the subject of the Claim. The Urgent Care Claim rules do not apply to claims involving urgent care where Plan benefits are not conditioned on prior approval. These claims are subject to the rules on Post-Service Claims described below.

A Physician with knowledge of the claimant's medical condition may determine if a Claim is one involving Urgent Care. If there is no such Physician, an individual acting on behalf of the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine may make the determination.

In the case of a Claim involving Urgent Care, responses must be made as soon as possible consistent with the medical urgency involved, and no later than the following times:

Notification to claimant of Claim determination	72 hours

Insufficient information on the Claim, or failure to follow the Plan's procedure for filing a Claim:

Notification to claimant, orally or in writing	24 hours
Response by claimant, orally or in writing	48 hours
Benefit determination, orally or in writing	48 hours
Notification of Adverse Benefit Determination on Appeal	72 hours

If there is an Adverse Benefit Determination on a Claim involving Urgent Care, a request for an expedited Appeal may be submitted orally or in writing by the claimant. All necessary information, including the Plan's benefit determination on review, may be transmitted between the Plan and the claimant by telephone, facsimile, or other similarly expeditious method.

Concurrent Care Claims

A Concurrent Care Claim is a special type of Claim that arises if the Plan informs a claimant that benefits for a course of treatment that has been previously approved for a period of time or number of treatments is to be reduced or eliminated. In that case, the Plan must notify the claimant sufficiently in advance of the effective date of the reduction or elimination of treatment to allow the claimant to file an Appeal. This rule does not apply if benefits are reduced or eliminated due to Plan amendment or termination.

In the case of a Concurrent Care Claim, the following timetable applies:

Notification to claimant of benefit reduction	Sufficiently prior to scheduled termination of course of treatment to allow claimant to appeal
Notification to claimant of rescission	30 days
Notification of determination on Appeal of Claims involving Urgent Care	24 hours (provided claimant files Appeal more than 24 hours prior to scheduled termination of course of treatment)
Notification of Adverse Benefit Determination on Appeal for non-Urgent Claims	As soon as feasible, but not more than 30 days

Pre-Service Claim

A Pre-Service Claim means any Claim for a benefit under this Plan where the Plan conditions receipt of the benefit, in whole or in part, on approval in advance of obtaining medical care. These are, for example, Claims subject to pre-certification. Please see the Cost Management section of this booklet for further information about Pre-Service Claims.

In the case of a Pre-Service Claim, the following timetable applies:

Notification to claimant of Adverse Benefit Determination	15 days
Extension due to matters beyond the control of the Plan	15 days
Insufficient information on the Claim:	
Notification of	15 days
Response by claimant	45 days

Notification, orally or in writing, of failure to follow the Plan's procedures for filing a Claim	5 days
Notification of Adverse Benefit Determination on Appeal	30 days

Post-Service Claim

A Post-Service Claim means any Claim for a Plan benefit that is not an Urgent Care Claim or a Pre-Service Claim; in other words, a Claim that is a request for payment under the Plan for medical services already received by the claimant.

In the case of a Post-Service Claim, the following timetable applies:

Notification to claimant of Adverse Benefit Determination	30 days
Extension due to matters beyond the control of the Plan	15 days
Extension due to insufficient information on the Claim	15 days
Response by claimant following notice of insufficient information	45 days
Notification of Adverse Benefit Determination on Appeal	60 days

Notice to claimant of Adverse Benefit Determinations

If a Claim is denied in whole or in part, the denial is considered to be an Adverse Benefit Determination. Except with Urgent Care Claims, when the notification may be oral followed by written or electronic notification within three days of the oral notification, the Claims Administrator on behalf of the Plan Administrator shall provide written or electronic notification of the Adverse Benefit Determination. The notice will state in a manner calculated to be understood by the claimant:

(1) The specific reason or reasons for the adverse determination.

(2) Reference to the specific Plan provisions on which the determination was based.

(3) A description of any additional material or information necessary for the claimant to perfect the Claim and an explanation of why such material or information is necessary.

(4) A description of the Plan's Appeal procedures. This description will include information on how to initiate the Appeal and the time limits applicable to such procedures. This will include a statement of the claimant's right to bring a civil action under section 502 of ERISA following a Final Adverse Benefit Determination.

(5) If the Adverse Benefit Determination was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the Adverse Benefit Determination and a copy will be provided free of charge to the claimant upon request.

(6) If the Adverse Benefit Determination is based on the Medical Necessity or Experimental or Investigational treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided free of charge, upon request.

Appeals

When a claimant receives notification of an Adverse Benefit Determination, the claimant generally has 180 days following receipt of the notification in which to file a written request for an Appeal of the decision. However, for Concurrent Care Claims, the Claimant must file the Appeal prior to the scheduled reduction or termination of treatment. A claimant may submit written comments, documents, records, and other information relating to the

Claim.

If the claimant so requests, he or she will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.

A document, record, or other information shall be considered relevant to a Claim if it:

(1) was relied upon in making the benefit determination;

(2) was submitted, considered, or generated in the course of making the benefit determination, without regard to whether it was relied upon in making the benefit determination;

(3) demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that benefit determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all claimants; or

(4) constituted a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit.

The period of time within which a benefit determination on Appeal is required to be made shall begin at the time an Appeal is filed in writing in accordance with the procedures of the Plan. This timing is without regard to whether all the necessary information accompanies the filing.

The review shall take into account all comments, documents, records, and other information submitted by the claimant relating to the Claim, without regard to whether such information was submitted or considered in the initial benefit determination. The review will not afford deference to the initial Adverse Benefit Determination and will be conducted by a fiduciary of the Plan who is neither the individual who made the adverse determination nor a subordinate of that individual.

If the determination was based on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is Experimental, Investigational, or not Medically Necessary or appropriate, the fiduciary shall consult with a health care professional who was not involved in the original benefit determination. This health care professional will have appropriate training and experience in the field of medicine involved in the medical judgment. Additionally, medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the initial determination will be identified.

If the Appeal of a Claim is denied, in whole or in part, the Plan Administrator shall provide written notification of the Adverse Benefit Determination on Appeal. The notice will state, in a manner calculated to be understood by the claimant:

(1) The specific reason or reasons for the adverse determination.

(2) Reference to the specific Plan provisions on which the determination was based.

(3) A description of any additional material or information necessary for the claimant to perfect the Claim and an explanation of why such material or information is necessary.

(4) A description of the Plan's review procedures and the time limits applicable to such procedures. This will include a statement of the claimant's right to bring a civil action under section 502 of ERISA following an Adverse Benefit Determination on review.

(5) A statement that the claimant 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 Claim.

(6) If the Adverse Benefit Determination was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the Adverse Benefit Determination and a copy will be provided free of charge to the claimant upon request.

(7) If the Adverse Benefit Determination is based on the Medical Necessity or Experimental or Investigational treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided free of charge, upon request.

COORDINATION OF BENEFITS

Coordination of the benefit plans. Coordination of benefits sets out rules for the order of payment of Covered Charges when two or more plans -- including Medicare -- are paying. When a Covered Person is covered by this Plan and another plan, or the Covered Person's Spouse is covered by this Plan and by another plan or the couple's Covered children are covered under two or more plans, the plans will coordinate benefits when a claim is received.

The plan that pays first according to the rules will pay as if there were no other plan involved. The secondary and subsequent plans will pay the balance up to each one's plan formula minus whatever the primary plan paid. This is called non-duplication of benefits. The total reimbursement will never be more than the amount that would have been paid if the secondary plan had been the primary plan -- 50% or 80% or 100% -- whatever it may be. The balance due, if any, is the responsibility of the Covered Person.

Benefit plan. This provision will coordinate the medical benefits of a benefit plan. The term benefit plan means this Plan or any one of the following plans:

(1) Group or group-type plans, including franchise or blanket benefit plans.

(2) Blue Cross and Blue Shield group plans.

(3) Group practice and other group prepayment plans.

(4) Federal government plans or programs. This includes, but is not limited to, Medicare and Tricare.

(5) Other plans required or provided by law. This does not include Medicaid or any benefit plan like it that, by its terms, does not allow coordination.

(6) No Fault Auto Insurance, by whatever name it is called, when not prohibited by law.

Allowable Charge. For a charge to be allowable it must be a Usual and Reasonable Charge and at least part of it must be covered under this Plan.

In the case of HMO (Health Maintenance Organization) or other in-network only plans: This Plan will not consider any charges in excess of what an HMO or network provider has agreed to accept as payment in full. Also, when an HMO or network plan is primary and the Covered Person does not use an HMO or network provider, this Plan will not consider as an Allowable Charge any charge that would have been covered by the HMO or network plan had the Covered Person used the services of an HMO or network provider.

In the case of service type plans where services are provided as benefits, the reasonable cash value of each service will be the Allowable Charge.

Automobile limitations. When medical payments are available under vehicle insurance, the Plan shall always be considered the secondary carrier regardless of the individual's election under PIP (personal injury protection) coverage with the auto carrier.

Benefit plan payment order. When two or more plans provide benefits for the same Allowable Charge, benefit payment will follow these rules:

(1) Plans that do not have a coordination provision, or one like it, will pay first. Plans with such a provision will be considered after those without one.

(2) Plans with a coordination provision will pay their benefits up to the Allowable Charge:

(a) The benefits of the plan which covers the person directly (that is, as an employee, member or subscriber) ("Plan A") are determined before those of the plan which covers the person as a dependent ("Plan B").

(b) The benefits of a benefit plan which covers a person as an Employee who is neither laid off nor retired are determined before those of a benefit plan which covers that person as a

laid-off or Retired Employee. The benefits of a benefit plan which covers a person as a Dependent of an Employee who is neither laid off nor retired are determined before those of a benefit plan which covers a person as a Dependent of a laid off or Retired Employee. If the other benefit plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.

(c) The benefits of a benefit plan which covers a person as an Employee who is neither laid off nor retired or a Dependent of an Employee who is neither laid off nor retired are determined before those of a plan which covers the person as a COBRA beneficiary.

(d) When a child is covered as a Dependent and the parents are not separated or divorced, these rules will apply:

(i) The benefits of the benefit plan of the parent whose birthday falls earlier in a year are determined before those of the benefit plan of the parent whose birthday falls later in that year;

(ii) If both parents have the same birthday, the benefits of the benefit plan which has covered the parent for the longer time are determined before those of the benefit plan which covers the other parent.

(e) When a child's parents are divorced or legally separated, these rules will apply:

(i) This rule applies when the parent with custody of the child has not remarried. The benefit plan of the parent with custody will be considered before the benefit plan of the parent without custody.

(ii) This rule applies when the parent with custody of the child has remarried. The benefit plan of the parent with custody will be considered first. The benefit plan of the stepparent that covers the child as a Dependent will be considered next. The benefit plan of the parent without custody will be considered last.

(iii) This rule will be in place of items (i) and (ii) above when it applies. A court decree may state which parent is financially responsible for medical and dental benefits of the child. In this case, the benefit plan of that parent will be considered before other plans that cover the child as a Dependent.

(iv) If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined above when a child is covered as a Dependent and the parents are not separated or divorced.

(v) For parents who were never married to each other, the rules apply as set out above as long as paternity has been established.

(f) If there is still a conflict after these rules have been applied, the benefit plan which has covered the patient for the longer time will be considered first. When there is a conflict in coordination of benefit rules, the Plan will never pay more than 50% of Allowable Charges when paying secondary.

(3) Medicare will pay primary, secondary or last to the extent stated in federal law. When Medicare would be the primary payer if the person had enrolled in Medicare, this Plan will base its payment upon benefits that would have been paid by Medicare under Parts A and B regardless of whether or not the person was enrolled under any of these parts. The Plan reserves the right to coordinate benefits with respect to Medicare Part D. The Plan Administrator will make this determination based on the information available through CMS. If CMS does not provide sufficient information to determine the amount Medicare would pay, the Plan Administrator will make reasonable assumptions based on published Medicare fee schedules.

(4) If a Plan Participant is under a disability extension from a previous benefit plan, that benefit plan will pay first and this Plan will pay second.

(5) The Plan will pay primary to Tricare and a State child health plan to the extent required by federal law.

Claims determination period. Benefits will be coordinated on a Calendar Year basis. This is called the claims determination period.

Right to receive or release necessary information. To make this provision work, this Plan may give or obtain needed information from another insurer or any other organization or person. This information may be given or obtained without the consent of or notice to any other person. A Covered Person will give this Plan the information it asks for about other plans and their payment of Allowable Charges.

Facility of payment. This Plan may repay other plans for benefits paid that the Plan Administrator determines it should have paid. That repayment will count as a valid payment under this Plan.

Right of recovery. This Plan may pay benefits that should be paid by another benefit plan. In this case this Plan may recover the amount paid from the other benefit plan or the Covered Person. That repayment will count as a valid payment under the other benefit plan.

Further, this Plan may pay benefits that are later found to be greater than the Allowable Charge. In this case, this Plan may recover the amount of the overpayment from the source to which it was paid.

Exception to Medicaid. In accordance with ERISA, the Plan shall not take into consideration the fact that an individual is eligible for or is provided medical assistance through Medicaid when enrolling an individual in the Plan or making a determination about the payments for benefits received by a Covered Person under the Plan.

THIRD PARTY RECOVERY PROVISION

RIGHT OF SUBROGATION AND REFUND

When this provision applies. The Covered Person may incur medical or dental charges due to Injuries which may be caused by the act or omission of a Third Party or a Third Party may be responsible for payment. In such circumstances, the Covered Person may have a claim against that Third Party, or insurer, for payment of the medical or dental charges. Accepting benefits under this Plan for those incurred medical or dental expenses automatically assigns to the Plan any rights the Covered Person may have to Recover payments from any Third Party or insurer. This Subrogation right allows the Plan to pursue any claim which the Covered Person has against any Third Party, or insurer, whether or not the Covered Person chooses to pursue that claim. The Plan may make a claim directly against the Third Party or insurer, but in any event, the Plan has a lien on any amount Recovered by the Covered Person whether or not designated as payment for medical expenses. This lien shall remain in effect until the Plan is repaid in full.

The payment for benefits received by a Covered Person under the Plan shall be made in accordance with the assignment of rights by or on behalf of the Covered Person as required by Medicaid.

In any case in which the Plan has a legal liability to make payments for benefits received by a Covered Person, to the extent that payment has been made through Medicaid, the payment for benefits under the Plan shall be made in accordance with any state law that has provided that the state has acquired the rights of the Covered Person to the payments of those benefits.

The Covered Person:

(1) Automatically assigns to the Plan his or her rights against any Third Party or insurer when this provision applies; and

(2) Must repay to the Plan the benefits paid on his or her behalf out of the Recovery made from the Third Party or insurer.

Amount subject to Subrogation or Refund. The Covered Person agrees to recognize the Plan's right to Subrogation and reimbursement. These rights provide the Plan with a 100%, first dollar priority over <u>any</u> and all Recoveries and funds paid by a Third Party to a Covered Person relative to the Injury or Sickness, including a priority over any claim for non-medical or dental charges, attorney fees, or other costs and expenses. Accepting benefits under this Plan for those incurred medical or dental expenses automatically assigns to the Plan any and all rights the Covered Person may have to recover payments from any responsible third party. Further, accepting benefits under this Plan for those incurred medical or dental expenses automatically assigns to the Plan the Covered Person's Third Party Claims.

Notwithstanding its priority to funds, the Plan's Subrogation and Refund rights, as well as the rights assigned to it, are limited to the extent to which the Plan has made, or will make, payments for medical or dental charges as well as any costs and fees associated with the enforcement of its rights under the Plan. The Plan reserves the right to be reimbursed for its court costs and attorneys' fees if the Plan needs to file suit in order to Recover payment for medical or dental expenses from the Covered Person. Also, the Plan's right to Subrogation still applies if the Recovery received by the Covered Person is less than the claimed damage, and, as a result, the claimant is not made whole.

When a right of Recovery exists, the Covered Person will execute and deliver all required instruments and papers as well as doing whatever else is needed to secure the Plan's right of Subrogation as a condition to having the Plan make payments. In addition, the Covered Person will do nothing to prejudice the right of the Plan to Subrogate.

Conditions Precedent to Coverage. The Plan shall have no obligation whatsoever to pay medical or dental benefits to a Covered Person if a Covered Person refuses to cooperate with the Plan's reimbursement and Subrogation rights or refuses to execute and deliver such papers as the Plan may require in furtherance of its reimbursement and Subrogation rights. Further, in the event the Covered Person is a minor, the Plan shall have no obligation to pay any medical or dental benefits incurred on account of Injury or Sickness caused by a responsible Third Party until after the Covered Person or his authorized legal representative obtains valid court recognition and approval of the Plan's 100%, first dollar reimbursement and Subrogation rights on all

Recoveries, as well as approval for the execution of any papers necessary for the enforcement thereof, as described herein.

Defined terms: "Covered Person" means anyone covered under the Plan, including minor dependents.

"Recover," "Recovered," "Recovery" or "Recoveries" means all monies paid to the Covered Person by way of judgment, settlement, or otherwise to compensate for all losses caused by the Injury or Sickness, whether or not said losses reflect medical or dental charges covered by the Plan. "Recoveries" further includes, but is not limited to, recoveries for medical or dental expenses, attorneys' fees, costs and expenses, pain and suffering, loss of consortium, wrongful death, lost wages and any other recovery of any form of damages or compensation whatsoever.

"Refund" means repayment to the Plan for medical or dental benefits that it has paid toward care and treatment of the Injury or Sickness.

"Subrogation" means the Plan's right to pursue and place a lien upon the Covered Person's claims for medical or dental charges against the other person.

"Third Party" means any Third Party including another person or a business entity.

Recovery from another plan under which the Covered Person is covered. This right of Refund also applies when a Covered Person Recovers under an uninsured or underinsured motorist plan (which will be treated as Third Party coverage when reimbursement or Subrogation is in order), homeowner's plan, renter's plan, medical malpractice plan or any liability plan.

Rights of Plan Administrator. The Plan Administrator has a right to request reports on and approve of all settlements.

CONTINUATION COVERAGE RIGHTS UNDER COBRA

Under federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), certain Employees and their families covered under Asbury University Employee Medical Benefit Plan (the Plan) will be entitled to the opportunity to elect a temporary extension of health coverage (called "COBRA continuation coverage") where coverage under the Plan would otherwise end. This notice is intended to inform Plan Participants and beneficiaries, in summary fashion, of their 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.

The Plan Administrator is Asbury University, 1 Macklem Drive, Wilmore, Kentucky, 40390, (859) 858-3511. COBRA continuation coverage for the Plan is administered by ARC Administrators, P.O Box 12290, Lexington, Kentucky 40582, (877) 309-2955. Complete instructions on COBRA, as well as election forms and other information, will be provided by the Plan Administrator or its designee to Plan Participants who become Qualified Beneficiaries under COBRA.

What is COBRA continuation coverage? COBRA continuation coverage is the temporary extension of group health plan coverage that must be offered to certain Plan Participants and their eligible family members (called "Qualified Beneficiaries") at group rates. The right to COBRA continuation coverage is triggered by the occurrence of a life event that results in the loss of coverage under the terms of the 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 can become a Qualified Beneficiary? In general, a Qualified Beneficiary can be:

(1) 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 who otherwise qualifies as a Qualified Beneficiary 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.

(2) Any child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, and any individual who is covered by the Plan as an alternate recipient under a qualified medical support order. If, however, an individual who otherwise qualifies as a Qualified Beneficiary 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 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., common-law employees (full or part-time), self-employed individuals, independent contractor, or corporate director). However, this provision does not establish eligibility of these individuals. Eligibility for Plan Coverage shall be determined in accordance with Plan Eligibility provisions.

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 nonresident 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 will also not be considered a Qualified Beneficiary by virtue of the relationship to the individual. A domestic partner is not a Qualified Beneficiary.

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 independent election to receive COBRA continuation coverage.

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

(1) The death of a covered Employee.

(2) The termination (other than by reason of the Employee's gross misconduct), or reduction of hours, of a covered Employee's employment.

(3) The divorce or legal separation of a covered Employee from the Employee's Spouse. If the Employee reduces or eliminates the Employee's Spouse's Plan coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a Qualifying Event even though the Spouse's coverage was reduced or eliminated before the divorce or legal separation.

(4) A covered Employee's enrollment in any part of the Medicare program.

(5) A Dependent child's ceasing to satisfy the Plan's requirements for a Dependent child (for example, attainment of the maximum age for dependency under the Plan).

If the Qualifying Event causes the covered Employee, or the covered 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 COBRA are also met. For example, any increase in contribution that must be paid by a covered Employee, or the Spouse, or a Dependent child of the covered Employee, for coverage under the Plan that results from the occurrence of one of the events listed above is a loss of coverage.

The taking of leave under the Family and Medical Leave Act of 1993 ("FMLA") does not constitute a Qualifying Event. A Qualifying Event will occur, 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.

What factors should be considered when determining to elect COBRA continuation coverage? You should take into account that a failure to continue your group health coverage will affect your rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied by other group health plans if there is more than a 63-day gap in health coverage and election of COBRA continuation coverage may help you avoid such a gap. (These pre-existing condition exclusions will only apply during Plan Years that begin before January 1, 2014.) Second, if you do not elect COBRA continuation coverage and pay the appropriate premiums for the maximum time available to you, you will lose the right to convert to an individual health insurance policy, which does not impose such pre-existing condition exclusions. Finally, you should take into account that you have special enrollment rights under federal law (HIPAA). You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your Spouse's employer) within 30 days after Plan coverage ends due to a Qualifying Event listed above. You will also have the same special right at the end of COBRA continuation coverage if you get COBRA continuation coverage for the maximum time available to you.

What is the procedure for obtaining COBRA continuation coverage? The Plan has conditioned the availability of COBRA continuation coverage upon the timely election of such coverage. An election is timely if it is made during the election period.

What is the election period and how long must it last? The election period is the time period within which the Qualified Beneficiary must elect COBRA continuation coverage under the Plan. The election period must begin no later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event and ends 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. If coverage is not elected within the 60 day period, all rights to elect COBRA continuation coverage are forfeited.

Note: If a covered Employee who has been terminated or experienced a reduction of hours qualifies for a trade readjustment allowance or alternative trade adjustment assistance under a federal law called the Trade Act of 2002, and the Employee and his or her covered Dependents have not elected COBRA coverage within the normal election period, a second opportunity to elect COBRA coverage will be made available for themselves and certain family members, but only within a limited period of 60 days or less and only during the six months immediately after their group health plan coverage ended. Any person who qualifies or thinks that he and/or his family members may qualify for assistance under this special provision should contact the Plan Administrator for further information about the special second election period.

The Trade Act of 2002 also created a tax credit for certain TAA-eligible individuals and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) (eligible individuals). Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. If you have questions about these new tax provisions, you may call the Health Coverage Tax Credit Consumer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact.

Is a covered Employee or Qualified Beneficiary responsible for informing the Plan Administrator of the occurrence of a Qualifying Event? The Plan will offer COBRA continuation coverage to Qualified Beneficiaries only after the Plan Administrator or its designee has been timely notified that a Qualifying Event has occurred. The employer (if the employer is not the Plan Administrator) will notify the Plan Administrator of the Qualifying Event within 30 days following the date coverage ends when the Qualifying Event is:

(1) The end of employment or reduction of hours of employment,

(2) Death of the Employee,

(3) Commencement of a proceeding in bankruptcy with respect to the employer, or

(4) Entitlement of the employee to any part of Medicare.

IMPORTANT:

For the other Qualifying Events (divorce or legal separation of the Employee and Spouse or a Dependent child's losing eligibility for coverage as a Dependent child), you or someone on your behalf must notify the Plan Administrator or its designee in writing within 60 days after the Qualifying Event occurs, using the procedures specified below. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator or its designee during the 60-day notice period, any Spouse or Dependent child who loses coverage will not be offered the option to elect continuation coverage. You must send this notice to the COBRA Administrator.

NOTICE PROCEDURES:

Any notice that you provide must be ***in writing***. Oral notice, including notice by telephone, is not acceptable. You must mail, fax or hand-deliver your notice to the person, department or firm listed below, at the following address:

Mail to:
ARC Administrators
P.O. Box 12290
Lexington, KY 40582

Fax to:
859-243-0381

In Person Delivery:
ARC Administrators
333 W Vine Street, Suite 900
Lexington, Kentucky 40507

If mailed, your notice must be postmarked no later than the last day of the required notice period. Any notice you provide must state:

- the **name of the plan or plans** under which you lost or are losing coverage,
- the **name and address of the Employee** covered under the plan,
- the **name(s) and address(es) of the Qualified Beneficiary(ies)**, and
- the **Qualifying Event** and the **date** it happened.

If the Qualifying Event is a **divorce or legal separation**, your notice must include **a copy of the divorce decree or the legal separation agreement.**

Be aware that there are other notice requirements in other contexts, for example, in order to qualify for a disability extension.

Once the Plan Administrator or its designee receives *timely 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 for their Spouses, and parents may elect COBRA continuation coverage on behalf of their children. For each Qualified Beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that plan coverage would otherwise have been lost. If you or your Spouse or Dependent children do not elect continuation coverage within the 60-day election period described above, the right to elect continuation coverage will be lost.

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 Plan Administrator or its designee, as applicable.

Is COBRA coverage available if a Qualified Beneficiary has other group health plan coverage or Medicare? Qualified beneficiaries who are entitled to elect COBRA continuation coverage may do so even if they are covered under another group health plan or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, a Qualified Beneficiary's COBRA coverage will terminate automatically if, after electing COBRA, he or she becomes entitled to Medicare or becomes covered under other group health plan coverage (but only after any applicable preexisting condition exclusions of that other plan have been exhausted or satisfied).

When may 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 not before the earliest of the following dates:

(1) The last day of the applicable maximum coverage period.

(2) The first day for which Timely Payment is not made to the Plan with respect to the Qualified Beneficiary.

(3) The date upon which the Employer ceases to provide any group health plan (including a successor plan) to any employee.

(4) 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.

(5) The date, after the date of the election, that the Qualified Beneficiary first becomes entitled to Medicare (either part A or part B, whichever occurs earlier).

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

(a) (i) 29 months after the date of the Qualifying Event, or (ii) the first day of the month that is more than 30 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

(b) 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 the Qualifying Event and the status of the Qualified Beneficiary, as shown below:

(1) In the case of a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period ends 18 months after the Qualifying Event if there is not a disability extension and 29 months after the Qualifying Event if there is a disability extension.

(2) In the case of a covered Employee's enrollment in the Medicare program before experiencing a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period for Qualified Beneficiaries ends on the later of:

(a) 36 months after the date the covered Employee becomes enrolled in the Medicare program. This extension does not apply to the covered Employee; or

(b) 18 months (or 29 months, if there is a disability extension) after the date of the covered Employee's termination of employment or reduction of hours of employment.

(3) 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.

(4) In the case of any other Qualifying Event than that described above, the maximum coverage period ends 36 months after the Qualifying Event.

Under what circumstances can the maximum coverage period be expanded? If a Qualifying Event that gives rise to an 18-month or 29-month maximum coverage period is followed, within that 18- or 29-month period, by a second Qualifying Event that gives rise to a 36-months maximum coverage period, the original period is expanded to 36 months, but only for individuals who are Qualified Beneficiaries at the time of and with respect to both Qualifying Events. In no circumstance can the COBRA maximum coverage period be expanded to more than 36 months after the date of the first Qualifying Event. The Plan Administrator must be notified of the second Qualifying Event within 60 days of the second Qualifying Event. This notice must be sent to the COBRA Administrator in accordance with the procedures above.

How does a Qualified Beneficiary become entitled to a disability extension? A disability extension will be granted if an individual (whether or not the covered Employee) who is a Qualified Beneficiary in connection with the Qualifying Event that is a termination or reduction of hours of a covered Employee's employment, is determined under Title II or XVI of the Social Security Act to have been disabled at any time during the first 60 days of COBRA continuation coverage. To qualify for the disability extension, the Qualified Beneficiary must also provide the Plan Administrator with notice of the disability determination on a date that is both within 60 days after the date of the determination and before the end of the original 18-month maximum coverage. This notice should be sent to the COBRA Administrator in accordance with the procedures above.

Does the Plan require payment for COBRA continuation coverage? For any period of COBRA continuation coverage under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. Qualified beneficiaries will pay up to 102% of the applicable premium and up to 150% of the applicable premium for any expanded period of COBRA continuation coverage covering a disabled Qualified Beneficiary due to a disability extension. The Plan will terminate a Qualified Beneficiary's COBRA continuation coverage as of the first day of any period for which timely payment is not made.

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 a payment made no later than 30 days after the first day of the coverage 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, the Plan does not require payment for any period of COBRA continuation coverage for a Qualified Beneficiary earlier than 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 postmarked to the Plan.

If Timely Payment is made to the Plan in an amount that is not significantly less than the amount the Plan requires to be paid for a period of coverage, then the amount paid will be deemed to satisfy the Plan's requirement for the amount to be paid, unless the Plan notifies the Qualified Beneficiary of the amount of the deficiency and grants a reasonable period of time for payment of the deficiency to be made. A "reasonable period of time" is 30 days after the notice is provided. A shortfall in a Timely Payment is not significant if it is no greater than the lesser of $50 or 10% of the required amount.

IF YOU HAVE QUESTIONS

If you have questions about your COBRA continuation coverage, you should contact the COBRA Administrator. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and

phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

KEEP YOUR PLAN ADMINISTRATOR INFORMED OF ADDRESS CHANGES

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

RESPONSIBILITIES FOR PLAN ADMINISTRATION

PLAN ADMINISTRATOR. Asbury University Employee Medical Benefit Plan is the benefit plan of Asbury University, the Plan Administrator, also called the Plan Sponsor. It is to be administered by the Plan Administrator in accordance with the provisions of ERISA. An individual or committee may be appointed by Asbury University to be Plan Administrator and serve at the convenience of the Employer. If the Plan Administrator or a committee member resigns, dies or is otherwise removed from the position, Asbury University shall appoint a new Plan Administrator as soon as reasonably possible.

The Plan Administrator shall administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits, to decide disputes which may arise relative to a Plan Participant's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator will be final and binding on all interested parties.

Service of legal process may be made upon the Plan Administrator.

DUTIES OF THE PLAN ADMINISTRATOR.

(1) To administer the Plan in accordance with its terms.

(2) To interpret the Plan, including the right to remedy possible ambiguities, inconsistencies or omissions.

(3) To decide disputes which may arise relative to a Plan Participant's rights.

(4) To prescribe procedures for filing a claim for benefits and to review claim denials.

(5) To keep and maintain the Plan documents and all other records pertaining to the Plan.

(6) To appoint a Claims Administrator to pay claims.

(7) To perform all necessary reporting as required by ERISA.

(8) To establish and communicate procedures to determine whether a medical child support order is qualified under ERISA Sec. 609.

(9) To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate.

PLAN ADMINISTRATOR COMPENSATION. The Plan Administrator serves **without** compensation; however, all expenses for plan administration, including compensation for hired services, will be paid by the Plan.

FIDUCIARY. A fiduciary exercises discretionary authority or control over management of the Plan or the disposition of its assets, renders investment advice to the Plan or has discretionary authority or responsibility in the administration of the Plan.

FIDUCIARY DUTIES. A fiduciary must carry out his or her duties and responsibilities for the purpose of providing benefits to the Employees and their Dependent(s), and defraying reasonable expenses of administering the Plan. These are duties which must be carried out:

(1) With care, skill, prudence and diligence under the given circumstances that a prudent person, acting in a like capacity and familiar with such matters, would use in a similar situation;

(2) By diversifying the investments of the Plan so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so; and

(3) In accordance with the Plan documents to the extent that they agree with ERISA.

THE NAMED FIDUCIARY. A "named fiduciary" is the one named in the Plan. A named fiduciary can appoint others to carry out fiduciary responsibilities (other than as a trustee) under the Plan. These other persons become fiduciaries themselves and are responsible for their acts under the Plan. To the extent that the named fiduciary allocates its responsibility to other persons, the named fiduciary shall not be liable for any act or omission of such person unless either:

(1) The named fiduciary has violated its stated duties under ERISA in appointing the fiduciary, establishing the procedures to appoint the fiduciary or continuing either the appointment or the procedures; or

(2) The named fiduciary breached its fiduciary responsibility under Section 405(a) of ERISA.

CLAIMS ADMINISTRATOR IS NOT A FIDUCIARY. A Claims Administrator 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.

FUNDING THE PLAN AND PAYMENT OF BENEFITS

The cost of the Plan is funded as follows:

For Employee and Dependent Coverage: Funding is derived from the funds of the Employer and contributions made by the covered Employees.

The level of any Employee contributions will be set by the Plan Administrator. These Employee contributions will be used in funding the cost of the Plan as soon as practicable after they have been received from the Employee or withheld from the Employee's pay through payroll deduction.

Benefits are paid directly from the Plan through the Claims Administrator.

PLAN IS NOT AN EMPLOYMENT CONTRACT

The Plan is not to be construed as a contract for or of employment.

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 an overpayment occurs in a Plan reimbursement amount, the Plan retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money. In the case of a Plan Participant, the amount of overpayment may be deducted from future benefits payable.

AMENDING AND TERMINATING THE PLAN

If the Plan is terminated, the rights of the Plan Participants are limited to expenses incurred before termination.

The Employer reserves the right, at any time, to amend, suspend or terminate the Plan in whole or in part. This includes amending the benefits under the Plan or the Trust agreement (if any).

CERTAIN PLAN PARTICIPANTS RIGHTS UNDER ERISA

Plan Participants in this Plan are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA specifies that all Plan Participants shall be entitled to:

> Examine, without charge, at the Plan Administrator's office, all Plan documents and copies of all documents governing the Plan, including a copy of the latest annual report (form 5500 series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.

Continue health care coverage for a Plan Participant, Spouse, or other dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event. Employees or dependents may have to pay for such coverage.

Review this summary plan description and the documents governing the Plan or the rules governing COBRA continuation coverage rights.

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

Under ERISA, there are steps a Plan Participant can take to enforce the above rights. For instance, if a Plan Participant requests a copy of Plan documents or the latest annual report from the Plan and does not receive them within 30 days, he or she may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and to pay the Plan Participant up to $110 a day until he or she receives the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If the Plan Participant has a claim for benefits which is denied or ignored, in whole or in part, the participant may file suit in state or federal court.

In addition, if a Plan Participant disagrees with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, he or she may file suit in federal court.

In addition to creating rights for Plan Participants, ERISA imposes obligations upon the individuals who are responsible for the operation of the Plan. The individuals who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of the Plan Participants and their beneficiaries. No one, including the Employer or any other person, may fire a Plan Participant or otherwise discriminate against a Plan Participant in any way to prevent the Plan Participant from obtaining benefits under the Plan or from exercising his or her rights under ERISA.

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

If the Plan Participant has any questions about the Plan, he or she should contact the Plan Administrator. If the Plan Participant has any questions about this statement or his or her rights under ERISA, including COBRA or the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, that Plan Participant should contact either the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) or visit the EBSA website at www.dol.gov/ebsa/. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

GENERAL PLAN INFORMATION

TYPE OF ADMINISTRATION

The Plan is a self-funded group health Plan and the administration is provided through a Third Party Claims Administrator. The funding for the benefits is derived from the funds of the Employer and contributions made by covered Employees. The Plan is not insured.

PLAN NAME

Asbury University Employee Medical Benefit Plan

PLAN NUMBER: 501

TAX ID NUMBER: 61-0458355

PLAN EFFECTIVE DATE: January 1st

PLAN YEAR ENDS: December 31st

EMPLOYER GROUP NUMBER: 000ASZ834

EMPLOYER INFORMATION

Asbury University
1 Macklem Drive
Wilmore, Kentucky 40390
(859) 858-3511

PLAN ADMINISTRATOR

Director of Human Resources
1 Macklem Drive
Wilmore, Kentucky 40390
(859) 858-3511

NAMED FIDUCIARY

President
1 Macklem Drive
Wilmore, Kentucky 40390

AGENT FOR SERVICE OF LEGAL PROCESS

Vice President of Business Affairs
1 Macklem Drive
Wilmore, Kentucky 40390

CLAIMS ADMINISTRATOR

ARC Administrators
P.O. Box 12990
Lexington, Kentucky 40582
(877) 309-2955

BY THIS AGREEMENT, Asbury University Employee Medical Benefit Plan is hereby adopted as shown.

IN WITNESS WHEREOF, this instrument is executed for Asbury University on or as of the day and year first below written.

By _____
Asbury University

Date 3/10/2020

Witness _____

Date 3/10/2020

HIPAA PRIVACY AMENDMENT

ASBURY UNIVERSITY
EMPLOYEE MEDICAL BENEFIT PLAN

BY THIS AGREEMENT, Asbury University Employee Medical Benefit Plan, the medical and prescription drug plan(s) (herein called the "Plan") are hereby amended as follows, effective as of January 1, 2019.

COMPLIANCE WITH HIPAA PRIVACY STANDARDS. Certain members of the Employer's workforce perform services in connection with administration of the Plan. In order to perform these services, it is necessary for these employees from time to time to have access to Protected Health Information (as defined below).

Under the Standards for Privacy of Individually Identifiable Health Information (45 CFR Part 164, the "Privacy Standards"), these employees are permitted to have such access only if the Plan is amended in accordance with the Privacy Standards.

Therefore, the Employer is amending the Plan as follows:

(1) **General.** The Plan shall not disclose Protected Health Information to any member of the Employer's workforce unless each of the conditions set out in this HIPAA Privacy section is met. "Protected Health Information" shall have the same definition as set out in the Privacy Standards but generally shall mean individually identifiable health information about the past, present or future physical or mental health or condition of an individual, including genetic information and information about treatment or payment for treatment.

(2) **Permitted Uses and Disclosures.** Protected Health Information disclosed to members of the Employer's workforce shall be used or disclosed by them only for purposes of Plan administrative functions. The Plan's administrative functions shall include all Plan payment and health care operations. The terms "payment" and "health care operations" shall have the same definitions as set out in the Privacy Standards, but the term "payment" generally shall mean activities taken with respect to payment of premiums or contributions, or to determine or fulfill Plan responsibilities with respect to coverage, provision of benefits, or reimbursement for health care. "Health care operations" generally shall mean activities on behalf of the Plan that are related to quality assessment; evaluation, training or accreditation of health care providers; underwriting, premium rating and other functions related to obtaining or renewing an insurance contract, including stop-loss insurance; medical review; legal services or auditing functions; or business planning, management and general administrative activities. However, Protected Health information that consists of genetic information will not be used for underwriting purposes.

(3) **Authorized Employees.** The Plan shall disclose Protected Health Information only to members of the Employer's workforce who are designated and are authorized to receive such Protected Health Information, and only to the extent and in the minimum amount necessary for these persons to perform duties with respect to the Plan. For purposes of this HIPAA Privacy section, "members of the Employer's workforce" shall refer to all employees and other persons under the control of the Employer.

(a) **Updates Required.** The Employer shall amend the Plan promptly with respect to any changes in the members of its workforce who are authorized to receive Protected Health Information.

(b) **Use and Disclosure Restricted.** An authorized member of the Employer's workforce who receives Protected Health Information shall use or disclose the Protected Health Information only to the extent necessary to perform his or her duties with respect to the Plan.

(c) **Resolution of Issues of Noncompliance.** In the event that any member of the Employer's workforce uses or discloses Protected Health Information other than as permitted by the Privacy Standards, the incident shall be reported to the privacy official. The privacy official shall take appropriate action, including:

(i) Investigation of the incident to determine whether the breach occurred inadvertently, through negligence, or deliberately; whether there is a pattern of breaches; and the degree of harm caused by the breach;

(ii) Applying appropriate sanctions against the persons causing the breach, which, depending upon the nature of the breach, may include, oral or written reprimand, additional training, or termination of employment;

(iii) Mitigating any harm caused by the breach, to the extent practicable; and

(iv) Documentation of the incident and all actions taken to resolve the issue and mitigate any damages.

(4) **Certification of Employer.** The Employer must provide certification to the Plan that it agrees to:

(a) Not use or further disclose the Protected Health Information other than as permitted or required by the Plan documents or as required by law;

(b) Ensure that any agent or subcontractor, to whom it provides Protected Health Information received from the Plan, agrees to the same restrictions and conditions that apply to the Employer with respect to such information;

(c) Not use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer;

(d) Report to the Plan any use or disclosure of the Protected Health Information of which it becomes aware that is inconsistent with the uses or disclosures permitted by this Amendment, or required by law;

(e) Make available Protected Health Information to individual Plan members in accordance with Section 164.524 of the Privacy Standards;

(f) Make available Protected Health Information for amendment by individual Plan members and incorporate any amendments to Protected Health Information in accordance with Section 164.526 of the Privacy Standards;

(g) Make available the Protected Health Information required to provide any accounting of disclosures to individual Plan members in accordance with Section 164.528 of the Privacy Standards;

(h) Make its internal practices, books and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Department of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Standards;

(i) If feasible, return or destroy all Protected Health Information received from the Plan that the Employer still maintains in any form, and retain no copies of such information when no longer needed for the purpose of 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 information unfeasible; and

(j) Ensure the adequate separation between the Plan and member of the Employer's workforce, as required by Section 164.504(f)(2)(iii) of the Privacy Standards.

Schedule I

The following members of Asbury University's workforce are designated as authorized to receive Protected Health Information from Asbury University Employee Medical Benefit Plan ("the Plan") in order to perform their duties with respect to the Plan: Glenn Hamilton, Vice President of Business Affairs, Gregory McGee, Director of Human Resources, Brenda Hilbert, Assistant Director of Human Resources.

IN WITNESS WHEREOF this Agreement has been executed on behalf of Asbury University.

By _____

Witness _____

Date 3/10/2020

HIPAA SECURITY AMENDMENT

ASBURY UNIVERSITY
EMPLOYEE MEDICAL BENEFIT PLAN

BY THIS AGREEMENT, Asbury University Employee Medical Benefit Plan, the medical and prescription drug plan(s) (herein called the "Plan") are hereby amended as follows, effective as of January 1, 2019.

COMPLIANCE WITH HIPAA ELECTRONIC SECURITY STANDARDS. Under the Security Standards for the Protection of Electronic Protected Health Information (45 CFR Part 164.300 et. seq., the "Security Standards"), the Plan documents must be amended to reflect certain obligations required of the Employer.

Therefore, the Employer is amending the Plan as follows:

(1) The Employer agrees to implement reasonable and appropriate administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of Electronic Protected Health Information that the Employer creates, maintains or transmits on behalf of the Plan. "Electronic Protected Health Information" shall have the same definition as set out in the Security Standards, but generally shall mean Protected Health Information that is transmitted by or maintained in electronic media.

(2) The Employer shall ensure that any agent or subcontractor to whom it provides Electronic Protected Health Information shall agree, in writing, to implement reasonable and appropriate security measures to protect the Electronic Protected Health Information.

(3) The Employer shall ensure that reasonable and appropriate security measures are implemented to comply with the conditions and requirements set forth in Compliance With HIPAA Privacy Standards provisions (3) Authorized Employees and (4) Certification of Employers.

IN WITNESS WHEREOF this Agreement has been executed on behalf of Asbury University.

By _____

Witness Brenda Gilbert

Date 3/10/2020

AMENDMENT #1 TO THE ASBURY UNIVERSITY EMPLOYEE MEDICAL BENEFIT PLAN DOCUMENT

THIS FIRST AMENDMENT TO THE ASBURY UNIVERSITY EMPLOYEE MEDICAL BENFIT PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION (the "Amendment")**,** is made and shall take effect as of January 1, 2020. This Amendment is made and entered into by Asbury University, (the "Plan Sponsor"), with its principal place of business located at 1 Macklem Drive, Wilmore, Kentucky, 40390.

WHEREAS, the Plan Sponsor has in effect an existing Plan Document and Summary Plan Description; and

WHEREAS, the terms of the existing Plan Document and Summary Plan Description are hereby being modified;

WHEREAS, this amendment shall take effect as of January 1, 2020;

NOW, THEREFORE, the Plan Document and Summary Plan Description for The Asbury University Employee Medical Benefit Plan is hereby amended as follows:

1. Amendments to existing Plan Document and Summary Plan Description.

   (a) SCHEDULE OF BENEFITS. Pgs. 3-5 The precertification list is hereby deleted and replaced with the following.

   Note: For Network services that are not precertified, claims will be denied for no pre-certification.

   Inpatient Services Including:
   Hospitalizations - Excludes 48/96 hour (legislated timeframe for delivery) maternity admissions
   Non-Emergency Inpatient Surgical Procedures
   Skilled Nursing Facility Stays
   Rehabilitation Facility Stays

   Outpatient Services Including:
   Surgical Procedures – Excludes colonoscopies, endoscopies and surgeries performed in an office setting
   Advanced Imaging Services (MRI/MRA/CAT/PET/SPECT/Diagnostic Mammograms)
   Cardiac Rehabilitation Therapy

   Behavioral Health Services Including:
   Inpatient Substance Abuse/Mental Disorder Treatments
   Intensive Outpatient Therapy
   Partial Hospitalization (PHO)
   Residential Care (RTC)

   Other Services Including:
   Transplants
   Home Health Care
   Private Duty Nursing
   Durable Medical Equipment (over $1,500)
   Genetic Testing/Molecular Pathology
   Sleep Disorder Testing
   Infusion Therapy

Radiation Therapy
Prosthetics and Orthotics (over $750)

b) **SCHEDULE OF BENEFITS. Human Organ Transplants. Page 13, and 19.** The Human Organ Transplants grids are hereby amended. All references to Healthlink throughout the grids are hereby removed and deleted from the plan document. All reference to Healthlink throughout the grids are now referring to ARC Administrators Care Coordination (855) 984-2583.

c) **SCHEDULE OF BENEFITS. Benefit Schedule Notes. Page 20.** The following note is hereby added to the Benefit Schedule Notes. Asbury University Employee Benefit Plan has visit limits in place. The ARC Care Coordination Department will provide review to ensure members do not exceed the visit limits in place under the terms of the plan. If a member has already exhausted their visits limit, a denial letter will go out to the provider advising them of the visit limit under the terms of the plan and the exhaustion of that visit limit by that specific member.

d) **COST MANGEMENT SERVICES. Page 43, Cost Management Services.** The Cost Management Services Provider Healthlink and their phone number (877)284-0102 is hereby removed and deleted from the plan document. All references to Healthlink throughout the Plan Document and Summary Plan Description are now referring to ARC Administrators Care Coordination (855) 984-2583.

All sections of the Plan Document and Summary Plan Description not specifically mentioned in this amendment shall remain intact as in the original Plan Document and Summary Plan Description.

BY THIS AGREEMENT, Asbury University Employee Benefit Plan is hereby adopted as shown.

IN WITNESS WHEREOF, this instrument is executed for Asbury University on or as of the day and year first below written.

By Gregory McGee

ASBURY UNIVERSITY

Date 12/01/2020

Witness_____

Date _____

AMENDMENT #2 TO THE ASBURY UNIVERSITY EMPLOYEE MEDICAL BENEFIT PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION

THIS SECOND AMENDMENT TO THE ASBURY UNIVERSITY EMPLOYEE MEDICAL BENEFIT PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION (the "Amendment"), is made and shall take effect as of March 9, 2020. This Amendment is made and entered into by Asbury University, (the "Plan Sponsor"), with its principal place of business located at 1 Macklem Drive, Wilmore, Kentucky, 40390.

WHEREAS, the Plan Sponsor has in effect an existing Plan Document and Summary Plan Description; and

WHEREAS, the Plan Sponsor hereto desires to amend the existing Plan Document and Summary Plan Description to modify the terms;

WHEREAS, the Plan Sponsor hereto desires for this amendment to take effect as of March 9, 2020;

NOW, THEREFORE, the Plan Document and Summary Plan Description for Asbury University Employee Medical Benefit Plan is hereby amended as follows:

1. Amendments to existing Plan Document and Summary Plan Description.

   (a) **Telehealth.** Telehealth services is a covered benefit under the Asbury University Employee Medical Benefit Plan until July 31, 2020. Benefits for Telehealth visits shall be paid as follows until July 31, 2020.

MEDICAL BENEFIT SCHEDULE – CORE PLAN

COVERED BENEFITS	NETWORK	NON-NETWORK
PHYSICIAN SERVICES	YOUR COST SHARE RESPONSIBILITY	
Telehealth Consultations (PCP/SCP)	No Cost Share	40% After Deductible

MEDICAL BENEFIT SCHEDULE –BUY UP PLAN

COVERED BENEFITS	NETWORK	NON-NETWORK
PHYSICIAN SERVICES	YOUR COST SHARE RESPONSIBILITY	
Telehealth Consultations (PCP/SCP)	No Cost Share	40% After Deductible

All sections of the Plan Document and Summary Plan Description not specifically mentioned in this amendment shall remain intact as in the original Plan Document and Summary Plan Description.

BY THIS AGREEMENT, ASBURY UNIVERSITY EMPLOYEE MEDICAL BENEFIT PLAN is hereby adopted as shown.

IN WITNESS WHEREOF, this instrument is executed for ASBURY UNIVERSITY on or as of the day and year first below written.

By Glenn Hamilton Digitally signed by Glenn Hamilton Date: 2020.06.22 17:43:32 -04'00'

ASBURY UNIVERSITY

Date 6/22/20

Witness Brenda Hilbert Digitally signed by Brenda Hilbert Date: 2020.06.23 08:11:22 -04'00'

Date 06/22/2020

AMENDMENT #3 TO THE ASBURY UNIVERSITY EMPLOYEE MEDICAL BENEFIT PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION

THIS THIRD AMENDMENT TO THE ASBURY UNIVERSITY EMPLOYEE MEDICAL BENEFIT PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION (the "Amendment"), is made and shall take effect as of January 01, 2022. This Amendment is made and entered into by Asbury University, (the "Plan Sponsor"), with its principal place of business located at 1 Macklem Drive, Wilmore, Kentucky, 40390.

WHEREAS, the Plan Sponsor has in effect an existing Plan Document and Summary Plan Description; and

WHEREAS, the Plan Sponsor hereto desires to amend the existing Plan Document and Summary Plan Description to modify the terms;

WHEREAS, the Plan Sponsor hereto desires for this amendment to take effect as of January 01, 2022;

NOW, THEREFORE, the Plan Document and Summary Plan Description for Asbury University Employee Medical Benefit Plan is hereby amended as follows:

1. Amendments to existing Plan Document and Summary Plan Description.

   (a) **Prescription Drug Benefits. Page 57.** The pharmacy drug plan administrator CVS/Caremark is hereby removed and deleted from the plan document. All references to CVS/Caremark throughout the Plan Document and Summary Plan Description are now referring to Aspirant RX (855) 242-2583.

All sections of the Plan Document and Summary Plan Description not specifically mentioned in this amendment shall remain intact as in the original Plan Document and Summary Plan Description.

BY THIS AGREEMENT, ASBURY UNIVERSITY EMPLOYEE MEDICAL BENEFIT PLAN is hereby adopted as shown.

IN WITNESS WHEREOF, this instrument is executed for ASBURY UNIVERSITY on or as of the day and year first below written.

By Glenn Hamilton
Glenn Hamilton (Jan 3, 2022 11:37 EST)
ASBURY UNIVERSITY

Date 01/03/2022

Witness _____

Date _____