



Summary Plan Description

Restated July 1, 2010

**HEALTHCARE PURCHASING ALLIANCE (HPA)
EMPLOYEE HEALTHCARE BENEFITS**

Restated July 1, 2010

Plan Sponsored By: Daytona State College

TO OUR ELIGIBLE EMPLOYEES:

Welcome. By electing to participate in this Plan, you have put quality, dependability and experience on your side. Benefits are big news these days, especially health care benefits. As health care costs continue to rise, your health care coverage becomes even more critical. This Plan has been designed to provide you and your family with both comprehensive and affordable coverage.

Please read the following pages carefully. Some of the words used in this booklet begin with a capital letter. These words are defined in the Definitions section. When reading this booklet, it may be helpful to refer to this section. Familiarize yourself with the Benefits available, then use the Plan to meet your needs; but use it wisely.

YOUR MEDICAL BENEFITS..... WHAT YOU SHOULD KNOW

You have enrolled under the Healthcare Purchasing Alliance (HPA) Employee Healthcare Benefits Plan. The Plan has contracted with a managed care network or networks of medical providers whose members have agreed to charge the Plan reduced or discounted charges for covered services provided to Covered Persons. Although you have the freedom to choose to receive care from any Physician, Hospital, or other medical care provider, as a general rule ***the amount or percentage of an otherwise Covered Expense payable by the Plan will vary, depending on whether the provider from whom you receive your care is a member of the Plan's PPO network(s)***. Generally, the Plan will pay a higher percentage of a Covered Expense if the care is received by a network provider. Thus, in order to receive the highest Benefit level, medical services and supplies should be received from a network provider.

Your Employee Health Care Plan ID card contains a toll-free phone number and/or a website you can use to obtain information about the health care providers who are members of the provider network(s).

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WHO TO CONTACT

Healthcare Purchasing Alliance (HPA)

FMH group No: DS0000

Benefit, Eligibility and Claims Information

FMH CoreSource (866) 500-5048
Website: www.f-m-h.com/hpa

Provider Networks

Volusia Health Network (VHN) (386) 425-4846
Website: www.myvhn.com

Florida Memorial Health Network (FMHN) (386) 615-4398 or (888) 839-7430
Website: www.fmhn.org

Florida Hospital Healthcare System (FHHS) (800) 741-4869 or (407) 741-4869

Provider Network for members living outside of the VHN/FMHN network service area

Private HealthCare Systems Network (PHCS) (866) 297-9122
Website: www.multiplan.com

Pharmacy Network

MedTrak Pharmacy Services (800) 771-4648
MedTrak SpecialtyRx (800) 771-4648
Website: www.medtrakrx.com

PRE-CERTIFICATION **Disease and Utilization Management** **(MEDICAL SERVICES ONLY)**

KePRO (formerly PPHA) (888) 522-7742
24-hour Nurse Help Line (877) 582-7061

Mental & Behavioral Health/Substance Abuse – for all outpatient care

Horizon Health (800) 272-7252
Website: www.horizoncarelink.com

Chiropractic Network - DPSC

Provider Inquiry Information (386) 615-0801

SCHEDULE OF BENEFITS

MEDICAL BENEFITS

All Benefits described in this Schedule are subject to the exclusions and limitations described more fully herein including, but limited to, the Plan Administrator's determination that:

- care and treatment is Medically Necessary;
- charges are Usual and Reasonable;
- services, supplies and care are not Experimental, Investigational or Unproven Services.

Deductibles/Co-payments Payable by Plan participants

Deductibles, Co-payments and Co-insurance are dollar amounts that the Covered Person must pay before this Plan pays. Each July 1st, a new deductible amount is required.

A Co-payment or Co-insurance is a smaller amount of money that may be paid each time a particular service is used.

Participating Provider Organization (PPO) Plan

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

The PPO organizations this Plan has contracted with for the In-Network Level of Benefits are:

- Volusia Health Network
 - Orlando Health
- Florida Memorial Health Network
 - Florida Hospital Health Systems
- Doctor's Professional Services Consultants
- Horizon Health

The PPO organization this Plan has contracted with for members living outside the VHN/FMHN network service area for the In-Network Level of Benefits is:

- PHCS Network (Private HealthCare Systems)

Therefore, when a Covered Person uses a participating provider, that Covered Person will receive the higher in-network level of Benefits from this Plan than when a non-participating provider (Out-of-Network) is used. It is the Covered Person's choice as to which provider to use.

A list of participating providers will be made available to covered Employees and updated on a regular basis.

SCHEDULE OF BENEFITS

Plan Sponsor: Healthcare Purchasing Alliance (HPA)
Plan Year: July 1, 2010 – June 30, 2011

Primary Plan Covered Services	In-Network	Out-of-Network
Lifetime Benefit Maximum	\$2,000,000	
Standard Plan Benefit Percentage The Plan pays 80/50%, then you pay the remaining 20/50%.	80%	50%
Deductible (per Plan Year) Individual Family <i>The Plan Year deductibles per network are not combined and do not apply to the Out-of-Pocket Maximum</i>	\$500 \$1,500	\$2,500 \$7,500
Out-of-Pocket Maximum (Includes Co-payments and Co-insurance percentages for Medical and Behavioral Health expenses only) Individual Family <i>The Plan Year Out-of-Pocket Maximum per network is not combined and the Deductible is not included</i>	\$2,500 \$7,500	\$10,000 \$30,000
Plan Benefit Percentage for Out-of-Network care (e.g. ancillary services such as <i>pathologist, radiologist, anesthesiologist</i>) while in the Hospital will be payable at the same level of Benefits as the Hospital:	In-Network rate if Hospital is In-Network Out-of-Network rate if Hospital is Out-of-Network	
Plan Benefit Percentage for Out-of-Network, Non-Emergent Care While Traveling:	Out-of-Network rate	
Plan Benefit Percentage for Out-of-Network, Emergent Care While Traveling:	In-Network rate	

Primary Plan Covered Services	In-Network	Out-of-Network
EFFECTIVE JULY 1, 2010		
	Deductible and Co-insurance Apply Except as Provided:	
Services Rendered by Radiology Associates Imaging Centers	90% (Deductible waived)	
Neurology & Pain Relief, LLC Office Visit	100% after \$35 Co-pay (Deductible waived)	50%
All Other Services	90%	50%
Diagnostic X-Rays, Imaging and Laboratory Services Inpatient, Outpatient and Independent Lab	80%	50%
Physician Services		
Primary Care Office Visit Includes (GYN/OB, Pediatrician, Internal Medicine)	100% after \$20 Co-pay (Deductible waived)	50%
Specialist Office Visit	100% after \$35 Co-pay (Deductible waived)	50%
<i>All Other Services rendered at time of visit</i>	80%	50%
Allergy Shots and Testing		
Injections	100% (Co-pay & Deductible waived)	50%
Testing and Serum	80%	50%
Inpatient Hospital Care	80%	50%
Note: Pre-Certification by KePRO (formerly PPHA) required		
Outpatient Services	80%	50%
Note: Pre-Certification by KePRO (formerly PPHA) required for certain Surgical and Medical Services		
Ambulance	80% After In-Network Deductible	
Emergency Room¹	80%	50%

¹ Coverage for emergency room treatment at an Out-of-Network Hospital for conditions that meet the definition of Emergency, payment will be considered at the In-Network level for Covered Expenses received in the emergency room. If you are then admitted to the Out-of-Network Hospital, Covered Expenses for Hospital and Physician services will be considered at the In-Network level until Your Attending Physician determines it is medically appropriate for You to be transferred.

Primary Plan Covered Services	In-Network	Out-of-Network
EFFECTIVE JULY 1, 2010		
Deductible and Co-insurance Apply Except as Provided:		
PrimeCare Urgent Care Centers		
Urgent Care Visit	100% after \$20 Co-pay (Deductible waived)	N/A
<i>All Other Services rendered at time of visit</i>	80%	N/A
Urgent Care Services	80%	50%
Note: If the choice of Hospital and/or Physician was beyond the control of the Covered Person, then all Urgent Care services rendered for a Medical Emergency will be payable at the In-Network level of Benefits		
WELLNESS CARE		
Note: <i>The Wellness maximum of \$250 <u>applies only</u> to the Wellness Care Benefit for Age 17 and over and <u>does not</u> apply to Well Child/Well Baby or Well Woman Care. Once \$250 maximum is exhausted, there is no Benefit until the next Plan Year.</i>		
Wellness Care (Age 17 and over) <i>\$250 Max. per Covered Person per Plan Year</i> Coverage Includes: Routine Physical Exam Hearing Exam PSA Exam and related Labs Colon Exam (Sigmoidoscopy and related services and related Labs) X-rays / Labs Immunizations and Inoculations Bone Density Study (Age 45 and over)	100% (Co-pay & Deductible waived)	Not Covered
Note: <i>Benefit sponsored activities approved by HPA, such as flu shots, will be payable at 100% (Deductible waived) for eligible Covered Persons. These Benefits <u>will not</u> apply to the \$250 Wellness Care Plan Year Maximum. Health Risk Appraisal and accompanying annual blood draw will be payable at 100% by the Plan (Deductible waived) when pre-certified through KePRO (formerly PPHA) once per Plan Year. These Benefits will not apply to the \$250 Wellness Care Plan Year Maximum. Any additional wellness-related blood draws during the Plan Year will be subject to the Wellness Care Benefit.</i>		
Well Child/Well Baby Care (Age 16 and under) <i>Limited to 18 visits Max. through Age 16</i> Coverage Includes: Routine Physical Exam Hearing Exam Developmental Assessment Labs Immunizations	100% (Co-pay & Deductible waived)	Not Covered

Primary Plan Covered Services	In-Network	Out-of-Network
EFFECTIVE JULY 1, 2010		
Deductible and Co-insurance Apply Except as Provided:		
Well Woman Care Coverage Includes: Gynecological or Contraceptive Exam (1 Exam per Plan Year) Pap smear (1 Exam per Plan Year) Contraceptive Injectables (i.e. Depo Provera)	100% (Co-pay & Deductible waived)	Not Covered
Mammogram Routine or Medically Indicated limited to: Age 35-39: 1 Baseline Age 40 and over: 1 per Plan Year Medically indicated mammogram diagnosed from the initial mammogram	100% (Co-pay & Deductible waived) 80%	50% 50%
Colonoscopy Routine or Medically Indicated limited to: Age 50 and over: 1 per covered member, 1 every ten (10) years thereafter (Includes Prep Kit and Supplies) Medically indicated colonoscopy diagnosed from the initial colonoscopy	100% (Deductible waived) 80%	50% 50%
Maternity Initial Physician Office Visit Physician Delivery Charge Hospital Charges	100% after \$20 Co-pay (Deductible waived) 100% after \$250 Co-pay (Deductible waived) 80%	50% 50% 50%
Organ Transplants Note: Pre-Certification by KePRO (formerly PPHA) required	80%	50%
Second Opinion	100% after \$35 Co-pay (Deductible waived)	50%
Skilled Nursing Facility Note: Pre-Certification by KePRO (formerly PPHA) required	80%	50%
Home Health Care Note: Pre-Certification by KePRO (formerly PPHA) required	80%	50%

Primary Plan Covered Services	In-Network	Out-of-Network
EFFECTIVE JULY 1, 2010		
	Deductible and Co-insurance Apply Except as Provided:	
Hospice Care Including Bereavement Counseling	80%	50%
Inpatient Rehabilitation Facility Note: Pre-Certification by KePRO (formerly PPHA) required	80%	50%
Physical, Occupational, Speech and Massage Therapy Inpatient, Outpatient and Physician Office Note: Pre-Certification by KePRO (formerly PPHA) required	80%	50%
Chiropractic Care 12 visit Max. per Plan Year	80%	50%
Note: Visits exceeding the initial 12 visit Max. per Plan Year must be approved by Doctors Professional Services Consultants (DPSC)		
Mental and Nervous/Substance Abuse		
Inpatient	80%	50%
Outpatient (including Partial Hospitalization)	80%	50%
Office	100% after \$20 Co-pay (Deductible waived)	50%
Note: Inpatient requires pre-certification through KePRO (formerly PPHA). Outpatient (including Partial Hospitalization) must be pre-certified through Horizon Health. Call Horizon Health at: 1-800-272-7252		
Durable Medical Equipment Except for diabetic supplies, which are covered through MedTrak Pharmacy Services Note: Pre-Certification by KePRO (formerly PPHA) required if over \$250	80%	50%
Infertility Treatment \$2,000 Max. per Lifetime for Diagnostic services only	80%	50%
Wigs Limited to the initial purchase after Chemotherapy or when diagnosed with Alopecia Areata	80% After In-Network Deductible	
Nutritionist Limited to treatment of Diabetes and Heart Disease	80%	50%

PRESCRIPTION DRUG CO-PAYS

Generic Provision Difference

If a generic equivalent of a prescription Drug is available and the Covered Person chooses the brand name over the generic equivalent, then he or she must pay the cost difference between the generic and brand name Drug in addition to the Co-pay.

Covered Benefits	In-Network
Retail Network (30-day supply):	
Generic (preferred):	\$10
Brand Name (preferred):	\$30
Brand Name (non-preferred):	\$60
MedTrak 90 (90-day supply):	
Generic (preferred):	\$20
Brand Name (preferred):	\$60
Brand Name (non-preferred):	\$120
Mail Order (90-day supply):	
Generic (preferred):	\$20
Brand Name (preferred):	\$60
Brand Name (non-preferred):	\$120
Note: In order to maximize your prescription Drug Benefit, you may utilize either the MedTrak 90 Program or the Mail Order option by obtaining a prescription for a 90-day supply from your Physician.	
Specialty Drugs	20% up to \$60 with a plan year out of pocket maximum of \$2,000

A Specialty Drug is only available in a 30-day supply and must be obtained through the pharmacy benefit manager's Specialty Drug program in order to be a covered Benefit. See the section titled, Covered Expenses, for details.

DENTAL BENEFITS	
Deductible (per Plan Year)	
Individual	\$50
Family	\$150
Benefit Plan Percentages:	
Class I – Preventive (including: oral exams, x-rays(adults), 2 cleanings per Plan Year and fluoride treatment (up to age 19))	80% Deductible waived
Class II – Basic (including: fillings, extractions, periodontics, endodontics and root canals)	80% after Deductible
Class III – Major (including: crowns, bridges and dentures)	50% after Deductible
Class IV – Orthodontia / Implants	50% after Deductible
Maximums	
Class I , II and III per person per Plan Year	\$1,000
Class IV Orthodontia and Implants, per person per Lifetime	\$1,000

Please refer to the Dental section of your HPA Summary Plan Description for detailed explanation of your Dental Benefits.

VISION BENEFITS	
Deductible (Per Plan Year)	None
Eye Exam (including refractions) Per Covered Person per Plan Year	100% up to \$50
Framed Lenses (In lieu of Contact Lenses or Disposable Lenses) One (1) pair per Plan Year	
Single Vision	100% up to \$25 per pair
Bi-focal	100% up to \$25 per pair
Tri-focal	100% up to \$32.50 per pair
Lenticular	100% up to \$32.50 per pair
Progressive	100% up to \$32.50 per pair
Frames One (1) pair every 24 month period	100% up to \$100
Contact Lenses (In lieu of frames and lenses or Disposable Contact Lenses) Per Covered Person per Plan Year	100% up to \$100
Disposable Contact Lenses (In lieu of frames and lenses or Contact Lenses) Per Covered Person per Plan Year	100% up to \$100
<p>Note: The Plan will only cover the purchase of one (1) of the following per Plan Year.</p> <ul style="list-style-type: none"> • Contact Lenses, Disposable Contact Lenses, or Lenses for glasses <p><i>Replacement lenses, frames, or contact lenses are not covered under this Plan.</i></p>	

Please refer to the Vision section of your HPA Summary Plan Description for detailed explanation of your Vision Benefits.

PRE-CERTIFICATION AND AUTHORIZATION OF MEDICAL CARE

KePRO (formerly PPHA) provides utilization management of medical care for the Healthcare Purchasing Alliance (HPA) Plan. Utilization management includes pre-certification of selected medical services to establish medical necessity and the appropriate level of care.

Pre-certification of the medical services, including Mental Health and Substance Abuse, listed below is mandatory. It is the Employee's or Covered Person's responsibility to make certain that the compliance procedures of this program are completed. Failure to pre-certify before services are rendered will result in a possible denial of Benefits or the following penalties (not to exceed covered charges):

Inpatient - \$1,000 per admission
Outpatient - \$250 per occurrence

The medical services listed below must be pre-certified by calling:

KePRO (formerly PPHA)
(888) 522-7742

Horizon Health
(800) 272-7252

1. All Inpatient Care

- Observation care lasting more than 23 hours
- Emergency admissions must be reported to KePRO (formerly PPHA) within 24 hours or the next Business Day after the admission

Notwithstanding the foregoing, this Plan will not restrict Benefits for any Hospital length of stay in connection with childbirth for the mother or newborn Child, following a normal vaginal delivery, to less than 48 hours, or to less than 96 hours in the case of a cesarean section. In addition, the Plan shall not require a Hospital, Physician or other medical provider to obtain authorization or pre-certification from the Plan Sponsor or its medical review specialist for prescribing any length of stay described above. However, these rules shall not apply where the decision to discharge the mother or her newborn Child prior to the expiration of the minimum length of stay periods described above is made by the mother's or Child's Attending Physician in consultation with the mother.

2. Outpatient Surgical and Medical Services

- Adenoidectomy
- Colonoscopy - under age 50
- Durable Medical Equipment - **over \$250**
- Durable Medical Equipment Repair or Replacement
- Home Health Care
- Hyperbaric Oxygen Treatments
- Nasal Surgery (includes nasal endoscopy, rhinoplasty, and septoplasty)
- PET Scans
- Prophylactic Surgery (for the prevention of breast and ovarian cancer)
- Reduction Mammoplasty
- Sleep Apnea Studies
- Therapies: Massage, Occupational, Physical, Radiation, and Speech
- TMJ/CMJ Surgery
- Tonsillectomy
- Varicose Vein Excision and Ligation

3. Specialty Drugs

- Specialty Drugs require pre-certification through MedTrak Pharmacy Services

If you have been admitted on an Emergency or maternity basis, the medical review specialist must be notified within 48 hours of the admission.

4. Mental Health and Substance Abuse

All Inpatient Care

- Emergency admissions must be reported to KePRO (formerly PPHA) within 24 hours or the next Business Day after the admission.

Outpatient Services (including Partial Hospitalization)

- Failure to pre-certify may result in the application of a \$250 penalty or possible denial of Benefits.

The Plan has the absolute authority to waive the normal provisions of the Plan if Horizon Health or KePRO (formerly PPHA) submits a written proposed alternative which meets the accepted standards of medical practice without sacrifice to quality of patient care and is no more expensive than regular Plan Benefits would be.

Horizon Health also provides free Employee Assistance Program (EAP) services 24 hours a day to all Employees and their family members, as well as pre-certification and authorization of Mental and Nervous Disorders and Substance Abuse Treatment Benefits under this Plan.

EAP Services provide short-term counseling for any problem which affects your well-being or ability to perform at work. Examples include stress, family or marital problems, Substance Abuse, financial or legal difficulties, or emotional problems. By using the EAP free services, you may avoid having to use costly Mental and Nervous Disorders and Substance Abuse Treatment altogether. Call Horizon Health at (800) 272-7252 for complete details.

CASE MANAGEMENT. In a case where your condition is expected to be or is of a serious nature, the Plan Sponsor may arrange for review and/or case management services from a professional qualified to perform such services. Based on the review, the Plan Sponsor shall have the right to alter or waive the normal provisions of the Plan, including Benefit limits, when it is reasonable to expect a cost effective result without a sacrifice to the quality of patient care. For example, if you require Custodial Care rather than Inpatient Hospital care, but the Plan does not cover Custodial Care and, as a result, the only practical alternative covered by the Plan is Inpatient Hospital care, the Plan may agree to treat your Custodial Care expenses as Covered Expenses in lieu of having you remain or re-admitted as a Hospital Inpatient, where doing so is cost effective to the Plan and does not compromise the quality of your care. This provision shall also operate to the extent required by any reinsurance contract between the Plan Sponsor and the reinsurer.

PREVENTIVE SERVICES

This Plan may cover annual physical examinations for eligible Covered Employees, Covered Spouses, and Covered Dependent Children. Well woman services are provided for eligible Covered Employees, Covered Spouses, and Covered Dependent Children.

Preventive Services are not subject to the Plan Year deductible.

Annual Physical Examinations

Annual routine physical exams are covered each Plan Year when using a Preferred Provider Physician.

The \$250 Maximum Annual Routine Physical Benefit includes and is limited to, the following services:

- Physical examinations and history
- EKG
- Laboratory tests
- Hemocult
- Urinalysis
- X-Rays*
- Bone density study – age 45 and over*
- Hearing screening
- Sigmoidoscopy
- PSA Blood Test
- Inoculations and immunizations
- Prostate exam

***Services rendered by Radiology Associates Imaging Centers are available at deeper discounts, which will help you maximize the use of your wellness benefit.**

All charges in excess of the \$250 maximum are the patients' responsibility and do not track toward the annual Out-of-Pocket Maximum or the deductible.

Health Risk Appraisal and accompanying annual blood draw may be payable at 100% by the Plan (Deductible waived) when pre-certified through KePRO (formerly PPHA) once per Plan Year. These Benefits will not apply to the \$250 Wellness Care Plan Year Maximum. Any additional wellness-related blood draws during the Plan Year are payable at Deductible and Co-insurance.

Well Woman Services

Covered Benefits include per Plan Year one mammogram, contraceptive injectables (i.e., Depo-Provera), and an annual pelvic examination with pap smear.

Well Child Care Services

The Plan covers certain well child care services provided by a Physician from the moment of birth through age sixteen. The Plan allows for a maximum of 18 visits during that time period.

The covered services for each visit to the Physician include: a history, anticipatory guidance, physician examination, appropriate immunizations, hearing exams, developmental assessment, and laboratory tests in keeping with prevailing medical standards.

ARTICLE I INTRODUCTION

This is the Plan Document. It also represents what is referred to as a Summary Plan Description. It describes the Benefits to which you and your covered Dependents are entitled, to whom Benefits are payable and other provisions, which govern or control the way in which Benefits are provided.

PLAN SPONSOR. The Plan Sponsor is **Daytona State College**. The Plan Sponsor has the authority to control and manage the operation and administration of the Plan; to establish Plan Benefits and provisions; to amend the Plan; to determine its policies; to appoint and remove the Claim Supervisor, and to exercise general administrative authority over the Supervisor.

CLAIM SUPERVISOR. The Claim Supervisor of the Plan is **FMH CoreSource**.

CONTRIBUTIONS TO THE PLAN. The Employer makes contributions to the Plan so that the Plan may make Benefit payments to you and your Dependents. You may also be required to make contributions to the Plan for your coverage or for coverage of your Dependents, or for both you and your Dependents' coverage. For more information concerning the funding of this Plan, see the section titled, *General Information--Funding Method*.

CLAIM PROCEDURES. Claim payments are made based on data furnished by you or your health care provider. In order to collect Benefits under the Plan, you or the provider must first provide information as to the validity of the claim for Benefits. For ease of administration, you may have to file a "claim form" for You and Your Dependents. This form contains essential information necessary for the Claim Supervisor to determine the validity of a claim for Benefits. Occasionally, further information may be necessary and you should provide this information to the Claim Supervisor as requested.

CLAIM DETERMINATION. A determination regarding payment of eligible Benefits will normally be made within 30 days from the Claim Supervisor's receipt of all necessary information regarding the claim for Benefits. All interpretations of the Plan's terms regarding Benefits will be made by the Plan Sponsor.

CLAIM FILING DEADLINE. A claim will not be considered unless it is filed within twelve (12) months after the date on which the expense is incurred. Terminated Employees (and their Dependents) must file all incurred but unfiled claims within twelve (12) months after the date of termination of their coverage. In the event of the Plan's termination, you must file all incurred but unfiled claims within twelve (12) months after the Plan's termination.

See the section of this booklet titled, *Claim Filing Procedures*, for more information about your rights with respect to claims and appeals of determinations that are made with respect to claims.

ARTICLE II ELIGIBILITY FOR COVERAGE

Coverage provided under this Plan for you and your Dependents will be in accordance with the eligibility, Effective Date and termination provisions that follow below.

EMPLOYEE ELIGIBILITY. In order to be eligible for coverage under this Plan you must be both an Employee and an *eligible* Employee. Generally, an *Employee* is a person employed by the Employer in a classification of employment that qualifies him for participation in the Plan and fulfilling their employment obligation as defined by the College. See the definition of “*Employee*” in the section of this booklet titled, *Definitions*. Generally, an *eligible* Employee is an Employee who has met any service requirements that the Employee must meet in order to become eligible. Those service requirements, if they apply, are described in the following paragraph.

DEPENDENT ELIGIBILITY. Your Dependents are eligible for coverage under the Plan on the date you become eligible for Employee coverage, or the date on which the Dependents become your Dependents, whichever occurs last. *However, under no circumstances may you enroll your Dependents if you are not also enrolled under the Plan.* If both you and your spouse are Employees, and both are eligible for Dependent coverage, either you or your spouse, but not both, may elect Dependent coverage for your other eligible Dependents (e.g., Dependent Children). No person may be covered under this Plan as both an Employee and as a Dependent. Dependent eligibility is also subject to the following rules:

Newborns. If you notify the Employer, in writing, of the birth of your newborn Child within thirty-one (31) days after the date of birth, coverage for the newborn becomes effective on the date of birth and any additional premium applicable to the newborn will be waived for the thirty-one (31) day notice period. If notice is given after thirty-one (31) days from the date of birth, but within sixty (60) days from the date of birth of the newborn Child, coverage for the newborn becomes effective on the date of birth only if any additional premium applicable to the newborn, from the date of birth, has been paid. If notice is not given within sixty (60) days from the date of the newborn Child, the covered Employee may not enroll the newborn in the Plan until the next annual open enrollment.

A newborn Child of a Covered Dependent Child is eligible to participate from birth up to age 18 months. Generally, coverage of newborn Children includes coverage for care or treatment of medically diagnosed congenital defects, birth abnormalities or prematurity; and for any routine nursery care provided under this Plan. See the description of Covered Expenses in the section of this booklet titled, *Covered Expenses*.

New Spouse. Your spouse will be considered an eligible Dependent the first of the month following the date of marriage, if you are an eligible Employee at that time and provide the Employee Benefits Department with a copy of your marriage certificate within 31-days of the date of marriage. Upon dissolution of the marriage, the now former spouse is no longer eligible for coverage as a spouse but may be offered COBRA (see section titled, *COBRA Continuation Coverage*).

Other New Dependents. If you acquire a Dependent (other than your spouse) due to marriage, legal adoption or legal guardianship, that Dependent shall be considered an eligible Dependent as of the date of such occurrence, if you are an eligible Employee at that time and you notify the Employer, in writing within thirty-one (31) days of that event. A Child will be considered adopted on the date the Child’s adoption becomes final or on the date the Child is placed for adoption (a Child is considered placed for adoption when you assume and retain a legal obligation for total or partial support of the Child in anticipation of adoption; the Child’s placement terminates upon termination of such legal obligation).

Continuing Coverage for Disabled Dependent Children. An unmarried Child who is a Dependent and who reaches the Plan’s limiting age for Dependent Children while covered under this Plan will remain eligible for coverage to the extent he is at that time incapable of self-sustaining employment and is dependent upon you for support due to a mental or physical illness or disability. He will remain eligible for coverage under this provision to the extent you remain eligible for Dependent coverage and he remains incapable of self-sustaining employment and dependent upon you for support due to the disability. Notification of incapacitation must be provided within thirty-one (31) days after the Child attains age 19. Proof of incapacitation may be required to determine whether or not the Child qualifies as disabled and may be required on an annual basis.

Qualified Medical Child Support Orders (QMCSO). The Plan will honor the terms of a Qualified Medical Child Support Order. A Qualified Medical Child Support Order is an order that is typically issued in or after divorce proceedings, and may create or recognize the right of your Child to be covered under this Plan. Such an order must be qualified and issued by a court of competent jurisdiction or authorized state agency in order for this Plan to be bound by it. Please contact your Employee Benefits Department for more information regarding whether or not a medical child support order is “qualified”. That department will “process” the order as follows:

- Your Employer, promptly after receiving a medical child support order, will notify you of each Child designated in the order. The notification will contain information that permits the Child to designate a representative for receipt of copies of notices that are sent to the Child with respect to a medical child support order.
- Within forty (40) business days after receipt of the order (or, in the case of a national medical support notice, the date of the notice) the Employer will determine whether the order is a “qualified” medical child support order. Upon determination of whether a medical child support order is or is not qualified, the Employer will send a written copy of the determination to you and each Child (or, where an official of the state agency issuing the order is substituted for the name of the Child, notify such official).
- If the Employer determines that the medical child support order is qualified, you, the Child or his representative must furnish to the Employer any required enrollment information. In the case of a national medical support notice, the Employer will (i) notify the state agency issuing the notice whether coverage is available to the Child under the Plan and, if so, whether such Child is covered under the Plan and either the Effective Date of such coverage or any steps to be taken by the Child’s custodial parent or an official of the state agency that issued the notice to effectuate such coverage, and (ii) provide the custodial parent (or, where an official of the state agency issuing the order is substituted for the name of the Child, notify such official) a description of the coverage available and any forms or documents necessary to effectuate such coverage.
- Typically you must provide such information to the Plan within forty-five (45) days immediately following the date the determination was made that the order was a Qualified Medical Child Support Order. In the case of a national medical support notice, if there are multiple coverage options available to the Child under the Plan the state agency issuing the notice will select an option, but if it fails to do so within twenty (20) days after the Employer’s notice described in the preceding paragraph, the Child will be enrolled under the Plan’s default option (if any).
- Unless the Qualified Medical Child Support Order provides otherwise, you will be responsible to make any required contribution to pay for such coverage.
- In no event will coverage provided under a Qualified Medical Child Support Order become effective for a Child prior to the date the Order is received by the Plan.
- If the Employer determines that the medical child support order is not “qualified”, a written determination to that effect will be furnished to you and the Child or the Child’s representative. You or the Child (or the Child’s representative) may appeal the determination to the Employer. Any request for review of a determination must be filed with the Employer within sixty (60) days after the Employer issues its original determination.

ARTICLE III EFFECTIVE DATE OF COVERAGE

EMPLOYEE EFFECTIVE DATE. Your coverage is effective as follows:

Enrollment when first eligible. If you complete and file with us the required enrollment forms no later than 31 days after the date you first become eligible, coverage will be effective the first of the month following one month of employment. For example, if you are hired on April 16th, coverage begins on June 1st. If your coverage Effective Date is later than the date you became eligible, you must still be eligible on your coverage Effective Date in order for coverage to begin.

Late Enrollment. If you decline to enroll within the first 31 days after you initially become eligible, you may enroll thereafter only by completing and filing with us the required enrollment forms either (1) within 31 days after experiencing a special enrollment event (60 days for a special enrollment event due to Children's Health Insurance Program Reauthorization Act of 2009), (as described below in the section titled, *Special Enrollment Events*), or (2) during the Plan's annual enrollment period.

If you enroll within 31 days after a **special enrollment event**, (60 days for a special enrollment event due to Children's Health Insurance Program Reauthorization Act of 2009) the date your coverage is effective depends on the type of special enrollment event. If the event is your acquisition of a Dependent Child by virtue of birth, adoption or placement for adoption, your coverage is effective as of the date of that event. If the event is loss of other coverage or your acquisition of a Dependent by virtue of marriage, your coverage is effective not later than the first day of the month following the month in which you file the required enrollment forms with us. In either case you must be eligible for coverage on the date your coverage would become effective.

If you enroll during the annual enrollment period, your coverage will be effective at the beginning of the new Plan Year (provided you are then still eligible).

DEPENDENT EFFECTIVE DATE.

Enrollment when first eligible. If you are already enrolled for Dependent coverage at the time you acquire a Dependent, coverage of the Dependent is effective on the date the Dependent became an eligible Dependent. In other cases, you must complete and file with us the required enrollment forms no later than 31 days after the date your Dependent first becomes eligible, in which case coverage of the Dependent will be effective at 12:01 a.m. on the first of the month coinciding with the date application is made (where the eligible Dependent is a newborn Child, coverage will be effective as of the date of birth, if this date is different than the date described above), provided your coverage is then in effect.

Late Enrollment. If you decline to enroll within the first 31 days after you initially become eligible, you may enroll thereafter only by completing and filing with us the required enrollment forms either (1) within 31 days after experiencing a special enrollment event (60 days for a special enrollment event due to Children's Health Insurance Program Reauthorization Act of 2009), as described below in the section titled, *Special Enrollment Events*, or (2) during the Plan's annual enrollment period.

You may also enroll the Dependent during the Plan's annual enrollment period.

If you enroll within 31 days after a **special enrollment event** (60 days for a special enrollment event due to Children's Health Insurance Program Reauthorization Act of 2009), the date your coverage is effective depends on the type of special enrollment event. If the event is your acquisition of a Dependent Child by virtue of birth, adoption or placement for adoption, your coverage is effective as of the date of that event. If the event is loss of other coverage or your acquisition of a Dependent by virtue of marriage, your coverage is effective as the date of marriage if you file the required enrollment forms with us within 31 days. In either case you must be eligible for coverage on the date your coverage would become effective

If you enroll during the annual enrollment period, your coverage will be effective at the beginning of the new Plan Year (provided you are then still eligible).

In all cases, we may require proof of dependency (and, in the case of an adopted Child or a Child placed with you for adoption, proof of the adoption or placement for adoption) as a condition to enrolling an eligible Dependent.

ENROLLMENT CHANGES UNDER FLEXIBLE BENEFITS PLAN. In addition to the changes in enrollment elections described above, you may also be eligible to change your enrollment election (to add, drop or change coverage for yourself, your Dependents, or both you and your Dependents) by changing your health coverage election under the Employer's flexible benefits plan, in accordance with the procedures described in that Plan.

SPECIAL ENROLLMENT EVENTS. For purposes of the enrollment rules described above, and/or for purposes of the Plan's Pre-Existing Condition restriction (if any), "special enrollment events" are:

Loss of Other Coverage. You or an eligible Dependent will be considered to have experienced this special enrollment event if:

- you or the eligible Dependent declined a previous opportunity to enroll or be enrolled under the Plan;
- at the time you or the eligible Dependent were previously offered the opportunity to enroll or to be enrolled you declined to enroll yourself (or, in case of an eligible Dependent, to enroll the eligible Dependent) because you had (or, in the case of an eligible Dependent, the eligible Dependent had) other health coverage; *and*
- that other coverage was either (1) COBRA Continuation Coverage which is now exhausted (other than for failure to pay premiums or for fraudulent behavior), or (2) non-COBRA Continuation Coverage under a group health plan or other health insurance which has been terminated due to loss of eligibility (other than for failure to pay premiums or for fraudulent behavior) or termination of employer contributions toward such other coverage. For this purpose, a "loss of eligibility" includes (but is not limited to) a loss of eligibility for coverage as a result of (i) divorce, (ii) cessation of Dependent status, (iii) death of an Employee, (iv) termination of employment, (v) reduction in hours, (vi) no longer residing or working in a required service area of the plan providing your coverage, (vii) a situation where you incur a claim that would meet or exceed a lifetime limit on all Benefits, or (viii) a situation where a plan no longer provides any Benefits to a class of similarly-situated individuals as yourself); (3) State Children's Health Insurance Program coverage; or (4) Medicaid coverage. Note: for both State Children's Health Insurance Program and Medicaid, Children or their parents have 60 days in which to request special enrollment under this Plan.
- switching from part-time to full-time employment status or from full-time to part-time status by the Employee or the Employee's spouse.
- taking an unpaid Leave of Absence by the Employee or Employee's spouse.

Loss of eligibility includes but is not limited to:

- loss of eligibility for coverage as a result of ceasing to meet the Plan's eligibility requirements (i.e., divorce, cessation of Dependent status, death of an Employee, termination of employment, reduction in the number of hours of employment);
- loss of coverage because the Covered Person no longer resides or works in the service area and no other coverage option is available through the plan providing your coverage;
- elimination of the coverage option a Covered Person was enrolled in, and another option is not offered in its place; and
- reaching the Plan's lifetime Benefit maximum on all Benefits, if the Covered Person is covered under a separate plan or a single plan with multiple options and the other option has a higher Lifetime Maximum, or the Benefits paid under the first option were not integrated with the second option.

For purposes of determining whether you had "non-COBRA Continuation Coverage" as described above, the term "group health plan" means a plan maintained or contributed to by an employer or employee organization (e.g., a union) to provide health care for employees and their families. The term "other health insurance" means benefits consisting of medical care under any Hospital or medical service policy or certificate, Hospital or medical service plan contract or HMO contract, by an insurance company, service, or organization required to be licensed to engage in the business of insurance in a state and that is subject to state insurance law. Specifically, "other health insurance" does not include coverage under Medicare or Medicaid.

Change in Status

If, as a result of a change in status, an Employee has the right to add additional coverage, then the Employee will have 31 days after the date of the event that constituted the change in status to notify the Plan of his or her new

election. If an Employee fails to notify the Plan within this 31-day period, the Employee would not be eligible to apply for the additional coverage until the next annual enrollment period.

Following are valid status changes:

- The legal marriage or divorce of an Employee;
- The death of the Employee's Dependent;
- The birth or adoption of a Child of the Employee;
- The termination or commencement of employment of Employee's spouse;
- The switching from part-time to full-time employment status or from full-time to part-time status by the Employee or the Employee's spouse;
- The taking of an unpaid leave of absence by the Employee or Employee's spouse; or
- A significant change occurs in the health coverage of the Employee or spouse attributable to the spouse's employment.

If, as a result of a change in status, an Employee has the right to reduce coverage (or if coverage is automatically reduced under the Plan), the Employee will have 31 days after the date of the change in status to notify the Plan of his or her election to reduce coverage. If the Employee notifies the Plan within this 31-day period, the change of coverage will apply the last day of the month in which your status change is approved.

Credit for any over deductions will only be reimbursed back to the date of written notification to the Plan. Employees cannot add, drop, or change coverage except during the annual open enrollment period or within 31 days of a change in status.

Acquisition of a Dependent by Virtue of Marriage, Birth, Adoption or Placement for Adoption. This special enrollment event occurs where you acquire a Dependent spouse or Child by virtue of marriage, or you acquire a Dependent Child by virtue of birth, adoption or placement for adoption.

Premium Assistance. This special enrollment event occurs where an eligible Child (and, under certain circumstances, the Child's parent-Employee) becomes eligible for premium assistance through State Children's Health Insurance Program or Medicaid. Children or their parents have 60 days in which to request special enrollment under this Plan.

Note that, in connection with enrolling under a "special enrollment event", you may be able to switch coverage options if the Employer offers more than one coverage option to you.

CHANGES IN COVERAGE. Should you change classifications which results in a coverage change, or should Benefits under this Plan be increased by a Plan change, the Effective Date of such change shall coincide with the date of the Benefit or classification change; however, if you are not actively at work, for reasons other than a health status-related reason, on the date the amount of your coverage would otherwise increase, such increase shall not become effective until the next following day on which you are actively at work.

Should Benefits under this Plan be decreased or deleted, the Effective Date of change will be the Effective Date of the decrease or deletion.

ARTICLE IV TERMINATION OF COVERAGE

TERMINATION OF COVERED EMPLOYEE'S COVERAGE. Except as provided in the Plan's coverage continuation provision, and any extension of Benefits provision in this Plan, your coverage as an Employee will terminate on the earliest of the following dates:

- If you fail to remit required contributions for your coverage when due, the date which is the end of the period for which the last timely contribution was made.
- The last day of the month in which you are no longer an Employee.
- The last day of the month in which your employment in an eligible class ceases; employment is considered to cease on the last day worked within the eligible class.
- The last day of the month in which you enter the military, naval or air force of any country or international organization on a full-time basis other than scheduled drills or other training not exceeding one month in any Benefit Period, subject to the requirements of the Uniformed Services Employment and Reemployment Rights Act or similar applicable federal laws.
- The date the Plan is terminated.
- The last day of the month in which you request your coverage to be terminated (subject, however, to any limitations, under an affiliated cafeteria plan under Section 125 of the Internal Revenue Code, on your right to change coverage elections prior to the end of the Plan Year).
- The date the Plan Sponsor determines, in its sole discretion, that you knowingly filed or knowingly assisted with the filing of a fraudulent claim for Benefits.
- The date you reach the Plan's Lifetime Maximum; provided, however, that you may choose to maintain your enrollment in the Plan notwithstanding the fact that you have reached the Plan's Lifetime Maximum (for example, you may wish to choose to maintain your enrollment so that the coverage of your Dependent(s) can continue under the Plan).

TERMINATION OF COVERED DEPENDENT'S COVERAGE. Except as provided in the Plan's coverage continuation provision, and any extension of Benefits provision in this Plan, your coverage as a covered Dependent will terminate on the earliest of the following dates:

- The date your sponsor's (the eligible Employee's) coverage terminates.
- If required contributions for your coverage are not remitted when due, the date which is the end of the period for which the last timely contribution was made.
- The last day of the month in which you cease to be in a class eligible for Dependent coverage.
- The last day of the month in which you cease to meet the definition of a *Dependent*; except that if you fail to meet the definition of *Dependent* due merely to attainment of the Plan's limiting age for Dependent Children, the termination Effective Date described in the definition of *Dependent*, in the section titled, *Definitions*, will control.
- The last day of the month in which you enter the military, naval or air force of any country or international organization on a full-time basis other than scheduled drills or other training not exceeding one month in any Benefit Period.
- The last day of the month in which you become covered as an Employee.
- The date Dependent coverage is discontinued under the Plan.
- The date the Plan is terminated.
- The date the Plan Sponsor determines, in its sole discretion that you knowingly filed or knowingly assisted with the filing of a fraudulent claim for Benefits.
- The date you reach the Plan's Lifetime Maximum.
- The date the Employee disenrolls a Child and enrolls that Child in a State Children's Health Insurance Program.

CELTIC MEDICAL CONVERSION PROGRAM. Coverage for you or your Dependents should terminate under the Plan, a conversion coverage option may be available. Check with your Employer for details of current conversion options at the time coverage terminates.

If coverage under this Plan terminates, participants may be eligible to purchase a conversion policy on an individual basis. Application must be made within 31 days of the date the group coverage terminates. Rules governing this purchase are established by the insurance carrier contracted to provide such services. All details concerning this policy will be furnished upon request.

EXCEPTIONS TO TERMINATION PROVISIONS - EXTENSION OF ACTIVE SERVICE (DURING ABSENCE FROM EMPLOYMENT). If your coverage as an eligible Employee would otherwise terminate due to termination of your active service due to a reason described below, your coverage may nevertheless continue (so long as the Plan remains in force) for a period of time.

In the case of an **approved full or partial paid leave of absence**, your coverage may continue up to the date your leave of absence terminates, or to the date that is twelve months after the date the leave of absence began. Premiums, which are the responsibility of the Employee, shall remain their responsibility.

In the case of an **unpaid leave of absence**, your coverage terminates. COBRA Continuation of Coverage is available with full premiums paid at the applicable rate.

In the case of your **Total Disability**, your coverage may continue for up to twelve months after the date the Total Disability begins.

Eligibility for coverage continued under this provision is in addition to coverage continued under the Plan's Continuation Coverage provisions except where the event giving rise to the continued eligibility would but for this provision be a "qualifying" or other event entitling you to continued coverage. In that latter case, the extended eligibility may run concurrently with the continued coverage. See also the Plan's Continuation Coverage rules that may apply in the case of leave, which is taken under the Family and Medical Leave Act, or in the case of certain uniformed service. These rules are described in the section of this booklet titled, *COBRA Continuation Coverage*.

OTHER METHODS OF CONTINUING COVERAGE

Family and Medical Leave Act

Regardless of the established leave policies of the Employer, the Plan shall at all times comply with the Family and Medical Leave Act of 1993 as outlined in the regulations issued by the Department of Labor, to the extent that Act applies. For an Approved Leave of Absence for 12 Weeks or less, coverage paid by the College continues as if you are an active Employee. Dependent premiums and Employee Co-Payments are paid directly to the Employee Benefits Department.

Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)

You may have certain rights to continue or reacquire coverage if you engage in periods of uniformed service, and satisfy certain requirements upon the completion of that service. Your Plan Sponsor has additional information about these special rules. Regardless of the Employer's established Leave of Absence policies, this Plan will at all times comply with the regulations of the Uniformed Services Employment and Reemployment Rights Act for Covered Employees going into or returning from military service.

For Employees electing coverage prior to December 10, 2004, these rights include up to 18 months of extended health care coverage upon payment of the entire cost of coverage plus a reasonable administration fee and immediate coverage in this Plan upon return from service. For Employees electing coverage on or after December 10, 2004, will receive up to 24 months of extended health care coverage upon payment of the entire cost of coverage plus a reasonable administration fee and immediate coverage in this Plan upon return from service. If, however, the military leave orders are for a period of 30 days or less, the Employee is not required to pay more than the amount he or she would have paid as an active Employee.

Plan exclusions and Waiting Periods may be imposed for any Sickness or Injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, military service. Election, payment and termination of the USERRA extension will be governed by the same requirements set forth under the COBRA Section, to the extent these COBRA requirements do not conflict with USERRA.

For additional information concerning the USERRA, including your rights and responsibilities under the Act, please contact the Employee Benefits Department.

CREDITABLE COVERAGE CERTIFICATES. When your coverage under this Plan terminates, as described above (including reaching the Plan's Lifetime Maximum), you will be provided with a certificate showing your periods of coverage under the Plan, and any Waiting Periods for coverage. You may be able to use this "creditable coverage certificate" when you acquire new health coverage, to avoid all or part of any Pre-Existing condition restriction that might apply to you under that new coverage. You will receive a creditable coverage certificate when:

- your coverage as an eligible Employee (or as the Dependent of an eligible Employee) terminates; and when
- your coverage under the Plan's coverage continuation provisions terminates (if you elect coverage under those provisions); and when
- you ask us for a certificate, if you ask for the certificate while covered under the Plan or within 24 months after the later of the events listed above.

In order to ask for a certificate, you (or an authorized representative) must make a request to the Employer/Plan Sponsor either in writing or by telephone. For this purpose, you should use the Employer/Plan Sponsor's contact information as shown in the section titled, *General Information*.

ARTICLE V DEFINITIONS

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

Accident/Accidental. A bodily Injury sustained independently of all other causes that is sudden, direct and unforeseen and is exact as to time and place. It does not include harm resulting from disease.

Ambulatory Surgical Center. An institution or facility, either free standing or as a part of a Hospital with permanent facilities, equipped and operated for the primary purpose of performing surgical procedures and to which a patient is admitted to and discharged from within a twenty-four (24) hour period. An office maintained by a Physician for the practice of medicine or dentistry, or for the primary purpose of performing terminations of pregnancy, is not an Ambulatory Surgical Center.

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

Attending Physician. The Physician who is in charge of, and who holds responsibility for, your medical care.

Benefit. The portion of Covered Expenses to be paid by the Plan in accordance with the coverage provisions as stated in the Plan. It is the basis used to determine your out-of-pocket expenses, if any, in excess of the deductible amount payable by you per Benefit Period, which are to be paid by you.

Benefit Period. The time period from July 1 to June 30. The Benefit Period terminates on the earliest of the following dates:

- the last day of the period so established; or
- the day the maximum lifetime Benefit has been paid to you or on your behalf; or
- the day you cease to be covered under the Plan.

Birthing Center. A facility, staffed by Physicians, which is licensed as a birthing center in the jurisdictions where it is located.

Child/Children. An Employee's:

- **natural child;**
- **foster child**, if the Employee has been appointed legal guardian or been given legal custody, provided that the child is wholly dependent upon the Employee for support and maintenance and is declared by the Employee as a dependent for Federal income tax purposes and resides with the Employee in a parent-child relationship;
- **step-child**, or a **child under the Employee's legal guardianship**, provided that the child is wholly dependent upon the Employee for support and maintenance and is declared by the Employee as a dependent for Federal income tax purposes and resides with the Employee in a parent-child relationship;
- a child who is **adopted** by or **placed for adoption** with the Employee, provided the adoption or placement occurs before the child reaches age 18; a child is considered placed for adoption with the Employee when the Employee assumes and retains a legal obligation for total or partial support of the child in anticipation of adoption; the placement terminates upon the termination of such legal obligation;
- a child who would otherwise satisfy the foregoing except that the child does not reside with the Employee, but the Employee is legally responsible for the provision of the child's medical care; and
- a child of the Employee to the extent required by a Qualified Medical Child Support Order.

Chiropractic Care. Services as provided by a licensed Chiropractor, M.D., or D.O., for manipulation or manual modalities in the treatment of the spinal column, neck, extremities or other joints, other than for a fracture or surgery.

Claim Supervisor. The person or firm employed by the Plan Sponsor to provide services to the Plan Sponsor in connection with the operation of the Plan and any other functions properly delegated to it, including the processing and payment of claims. **FMH CoreSource** is the Claim Supervisor.

COBRA Continuation Coverage. The coverage provided under the provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) and its amendments.

COBRA Qualified Beneficiary. Any formerly covered Employee or covered Dependent who has rights and is continuing participation under the provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) and its amendments.

Co-insurance. A form of cost sharing whereby you pay a percentage of Covered Expenses after your deductible is met.

Co-pay or Co-payment. A form of cost sharing whereby you pay a fixed dollar amount for certain covered services or supplies.

Cosmetic Surgery. A procedure performed solely for the improvement of your appearance rather than for the improvement or restoration of bodily function.

Covered Expense. The portion of a medical expense incurred by or on behalf of a covered Employee or covered Dependent which is eligible for reimbursement under this Plan, but only to the extent the amount of the expense is the Usual, Customary and Reasonable (UCR) charge for the service or supply, as determined by the Plan, and provided further that the expense is for a medical service or supply which is:

- ordered by a Physician; and
- Medically Necessary for the treatment of the Sickness or Injury (except where the expense is for preventive care covered under the Plan); and
- not of a luxury or personal nature; and
- not excluded under the *General Exclusions and Limitations* section of this Plan.

An expense for a medical service or supply rendered or provided to a Covered Person shall be considered to have been incurred at the time or on the date the service or supply is actually provided.

Covered Person. A covered Employee or covered Dependent, or a participating COBRA Beneficiary who meets the eligibility requirements for coverage as specified in this Plan and is properly enrolled under the Plan.

Custodial Care. The type of care (which may or may not be recommended, prescribed or provided by a Physician) which is designed primarily to assist a covered individual, whether or not Totally Disabled, in the activities of daily living. Such activities include, but are not limited to: bathing, dressing, feeding, and preparation of special diets, assistance in walking or in getting in and out of bed, and supervision over medication which can normally be self-administered.

Dependent. With respect to an Employee, is:

- the Employee's opposite sex *spouse* to whom the Employee is legally married, except that a common law spouse is not considered the Employee's "spouse" for purposes of this Plan. A spouse ceases to be a spouse for purposes of this Plan on the date a decree of divorce is entered by the court, or on the date of the spouse's death; or
- a *Dependent Child's* newborn Child up to 18 months; or
- the Employee's unmarried *disabled Child*, regardless of age, see the section of this booklet titled, *Eligibility for Coverage*; or
- the Employee's *unmarried Child* to the end of the Plan Year in which the Child reaches the age of **19**. However, a Child will remain a Dependent until the end of the Plan Year in which the Child reaches the age of **26**, provided the Child meets all of the following requirements:
 - (a) the Child is principally dependent upon the Employee for maintenance and support; and
 - (b) the Child is unmarried and does not have a dependent of his or her own; and
 - (c) the Child is living in the household of the Employee, unless:

- (i) the Child is a full-time or part-time student. Coverage of a Dependent Child who is a student shall cease upon the earlier of the Dependent Child reaches age 26, or (ii) cessation of school attendance, unless the cessation is due to school vacation (provided that Dependent status shall terminate on the date school reconvenes if the Dependent does not resume attendance) or unless the cessation is due to Total Disability which prevents school attendance, in which case Dependent status shall terminate at the last day of the academic semester or quarter (whichever is earlier) in which the Total Disability occurred; or
 - (ii) a Qualified Medical Child Support Order exists; or
- the Employee's *unmarried Child* from the end of the Plan Year in which the Child reaches the age of **26** until the end of the Plan Year in which the Child reaches the age of **30**, provided the Child meets all of the following requirements:
 - (a) the Child is a Florida resident or, if not, the Child is a full-time or part-time student; and
 - (b) the Child is unmarried and does not have a dependent of his or her own; and
 - (c) the Child is not eligible for coverage by another health plan or policy (group or individual) or by Medicare; and
 - (d) if the Child was covered under the parent's health insurance policy after the end of the Plan Year in which the Child reached age **26**, and the Child's coverage was subsequently terminated, the Child must have been continuously covered by other health insurance without a gap of more than 63 days in order to re-enroll in the eligible parent's health insurance plan.

Coverage of a Dependent Child who meets the full-time student requirements described above and who takes a Medically Necessary leave of absence shall cease upon the earlier of (i) the date that is one year after the first day of the Medically Necessary leave of absence, or (ii) the date on which such coverage would otherwise terminate under the terms of the Plan. A Medically Necessary leave of absence means a leave of absence (or a reduction in credit hours) from an accredited high school, college or university that commences while such Child is suffering from a serious illness or Injury, is Medically Necessary, and causes such Dependent Child to lose student status for purposes of coverage under the terms of the Plan. Coverage under this provision will be granted only if the Plan receives a written certification by a treating Physician of the Dependent Child which states that the Child is suffering from a serious illness or Injury and that the leave of absence is Medically Necessary.

If the Employee fails to notify the Plan Administrator, in writing, within 60 days, of a Dependent's change in eligibility status, the Dependent shall lose the right of Continuation of Coverage under COBRA. (See the COBRA section of this book for further details.)

Notwithstanding any other provision of this Plan to the contrary, a Child shall not be considered a Dependent if the Child is not a "qualifying child" or a "qualifying relative" as defined in Section 152 of the Tax Code (disregarding for this purpose subsections 152(b)(1), (b)(2) and (d)(1)(B)). Generally, this requires the Child to rely upon the Employee for over half the Child's support during the taxable year (special support rules apply in the case of a Child of divorced parents).

The term *Dependent* also does not include any person who:

- resides outside of the United States;
- is in the armed forces of any country; or
- is himself a covered Employee or is already considered a Dependent of another covered Employee (the Dependent will be considered the Dependent of only one such person).

Drug. Any medicinal substance the label of which is required by the Federal Food, Drug and Cosmetic Act to bear the legend: "Caution: Federal Law prohibits dispensing without prescription".

Durable Medical Equipment. Equipment which is able to withstand repeated use; primarily and customarily used to serve medical purpose; and not generally useful to a person in the absence of Sickness or Injury.

Effective Date. The date your coverage becomes effective.

Emergency. A sudden, unexpected acute medical condition that, without medical care within 48 hours of onset, could result in death or cause serious impairment to bodily functions.

Employee. Any person who is in one of the following categories of common law employees of the Employer, as determined from the Employer's books and records on a basis precluding individual selection.

- Regular, full-time employees
- Regular, part-time employees

Persons not considered Employees for purposes of participating in this Plan include any person not described above and, notwithstanding anything above to the contrary, specifically include:

- Adjunct faculty;
- Leased employees; (A leased employee is an employee described in Section 414(n) of the Internal Revenue Code.); and
- Independent contractors.

No person may be simultaneously covered under this Plan as both an Employee and a Dependent.

If, for any period of time, an individual has not been treated as a common law employee on the books and records of the Employer (because he is paid through accounts payable rather than payroll, or for any other reason), and a court or government agency subsequently makes a determination that the individual was in fact a common law employee during that period of time, such determination shall not entitle the individual to any retroactive rights under the Plan, and the individual's prospective rights under the Plan shall be determined solely in accordance with the terms of the Plan.

Employer. Daytona State College.

Extended Convalescent Care Facility. A duly licensed institution meeting the conditions of participation for an extended care facility under Title XVIII of the Social Security Act as enacted or as thereafter amended. This term shall also include an institution, which describes itself as a skilled nursing facility, extended care facility, convalescent nursing home or similar facility.

Extended Convalescent Period. A period of time commencing with the date of confinement by a Covered Person to a convalescent nursing facility, provided such confinement commences within fourteen (14) days after discharge from a Hospital; the Hospital confinement was for a period of not less than three (3) consecutive days; and both the Hospital and convalescent confinements must have been for the care and treatment of the same Sickness or Injury.

An Extended Convalescent Period will terminate when the Covered Person has been free of confinement in any and all institutions providing hospital or nursing care for a period of ninety (90) consecutive days. A new convalescent period shall not commence until a previous convalescent period has terminated.

Home Health Care Agency. A public or private agency or organization that specializes in providing medical care and treatment in the home. Such a provider must:

- be primarily engaged in and duly licensed, if such licensing is required, by the appropriate licensing authority, to provide skilled nursing services and other therapeutic services;
- have policies established by a professional group associated with the agency or organization; this professional group must include at least one Physician and at least one registered Nurse (R.N.) to govern the services provided and must provide for full-time supervision of such services by a Physician or registered Nurse;
- maintain a complete medical record on each individual to whom it provides care;
- have a full-time administrator; and

- not provide Custodial Care or care and treatment of the mentally ill.

Home Health Care Plan. A program for care and treatment of the Covered Person established and approved by the Covered Person's Attending Physician, which is in lieu of continued confinement as an Inpatient in a Hospital in the absence of the services and supplies provided as part of the Home Health Care Plan.

Home Health Care Visit. A visit by a member of a home health care team. Each such visit that lasts for a period of four (4) hours or less is treated as one home health care visit. If the visit exceeds four (4) hours, each period of four (4) hours is treated as one visit and any part of a four (4) hour period that remains is treated as one Home Health Care Visit.

Hospice. A health care program providing a coordinated set of services rendered at home, in outpatient settings or in institutional settings for Covered Persons suffering from a condition that has a terminal prognosis. A Hospice must have an interdisciplinary group of personnel which includes at least one Physician and one registered Nurse (R.N.), and it must maintain central clinical records on all patients. A Hospice must meet applicable state licensing requirements.

Hospice Benefit Period. The specified amount of time during which the Covered Person undergoes care by a Hospice. Such time period begins on the date the Attending Physician of a Covered Person certifies a diagnosis of terminally ill, and the Covered Person is accepted into a Hospice program. The period shall end at the earliest of six (6) months from this date or at the death of the Covered Person. A new Benefit Period may begin if the Attending Physician certifies that the patient is still terminally ill; however, additional proof may be required by the Plan Sponsor before a new Benefit Period can begin.

Hospital. Either (1) An institution constituted, licensed, and operated in accordance with the laws pertaining to hospitals, which maintains on its premises all the facilities necessary to provide for the diagnosis and medical and surgical treatment of Sickness or Injury and which provides such treatment for compensation, by or under the supervision of Physicians on an Inpatient basis with continuous 24-hour nursing service by registered Nurses (R.N.s); or (2) An institution which is licensed and operated in accordance with the state laws pertaining to osteopathic hospitals, free standing surgical facilities, Birthing Centers, a place for alcoholics, drug addicts or rehabilitation centers and which is accredited by any nationally recognized accrediting program.

Immediate Family. With respect to a Covered Person, includes the spouse, mother, father, sister, brother, child or in-laws of the Covered Person.

Injury. A condition caused by Accidental means that results in damage to the Covered Person's body from an external force.

Inpatient. A confinement of a Covered Person in a Hospital, Hospice or Extended Convalescent Care Facility as a registered bed patient, for twenty-three (23) or more consecutive hours and for whom charges are made for Room and Board.

Late Enrollee. A Covered Person who enrolls other than when first eligible to do so, except that the term "Late Enrollee" shall not include any such person who enrolls on account of a special enrollment event, described in the Plan's *Effective Date of Coverage* provisions.

Lifetime Maximum. The maximum amount payable for all Covered Expenses incurred during each Covered Person's lifetime is stated in the Schedule of Benefits. The word "lifetime" means the duration of your participation in this Plan. The Lifetime Maximum amount shall not apply to any Covered Expense obtained through the Plan's contracted pharmacy benefit manager.

Medically Necessary. Medical services, supplies or treatment:

- which are appropriate and required for the diagnosis or treatment of the Sickness, Accidental Injury or pregnancy;
- which are safe and effective according to accepted clinical evidence reported by generally recognized medical professionals or publications; and

- provided there are not less intensive or more appropriate diagnostic or treatment alternatives that could have been used in lieu of the services or supplies given.

The Plan Sponsor may determine, at its discretion, if such services or supplies are “Medically Necessary” for the diagnosis or treatment of the Sickness, Accidental Injury or pregnancy. This determination, in part, is based on and is consistent with standards outlined above and approved by the Plan Sponsor.

Medicare/Medicare Benefits. The program of benefits under Parts A and/or B of Title XVIII of the Social Security Act of 1965, as enacted or thereafter amended.

Mental and Nervous Care/Treatment. Care and treatment for mental and nervous disorders or conditions, as accepted by the general psychiatric community in the judgment of the Plan Sponsor.

Nurse. An individual who has received specialized nursing training and is authorized to use the designation “R.N.” (registered nurse) or “L.P.N.” (licensed practical nurse) and who is duly licensed by the state or regulatory agency responsible for such license in the state in which the individual performs the nursing services.

Occupational Therapy. A program of care which focuses on the physical, cognitive and perceptual disabilities that influence the patient’s ability to perform functional tasks to increase independent function, enhance development and prevent disability.

Out-of-Pocket Maximum Amount. The maximum dollar amount you will pay in any one Benefit Period for medical expenses covered by this Plan, unless otherwise specified elsewhere in the Plan.

Outpatient Care. The 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 an Ambulatory Surgical Center.

Outpatient Psychiatric Facility. An administratively distinct governmental, public, private or independent unit or part of such unit that provides treatment by a psychiatrist who has regularly scheduled hours in the facility, and who assumes the overall responsibility for coordinating the care for all patients.

Pervasive Developmental Disorder. A group of developmental conditions that affect children and involve delays or impairments in the development of many basic skills, most notably the ability to socialize with others, to communicate and to use imagination. Common types of Pervasive Developmental Disorders include Autism, Asperger Syndrome, Childhood Disintegrative Disorder and Rett Syndrome.

Physical Therapy. A plan of care provided by a qualified physical therapist to restore or improve a patient’s motor functions. Physical Therapy includes evaluation by a qualified physical therapist of the patient’s muscle tone, movement, balance, endurance, ability to ambulate and ability to plan motor movements, strength and coordination. If the patient requires special equipment (such as a wheelchair, walker or splint), Physical Therapy includes evaluation by the physical therapist of the patient’s ability to use the equipment and a determination of the correct size and type of equipment for the specific patient.

Physician. Includes:

- an individual who is licensed to prescribe and administer Drugs or to perform surgery and who is operating within the scope of his license;
- a chiropractor (D.C.) who is operating within the scope of his license; or
- a clinical psychologist who is duly licensed or certified, who is working within the scope of such license or certification and who is referred by, or working under the supervision of, a person described in the first subparagraph above.

The term “Physician” also includes a certified licensed nurse-midwife, a certified registered nurse anesthetist (CRNA), and a social worker with the degree of “MSW”, but only to the extent any such individual is licensed as such pursuant to any applicable state licensing authority, and is acting within the scope of that license.

Plan. The Healthcare Purchasing Alliance Employee Healthcare Benefits Plan as herein set forth and as from time to time amended.

Plan Administrator. The entity responsible for the functions and arrangements of the Plan. The Plan Administrator may also employ persons or firms to process claims and perform other Plan-related services.

Plan Sponsor. Daytona State College.

Plan Year. The time period from July 1 to June 30. The Benefit Period terminates on the earliest of the following dates:

- the last day of the period so established; or
- the day the maximum lifetime Benefit has been paid to you or on your behalf; or
- the day you cease to be covered under the Plan.

Pre-Admission Testing. The program of tests conducted by a Hospital, at the direction of a Physician, with respect to a Covered Person on an outpatient basis, which are Medically Necessary prior to a scheduled Inpatient confinement at the same facility.

Pre-Existing Condition. A condition (except pregnancy or a condition based solely on genetic information), either physical or mental, regardless of its cause for which you received medical advice, diagnosis, care or treatment (or a recommendation for same), or for which Drugs or medicines were prescribed, by an individual licensed or otherwise duly authorized to provide such services under state law, and acting within the scope of that authority, within the **six (6) months** period ending on your enrollment date under the Plan. For this purpose, the term “enrollment date” means the first day of coverage or, if there is a Waiting Period, the first day of the Waiting Period.

Preferred Provider. Any Physician, medical professional or medical facility listed in network directories under contract with the Plan.

Qualified Medical Child Support Order (QMCSO). A medical child support order issued by a court having proper jurisdiction, or issued under an administrative process established under state law that has the force and effect of law under applicable state law and which creates or recognizes the existence of a Child’s rights to, or assigns to such Child the right to, receive Benefits for which a Dependent is eligible under this Plan, provided such order clearly specifies:

- the name and last known mailing address of the Employee, and the name and mailing address of each Child covered by the order (to the extent provided in the order, the name and mailing address of an official of the state agency issuing the order may be substituted for the name and mailing address of the Child);
- a reasonable description of the type of coverage to be provided by the Plan to each Child, or the manner in which coverage is to be determined;
- the time period to which such order applies; and
- the Plan’s name, and meets other legal requirements.

A national medical support notice that meets (or, pursuant to federal regulations, is deemed to meet) the foregoing requirements will be considered a Qualified Medical Child Support Order.

Rehabilitation Facility. A legally operating institution or a distinct part of an institution which has a transfer agreement with one or more Hospitals, and which is primarily engaged in providing comprehensive multi-disciplinary physical restorative services, post acute Hospital and rehabilitation Inpatient care and is duly licensed by the appropriate governmental agency to provide such services. It does not include institutions which provide only minimal care, Custodial Care, ambulatory or part-time care services, or an institution which primarily provides treatment of mental disorders, Chemical Dependency, Substance Abuse or tuberculosis, except if such facility is licensed, certified or approved as a Rehabilitation Facility for the treatment of medical conditions or Chemical Dependency or Substance Abuse in the jurisdiction where it is located, or is accredited as such facility by the Joint Commission for the Accreditation of Healthcare Organizations or the Commission for the Accreditation of Rehabilitation Facilities.

Room and Board. All charges commonly made by a Hospital on its own behalf for room and meals and for all general services and activities essential to the care of registered bed patients.

Sickness. Any physical illness, mental illness, or functional nervous disorder. A recurrent Sickness will be considered one Sickness. Concurrent Sicknesses will be considered one Sickness unless the concurrent Sicknesses are totally unrelated. The term “Sickness” shall include pregnancy, childbirth or resulting complications.

Specialty Drug. A specialty drug is a high-cost, complex pharmaceutical (usually injectable) that has unique clinical, administration, distribution and/or handling requirements and is not commonly available in traditional community and mail order pharmacies.

Speech Therapy. A program of care that evaluates the patient’s motor-speech skills, expressive and receptive language skills, writing and reading skills, and determines if the patient requires an extensive hearing evaluation by an audiologist.

Substance Abuse/Chemical Dependency. The physiological and psychological addiction to a controlled drug or substance, or to alcohol. Dependence upon tobacco, nicotine and caffeine are not included in this definition.

Substance Abuse Treatment. An institution that provides a program for diagnosis, evaluation and treatment of alcoholism and/or drug use or abuse; is at all times supervised by a staff of Physicians; provides at all times skilled nursing care by Nurses who are directed by a full-time registered Nurse (R.N.); and is a facility that meets applicable licensing standards.

Total Disability/Totally Disabled. Your physical state resulting from a Sickness or Injury, which wholly prevents you (as an eligible Employee) from engaging in any and every business or occupation and from performing any and all work for compensation or profit; and in the case of your Dependent COBRA Beneficiary, prevents that person from performing the normal activities of a person of that age and gender who is in good health.

Usual, Customary and Reasonable Charges (UCR). Charges made for medical services or supplies essential to your care if they are the amount normally charged by the provider for similar services and supplies and do not exceed the amount ordinarily charged by most providers of comparable services and supplies in the locality where the services or supplies are received. In determining whether charges are Usual, Customary and Reasonable, due consideration will be given to the nature and severity of the condition being treated and any medical complications or unusual circumstances which require additional time, skill or experience. Usual, Customary and Reasonable charges may alternatively be determined and established by the Plan using normative data such as Medicare cost to charge ratios, average wholesale price (AWP) for prescriptions, and/or manufacturer’s retail pricing (MRP) for supplies and devices.

Waiting Period. The period of time during which you must be in an eligible class before becoming covered under this Plan.

We. The Plan Sponsor.

You/Your. Generally, a covered Employee, although depending on the context, may mean any person who is covered under the Plan as an eligible Employee or a Dependent, subject to the enrollment and contribution requirements of the Plan.

ARTICLE VI MEDICAL BENEFITS

LIFETIME MAXIMUM AMOUNT. The maximum amount payable for all Covered Expenses incurred during each Covered Person's lifetime is stated in the Schedule of Benefits. The word "lifetime" means the duration of your participation in this Plan. The Lifetime Maximum amount shall not apply to any Covered Expense obtained through the Plan's contracted pharmacy benefit manager.

DEDUCTIBLE AMOUNT. The deductible amount for each Covered Person is the amount of Covered Expenses that must be paid by you during each Benefit Period and while covered by the Plan before Benefits begin under the *Medical Benefits* provisions of this Plan. The deductible amount is shown in the Schedule of Benefits. The deductible may not apply to certain Benefits (that is, some Benefits may be paid even if you have not satisfied your deductible for the Benefit Period).

The Schedule of Benefits reflects a "family" deductible. When any two or more Covered Persons in the family pay, in the same Benefit Period and while covered by the Plan, the amount shown as the "family" deductible, then all Covered Persons in the family will be deemed to have satisfied their individual deductible amount for the Benefit Period. "Family" means you as the covered Employee and all your covered Dependents.

Where the Schedule of Benefits reflects deductible amounts for both In-Network and Out-of-Network care, the deductibles apply separately. Thus, for example, if you have already satisfied your In-Network deductible for the Benefit Period and have not incurred any expenses outside of the network, and then you receive care outside of the network, your In-Network expenses that were applied to satisfy your In-Network deductible cannot be applied toward satisfying your Out-of-Network deductible.

OUT-OF-POCKET MAXIMUM AMOUNT. The Schedule of Benefits may reflect an "Out-of-Pocket Maximum Amount" payable by a Covered Person and his or her family. The Out-of-Pocket Maximum Amount is the amount of otherwise Covered Expenses that you must pay during a Benefit Period and while covered by the Plan before the Plan's Co-insurance payment percentage increases (typically, to 100%). Payments a Covered Person makes to satisfy his or her deductible amount are not taken into account in determining whether a Covered Person has met the Out-of-Pocket Maximum Amount for the Benefit Period. Also, the following expenses are not applied to the Out-of-Pocket Maximum Amount:

- expenses not covered by the Plan
- expenses in excess of amounts covered by the Plan
- penalty amounts for failure to pre-certify
- expenses in excess of Usual, Customary and Reasonable amounts

In some cases, as described in the Schedule of Benefits, the Plan will pay 100% of the Covered Expense even if the Covered Person has *not* met the Out-of-Pocket Maximum Amount for the Benefit Period.

Even if the Out-of-Pocket Maximum Amount has been met for a Benefit Period, some Covered Expenses are never paid by the Plan at a Co-insurance rate in excess of the Co-insurance payment rate reflected in the Schedule of Benefits. Such Covered Expenses include:

- Co-payments

The Schedule of Benefits reflects a "family" Out-of-Pocket Maximum Amount. When any two or more Covered Persons in the family pay, in the same Benefit Period and while covered by the Plan, the amount shown as the "family" Out-of-Pocket Maximum Amount, then all Covered Persons in the family will be deemed to have satisfied their individual Out-of-Pocket Maximum Amount for the Benefit Period. "Family" means you as the covered Employee and all your covered Dependents.

Where the Schedule of Benefits reflects Out-of-Pocket Maximum Amounts for both In-Network and Out-of-Network care, the Amounts apply separately. Thus, for example, if you have already satisfied your In-Network Out-of-Pocket Maximum Amount for the Benefit Period and have not incurred any expenses outside of the network, and then you receive care outside the network, none of your In-Network expenses that were applied to satisfy your In-

Network Out-of-Pocket Maximum Amount are applied toward satisfaction of your Out-of-Network Out-of-Pocket Maximum Amount.

BENEFIT MAXIMUMS. The Schedule of Benefits may reflect certain Benefit limits that apply under the Plan. If a Benefit limit is listed more than once in the Schedule of Benefits (for example, if listed once under the “In-Network” column, and listed again under the “Out-of-Network” column), the limit is an aggregate limit. For example, if a Benefit is limited to 30 days per year under the In-Network column, and 30 days per year under the Out-of-Network column, once a total of 30 days of Benefits have been paid (whether In-Network, Out-of-Network or part In-Network and part Out-of-Network), no further Benefits are payable for the remainder of the period.

ARTICLE VII COVERED EXPENSES

The term “Covered Expenses” is defined in the Definitions section of this booklet, and generally includes all Usual, Customary and Reasonable charges actually incurred for Medically Necessary and essential care and treatment for Sickness and Accidental Injury recommended by a licensed Physician which include but which are not limited to these expenses listed below:

1. COVERED MEDICAL EXPENSES.

- a. Hospital Charges for:
 - i) The actual Room and Board expenses incurred for a ward or semi-private room or the lowest private room rate for a Hospital that does not have semi-private accommodations. Private room expenses are limited to the average semi-private rate of the Hospital in which confined.
 - ii) The actual expense incurred for confinement in an intensive care unit, cardiac care unit or burn unit.
 - iii) Miscellaneous Hospital services and supplies during Hospital confinement.
 - iv) Inpatient charges for a well newborn baby for nursery Room and Board, and for professional service required for the healthy newborn. Covered Expenses also include charges for pediatric services and circumcision. Eligible expenses for the baby as a Dependent Child will be subject to a separate deductible. Benefits will be payable from the date of birth until the earliest of the date the mother is released; the date the Child is released; or the Child’s fifth day of age. Maternity expenses for Dependent Children are covered. A newborn child of a Covered Dependent Child is eligible to participate from birth to age 18 months.
- b. Charges incurred for confinement in a Rehabilitation Facility, limited to the facility’s average semi-private room rate.
- c. Charges for a Medically Necessary surgical procedure.
- d. Charges for the services of a legally qualified Physician for medical care and/or surgical treatments including office, home visits, Hospital Inpatient care, Hospital outpatient visits/exams, clinic care, and surgical opinion consultations.
- e. Charges for the services of a Nurse for Inpatient private duty nursing.
- f. Charges for the treatment or services rendered by a licensed physical therapist under the direct supervision of a Physician in a home setting or at a facility or institution whose primary purpose is to provide medical care for a Sickness or Injury.
- g. Charges of a legally qualified Physician or qualified speech therapist under direct supervision of a Physician for restorative Speech Therapy for speech loss or impairment due to a Sickness or Injury, or due to surgery performed on account of a Sickness or Injury, other than a functional nervous disorder. If the speech loss is due to a congenital anomaly, surgery to correct the anomaly must have been performed prior to the therapy.
- h. Charges for professional ambulance service to the Hospital where treatment is given or between medical facilities when Medically Necessary, including air transport to and from the nearest facility qualified to render treatment.
- i. Charges for Drugs requiring the written prescription of a licensed Physician; such Drugs must be necessary for the treatment of a Sickness or Injury. Note: This subsection is intended to describe generally the type and nature of Drugs covered by the Plan; if the Plan restricts Benefits for Drugs (either on the basis of the type of Drug, or the provider of the Drug) in other sections or subsections of this Plan, the rules of those other sections and subsections shall operate as a limitation on this subsection.
- j. Charges for x-rays, microscopic tests, laboratory tests and radioactive isotopes.
- k. Charges for radiation therapy or treatment and chemotherapy.
- l. Charges for blood or blood plasma and its processing and administration.
- m. Charges for oxygen and other gases and their administration.
- n. Charges for electrocardiograms, electroencephalograms, pneumoencephalograms, basal metabolism tests, or similar well-established diagnostic tests generally approved by Physicians throughout the United States.
- o. Charges for the cost and administration of an anesthetic.

- p. Charges for dressings, sutures, casts, splints, trusses, crutches, braces or other necessary medical supplies, with the exception of dental braces.
- q. Charges for rental or purchase, whichever is less costly, of Medically Necessary Durable Medical Equipment, which is prescribed by a Physician and required for therapeutic use by the Covered Person. Repair or replacement of purchased Durable Medical Equipment, which is Medically Necessary due to normal use, or a physiological change in the patient's condition will be considered a Covered Expense.
- r. Charges for the initial purchase of artificial limbs, eyes or larynx, to replace natural limbs, eyes or larynx. Replacement of artificial limbs, eyes or larynx that is Medically Necessary due to normal use or a physiological change in the patient's condition will be considered a Covered Expense.
- s. Charges for one sonogram per pregnancy. Additional sonograms will be covered if there is an indication of complications.
- t. Charges for services for voluntary sterilization for covered Employees and covered Dependent spouses; reversal of sterilization is not covered.
- u. Charges made by an Ambulatory Surgical Center or minor emergency medical clinic.
- v. Charges for hyperalimentation or Total Parenteral Nutrition (TPN) for person recovering from or preparing for surgery.
- w. Charges for maternity care (including maternity care for covered Dependent Children) on the same basis as any Sickness covered under this Plan.
- x. Charges made by a Hospital (excluding charges made by the Nurse or Physician) for laboratory and x-ray testing within seven days prior to a scheduled admission to that Hospital.
- y. Charges for an opinion as to whether or not a recommended surgery is appropriate, so long as the second opinion is given by a Physician who also personally examines the Covered Person and provides a written opinion; and that Physician does not perform the surgery or practice in association with the Physician making the initial recommendation.
- z. Charges for allergy shots and testing.
- aa. Charges for marriage and family counseling.
- bb. Charges for diagnostic services for the treatment of infertility.
- cc. Charges for massage therapy.
- dd. Charges for services rendered by a nutritionist limited to treatment of diabetes and heart disease.
- ee. Charges for treatment of temporomandibular joint dysfunction, craniomandibular joint dysfunction; myofascial pain syndrome; and all related conditions.
- ff. Charges for sleep studies and treatment of sleep apnea and other sleep disorders.
- gg. Charges for nerve stimulators.
- hh. Charges for colonoscopy.
- ii. Charges for ostomy supplies.
- jj. Charges for Wellness Care, well woman care and well baby/well child Benefits are subject to restrictions and limits as described in the section of this booklet titled, *Preventive Services*.
- kk. Charges for growth hormones when Medically Necessary.
- ll. Charges for contraceptive devices for Employee, Spouse and covered Dependent Children.

2. *EXTENDED CONVALESCENT CARE FACILITY/SKILLED NURSING FACILITY.* Charges incurred for confinement in an Extended Convalescent Care Facility up to the maximum stated in the Schedule of Benefits. However, such expenses are limited as follows:

- a. charges will be considered only if confinement begins within fourteen (14) days after a Hospital confinement of at least three (3) consecutive days.
- b. charges will be considered only if they are incurred in connection with care related to the Sickness or Injury for which you were confined.
- c. charges will be considered only if documentation shows progress in rehabilitation or restoration.
- d. charges for Custodial Care are not covered.

An Extended Convalescent Period will terminate when you have been free of confinement in any and all institutions providing hospital or nursing care for a period of ninety (90) consecutive days. A new Convalescent Period shall not commence until a previous Convalescent Period has terminated. No Benefits are payable under this provision for treatment of Mental and Nervous Disorders or Substance Abuse.

3. **HOSPICE CARE.** Charges related to Hospice care provided that the Covered Person has a life expectancy of six (6) months or less and subject to the maximums, if any, stated in the Schedule of Benefits. Covered Hospice expenses are limited to:

- a. room and board for confinement in a Hospice;
- b. ancillary charges furnished by the Hospice while the patient is confined therein, including rental of Durable Medical Equipment which is solely for treating a Sickness or Injury;
- c. medical supplies, Drugs and medicines prescribed by the Attending Physician, but only to the extent such items are necessary for pain control and management of the terminal condition;
- d. physician services and/or nursing care by a Nurse or a Licensed Vocational Nurse (L.V.N.);
- e. home health aide services;
- f. home care charges for home care furnished by a Hospital or Home Health Care Agency, under the direction of a Hospice, including Custodial Care if it is provided during a regular visit by a Nurse or a home health aide;
- g. medical social services by licensed or trained social workers, psychologists or counselors;
- h. nutrition services provided by a licensed dietitian;
- i. respite care;
- j. Bereavement counseling is a supportive service provided by the Hospice team and/or a licensed social worker (LSW) or a licensed pastoral counselor to Covered Persons in the deceased's Immediate Family after the death of such terminally ill person. Such visits are to assist the Covered Persons in adjusting to the death. Benefits will be considered for the charges provided:
 - i) on the date immediately before his death, the terminally ill person was in a Hospice Care Program and a Covered Person under the Plan; and
 - ii) charges for such services are incurred within six (6) months of the terminally ill person's death.

4. **COSMETIC SURGERY.** Charges for Cosmetic Surgery, but only in the following situations:

- a. the treatment is received within twelve (12) months of an Accidental bodily Injury, and the Cosmetic Surgery is for the purpose of restoring the Covered Person to his normal function immediately prior to the Accident; or
- b. the surgery is necessary to correct significant deformity arising from, or directly related to, disease, trauma, or previous therapeutic process; or
- c. the surgery is a correction of a congenital anomaly, for example, a birth defect, in a Child who is a Covered Dependent; or
- d. with respect to any Covered Person who is receiving Benefits for a mastectomy and who elects breast reconstruction in connection with the mastectomy;
 - i) reconstruction of the breast on which the mastectomy was performed;
 - ii) surgery and reconstruction of the other breast to produce a symmetrical appearance; and
 - iii) prostheses and physical complications with respect to all stages of mastectomy, including lymphedemas, in a manner determined in consultation with the Attending Physician and the Covered Person.

5. **ORGAN TRANSPLANT.** Charges for services and supplies in connection with human-to-human tissue and organ transplant procedures, subject to the following conditions:

- a. All transplant-related services, including evaluation, must be referred to and authorized by the Plan's medical review specialist prior to the patient receiving any such services. It is the responsibility of the patient to obtain pre-certification. Failure to obtain pre-certification will result in a reduction of Benefits.
- b. If the donor is covered under this Plan, Covered Expenses incurred by the donor will be considered for Benefits to the extent donor benefits are not provided under the recipient's Plan.
- c. If the recipient is covered under this Plan, Covered Expenses incurred by the recipient will be considered for Benefits. Expenses incurred by the donor, who is not ordinarily covered under this Plan according to participant eligibility requirements, will be considered Covered Expenses to the extent that such expenses are not payable by the donor's plan. In no event will Benefits be

payable in excess of the Human Organ and Tissue Transplant Maximum Benefit stated in the Schedule of Benefits which are available to the recipient.

- d. If both the donor and the recipient are covered under this Plan, eligible medical expenses incurred by each person will be treated separately.
- e. The Plan has a \$10,000 maximum procurement fee unless the procurement-related charges are part of a negotiated case rate. Surgical, storage and transportation costs directly related to procurement of an organ or tissue used in a transplant procedure will be covered for each procedure completed. If an organ or tissue is sold rather than donated, the purchase price of such organ or tissue shall not be considered a Covered Expense under this Plan.

Special Transplant Benefit

In addition to any standard transplant benefit set forth in this booklet, a Special Transplant Benefit may be available when a Covered Person participates in the Special Transplant Program. The Special Transplant Benefit provides enhanced transplant Benefits and participation in the Program is voluntary. Additional information regarding the Special Transplant Program may be obtained through your Employer.

The Special Transplant Benefit provides the following Benefits in addition to any transplant Benefits available under this plan:

- a. access to Centers of Excellence Transplant Facilities throughout the United States;

In addition, if your Plan provides the following Benefits as covered Benefits, under the SunExcel Transplant Benefit, eligible expenses will include:

- b. reimbursement, up to a total of \$5,000, for expenses incurred by the Covered Person and one companion, or both parents or both legal guardians if the Covered Person is a minor Child:
 - 1. for travel to and from the Centers of Excellence facility when that travel is related to the actual transplant occurrence; and
 - 2. for lodging expenses related to such travel and occurring prior to and following the actual transplant occurrence; and
- c. waiver of the Covered Person's deductible and Co-payments up to \$1,500 during the year in which the transplant occurs.

The Special Transplant Benefit is only available when a Covered Person participates in the Special Transplant Program and satisfies all of the following requirements:

- a. notification of the transplant procedure must be provided to your pre-certification company in accordance with its guidelines;
- b. the Covered Person or Covered Person's representative or whomever the Employer or TPA designates must call the Special Transplant Program at 1-800-432-1102 extensions 1148, 2387, 1359 or 1135 as soon as the Covered Person is identified as a potential transplant candidate to notify the Special Transplant Program of the impending transplant; and
- c. all transplant services must be rendered at a Centers of Excellence Transplant Facility, which participates in this Program for the specific organ or tissue transplant required. A current list of participating Centers of Excellence facilities for each type of transplant is available from your Employer.

- 6. **HOME HEALTH CARE.** Charges made by a Home Health Care Agency for care in accordance with a Home Health Care Plan up to the maximums stated in the Schedule of Benefits. Home Health Care is subject to pre-certification. Prior to the initiation of services, you or your Physician must contact the medical review specialist and have the proposed treatment plan reviewed and approved or "pre-certified". Such charges include expenses for:

- a. part-time or intermittent nursing care by a Nurse or a vocational nurse or public health nurse who is under the direct supervision of a registered nurse.

- b. home health aides.
- c. physical, respiratory, occupational or speech therapy.
- d. medical supplies, Drugs and medicines prescribed by a Physician, and laboratory services provided by or on behalf of a Hospital, but only to the extent that they would have been covered under this Plan if you had remained in the Hospital.

Specifically excluded from coverage under the Home Health Care Benefit are the following:

- a. services and supplies not included in the Home Health Care Plan;
- b. services of a person who ordinarily resides in your home, or is a member of your Immediate Family;
- c. services of any social worker;
- d. transportation services;
- e. custodial care and housekeeping;
- f. food, food supplements and home delivered meals;
- g. nursing care services, except as specified;
- h. charges for services in excess of the maximum shown on the Schedule of Benefits.

7. *MENTAL AND NERVOUS DISORDER AND SUBSTANCE ABUSE.* Charges for Mental and Nervous Disorder and Substance Abuse treatments for the following services and supplies:

- a. hospital charges;
- b. convulsive or shock treatment;
- c. surgical charges;
- d. psychiatric visits in the Hospital;
- e. prescription Drugs;
- f. out-of-Hospital charges including covered Physician charges.

8. *REHABILITATION SERVICES.* Charges for Inpatient rehabilitation services in a licensed Rehabilitation Facility and outpatient rehabilitation services (including, but not limited to, physical, occupational, speech and hearing therapy services), are covered only if such services are expected to result in significant improvement in the Covered Person's condition.

9. *PRESCRIPTION DRUG EXPENSE BENEFITS.*

Direct Mail Prescriptions. The Plan may contract with a Direct Mail Prescription Drug Provider, which will enable you to obtain your prescriptions (typically maintenance prescriptions) at a reduced cost. If the Plan so contracts with a Direct Mail Prescription Drug Provider, that fact will be reflected in the Schedule of Benefits, and the Plan Sponsor will provide you with additional information about how to utilize the services of the Direct Mail Prescription Drug Provider. If the Plan contracts with such a provider, you may be required to utilize that provider to have certain prescriptions filled at the Plan's expense. The Provider will bill the Plan for any amount in excess of the Co-pay shown in the Schedule of Benefits. **Note:** The separate Co-pay is not eligible for reimbursement under these *Medical Benefits* provisions.

Direct Pharmacy Benefit. The Plan may contract with a pharmacy network to provide you with covered Drugs. To utilize this Benefit, you must take your Physician's written prescription to a network pharmacy. When the prescription is filled you will be required to pay the Co-pay amount specified in the Schedule of Benefits. The network provider will then bill the Plan for any amount in excess of the Co-pay shown in the Schedule of Benefits. **Note:** The amount you pay is not eligible for reimbursement under these *Medical Benefits* provisions.

Diabetic test supplies such as insulin and insulin syringes, needles, test strips and supplies will be covered under the pharmacy benefit manager.

Contraceptives, with the exception of devices, will be covered under the pharmacy benefit manager.

Expenses for Drugs obtained *outside* of the network are not Covered Expenses, except to the extent the Plan specifically provides coverage for Drugs obtained outside of the network (for example, the Plan may specifically provide that Drugs obtained outside of the network are covered if they are obtained outside of the network's area by a Covered Person who resides outside of the network area).

The Pre-Existing Condition Restriction shall not apply to any Covered Expense obtained through the Plan's contracted pharmacy benefit manager.

Specialty Drug Program. This Plan utilizes a mandatory Specialty Drug program administered by a Pharmacy Benefit Manager (PBM). All Specialty Drugs require prior authorization by the PBM. If prior authorization is granted, the Specialty Drug must be obtained through the PBM's Specialty Drug program in order for Benefits to be paid.

A Specialty Drug will be excluded from coverage if:

- prior authorization is not granted by the PBM; or
- the Specialty Drug is dispensed by a physician or pharmacy that is not participating in the Specialty Drug program.

Questions about the mandatory Specialty Drug Program should be directed to the PBM. Information about the PBM, including the phone number, is listed on your ID card.

10. DENTAL CARE. Benefits for dental care, under these *Medical Benefits* provisions, are limited to:

- a. Services provided for an Accidental Injury to sound, natural teeth incurred within 6 months of the Accident causing the Injury.
- b. The following oral surgery:
 - i) surgical removal of impacted wisdom teeth;
 - ii) reduction of fractures of facial bones;
 - iii) excisions of mandible joints;
 - iv) treatment of lesions;
 - v) incision of accessory sinuses, mouth, salivary glands or ducts;
 - vi) plastic reconstruction or repair of the mouth or lips to correct Accidental Injury.
- c. Anesthesia and facility charges associated with necessary dental services for the following groups who otherwise would not be able to receive the dental services:
 - i) covered Children under the age of 5;
 - ii) severely disabled members; or
 - iii) members with certain medical or behavioral conditions.

11. CHIROPRACTIC CARE. Covered Expenses include initial consultation, x-rays and treatment, subject to the maximum Benefit, if any, shown on the Schedule of Benefits. Maintenance, supportive and preventive care are not covered.

ARTICLE VIII PRE-EXISTING CONDITION RESTRICTION

The Plan limits Benefits for otherwise covered treatment of a Covered Person's Pre-Existing Conditions. The Plan will not pay otherwise Covered Expenses for treatment of a Covered Person's Pre-Existing Condition until the end of the 12-month period (18-month period, in the case of a Late Enrollee) beginning on the Covered Person's enrollment date.

The 12-month (or 18-month) period described above may be reduced by your periods of "creditable coverage" under your prior health insurance policies or prior health plans (although a period of prior creditable coverage will be disregarded if you have a 63-day or longer break in creditable coverage after that period). We will assist you, if necessary, in determining the amount of your prior creditable coverage, and in obtaining information from your prior health insurer or health plan concerning your creditable coverage under that insurance policy or plan. Then, we will tell you how much of the 12-month (or 18-month) period remains to be satisfied in your case, after taking into account your prior creditable coverage. We will make this determination in accordance with the rules and regulations under the Health Insurance Portability and Accountability Act of 1996, as amended. You can appeal our determination in accordance with the claim appeal procedures described later in this booklet.

For purposes of this rule, the term "enrollment date" has the same meaning as described in the definition of Pre-Existing Condition.

Notwithstanding anything above to the contrary, in the case of an eligible Dependent who is a Child, such Child will be deemed to have at least 18 months of creditable coverage, regardless of the Child's actual period of creditable coverage, provided the Child was enrolled under creditable coverage within 30 days after birth, adoption or placement for adoption, and did not thereafter experience a 63-day or longer break in creditable coverage.

This Pre-Existing Condition limitation shall not apply to any Covered Person who is a Dependent Child and who is adopted by or placed for adoption with an Employee or who is covered due to a QMCSO.

This Pre-Existing Condition limitation shall not apply to any Dependent that has enrolled as the result of a special enrollment event under the Children's Health Insurance Program Reauthorization Act of 2009.

The Pre-Existing Condition Restriction shall not apply to any Covered Expense obtained through the Plan's contracted pharmacy benefit manager.

The period between an Employee's COBRA qualifying event and the first day of a Special Trade Act COBRA election period will not be treated as a break in creditable coverage.

The period between an Employee's COBRA qualifying event and the first day of COBRA coverage as a result of The American Recovery Act of 2009 will not be treated as a break in creditable coverage.

ARTICLE IX GENERAL EXCLUSIONS AND LIMITATIONS

Except as and to the extent otherwise specifically provided in this booklet, Covered Expenses do not include, and no Benefits (whether or not the care was Medically Necessary) will be paid with respect to:

1. **Abdominoplasty** - Charges for abdominoplasty.
2. **Acupressure and Acupuncture** - Charges for acupuncture, acupressure and related or similar treatments.
3. **Admission Charges** - Charges for Physician or Hospital bed patient services (other than diagnostic x-ray and laboratory tests and charges for Physical Therapy) if admission was primarily for diagnostic reasons or for Physical Therapy, and if such services could have been provided adequately on an outpatient basis without endangering the patient's health.
4. **Alternate Treatment** - Charges for rolfing, aromatherapy and other forms of alternative treatment as defined by the Office of Alternative Medicine of the National Institutes of Health, except as otherwise specified as covered.
5. **Artificial Organ** - Charges for services related to obtaining or implanting a non-human, artificial or mechanical organ.
6. **Biofeedback** - Charges for biofeedback.
7. **Blood Products** - Charges for blood products storage when not necessary or not in conjunction with a scheduled covered surgery; or blood products when replaced by donation. Charges for procurement and storage of one's own blood, unless incurred within three months prior to the scheduled surgery.
8. **Breast Reduction** - Charges for reduction mammoplasty (breast reduction surgery), unless determined to be Medically Necessary or covered under the Cosmetic Surgery provisions of the Plan.
9. **Circumcision** - Charges for circumcisions other than those for a newborn male, unless deemed Medically Necessary.
10. **Comfort Items** - Charges for items or devices primarily used for comfort, including but not limited to air purifier, humidifier, dehumidifier, whirlpool, air conditioning, waterbed, exercise equipment, ultraviolet lighting, or anything useful in the household.
11. **Complications** - Charges for services or supplies received for treatment of complications resulting from services that are not covered.
12. **Contraceptives** - Charges for contraceptives, with the exception of devices, for Employees, Spouse and covered Dependent Children.
13. **Controlled Substance, Under the Influence of** - Charges for services, supplies, care or treatment to a Covered Person for Sickness or Injury resulting from that Covered Person's voluntary taking of or being under the influence of any controlled substance, chemical or drug, unless such controlled substance, chemical or drug was administered on the advice of a Physician. Expenses will be covered for Substance Abuse treatment as specified in this Plan. Expenses will also be covered for Covered Persons other than the person using controlled substances. This exclusion does not apply if the Sickness or Injury resulted from an act of domestic violence or a medical condition (regardless of whether such medical condition is physical or mental, and regardless of whether the medical condition is diagnosed prior to the Sickness or Injury).
14. **Cosmetic Surgery** - Charges for Cosmetic Surgery or procedure and all related services.
15. **Court-Required Treatment** - Charges for treatment of Substance Abuse, alcohol dependency or Mental and Nervous Disorders that is required by a court as an alternative to a conviction or for a reduction in penalty or sentence.
16. **Coverage Dates** - Charges for services rendered and or supplies received prior to the Effective Date or after the termination date of a person's coverage.
17. **Criminal Act** - See Military Injury.
18. **Custodial Care** - Charges for Custodial Care to assist in daily living needs not Medically Necessary to recover from a Sickness or Injury; or for Custodial Care or similar services by a member of your Immediate Family or someone who resides with you.
19. **Dental** - Charges for dental treatment resulting from chewing injuries; dental implants; and dental treatment.
20. **Developmental Delay** - Charges for treatment for learning disabilities or developmental conditions except for therapy for Pervasive Development Disorders (also known as autism spectrum disorders) for which charges will be considered only for Children 12 years of age or younger when documentation shows developmental progress.

21. **Diabetes Supplies** - Charges for insulin, needles and clinitest necessary to treat diagnosed diabetes. See the section titled, *Prescription Drug Expense Benefits*, for a description of what is covered under the pharmacy benefit manager.
22. **Education** - Charges for testing or training for education or vocation, except that diabetic and heart disease education will be a Covered Expense under the Plan.
23. **Exams and Tests for Miscellaneous Purposes** - Charges for physical exams and related x-ray and lab expenses when rendered for purposes of employment, school, travel, immigration, or to buy insurance; or for pre-marital or family planning tests and exams; related to judicial or administrative proceedings or orders; or conducted for the purpose of medical research.
24. **Experimental or Investigational** - Charges for Drugs, devices, supplies, treatments, procedures or services that are considered experimental or investigative by the Plan. The Plan will consider a Drug, device, supply, treatment, procedure or service to be “experimental” or “investigative”:
 - a. if, in the case of a Drug, device or supply, the Drug, device or supply 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
 - b. if the Drug, device, supply, treatment, procedure or service, or the patient’s informed consent document utilized with respect to the Drug, device, supply, treatment, procedure or service 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
 - c. if the Plan Sponsor determines in its sole discretion that the Drug, device, supply, treatment, procedure or service 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 maximum tolerated dose, toxicity, safety or efficacy; or
 - d. if the Plan Sponsor determines in its sole discretion based on documentation in one of the standard reference compendia or in substantially accepted peer-reviewed medical literature that the prevailing opinion among experts regarding the Drug, device, supply, treatment, procedure or service is that further studies or clinical trials are necessary to determine its maximum tolerated dose, toxicity, safety or efficacy.
25. **Family Member, Services Rendered by** - Charges for services or supplies rendered by a member of your Immediate Family or any person residing in your household.
26. **Food Supplements, Drugs** - Charges for Drugs and medicines not prescribed by a Physician or that are not required to have a written prescription; food and food supplements.
27. **Foot Care** - Charges for routine, palliative or cosmetic foot care, including, but not limited to, treatment of weak, unstable, flat, strained or unbalanced feet, including orthopedic shoes, shoe inserts, strapping and other supportive devices; subluxations of the foot, treatment of corns or calluses; non-surgical care of toenails, except as Medically Necessary for the treatment of metabolic or peripheral-vascular disease.
28. **Genetic Testing** - Charges for genetic testing except when Medically Necessary and when the intent is to use the results to help determine a course of treatment or care.
29. **Governmental Plan** - Charges for services and supplies that are: furnished by a governmental plan, Hospital or institution, unless you are legally required to pay for the services; paid by an association or foundation; or required by law to be provided by an educational institution to you; nevertheless, such charges shall be considered for payment under the Plan to the extent required by federal law, but only to the extent the Plan would have considered such charges for payment had the services or supplies been provided by other than a governmental Hospital or institution.
30. **Hair** - Charges for wigs, hairpieces, hair transplants, or any Drug (whether prescribed by a Physician or not) used to eliminate baldness or stimulate hair growth, except the initial purchase of a wig following chemotherapy treatment or when diagnosed with alopecia areata will be a Covered Expenses up to the maximum specified in the Schedule of Benefits.
31. **Hearing** - Charges for services or supplies for hearing aids or exams for their fittings, cochlear implants or other surgically implanted hearing devices.
32. **Hospital Employees, Services Billed By** - Professional services billed by a Physician or Nurse who is an employee of a Hospital or Skilled Nursing Facility and paid by the Hospital or facility for the service.
33. **Hypnosis** - Charges for hypnosis.
34. **Incurred Expenses** - Charges for any expense that is not incurred at the time a person is a Covered Person, unless a Plan provision specifically provides otherwise. For this purpose, an expense is incurred at the time the service or supply is actually provided.
35. **Infertility** - See Sexual Dysfunction.
36. **International Services** - Charges incurred outside the U.S. if you traveled to such location for the sole purpose of obtaining medical services, Drugs or supplies.

37. **Maximum Allowable Charge** - Charges in excess of the maximum allowable charge; charges for services, supplies or treatment for which the Covered Person is not legally required to pay; or for which no charge would usually be made; or for which such charge, if made, would not usually be collected if no coverage existed; or to the extent the charge for the care exceeds the charge that would have been made and collected if no coverage existed.
38. **Medically Necessary** - Charges for services or supplies, which are not Medically Necessary.
39. **Military Injury, Criminal Act, Self-Inflicted** - Charges for treatment of a Sickness or Injury suffered or incurred:
- in the course of an act of declared or undeclared war;
 - in the course of, or related to, service in the military forces of any country, including non-military units supporting such forces;
 - in connection with any Sickness or Injury of the Covered Person resulting from or occurring during the Covered Person's commission or attempted commission of a criminal battery or felony. Claims shall be denied if the Plan Administrator has reason to believe based on objective evidence, such as, police reports or medical records, that a criminal battery or felony was committed by the Covered Person;
 - while taking part in a riot (meaning taking an active part in common with three or more others by using or threatening to use force or violence without authority of law); or
 - as the result of an intentionally self-inflicted wound, unless as a result of 1) an act of domestic violence, or 2) a medical condition (regardless of whether such medical condition is physical or mental, and regardless of whether the medical condition is diagnosed prior to the Sickness or Injury).
40. **Monitoring Devices** - Charges for warning devices, stethoscopes, blood pressure cuffs or other types of apparatus used for diagnosis or monitoring, except glucometers and sleep apnea monitors.
41. **Non-Compliant with Florida's Seat Belt Law** - This plan recognizes and provides benefit coverage based on Florida law. Therefore, the Plan excludes payment of all medical costs (including pharmacy) incurred by Covered persons found to be non-compliant with "Florida's Mandatory Seat Belt Law".
42. **Obesity** - See Weight Reduction.
43. **Orthognathic Reconstructive Surgery** - Charges for orthognathic reconstructive surgery, unless Medically Necessary.
44. **Orthotic Repair** - The repair of orthotic.
45. **Physician Approval, Scope of License** - Charges for services and supplies that are not recommended and approved by a Physician; or not rendered within the scope of the Physician's license. (If the Physician is not an M.D., then services are only covered if they would otherwise be covered if rendered by an M.D.).
46. **Pre-Existing Conditions** - Charges for treatment of Pre-Existing Conditions for which Benefits are limited as described in this Plan.
47. **Private Duty Nursing** - Charges for outpatient private duty nursing, except as shown under Home Health Care. Outpatient private duty nursing on a 24-hour shift basis is not covered.
48. **Prophylactic Surgery** - Charges for prophylactic surgery unless when Medically Necessary for the prevention of breast or ovarian cancer.
49. **Prosthetic Repair** - The repair of fitted prosthetic devices which replace body parts.
50. **Reasonable & Customary** - Charges to the extent they exceed the Usual, Customary and Reasonable charge.
51. **Self-Inflicted** - See Military Injury.
52. **Sexual Dysfunction, Infertility, Sex Change** - Charges for:
- services, supplies or treatment of transsexualism, gender dysphoria or sexual reassignment or change, including medications, implants, hormone therapy, surgery, medical or psychiatric treatment. However, treatment of congenital hermaphroditism is a Covered Expense;
 - surgery, services, supplies or treatment for sexual dysfunction or inadequacies, including sexual therapy and prosthetic devices, unless related to Injury or organic Sickness;
 - in-vitro and in-vivo fertilization testing;
 - treatment or medication for the primary purpose of achieving conception, infertility and impotency testing and treatment; however, diagnostic services will be a Covered Expense.
 - reversal procedures of sterilization (this exclusion applies even if the Plan otherwise covers treatment of infertility).
53. **Skin Removal** - Charges for panniculectomy (surgical removal of excess skin and fat) or other procedure to remove excess skin or fat, unless determined to be Medically Necessary and to not be treatment related to weight loss surgery.

54. **Smoking** - Charges for the diagnosis and/or treatment of nicotine dependence; and smoking cessation programs, including, but not limited to, nicotine gum and deterrent patches, unless due to a severe active lung illness such as emphysema or asthma.
55. **Speech Therapy** - Charges for speech therapy for other than acute traumatic Injury or functional defect or Pervasive Developmental Disorders in Children 12 years of age or younger when documentation shows developmental progress.
56. **Sports-Related Devices and Performance Programs** - Devices used specifically as safety items or to affect performance primarily in sports-related activities. All charges related to physical conditioning programs, such as athletic training, body-building, exercise, fitness flexibility and diversion or general motivation.
57. **Supplies and Over-the-Counter Drugs** - Outpatient prescribed or non-prescribed medical supplies including, but not limited to, over-the-counter drugs and treatments, elastic stockings, Ace bandages, gauze, and similar supplies.
58. **Surrogate Pregnancy** - Charges related to surrogate pregnancies, or charges for the birth expenses of the mother (who is not covered by this Plan) where the covered Employee will adopt the mother's child.
59. **Travel** - Charges for travel, whether or not recommended by a Physician or Nurse, except for charges for Ambulance service to the extent they are otherwise Covered Expenses.
60. **Weekend Hospital Admission** - Charges for a Hospital admission which occurs between Friday at 8:00 a.m. through Sunday 12:01 p.m. due to a surgery that is to be performed the following Monday or later, unless special circumstances are shown, or because of an Emergency.
61. **Varicose Veins** - Charges for treatment of varicose veins of extremities, unless determined by the Plan to be Medically Necessary.
62. **Vision** - Charges for routine vision examinations and eye refractions; vision therapy (orthoptics); eyeglasses or contact lenses; radial keratotomy or any other eye surgery to correct refractive defects of the eye. This exclusion shall not apply to the initial purchase of eyeglasses or contact lenses following cataract surgery.
63. **Weight Reduction Programs** - Charges for services, supplies or treatment primarily for weight reduction or treatment of obesity, including, but not limited to, exercise programs or use of exercise equipment; special diets or diet supplements; appetite suppressants; Nutri/System, Weight Watchers or similar programs; and Hospital confinements for weight reduction programs.
64. **Weight Reduction Surgery** - Charges for surgical weight reduction procedures and all related charges, even if resulting from morbid obesity.
65. **Wigs** - See Hair.
66. **Worker's Compensation** - Charges for treatment of a Sickness or Injury for which Benefits are or, upon compliance with all applicable laws, would be provided under Worker's Compensation Law; or charges for treatment of a Sickness or Injury occurring during or arising from secondary employment for wage or profit.

ARTICLE X COORDINATION OF BENEFITS, SUBROGATION AND REIMBURSEMENT

This section is intended to prevent the duplicate payment of Benefits, or to prevent reimbursement, with respect to any expense, which exceeds the expense incurred. It applies when a Covered Person is also covered by any other Plan or Plans (as defined in this Section), or is entitled to payments from some other source. When benefits are payable from more than one source, one plan normally pays benefits on a primary basis (as though there were no other source) and the other plan pays a reduced benefit, or pays on a secondary basis. This Plan will always provide coverage either on a primary or secondary basis so that the Benefits it pays, when added to the benefits payable by another source, will not exceed the total allowable expenses. Only the amount paid by this Plan will be charged against the Plan maximums.

DEFINITIONS

This Article contains certain terms, which are defined in a special way. Those definitions follow below. Other defined terms are explained in the Article of this booklet titled, *Definitions*. In the case of ambiguity, terms shall be construed by the Plan Sponsor in a manner consistent with the intention of this Article.

Allowable Expense

An expense which is covered in whole or in part either by this Plan or by the other Plan. It is limited to the Usual, Customary and Reasonable expense for the medical care or treatment provided.

Person

Any individual, association, partnership, corporation or any other organization.

Plan

Includes, but is not limited to, any of the following providing payments on account of a Sickness or Injury:

- any group, blanket or franchise health insurance, or coverage similar to same;
- a group contractual prepayment or indemnity plan, or coverage similar to same;
- a Health Maintenance Organization (HMO), whether group practice or individual practice association;
- a labor-management trusted plan or a union welfare plan;
- an employer or multi-employer plan or employee welfare benefit plan;
- a governmental medical benefit program;
- insurance required or provided by statute;
- automobile, no-fault, homeowners or general liability insurance (not merely the medical expense benefit provisions of such insurance);
- settlement or judgment proceeds (regardless of the manner in which such proceeds are characterized).

The term "Plan" does not include any individual health insurance policies or contracts, or public medical assistance programs such as Medicaid, except as otherwise provided herein. The term "Plan" shall be construed separately with respect to each policy, contract, or other arrangement for benefits or services and separately with respect to that portion of any such policy, contract, or other arrangement which reserves the right to take the benefits or services of other plans into consideration in determining its benefits and that portion which does not.

Primary Plan/Secondary Plan

When this Plan is primary, its Benefits are determined before those of the other Plan. The benefits of the other Plan are not considered. When this Plan is secondary, its Benefits are determined after those of the other Plan. Its Benefits may be reduced because of the other Plan's benefits. When there are more than two Plans, this Plan may be primary as to one and may be secondary as to another.

COORDINATION OF BENEFITS

What this Plan Pays as the Secondary Plan

When this Plan is the Secondary Plan, it considers the total expense to determine what the Plan would have paid had it been the Primary Plan. Then, this Plan pays an amount equal to the lesser of (i) the difference between what the Primary Plan paid and the amount of the total expense, and (ii) the amount this Plan would have paid had it been the Primary Plan.

Carve-Out (applicable for Medicare Participants Only). When this Plan is the Secondary Plan, it considers the total expense to determine what the Plan would have paid had it been the Primary Plan. Then, this Plan pays the difference (if any) between what the Primary Plan paid and what this Plan would have paid had it been the Primary Plan.

Example:

Medicare patient's hospital bill:	\$1,000
Medicare pays:	<u>less \$750</u>
Balance Remaining:	\$250

Non Medicare patient's hospital bill:	\$1,000
This plan pays:	<u>less \$800</u>
Balance Remaining:	\$200

Difference between benefit amounts:	
Non Medicare Payment:	\$800
Medicare Payment:	<u>less \$750</u>
Carve-Out payment from this plan:	\$50

Secondary Amount Rule

Where this Plan is the Secondary Plan, then notwithstanding any other provision of this Plan to the contrary, the Benefits payable by this Plan are subject to the “secondary amount rule”. The “secondary amount rule” applies where the Primary Plan (as determined under applicable coordination of benefits rules) contains a coordination of benefits (or similar type of) provision that reduces the Primary Plan’s benefits (either directly or indirectly) on account of the existence of secondary coverage to an amount less than such Primary Plan would have paid had there been no secondary coverage. For example, a Primary Plan might provide that if there is secondary coverage, the Primary Plan’s benefits are limited to \$1,000. In that event, this Plan will never pay more than the “secondary amount”. The “secondary amount” payable by this Plan is the amount this Plan would by its terms pay, as determined by this Plan in its sole discretion, had the Primary Plan paid benefits as though there were no secondary coverage (that is, had the Primary Plan not reduced its benefits on account of the existence of the secondary coverage).

Order Of Determination

This Plan determines its order of Benefits using the *first* of the following which applies:

- a. **Other Plan Does Not Coordinate.** A Plan that does not coordinate with other Plans is always the Primary Plan.
- b. **Non-Dependent/Dependent.** The benefits of the Plan that covers the person as an Employee, laid-off Employee, former Employee, retired Employee, member or subscriber (other than a Dependent) is the Primary Plan; the Plan which covers the person as a Dependent is the Secondary Plan. However, if that person is a Medicare beneficiary, and if as a result of the provisions of Title XVIII of the Social Security Act and its regulations Medicare is (i) secondary to the plan covering the person as a Dependent, and (ii) primary to the plan covering the person other than as a Dependent (e.g., as a retired Employee), then the order of benefits is reversed so that the plan covering the person as an Employee, member, subscriber or retiree is secondary and the other plan is primary.
- c. **Dependent Child/Parents Not Divorced.** Except as provided below, in the subsection titled, *Dependent Child/Divorced Parents*, when this Plan and another Plan cover the same Child as a Dependent of different parents:
 - the Primary Plan is the Plan of the parent whose birthday (month and day) falls earlier in the year. The Secondary Plan is the Plan of the parent whose birthday falls later in the year; but
 - if both parents have the same birthday, the benefits of the Plan which covered the parent the longer is the Primary Plan; the Plan which covered the parent the shorter time is the Secondary Plan.
 - if the other Plan does not have the birthday rule, but has the gender rule and if, as a result the Plans do not agree on the order of benefits, the rule in the other Plan will determine the order of benefits.
- d. **Dependent Child/Divorced Parents.** If two or more Plans cover a person as a Dependent Child of divorced parents (whether or not the parents were ever married), benefits for the Child are determined in this order:
 - first, the Plan of the parent with custody of the Child;

- then, the Plan of the spouse of the parent with custody;
- finally, the Plan of the parent without custody of the Child.

However, if the specific terms of a court decree state that one parent is responsible for the health care expenses of the Child, then that parent's Plan is the Primary Plan. In the case where the parents of a Dependent Child were never married to each other, these rules shall apply as though such parents were divorced.

- e. **Active/Inactive Employee.** The Primary Plan is the Plan that covers the person as an Employee who is neither terminated, laid-off or retired (or as that Employee's Dependent). The Secondary Plan is the Plan, which covers that person as a former, laid-off or retired Employee (or as that Employee's Dependent). If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule does not apply.
- f. **Longer/Shorter Length of Coverage.** If none of the above rules determines the order of benefits, the Primary Plan is the Plan, which covered the Employee, member or subscriber longer; the Secondary Plan is the Plan, which covered that person the shorter time.

In order to prevent total payments from exceeding a Covered Person's medical expenses, this Plan may, at its option, defer payment of Benefits until the amount of benefits payable under any other plan has been determined.

Medicare Reduction/Coordination

- a. **Active Employees, or Dependents of Active Employees Eligible for Medicare Due to Age.** If you are covered under this Plan due to your or someone else's current employment with the Employer, and are also eligible for Medicare due to age, you may:

- continue your coverage under this Plan (to the extent you remain eligible, of course) and defer enrollment in Medicare; or
- continue your coverage under this Plan and also enroll in Medicare; this Plan would be your primary medical coverage and Medicare your secondary medical coverage as long as your coverage under this Plan is attributable to current employment with the Employer; or
- drop your coverage under this Plan and enroll in Medicare, in which case Medicare would be your primary medical coverage.

CAUTION: If when your coverage ceases due to termination of your or someone else's current employment status with the Employer you (1) are eligible for Medicare, and (2) you elect COBRA coverage under this Plan, you should know three important facts:

- First, your COBRA coverage is not attributable to "current employment status". That means that if you were enrolled in Medicare this Plan would pay *second*, behind Medicare (except in some cases where your Medicare is due to end-stage renal disease).
- Secondly, under the Plan, if you're *eligible* for Medicare we'll deem you to be *enrolled* in Medicare, and only pay Benefits after calculating what Medicare *would have paid*. So if you don't enroll in Medicare after losing your coverage attributable to current employment status (that is, if you don't enroll in Medicare when you become eligible for COBRA coverage), ***you may have to pay out-of-pocket the amount Medicare would have paid had you been enrolled.***
- Thirdly, you have a limited, eight-month special enrollment period for Medicare after your coverage under this Plan ends due to termination of the current employment status. If you wait to enroll in Medicare until after you exhaust COBRA coverage, you may not be able to enroll in Medicare immediately, and you may be required to pay an additional premium for Medicare Parts B and D.

In sum, whether or not you elect COBRA coverage you should consider enrolling in Medicare immediately after your coverage under this Plan ceases to be provided due to your or someone else's current employment status (assuming, of course, you are eligible for Medicare when the current employment status ends).

- b. **Covered Persons Eligible for Medicare Due to Disability.** This Plan is primary and Medicare is secondary if you are eligible for Medicare by reason of disability (but not age), and your coverage under this Plan is on account of your (or someone else's) current employment with the Employer. If coverage under this Plan is not on account of current employment status with the Employer, and you are eligible for Medicare solely by reason of disability, Medicare is primary and this Plan is secondary. Note that in this latter case, where this Plan is secondary, this Plan will deem you or the Dependent, as the case may be, to

be enrolled in Medicare Parts A and B even if you or the Dependent, as the case may be, is not so enrolled. The rules in this section continue to apply for as long as the Plan has at least 100 participants as described in federal Medicare regulations. *See the special “Caution” text box above concerning the possible effects of not enrolling in Medicare immediately where Medicare would be your primary payer because of the absence of your or someone else’s current employment with the Employer.*

- c. **End-Stage Renal Disease (ESRD).** If you become eligible for Medicare solely on account of end-stage-renal disease (ESRD), then this Plan will be primary to Medicare for up to 30 months (called the “coordination period”); after that, the Plan becomes the secondary payer (assuming you’re still eligible for coverage), and Medicare is the primary payer. The coordination period begins on the first day of the month for which you are eligible for Medicare benefits on account of your ESRD, and ends not later than 30 months later (it might end earlier in some cases, such as when your coverage ends under this Plan). If at the time you become eligible for Medicare benefits due to ESRD you are already entitled to Medicare benefits on account of age or disability, and Medicare is the primary payer (and this Plan is secondary), then Medicare remains the primary payer, even after you become eligible for Medicare benefits due to your ESRD. Please note that for purposes of this provision, the coordination period begins in the month you are merely eligible for Medicare benefits due to ESRD, whether or not you actually enroll in Medicare then.

Medicaid and State Children’s Health Insurance Program Coordination

This Plan will always be primary, and any Medicaid or State Children’s Health Insurance Program will be secondary only.

Coordination With Automobile Insurance Coverage

This Plan’s liability for otherwise Covered Expenses arising out of an automobile Accident is based on the type of automobile insurance law enacted by your state. Currently there are three types of state automobile laws (i) No-fault automobile laws; (ii) Financial responsibility laws; and (iii) Other automobile liability insurance laws. It is the Plan’s general intent not to pay medical expenses resulting from automobile Accidents, and the Plan will be so interpreted.

- a. **Coordination Under Auto No-Fault Coverage.** Except as required by law, the Plan is secondary to any no-fault automobile coverage. It is not intended to reduce the level of coverage that would otherwise be available through a no-fault automobile insurance policy nor does it intend to be primary in order to reduce the premiums or costs of no-fault automobile coverage. If you incur Covered Expenses as a result of an automobile Accident (either as a driver, passenger or pedestrian), the amount of Covered Expenses that the Plan will pay is limited to:

- any deductible under the automobile coverage; and
- any Co-payment under the automobile coverage; and
- any expense properly excluded by the automobile coverage that is a Covered Expense; and
- any expense that the Plan is required to pay by law.

An individual is considered to be covered under an automobile insurance policy if he or she is either:

- an owner or principal named insured of the policy; or
- a family member of a person insured under the policy; or
- a person who would be eligible for medical expense benefits under an automobile insurance policy if this Plan did not exist.

- b. **Coordination Under Financial Responsibility Law.** This Plan is secondary to automobile coverage or to any other party who may be liable for your medical expenses resulting from the automobile Accident. If your state has a “financial responsibility” law which does not allow the Plan to pay Benefits as secondary or which does not allow the Plan to pay advance payments with the intent of subrogating or recovering the payment, the Plan will not pay to you or on your behalf any Benefits related to an automobile Accident.

- c. **Coordination Under Other Automobile Liability Insurance.** If your state does not have a no-fault automobile insurance law or a “financial responsibility” law, this Plan is secondary to any applicable automobile insurance coverage or to any other party who may be liable for the automobile Accident.

Coordination With Underinsured/Uninsured Motorist Coverage

If you are involved in an automobile Accident and as a result of the Accident the Plan pays Benefits, and if you receive a settlement or judgment under an uninsured or underinsured motorist policy, the Plan is entitled to receive, from the proceeds of the uninsured or underinsured motorist coverage, an amount equal to the Covered Expenses paid or payable by the Plan whether or not the proceeds are characterized as reimbursement for medical expenses, and whether or not the proceeds are sufficient to make you “whole”. The amounts payable to the Plan shall not be reduced on account of your expenses, including attorneys’ fees, unless the Plan specifically agrees, in writing, to such a reduction. The Plan may, in the sole discretion of the Plan Sponsor, agree to payment of Benefits prior to the receipt by you of any recovery from the uninsured or underinsured motorist policy, and you agree, as a condition of your and your eligible Dependents’ coverage under this Plan, to remit to the Plan the proceeds of any recovery received from an uninsured or underinsured motorist policy up to the amounts paid or payable by the Plan.

Any Covered Expenses paid or payable by the Plan, which are in excess of the proceeds received by the uninsured or underinsured motorist policy will be the responsibility of the Plan pursuant to the terms and conditions of the Plan.

TRICARE Coordination Rules

Notwithstanding any provision of this Plan to the contrary, the following rules shall apply:

- a. This Plan shall not offer any financial or other incentives for a TRICARE-eligible Employee not to enroll (or to terminate enrollment) in this Plan in the situation where this Plan would (in the case of enrollment) be a Primary Plan, in the same manner as the provisions of the Social Security Act apply to prohibit the offering of any financial or other incentives for an individual entitled to Medicare benefits not to enroll (or to terminate enrollment) under a group health plan or large group health plan which would (in the case of enrollment) be a Primary Plan.
- b. A TRICARE-eligible Employee shall have the opportunity to elect to participate in this Plan and receive primary coverage for health care services under the Plan in the same manner and to the same extent as similarly situated Employees who are not TRICARE-eligible Employees.

For purposes of this provision, the term “TRICARE-eligible Employee” means a covered beneficiary under 10 U.S.C. Section 1097c(f)(3) who is entitled to health care benefits under the TRICARE program.

These TRICARE coordination rules shall not apply to any employer who has fewer than 20 employees.

RIGHT TO RECOVERY, REIMBURSEMENT, SUBROGATION AND SET-OFF

Corrective Payments

Whenever payments which should have been made under this Plan in accordance with the coordination of benefits provisions have been made under any other Plans, this Plan shall have the right to pay to any persons making such other payments any amounts they determine to be warranted in order to satisfy the intent of the coordination of benefits provisions. Amounts so paid shall be deemed to be Benefits paid under this Plan and, to the extent of such payments, this Plan shall be fully discharged from liability.

Reimbursement

Whenever this Plan makes payments which together with the payments the Covered Person has received or is entitled to receive from any other Plan or Person, exceed the maximum amount necessary to satisfy the intent of this provision; or exceed, under the terms of this Plan, the Benefits properly payable to the Covered Person, Plan, provider or Person to or for or with respect to whom the payments were made, this Plan shall have the right to recover such payments, to the extent of such excess, from among one or more of the following, as the Plan Sponsor in its sole discretion shall determine:

- the Covered Person;
- if the Covered Person is an eligible Dependent or former eligible Dependent, the eligible Employee or former eligible Employee with respect to whom the Covered Person is or was an eligible Dependent;
- any other Plan, provider or Person to or for or with respect to whom such payments were made;
- any insurance company or other Plan or person which should have made the payment; and
- any other organizations.

Alternatively, the Plan Sponsor or its designee may set-off the amount of such payments, to the extent of such excess, against any amount owing, at that time or in the future, under this Plan to one or more of the Covered Person, Plans, Persons, providers, insurance companies or other organizations as listed above.

For example, but not by way of limitation, if this Plan pays a claim submitted by a Covered Person or by a health care provider who treated the Covered Person, and the Plan Sponsor or its designee later determine that the claim was for an expense not covered under this Plan, the Plan is entitled to recover the payment from the Covered Person or the provider, or to recover part of the payment from the Covered Person and part from the provider, or set-off the amount of the payment from amounts the Plan may owe in the future to the Covered Person or the provider or both. This same rule applies if the Plan makes payment to a Covered Person or a provider of an expense which is a Covered Expense, but the amount so paid exceeds the amount the Plan requires be paid.

These Reimbursement provisions also apply where this Plan makes payments of Covered Expenses incurred for treatment of a Sickness or Injury for which another Plan or Person (as defined in these coordination and reimbursement/subrogation provisions) is or may be liable, and where this Plan's subrogation provisions do not provide this Plan with a right to recover amounts this Plan pays or may pay for treatment of the Sickness or Injury. If the other Plan or Person makes payment to or on behalf of a Covered Person as compensation for the Sickness or Injury, and this Plan is not subrogated with respect to the payment, this Plan is entitled to reimbursement from the Covered Person (or anyone who received such payment on behalf of the Covered Person) from the payment made by the other Plan or Person, in an amount equal to (i) the lesser of the Benefits paid by this Plan for treatment of the Sickness or Injury, or (ii) the amount of the payment made by the other Plan or Person. This provision shall not apply where the other Plan is a health plan with respect to which this Plan, pursuant to its coordination of benefits provisions, is the primary payer of the Covered Person's Covered Expenses.

These reimbursement provisions shall not be construed to prevent the Plan, in its sole discretion, from obtaining full reimbursement from the Covered Person (or, in the Plan's sole discretion) from any other Person who received payment on behalf of the Covered Person (such as a parent or guardian) by, for example, apportioning the obligation to reimburse the Plan among the Covered Person and any other Person, such as the Covered Person's legal counsel. The preceding sentence is specifically intended to avoid requiring the Plan, in order to obtain full reimbursement, to seek reimbursement from any Person (such as the Covered Person's legal counsel) other than the Covered Person (or the Person, such as a parent or legal guardian, who received payment on behalf of the Covered Person) where the Plan can be made whole entirely from amounts actually received by the Covered Person (or the Person, such as a parent or legal guardian, who received such amounts on behalf of the Covered Person). This same rule shall apply to the Plan's rights to set-off as described above.

In addition, where another Plan or Person (as defined in this Article) pays compensation to or on behalf of a Covered Person for a Sickness or Injury for which another Plan or Person is or may be liable, and the Covered Person incurs (either before or after payment of such compensation) otherwise Covered Expenses for treatment of the Sickness or Injury, a special rule applies. In such a case, such otherwise Covered Expenses which were incurred after the date on which the compensation was paid, or which were incurred before such date but not paid by the Plan as of such date, shall be excluded from coverage under the Plan to the extent of the excess (if any) of the compensation received by or on behalf of the Covered Person, over the Covered Expenses which the Plan has already paid for treatment of the Sickness or Injury.

This Plan shall not be responsible for any costs or expenses (including attorneys' fees) incurred by or on behalf of a Covered Person in connection with any recovery from any other Plan or Person unless this Plan agrees, in writing, to pay a part of those expenses. The characterization of any amounts paid to or on behalf of a Covered Person, whether in a settlement agreement or otherwise, shall not affect this Plan's right to reimbursement and to characterize otherwise covered charges as excludable Covered Expenses pursuant to these provisions.

Subrogation

The Plan shall be subrogated, to the extent of Benefits paid or payable by this Plan, to any monies (i.e., "first dollar" monies) paid or payable by any other Plan or Person (as defined in this Article) by reason of the Sickness or Injury which occasioned or would occasion the payment of Benefits by this Plan, whether or not those monies are sufficient to make whole the Covered Person to whom or on whose behalf this Plan made its payments or to whom or on whose behalf this Plan's payments are payable. The Plan shall not be responsible for any costs or expenses, including attorneys' fees, incurred by or on behalf of a Covered Person in connection with any efforts to recover monies from any other plan, unless this Plan agrees, in writing, to pay a portion of those expenses. The characterization of any amounts paid to or on behalf of a Covered Person, whether under a settlement agreement or

otherwise, shall not affect this Plan's right to subrogation and to claim, pursuant to such right, all or a portion of such payment.

These subrogation provisions shall not be construed to prevent the Plan, in its sole discretion, from obtaining full satisfaction of its subrogation lien from the Covered Person (or, in the Plan's sole discretion) any other Person who received payment on behalf of the Covered Person (such as a parent or guardian) by, for example, apportioning liability for satisfaction of the subrogation lien among the Covered Person and any other Person, such as the Covered Person's legal counsel.

This Plan shall also be subrogated to the extent of Benefits paid under this Plan to any claim a Covered Person may have against any other Plan or Person for the Sickness or Injury which occasioned the payment of Benefits under this Plan. Upon written notification to the Covered Person, this Plan may (but shall not be required to) collect the claim directly from the other Plan or Person in any manner this Plan chooses without the Covered Person's consent. This Plan shall apply any monies collected from the other Plan or Person to payments made under this Plan and to any reasonable costs and expenses (including attorneys' fees) incurred by this Plan in connection with the collection of the claim up to the amount of the award or settlement. Any balance remaining shall be paid to you as soon as administratively practical. The Plan Sponsor may, within its sole discretion, apportion the monies such that this Plan receives less than full reimbursement.

Implementation

The Plan Sponsor shall determine which of the Plan's rights and remedies it is within the best interests of this Plan to pursue. The Plan Sponsor may agree to recover less than the full amount of excess payments or to accept less than full reimbursement if (i) this Plan has made, or caused to be made, such reasonable, diligent and systematic collection efforts as are appropriate under the circumstances; and (ii) the terms of such agreement are reasonable under the circumstances based on the likelihood of collecting such monies in full or the approximate expenses this Plan would incur in an attempt to collect such monies.

Where this Plan is entitled to reimbursement or subrogation under the provisions of this section, the Plan shall be permitted to obtain reimbursement or satisfy its subrogation lien by reducing Benefits payable to the Covered Person and/or, in the Plan's discretion, any covered member of the Covered Person's family, for Covered Expenses then incurred but not yet paid, and for Covered Expenses incurred in the future.

Subrogation/Reimbursement Agreement

Except as otherwise provided herein (e.g., the coordination rules regarding automobile insurance), if a Covered Person incurs a Sickness or Injury under circumstances where compensation may be payable to the Covered Person by some other Plan or Person (as defined in this Article), the Plan is not required to pay Benefits for treatment of the Sickness or Injury (notwithstanding any other provision of this Plan to the contrary), but may agree to pay Benefits for that Sickness or Injury to the extent otherwise payable under the Plan. As a condition of paying such Benefits, the Plan may (but is not required to) require the Covered Person or someone legally qualified and authorized to act for the Covered Person, in writing, to:

- consent to the Plan's subrogation of any recovery or right of recovery the Covered Person has with respect to the Sickness or Injury;
- promise not to take any action which would prejudice the Plan's subrogation rights;
- promise to reimburse the Plan for any such Benefits payments to the extent that the Covered Person receives a recovery from another Plan or Person, irrespective of how the recovery is made or characterized, and irrespective of whether the recovery is sufficient to make the Covered Person whole. This reimbursement must be made within 30 days after the Covered Person (or anyone on his or her behalf) receives the payment; and
- promise to cooperate fully with the Plan in asserting its subrogation rights and supply the Plan with any and all information and execute any and all forms the Plan may need for this purpose.

In the event the Covered Person fails to, or refuses to execute whatever assignment, form or document requested by the Plan Sponsor or its designee, the Plan shall be relieved of any and all legal, equitable or contractual obligation for any Benefits or Covered Expense incurred by the Covered Person and each member of the Covered Person's family, including claims not yet incurred and claims then incurred but unpaid.

Nothing in this Reimbursement Agreement provision shall be construed to prevent application of the provisions of the Reimbursement provisions of this Plan, regarding the Plan's exclusion of otherwise Covered Expenses which have not been paid at the time the Covered Person receives compensation for the Sickness or Injury which gave rise to the expenses.

Constructive Trust

In the event the Plan, pursuant to these Reimbursement and Subrogation provisions, is entitled under such provisions to be reimbursed for Benefits it has paid for treatment of a Covered Person's Sickness or Injury, and where the Covered Person or someone (including an individual, estate or trust) on behalf of the Covered Person receives or is entitled to receive compensation for such Sickness or Injury from some other source, the Plan shall have a constructive trust on such compensation to the extent of the Benefits paid by this Plan. Such constructive trust shall be imposed upon the person or entity then in possession of such compensation.

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION

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

ARTICLE XI COBRA CONTINUATION COVERAGE

Eligible Employees and Dependents have the opportunity to continue their coverage in certain instances where coverage would otherwise terminate. Such continuation coverage is as described in the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), and is therefore sometimes referred to as “COBRA Continuation Coverage”. This notice is intended as a summary of a Covered Person’s rights and obligations under the provisions of that law.

ENTITLEMENT AND QUALIFYING EVENTS

Qualifying Events

Under COBRA, a covered Employee or covered Dependent may elect to continue health coverage if that coverage would otherwise terminate due to a “qualifying event”. Qualifying events are:

- a. a covered Employee’s termination of employment, for reasons other than gross misconduct, or reduction in work hours;
- b. death of the covered Employee;
- c. divorce of the covered Employee and his spouse;
- d. a covered Dependent Child’s ceasing to satisfy the Plan’s definition of *Dependent Child*; or
- e. a covered Employee’s entitlement to Medicare.

COBRA Qualified Beneficiaries

A COBRA Qualified Beneficiary is an individual who is entitled to COBRA Continuation Coverage. In addition to those individuals covered under the Plan immediately preceding a qualifying event, a Child born to a Qualified Beneficiary who is a former covered Employee or who is adopted by or placed for adoption with such a former covered Employee, during the Employee’s period of COBRA Continuation Coverage, is also a COBRA Qualified Beneficiary.

Sometimes, filing a proceeding in bankruptcy under Title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to Healthcare Purchasing Alliance, and that bankruptcy results in the loss of coverage of any retired Employee covered under the Plan, the retired Employee is a qualified beneficiary with respect to the bankruptcy. The retired Employee’s spouse, surviving spouse, and Dependent Children will also be qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

NOTIFICATION OF A QUALIFYING EVENT

The Plan will offer COBRA Continuation Coverage to qualified beneficiaries only after the Plan Sponsor or its designee has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, your death, commencement of a proceeding in bankruptcy with respect to the Employer, or your enrollment in Medicare (Part A, Part B or both), the Employer must notify the Plan Sponsor or its designee of the qualifying event within 30 days of any of these events (of course, where the Plan Sponsor or its designee is the Employer, there’s no need for the Employer to notify itself of these events).

You must notify the Plan Sponsor or its designee (at the address listed below) within 60 days of a divorce, of a Child ceasing to meet the Plan’s definition of “*Dependent*”, or of the Social Security Administration’s determination of disability. In addition, if you were a disabled individual who obtained 29 months of COBRA Continuation Coverage, you must notify the Plan Sponsor or its designee of any determination by the Social Security Administration that you are no longer disabled. Notification of disability to the Plan Sponsor or its designee must be made within 30 days of the date such determination is made.

Notice for the qualifying events described above must be sent, ***in writing*** (describing the qualifying event and the date it occurred) to:

Daytona State College Employee Benefit Department
1200 West International Speedway Blvd.
Daytona Beach, FL 32120-2811

MAXIMUM COVERAGE CONTINUATION PERIODS

General Rules

Coverage under COBRA may continue for up to:

- a. eighteen (18) months if you are an Employee or Dependent whose coverage would cease because of a termination of employment or reduction in work hours; or
- b. twenty-nine (29) months (i.e. 18 plus 11) if you are a disabled individual who:
 - becomes entitled to the 18 months of continued coverage available after an Employee's termination of employment or reduction in work hours;
 - is determined by the Social Security Administration to have been disabled on the date of that termination of employment or reduction in work hours or at any time during the first 60 days of COBRA Continuation Coverage; and
 - notifies the Plan of that disability determination within 60 days after you receive it and while you are still purchasing your first 18 months of COBRA.

Please note that you are eligible for this additional 11 months of coverage, even if you are not disabled, if you are entitled to COBRA Continuation Coverage due to the same qualifying event that entitles a disabled person to the additional 11 months of coverage.

- c. thirty-six (36) months, if you are a divorced or widowed spouse, or a Child who has ceased to be a "Dependent" under the terms of the Plan.

Multiple Qualifying Events

If a Dependent is eligible to choose and chooses to continue coverage under these provisions after an Employee's termination of employment or reduction in work hours, and then another COBRA qualifying event (other than termination of employment or reduction in work hours) occurs during the original COBRA Continuation Coverage period, that Dependent may continue coverage for up to 36 months, measured from the date of the initial qualifying event. However, for an event to operate as a *second* qualifying event, it must be an event that would have triggered a loss of coverage had it been the *initial* qualifying event. *In no case will any period of COBRA Continuation Coverage exceed 36 months.* The Plan Sponsor or its designee must be notified of the second qualifying event within 60 days of the second qualifying event. This notice must be sent, in writing, to the appropriate person described above. Please note that for the Employee's Medicare entitlement to be considered a second qualifying event for eligible Dependents, the Plan must provide that Medicare entitlement causes a loss of coverage for the Dependents.

Special Continuation of Coverage Period for Medicare Entitlement

When an individual becomes entitled to Medicare and then, within 18 months thereafter, experiences a qualifying event that is loss of coverage due to termination of employment or reduction in work hours, the COBRA Continuation Coverage period for the Dependent spouse or Dependent Children may continue for up to 36 months from the date of the Medicare entitlement.

SPECIAL TRADE ACT EXTENSION

Special COBRA rights apply to eligible Employees who lose health coverage as a result of termination or reduction of hours and who qualify for a "trade readjustment allowance" or "alternative trade adjustment assistance" under a federal law called the Trade Act of 1974. These special rules were added to the Trade Act in 2002. These Employees are entitled to a second opportunity to elect COBRA coverage for themselves and certain family members (if they did not already elect COBRA coverage) during a special second election period. This special second election period lasts for 60 days or less. It is the 60-day period beginning on the first day of the month in which the Employee begins receiving a trade readjustment allowance (or would be eligible to begin receiving the allowance but for the requirement to exhaust unemployment benefits) or begins receiving alternative trade adjustment assistance, but only if the election is made within the six months immediately after the Employee's group health plan coverage ended. The Plan will not treat the period between the initial COBRA qualifying event and the first day of a Special Trade Act COBRA election period as a break in creditable coverage for determining application of the Plan's Pre-Existing Condition exclusion. If you qualify or may qualify for assistance under the Trade Act of 1974, you may contact Healthcare Purchasing Alliance for additional information. You must contact Healthcare Purchasing Alliance promptly after qualifying for assistance under the Trade Act of 1974 or you will lose your special COBRA rights.

EARLY TERMINATION OF COBRA COVERAGE

Once you elect to continue your coverage, your coverage may continue for the period described above, unless:

- a. you were entitled to 29 months of COBRA Continuation Coverage (due to your or another person's disability), the Social Security Administration determines that you (or such other person) are no longer disabled, in which case your extended COBRA Continuation Coverage will cease on the first day of the month that begins more than 30 days after the Social Security Administration makes such a determination;
- b. you become entitled to Medicare, after the date you elect COBRA Continuation Coverage;
- c. you fail to make a required monthly payment within the 30 day grace period pursuant to this provision;
- d. you become covered - after the date you elect COBRA Continuation Coverage - under another employer group health plan (because of employment or otherwise) and that coverage contains no exclusion or limitation with respect to any Pre-Existing Condition;
- e. you become covered - *after the date you elect COBRA Continuation Coverage* - under another group health plan (because of employment or otherwise) that contains an exclusion or limitation with respect to a Pre-Existing Condition which is nullified, waived or does not apply because of the Health Insurance Portability and Accountability Act (HIPAA) rules; or
- f. the Plan is terminated and the Employer maintains no group health plan for any of its active Employees.

BENEFITS THAT MAY CONTINUE

If you elect COBRA Continuation Coverage, it will be identical to the health coverage then being provided under the Plan to active Employees or, if you are a Dependent, to covered Dependents of active Employees. You do not have to prove insurability to choose Continuation Coverage, but you do have to pay for it.

APPLICATION AND PAYMENT PROCEDURES

After you experience a COBRA qualifying event (and provide any notice required by the preceding, *Notification of a Qualifying Event*, section of this Plan), you will be sent a more detailed notice and an Application for Continued Coverage. To continue coverage under COBRA, you must complete and return the Application to the Plan Sponsor or its designee (the COBRA election notice will show to whom you should send the payment) within 60 days from the later of the date the Application is sent to you or the date your coverage would otherwise terminate.

Your payment for the period from the date your coverage would otherwise terminate through the 45th day after COBRA Continuation Coverage is elected must be made by that 45th day (for example, if you elect COBRA Continuation Coverage on the 30th day after the start of your 60-day election period, you must make your first payment by the 75th day after the start of your election period, and the payment must be for the period of COBRA Continuation Coverage from the date you would otherwise lose coverage to that 75th day). Thereafter, payments must be made within thirty (30) days after the monthly premium due date to be considered timely. The Plan will terminate coverage as of the qualifying event, but will reinstate it retroactively to the date of the qualifying event if a timely election for COBRA Continuation Coverage, and timely initial payment, are made.

Although you may receive a monthly bill, payment coupons or any other payment reminder from the Plan Sponsor or its designee, the Plan is not required to send you such payment information. Failure to remit your premium on time even because you did not receive a bill or reminder will not be reason for your coverage to be reinstated once it has ended.

The monthly cost of COBRA Continuation Coverage will be set for 12-month periods by the Plan Sponsor, or its designee, and will not exceed 102% of the cost of coverage under the Plan for similarly situated Covered Persons. However, if you qualify for periods of extended coverage due to a disability (whether yours or another Qualified Beneficiary's), the monthly COBRA premium during the period of extended coverage may be 150% of the cost of coverage under the Plan for similarly situated Covered Persons, depending on whether the disabled person continued coverage during the extended coverage period.

QUESTIONS AND MORE INFORMATION

If you have questions about your COBRA Continuation Coverage, you should contact:

FMH CoreSource
P.O. Box 25946
Overland Park, KS 66225-5946

or you may 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.

In order to protect your family's rights, you should keep your Plan Sponsor or its designee 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 your Plan Sponsor or its designee.

ARTICLE XII CLAIM FILING PROCEDURES

Claim Filing Deadlines.

Written proof of claim for each eligible expense must be given to the Claim Supervisor or the Plan Sponsor within twelve (12) months after the date on which the expense is incurred. Terminated Employees (and their Dependents) must file all incurred but unfiled claims within twelve (12) months after the date of termination of their coverage. In the event of the Plan's termination, you must file all incurred but unfiled claims within twelve (12) months after the Plan's termination.

Where a claim's submission date is within the appropriate claim filing deadline, and the claim is later supplemented or resubmitted (either because the initial submission was incomplete, or the Claimant understated the amount due to it, or for any other reason), the initial claim submission date does not apply to the later supplementation or resubmission. The intent of this paragraph is to require the resubmitted claim to be filed within the deadlines described in the preceding paragraph. In the case of an incomplete claim, however, in no event shall the Plan refuse to accept for processing a resubmission or supplementation of such a claim that is resubmitted or supplemented within the "applicable periods" (including extensions requested by the Plan) described below in the section titled, *Categories of Claims, "Applicable Periods", and Extensions.*

Payment of any claim will be made to the Employee unless he/she has previously authorized payment to any entity rendering covered services, treatment or supplies. If the Employee dies before all Benefits have been paid, the remaining Benefits may be paid to any relative of the Employee or to any person appearing to the Plan Sponsor to be entitled to payment. The Plan Sponsor shall fully discharge its liability by such payments.

Action on Submitted Claims.

Any time a claim for Benefits receives an adverse determination (that is, the claim is denied in whole or in part), the Employee or beneficiary ("Claimant") shall be given written notice of such action within the "applicable period" after the claim is filed, unless special circumstances require an extension of time for processing. If there is an extension, the Claimant shall be notified of the extension and the reason for the extension within the initial applicable period. If any urgent care or pre-service claim is approved, the Claimant shall be notified of such approval and provided sufficient information to understand the importance of the approval.

Categories of Claims, "Applicable Periods", and Extensions.

- ***"Urgent Care Claims"***. Urgent care claims are requests for verification or approval of coverage for medical care or treatment where, if the request was not handled expeditiously the delay could jeopardize the life or health of the Claimant or the ability of the Claimant to regain maximum function, or in the opinion of a Physician with knowledge of the Claimant's medical condition, would subject the Claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

The "applicable period" for an urgent care claim is no longer than the period necessary to decide the matter (that is, "as soon as possible"), but in no event longer than 72 hours. If the Plan cannot render a decision within 72 hours because the Claimant has not provided sufficient information to determine whether, or to what extent, Benefits are covered or payable under the Plan, the Claim Supervisor will notify the Claimant within 24 hours of the specific information needed to complete the claim. The Claimant will have at least 48 hours to provide the required information. Within 48 hours after the earlier of (1) the Plan's receiving the required information, or (2) the expiration of the period afforded to the Claimant to provide the information, the Claim Supervisor will notify the Claimant of the Plan's benefit determination. The Claimant may agree, upon request of the Plan, to extend the deadlines applicable to the Plan.

- ***"Pre-Service Claims"***. A pre-service claim is any request for approval of coverage for a service or item that under the terms of the Plan requires advance approval. The "applicable period" for a pre-service claim is 15 days after receipt of the claim by the Plan. The Claim Supervisor may extend the review period for an additional 15 days if necessary due to circumstances beyond the control of the Plan. The Claim Supervisor will notify the Claimant within the timeframe of the reason for the extension and the date the Plan expects to render its decision.

If the Claimant has not followed the Plan's procedures for filing a pre-service claim, the Claim Supervisor will notify the Claimant within 5 days of the proper procedures to be followed in order to complete the claim. Further, if the Plan cannot render a decision within 15 days because the Claimant has not provided sufficient information to determine whether, or to what extent, Benefits are covered or payable under the Plan, the notice of extension will describe the specific information needed to complete the claim; the Claimant will have at least 45 days from receipt of the notice to provide the required information; and the Plan has 15 days from the date of receiving the Claimant's information to render its decision. The Claimant may agree, upon request of the Plan, to extend the deadlines applicable to the Plan.

- **“Concurrent Care Claims”**. A concurrent care claim may be either an urgent care claim or a pre-service claim. Generally, it is a claim for an ongoing course of treatment to be provided over a period of time or number of treatments. An adverse determination involving concurrent care will be made sufficiently in advance of any reduction or termination in treatment to allow the Claimant to appeal the adverse Benefit determination. If a course of treatment involves urgent care, a request by the Claimant to extend the course of treatment will be decided as soon as possible, but not later than 24 hours after receipt of the request by the Claim Supervisor, provided that the request is made at least 24 hours prior to the expiration of treatment.

Expiration of an approved course of treatment is not an adverse determination under this section. However, any reduction or termination by the Plan of the course of treatment (other than by Plan amendment or termination) before the end of the period of time or number of treatments originally prescribed is an adverse determination and may be appealed. Notice will be provided a reasonable time before the coverage for treatments will stop; however, the Claimant does not have 180 days to appeal the Plan's decision, before the Plan may terminate the treatment (see the rules below, concerning the time a Claimant normally has to appeal an adverse Benefit determination).

- **“Post-Service Claims”**. A post-service claim is a claim that is not an urgent care, pre-service or concurrent care claim. The “applicable period” for a post-service claim is 30 days after receipt of the claim by the Plan. The Claim Supervisor may extend the review period for an additional 15 days if necessary due to circumstances beyond the control of the Plan. The Claim Supervisor will notify the Claimant within the timeframe of the reason for the extension and the date by which the Plan expects to render its decision.

If the Plan cannot render a decision within 30 days because the Claimant has not provided sufficient information to determine whether, or to what extent, Benefits are covered or payable under the Plan, the notice of extension will describe the specific information needed to complete the claim. The Claimant will have at least 45 days from receipt of the notice to provide the required information. The Plan will then have 15 days from the date of receiving the Claimant's information to render its decision. The Claimant may agree, upon request of the Plan, to extend the deadlines applicable to the Plan.

- **“Disability Benefit Claims”**. If the Plan includes short-term or long-term disability Benefits, the “applicable period” for deciding such claims is 45 days after receipt of the claim by the Plan. If the Plan requires additional time to process the claim, it may extend the applicable period by up to two (2) thirty-day extensions, but the Claim Supervisor will notify the Claimant of the need for the extension prior to the beginning of any such extension period.

If the Plan cannot render a decision within 45 days because the Claimant has not provided sufficient information to determine whether, or to what extent, Benefits are covered or payable under the Plan, the notice of extension will describe the specific information needed to complete the claim. The Claimant will have at least 45 days from receipt of the notice to provide the required information. The Plan will then have 30 days from the date of receiving the Claimant's information to render its decision. The Claimant may agree, upon request of the Plan, to extend the deadlines applicable to the Plan.

Please note that if the Claim Supervisor does not administer claims for disability benefits, references in this paragraph, and below, to the “Claim Supervisor” means the person or entity who administers such claims.

Form and Content of Notice of Adverse Determination on Claims.

If a claim is denied in whole or in part, notice of such adverse determination will be provided to the Claimant. Notice will be written or electronic; oral notice might be provided only with respect to urgent care claims, but only if written or electronic confirmation is furnished to the Claimant within three (3) days after the oral notice is provided.

The notice will include the following:

- the specific reason or reasons for the adverse determination;
- reference to the specific Plan provisions on which the determination is based;
- if applicable, a description of any additional information needed for the Claimant to perfect the claim and an explanation of why such information is needed;
- a description of the Plan's review procedures;
- a copy of any internal rule, guideline, protocol or other similar criteria relied on in making the adverse determination or a statement that it will be provided without charge upon request;
- if the adverse determination is based on medical necessity or experimental treatment or a similar exclusion or limit, either an explanation of the scientific or clinical judgment, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that this will be provided without charge upon request; and
- in the case of an adverse determination involving urgent care, a description of the expedited review process available to such claims.

Appealing a Denied Claim.

Any Claimant who has had a claim for Benefits denied in whole or in part by the Claim Supervisor or Plan Administrator, or is otherwise adversely affected by action of the Claim Supervisor or Plan Administrator, has the right to request review by the Plan Administrator. Such request must be, in writing, and must be made within 180 days after the Claimant is advised of the Plan Administrator's action. If written request for review is not made within such 180-day period, the Claimant will forfeit his or her right to review. The Claimant or a duly authorized representative of the Claimant may review all pertinent documents and submit issues and comments, in writing. The Plan Administrator or its designee may prescribe a reasonable procedure under which a Claimant may designate an authorized representative.

Where an appeal's submission date is within the appropriate deadline, and the appeal is later supplemented or resubmitted (either because the initial submission was incomplete, or for any other reason), the initial appeal submission date does not apply to the later supplementation or resubmission. The intent of this paragraph is to require the resubmitted appeal to be filed within the deadlines described in the preceding paragraph. In the case of an incomplete appeal, however, in no event shall the Plan refuse to accept for processing a resubmission or supplementation of such an appeal that is resubmitted or supplemented within the deadline described in the preceding paragraph.

Review of Claim and Notice of Benefit Determination on Appeal.

The Plan Administrator or its designee will then review the claim. The person or entity that reviews the claim will be a Fiduciary under the Plan, and will not be the same person, or a person subordinate to the person, who initially decided the claim. If the adverse Benefit determination was based on medical judgment, the person handling the appeal will consult with a health care professional with an appropriate level of training and expertise in the field of medicine involved, and such professional will not be the same professional who was consulted with respect to the initial action on the claim. Upon request, the Claim Supervisor shall identify any medical expert whose advice was obtained in connection with the denied claim.

The person or entity deciding the appeal may hold a hearing if it deems it necessary and shall issue a written or electronically disseminated decision reaffirming, modifying or setting aside the initial decision on the claim. The decision on appeal will be made within 72 hours for a claim involving urgent care, 30 days for a pre-service claim, 45 days for a disability benefit claim, or 60 days for a post-service claim; the time period begins to run on the date the appeal is received by the Plan or its designee. In the case of a claim for disability benefits the period for deciding the appeal may be extended for an additional 45 days, provided the Plan Administrator or Claim Supervisor provides the Claimant with notice, prior to the end of the initial 45-day period, of the need for an extension. The Claimant may agree, upon the request of the Plan, to further extend these deadlines.

A copy of the decision will be furnished to the Claimant. The decision shall set forth:

- the specific reason or reasons for the adverse determination;
- reference to the specific Plan provisions on which the determination is based;
- a statement that the Claimant is entitled to receive without charge reasonable access to any document (1) relied on in making the determination; (2) submitted, considered or generated in the course of making the Benefit determination; (3) that demonstrates compliance with the administrative processes and safeguards required in making the determination; or (4) constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment without regard to whether the statement was relied on;
- a statement of any voluntary appeals procedures;
- a copy of any internal rule, guideline, protocol or other similar criteria relied on in making the adverse determination or a statement that it will be provided without charge upon request;
- if the adverse determination is based on medical necessity or experimental treatment or a similar exclusion or limit, either an explanation of the scientific or clinical judgment, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that this will be provided without charge upon request; and
- the following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency." However, this latter statement is not required if there is no alternative dispute resolution process (e.g., arbitration).

The decision will be final and binding upon the Claimant and all other persons involved.

The Claim Supervisor shall have no power to add to, subtract from, or modify any of the terms of the Plan, or to change or add to any Benefits provided by the Plan, or to waive or fail to apply any requirements of eligibility for a Benefit under the Plan.

**ARTICLE XIII
GENERAL INFORMATION**

Employer/Plan Sponsor

Daytona State College

Address and Telephone Number

1200 West International Speedway Blvd.
Daytona Beach, FL 32120-2811
(386) 506-3083

Name of Plan

Healthcare Purchasing Alliance (HPA) Employee Healthcare Benefits

Plan Effective Date

This Plan is effective July 1, 2010

Identification Numbers

Employer Tax ID No.: 59-1211226

Fiscal Year

This Plan's fiscal year is from July 1 to June 30.

ACTIONS AT LAW

No legal action may be brought to recover on this Plan prior to the last day after proof of expenses incurred has been filed. No such action may be brought after three (3) years from the time written proof of loss is required to be given. No action may be brought unless and until the Claimant has exhausted all administrative remedies under this Plan.

PAYMENT OF BENEFITS

All Benefits are payable when the Plan Sponsor receives written proof of loss. All Benefits are payable to the covered Employee, unless assigned.

WORKER'S COMPENSATION

This Plan and the Benefits provided are not in lieu of, nor shall affect any requirements for coverage under any worker's compensation law or other similar law.

FACILITY OF PAYMENT

If a Claimant is a minor or is physically or mentally incapable of giving a valid release for payment, the Plan Sponsor, at its option, may make payment to a party who has assumed responsibility for the care of such person. Such payments will be made until claim is made by a guardian. If a Claimant dies while Benefits remain unpaid, Benefits will be paid, at the Plan Sponsor's option to:

- a person or institution on whose charges claim is based; or
- a surviving relative (spouse, parent or Child)

Such payment will release the Plan Sponsor of all further liability to the extent of payment.

ASSIGNMENT

The Benefits provided under this Plan shall not be assignable without the consent of the Plan Sponsor. The Employee may authorize the Plan Sponsor to pay Benefits directly to the Hospital, Physician or other party providing medical treatment. Any such payment will discharge the Plan Sponsor to the extent of payment made. Unless permitted by law, payments may not be attached, nor be subject to the Employee's debts.

RECORDS

The Plan Sponsor will keep records of the Covered Persons under the Plan. Such records will include the following:

- covered persons by name, age and amount of coverage;
- effective date of coverage and date coverage ends;
- change of status;
- other related data.

CLERICAL ERROR

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

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

EXAMINATION

The Plan Sponsor has the right to have the Claimant examined as often as reasonably necessary while a claim is pending. Benefits are payable under this Plan only if they are Medically Necessary for the Sickness or Accidental Injury of the participant. This Plan reserves the right to make a utilization review to determine whether services are Medically Necessary for the proper treatment of the Covered Person. All such information will be confidential.

NOTICE OF PAYMENT

If the Plan Sponsor cannot locate any person to whom a payment is due, after three (3) months from the date such payment is due, a notice of payment due will be mailed to the last known address of that person. If within three (3) months after that mailing, such person has not made written claim, the Plan Sponsor may direct that such payment and all remaining payments otherwise due to such person be canceled. The Plan shall have no further liability upon such cancellation.

FREE CHOICE OF PHYSICIAN

Generally, the Covered Person shall have free choice of any legally qualified Physician or surgeon and the Physician/patient relationship shall be maintained. The Plan may, however, pay a larger percentage of Covered Expenses if care is received from certain providers.

WAIVER OR ESTOPPEL

No term, condition or provision of the Plan shall be deemed to have been waived, and there shall be no estoppel against the enforcement of any provision of the Plan, except by written instrument of the party charged with such waiver or estoppel. No such waiver shall be deemed a continuing waiver unless specifically stated. Each waiver shall operate only as to the specific term or condition waived and shall not constitute a waiver of such term or condition for the future or as to any act other than that specifically waived.

RESPONSIBILITY FOR PAYMENT OF CLAIMS

The Plan shall be the sole source of Benefits under the Plan, and to the maximum extent permitted by law, the Plan Sponsor assumes no liability or responsibility for payment of Benefits, and each Employee or other person who shall claim the right to any payment with respect to Benefits under the Plan shall be entitled to look only to the Plan for such payment and shall not have any right, claim or demand thereof against the Plan Sponsor or the medical board or any officer, Employee or director of the Plan Sponsor. The Claim Supervisor shall similarly have no liability or responsibility to fund Benefit payments under the Plan.

CONSTRUCTION

Wherever found in this Plan, a masculine pronoun includes the feminine pronoun.

PLAN INTERPRETATION

The Plan Sponsor have full discretionary authority to interpret and apply all Plan provisions (this includes the power to make factual findings and determinations), including, but not limited to, all issues concerning eligibility for and determination of Benefits. The Plan Sponsor may contract with an independent administrative firm to process claims, maintain Plan data and perform other Plan connected services; however, final authority to construe and

apply the provisions of the Plan rests exclusively with the Plan Sponsor. Decisions of the Plan Sponsor shall be final and binding, and subject to the most deferential standard on review.

PROTECTION AGAINST CREDITORS

No Benefit payment under this Plan shall be subject in any way to alienation, sale, transfer, pledge, attachment, garnishment, execution or encumbrance of any kind, and any attempt to accomplish the same shall be void. If the Plan Sponsor shall find that such an attempt has been made with respect to any payment due or to become due to any Covered Person, the Plan Sponsor in its sole discretion may terminate the interest of such Covered Person or former Covered Person, his spouse, parent, adult, Child, guardian of a minor child, brother or sister, or other relative or a Dependent of such Covered Person or former Covered Person, as the Plan Sponsor may determine, any such application shall be complete discharge of all liability with respect to such Benefit payment.

PLAN AMENDMENTS

This document contains all the terms of the Plan and may be amended from time to time by the Plan Sponsor in its sole discretion. Any changes so made shall be binding on each Covered Person referred to in this Plan Document.

TERMINATION OF PLAN

The Plan Sponsor reserves the right at any time to terminate the Plan by a written instrument to that effect. All previous contributions by the Plan Sponsor shall continue to be issued for the purpose of paying Benefits under the provisions of this Plan with respect to claims arising before such termination, or shall be used for the purpose of providing similar health benefits to Covered Persons, until all contributions are exhausted. The Plan Sponsor specifically reserves the right to eliminate, reduce or otherwise modify coverage for retired Employees and their Dependents at any time.

PLAN IS NOT A CONTRACT

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

SUMMARY PLAN DESCRIPTIONS

Each Employee covered under this Plan will be issued an individual Summary Plan Description, which may be satisfied by provision of this booklet, describing the Benefits to which the Covered Persons are entitled, to whom Benefits are payable, and summarizing the provisions of the Plan.

MISSTATEMENT OF AGE

If the age of the Covered Person has been misstated and if the amount of the contribution is based on age, an adjustment of contributions shall be made on the Covered Persons true age. If age is a factor in determining eligibility or amount of coverage and there has been a misstatement of age, the coverages and amounts of Benefits, or both, for which the person is covered shall be adjusted in accordance with the Covered Persons true age. Any such misstatement of age shall neither continue coverage otherwise validly terminated, nor terminate coverage otherwise validly in force. Contributions and Benefits will be adjusted on the contribution due date next following the date of the discovery of such misstatement.

GOVERNING LAW

The Plan is established in and subject to the law of the State of Florida, to the extent federal law does not apply.

**ARTICLE XIV
HEALTH INSURANCE PORTABILITY
AND ACCOUNTABILITY ACT OF 1996
PRIVACY & SECURITY REQUIREMENTS**

INTRODUCTION

The Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) imposes upon this Plan and certain other entities certain responsibilities to ensure that Protected Health Information (“PHI”) pertaining to Covered Persons remains confidential, subject to limited exceptions in which PHI may be disclosed. “Protected Health Information” means health information (including oral information) that:

- is created or received by health care providers, health plans or health care clearinghouses;
- relates to an individual’s past, present or future physical or mental health condition, the provision of health care to an individual or the past, present or future payment for the provision of health care to an individual; and
- identifies the individual or creates a reasonable basis to believe that the information, including demographic information, can be used to identify the individual.

HIPAA also imposes special requirements upon the Plan and the Employer with respect to *electronic* PHI (“ePHI”). Electronic PHI is PHI, as defined above, that is transmitted by or maintained in “electronic media”, as that term is defined in federal regulations, specifically 45 C.F.R. § 160.103.

EFFECTIVE DATE

The rules contained in this Article do not apply to the Plan or the Employer until such date as the HIPAA Privacy and Security regulations (45 C.F.R. § 160.101 et seq.) apply to the Plan.

DISCLOSURES OF PHI/ePHI BY THE PLAN TO THE EMPLOYER

The Plan (or the Employer on behalf of the Plan) provides to Covered Persons a HIPAA Privacy Notice that, among other things, states the Plan may disclose PHI/ePHI (relating to a Covered Person) to the Employer, as further described below, without the consent or authorization of the Covered Person. In no event may the Plan disclose PHI/ePHI to the Employer, without the consent or authorization of the Covered Person or his authorized representative, for purposes of employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Employer (although the Plan may disclose summary ePHI or enrollment-related ePHI to the Employer, without authorization, as further described below).

The Plan may disclose PHI/ePHI to the Employer, without the consent or authorization of the Covered Person, subject to the Employer’s obligations described below (in the sections titled, *Employer Obligations with Respect to PHI Obtained from the Plan* and *Additional Employer Obligations with Respect to ePHI Obtained from the Plan*) for Plan administrative functions such as wellness initiatives under the Plan, quality assurance, claims processing, accounting, auditing and monitoring. However, only the minimum amount of PHI/ePHI necessary to accomplish a particular Plan administrative function may be disclosed to the person(s) performing such functions.

In addition to disclosing PHI/ePHI to the Employer to allow the Employer to perform Plan administrative functions, the Plan may disclose certain limited summary health information, including electronic summary health information, to the Employer, without the consent or authorization of the Covered Person, for purposes such as obtaining premium bids for health insurance or reinsurance, or for modifying, amending or terminating the Plan. “Summary health information” is health information that summarizes claims history, expenses or types of claims by individuals, but from which has been removed at least 18 specific identifiers, including names, dates (except year), telephone numbers, Social Security numbers, medical record numbers and other identifiers. In addition, the Plan may disclose enrollment and disenrollment information, including electronic enrollment and disenrollment information, to the Employer without the consent or authorization of the Covered Person.

EMPLOYER OBLIGATIONS WITH RESPECT TO PHI OBTAINED FROM THE PLAN

As a condition of receiving PHI from the Plan for Plan administrative functions the Employer specifically agrees to:

- not use or further disclose the PHI other than as permitted by this Plan or as required by law, or as permitted by the Covered Person to whom the PHI relates;
- ensure that any agents or subcontractors to whom it shares or provides the PHI received from the Plan agree to these same restrictions and conditions;
- not use the PHI for employment-related actions or in connection with any of its other benefit plans without the consent or authorization from the Covered Person to whom the PHI relates;
- report to the Plan any improper uses or disclosures of the PHI;
- provide Covered Persons access to PHI that relates to them, allow them to request amendments to the PHI, and upon request provide Covered Persons an accounting of all disclosures of their PHI by the Employer (except for those disclosures with respect to which no accounting is required);
- make available to appropriate federal authorities the Employer's internal practices, books and records relating to the use and disclosure of PHI received from the Plan; and
- return or destroy (to the extent feasible) all copies of the PHI received from the Plan once the Employer's need for which the PHI was requested no longer exists or, if this is not feasible, limit further uses and disclosures of the PHI.

ADDITIONAL EMPLOYER OBLIGATIONS WITH RESPECT TO ePHI OBTAINED FROM THE PLAN

As a condition of receiving ePHI from the Plan for Plan administrative functions the Employer specifically agrees to:

- implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the ePHI that it creates, receives, maintains or transmits on behalf of the Plan;
- ensure that the adequate separation (as required by 45 C.F.R. § 164.504(f)(2)(iii)), between the ePHI and persons who have no legitimate need to access such ePHI, is supported by reasonable and appropriate security measures;
- ensure that any agent, including a subcontractor, to whom it provides this information agrees to implement reasonable and appropriate security measures to protect the information; and
- report to the Plan any security incident of which it becomes aware.

USE AND DISCLOSURE OF PHI BY THE EMPLOYER; DISPUTE RESOLUTION

When the Employer obtains PHI from the Plan for Plan administrative functions, the PHI will be provided to the Employee Benefits Department of the Employer, and may also be provided to the Employer's payroll department (for purposes of processing payroll deductions for payment of premium) and chief financial officer and his designees. The persons in these departments, except as otherwise provided in a specific authorization granted by the Covered Person or his authorized representative to the Employer, will have access to and may use the PHI solely to perform Plan administrative functions that the Employer performs for or with respect to the Plan.

The Employer may use PHI that it receives from the Plan to carry out Plan administrative functions and may use summary health information for the purposes described in the section above titled, *Disclosures of PHI by the Plan to the Employer*. The Employer may also disclose PHI relating to a Covered Person, without the consent or authorization of the Covered Person, as required or as otherwise permitted by law. For example, the law allows PHI to be disclosed, without the consent or authorization of the Covered Person, to law enforcement, public health and judicial agencies in certain circumstances. PHI pertaining to a minor Covered Person may, to the extent permitted by local law, be disclosed to the Covered Person's parent or guardian without the consent or authorization of the minor. There are other situations in which PHI may be disclosed without the Covered Person's consent. For more information please review the Plan's Privacy Notice or see the Plan's Privacy Official.

In the event a Covered Person or any other person believes that the Employer or any of its agents have misused PHI disclosed to it or to them by the Plan, such persons may notify the Employer's Privacy Official (contact the Employee Benefits Department for more information regarding the Privacy Official), or may file a complaint as described in the Plan's Privacy Notice, a copy of which you should have already received (an additional copy is available from the Employee Benefits Department). If the complaint is filed with the Privacy Official the Privacy Official will investigate the complaint and the events and circumstances related to it, as provided in the Employer's Privacy Policy and Procedure.

APPENDIX A DENTAL BENEFITS

BENEFITS

We will consider expenses that are Usual, Customary and Reasonable for covered dental services rendered by a legally qualified dentist acting within the scope of his license. We will provide Benefits according to the percentage shown in the Schedule of Benefits for charges that exceed the deductible amount, if any, and up to the maximum payable in any one Benefit Period, as shown in the Schedule of Benefits.

DEDUCTIBLE

The “deductible amount” for purposes of this Appendix is the amount of Covered Expenses which the Covered Person must pay each Benefit Period before Benefits are payable under this part. The deductible amount is shown in the Schedule of Benefits.

COVERED DENTAL EXPENSES

Covered dental charges are the charges by a licensed dentist, acting within the scope of his license, which you are required to pay for the following dental services and supplies received:

1. *Class I Services: Preventive & Diagnostic.*

- a. Oral examinations (two during any Benefit Period).
- b. Dental x-rays:
 - i) bitewing x-rays (two during any Plan Year)
 - ii) full mouth x-rays (one during any thirty-six (36) consecutive month period)
 - iii) panoramic x-rays (one during any thirty-six (36) consecutive month period)
 - iv) occlusal, periapical and other x-rays, as necessary
- c. Prophylaxis (two during any Benefit Period).
- d. Topical fluoride for Children under age 19 (two (2) application in Plan Year).

2. *Class II Services: Basic.*

- a. Tests and laboratory examinations.
- b. Biopsy.
- c. Space maintainers for Children to replace primary teeth.
- d. Sealants (for Children under age 18).
- e. Emergency palliative treatment for pain.
- f. Sedative fillings, pin retention.
- g. Bacteriological culture, histopathologic examinations, pulp vitality test, and diagnostic casts.
- h. Amalgam, silicate, acrylic, synthetic porcelain and composite filling restorations.
- i. Treatment of periodontal and other diseases of the gums and tissues of the mouth; periodontal appliances.
- j. Gingivectomy and gingival curettage.
- k. Endodontic treatment:
 - i) Pulp cap, vital pulpotomy, root canal therapy including treatment plan, diagnostic x-rays, clinical procedures and follow-up care
 - ii) Apexification, apicoectomy, retrograde filling (Apicoectomy and retrograde filling are covered as a separate procedure only if performed more than one year after the root canal therapy is completed)
 - iii) Apical curettage, root resection
 - iv) Hemisection and labial frenectomy
- l. Osseous surgery and osseous graft, only one of these procedures is covered per area of the mouth per Benefit Period.
- m. Extractions, including local anesthesia and routine postoperative care.
- n. Oral surgery:
 - i) extraction of teeth (but not to include partially or fully impacted teeth)
 - ii) alveoloplasty
 - iii) removal of dental cysts and tumors
 - iv) surgical incision and drainage of dental abscess
 - v) other surgical procedures (i.e. surgical exposure to aid eruption)

- vi) surgical repositioning of teeth
- vii) excision of hyperplastic tissue
- o. General anesthesia when Medically Necessary and administered in connection with oral or dental surgery.
- p. Injection of antibiotic Drugs, prescription Drugs (for a dental condition only).
- q. Professional consultation.
- r. Recementing of inlay, crown, bridge or space maintainer.
- s. Stainless steel crowns.

3. Class III Services: Major.

- a. Repairs of crowns.
- b. Repairs to bridges and full or partial dentures.
- c. Adding tooth to partial denture.
- d. Relining and rebasing full or partial denture (covered only if relining is done more than one year after the initial installation and then not more than once each thirty-six (36) month period).
- e. Inlays, onlays, gold fillings, or crown restorations covered only when the tooth cannot be restored with amalgam, silicate, acrylic, synthetic porcelain or composite filling restoration.
- f. Initial installation of partial or full removable dentures to replace one or more teeth, at least one of which was a natural tooth extracted while covered under this Plan; or to replace teeth.
- g. Initial installation of fixed bridgework, including inlays and crowns as abutments to replace one or more teeth at least one of which was a natural tooth extracted while covered under this Plan; or to replace teeth which were missing prior to the date the individual became covered under this Plan.
- h. Replacement of crowns, inlay or onlay restorations.
- i. Cast post and core covered only for teeth that have had root canal therapy; steel post and composite or amalgam.
- j. Replacement of an existing partial or full removable denture or fixed bridgework by a new denture or by new bridgework, only when the existing denture or bridgework cannot be made serviceable and must take place within 24 consecutive months from the date the temporary denture was installed).

4. Class IV Services.

- a. Orthodontic Benefits. The Plan provides orthodontic care Benefits, those Benefits, and the persons for whom they're available, are described in the Schedule of Benefits.
- b. Implants.

5. Expenses Incurred. The following special rules are applied to determine when dental expenses are considered to have been incurred:

- a. For an appliance or modification of an appliance, an expense is considered incurred at the time the impression is made.
- b. For dentures or partials, an expense is considered incurred on the date the impression from which the dentures will be prepared is made.
- c. For a crown, bridge, inlay, onlay or gold restoration an expense is considered incurred at the time the tooth or teeth are prepared and final impressions have been made.
- d. For root canal therapy, an expense is considered incurred at the time the pulp chamber is opened and the pulp canal explored to the apex.
- e. All other expenses are considered incurred at the time a service is rendered or a supply is furnished.

6. Benefits For Temporary Work. Charges for services or supplies for temporary dental care or treatment will be treated as part of the final dental care or treatment; they will not be paid as separate services or supplies.

7. Pre-determination Of Benefits. You should file a dental treatment plan with the Claim Supervisor prior to any course of dental treatment which will exceed \$500 in cost. The Claim Supervisor will notify you what dental expense Benefits will be paid. Pre-determination of Benefits is not required for Emergency treatments, routine oral exams, x-rays, cleaning and scaling, or dental services costing less than \$500.

8. **Additional Proof Of Claim.** As a proof of claim, the Claim Supervisor may require a complete dental chart showing any extractions, fillings or other work performed prior to the date of loss for which a claim is being made; itemized bills of the dentist, Physician or other sources of services; supplies and treatments, x-rays, laboratory or Hospital reports; or casts, molds, study models, or other similar evidence of the condition or treatment of the tooth or mouth.
9. **Exclusions.** Covered dental expenses do not include, and Benefits are not payable with respect to:
- a. **Before Coverage** - Care, Treatment or supplies for which a charge was incurred before a person was covered under this Plan.
 - b. **Cosmetic Dentistry** - Charges for or related to Cosmetic Dentistry, including charges for personalization or characterization of dentures. Veneers or coverings placed on teeth except when used to return the tooth to normal form and function are considered cosmetic in nature.
 - c. **Criminal Act** - See Military Injury.
 - d. **Crowns** - Crowns for teeth that are restorable by other means or for the purpose of Periodontal Splinting.
 - e. **Dental Hygienist** - Charges for Treatment by other than a Dentist, except charges for cleaning of teeth performed by a licensed Dental Hygienist, under the supervision of a Dentist.
 - f. **Duplicate Prosthetics** - Charges for any duplicate prosthetic device or any other duplicate appliance.
 - g. **Excluded under Medical** - Services that are excluded under Medical Plan Exclusions.
 - h. **Facilities Maintained by Employer** - Charges for services rendered through a medical department, clinic, or similar facility provided or maintained by your Employer.
 - i. **Family Member, Services Rendered by** - Charges for services or supplies rendered by a member of your Immediate Family or any person residing in your household.
 - j. **Failure to Keep Appointment** - Charges for failure to keep a scheduled visit with the dentist and charges for the completion of any insurance forms.
 - k. **Governmental Plan** - Charges for care, treatment or supplies furnished by a program or agency funded by any government. This does not apply to Medicaid or when otherwise prohibited by law.
 - l. **Hygiene** - Oral hygiene, plaque control programs or dietary instructions.
 - m. **International Services** - Charges incurred outside the U.S. if you traveled to such location for the sole purpose of obtaining medical services, Drugs or supplies.
 - n. **Medical Services** - Services that, to any extent, are payable under any medical expense benefits of this Plan.
 - o. **Military Injury, Criminal Act, Self-Inflicted**- Charges for treatment of a Sickness or Injury suffered or incurred:
 - a. in the course of an act of declared or undeclared war;
 - b. in the course of, or related to, service in the military forces of any country, including non-military units supporting such forces;
 - c. in connection with any Sickness or Injury of the Covered Person resulting from or occurring during the Covered Person's commission or attempted commission of a criminal battery or felony. Claims shall be denied if the Plan Administrator has reason to believe based on objective evidence, such as, police reports or medical records, that a criminal battery or felony was committed by the Covered Person;
 - d. while taking part in a riot (meaning taking an active part in common with three or more others by using or threatening to use force or violence without authority of law); or
 - e. as the result of an intentionally self-inflicted wound, unless as a result of 1) an act of domestic violence, or 2) a medical condition (regardless of whether such medical condition is physical or mental, and regardless of whether the medical condition is diagnosed prior to the Sickness or Injury).
 - p. **No Charge** - Care and Treatment for which there would not have been a charge if no coverage had been in force.
 - q. **No Listing** - Services which are not included in the list of covered dental services.
 - r. **No obligation to pay** - Charges incurred for which this Plan has no legal obligation to pay.
 - s. **Non-Compliant with Florida's Seat Belt Law** - This plan recognizes and provides benefit coverage based on Florida law. Therefore, the Plan excludes payment of all medical costs (including pharmacy) incurred by Covered persons found to be non-compliant with "Florida's Mandatory Seat Belt Law".

- t. **Not Medically Necessary** - Care and Treatment that is not Medically Necessary, as defined by this Plan.
- u. **Orthognathic Reconstructive Surgery** - Surgery to correct a receding or protruding jaw.
- v. **Personalization** - Personalization of dentures.
- w. **Plan design** - Charges excluded or limited by the Plan design as stated in this document.
- x. **Reasonable & Customary** - Charges to the extent they exceed the Usual, Customary and Reasonable charge.
- y. **Replacement** - Replacement of lost or stolen appliances.
- z. **Self-inflicted** - See Military Injury
- aa. **Services Prior to Effective Date** - Charges for any procedure which began before the date the Covered Person's dental coverage started, to include a service which is:
 - i) an appliance, or modification of an appliance, for which an impression was made before such person became covered, or
 - ii) a crown, bridge or gold restoration, for which a tooth was prepared before such person became covered, or
 - iii) root canal therapy, for which the pulp chamber was opened before such person became covered.
- bb. **Splinting** - Crowns, fillings or appliances that are used to connect (splint) teeth, or change or alter the way the teeth meet, including altering the vertical dimension, restoring the bite (occlusion) or are cosmetic.
- cc. **TMJ** - All diagnostic and Treatment services related to the Treatment of jaw joint problems including Temporomandibular Joint (TMJ) Syndrome.
- dd. **War** - See Military
- ee. **Worker's Compensation** - Charges for treatment of a Sickness or Injury for which Benefits are or, upon compliance with all applicable laws, would be provided under Worker's Compensation Law; or charges for treatment of a Sickness or Injury occurring during or arising from secondary employment for wage or profit.

10. *Extended Benefits.* Benefits will be paid for the following dental work which is started while your coverage is in force and which is completed within 60 days after coverage ends:

- a. A denture, if the final impressions were taken before coverage ended.
- b. A crown, bridge, or gold filling if the tooth was prepared and impressions taken prior to termination of coverage.
- c. Root canal work, if the pulp chamber was opened and the canal explored to the apex before coverage ended.

No extended Benefits will be paid for any type of work not listed above.

11. *Re-enrollment of Coverage.* If an Employee chooses to drop dental coverage for self or covered Dependents, the Employee and/or covered Dependents will not be able to re-enroll in the Dental Plan for a minimum of five (5) years. If after the five (5) years the Employee chooses to re-enroll and add Dependents formerly on the Plan, a one (1) year Pre-Existing Restriction Condition limitation will be imposed. This means, you and/or your Dependents cannot re-enroll in the dental Plan within five (5) years from the date the coverage ended.

APPENDIX B VISION BENEFITS

1. **Benefits.** If you incur expenses for any of the services or supplies shown in the Schedule of Benefits, the Benefits described and limited in the following paragraphs will be paid. For charges made by a Physician for such services or supplies, the Plan will pay an amount equal to the charges but not more than the amount shown in the Schedule of Benefits.

2. **Limitations.**
 - a. During any period of twelve (12) consecutive months, payment for no more than one complete examination will be made.
 - b. Benefits will be paid for no more than two (2) lenses during any period of twelve (12) consecutive months.
 - c. Benefits will be paid for no more than one (1) set of frames during any period of twenty-four (24) consecutive months.
 - d. The full Benefit is payable for contact lenses if they are the means of correcting vision in the better eye to at least 20/70 visual acuity.

3. **Exclusions.** Covered vision expenses do not include and Benefits are not payable for:
 - a. **Contact Lenses Supplemental Testing** - Charges for supplemental testing for contact lenses.
 - b. **Criminal Act** - See Military Injury
 - c. **Eye Disease or Injury** - Charges furnished for surgical or medical care and treatment of eye disease or Injury.
 - d. **Eye Examination for Employment** - Charges for eye examination required by an employer as a condition of employment.
 - e. **Family Member, Services Rendered by** - Charges for services or supplies rendered by a member of your Immediate Family or any person residing in your household
 - f. **Governmental Plan** - Charges for services and supplies that are: furnished by a governmental plan, Hospital or institution, unless you are legally required to pay for the services; paid by an association or foundation; or required by law to be provided by an educational institution to you; nevertheless, such charges shall be considered for payment under the Plan to the extent required by federal law, but only to the extent the Plan would have considered such charges for payment had the services or supplies been provided by other than a governmental Hospital or institution.
 - g. **International Services** - Charges incurred outside the U.S. if you traveled to such location for the sole purpose of obtaining medical services, Drugs or supplies.
 - h. **Military Injury, Criminal Act, Self-Inflicted** - Charges for treatment of a Sickness or Injury suffered or incurred:
 - a. in the course of an act of declared or undeclared war;
 - b. in the course of, or related to, service in the military forces of any country, including non-military units supporting such forces;
 - c. in connection with any Sickness or Injury of the Covered Person resulting from or occurring during the Covered Person's commission or attempted commission of a criminal battery or felony. Claims shall be denied if the Plan Administrator has reason to believe based on objective evidence, such as, police reports or medical records, that a criminal battery or felony was committed by the Covered Person;
 - d. while taking part in a riot (meaning taking an active part in common with three or more others by using or threatening to use force or violence without authority of law); or
 - e. as the result of an intentionally self-inflicted wound, unless as a result of 1) an act of domestic violence, or 2) a medical condition (regardless of whether such medical condition is physical or mental, and regardless of whether the medical condition is diagnosed prior to the Sickness or Injury).
 - i. **No Payment Required** - Charges for which you would not be required to pay if there were no coverage.
 - j. **Non-Compliant with Florida's Seat Belt Law** – This plan recognizes and provides benefit coverage based on Florida law. Therefore, the Plan excludes payment of all medical costs (including pharmacy) incurred by Covered persons found to be non-compliant with “Florida's Mandatory Seat Belt Law”.

- k. **Orthoptics, Vision Training, or Anisometropia** - Charges for orthoptics, vision training, or anisometropia.
- l. **Other Provision of the Plan** - Charges payable under any other provision of the Plan, but only to the extent that Benefits are so payable.
- m. **Reasonable & Customary** - Charges to the extent they exceed the Usual, Customary and Reasonable charge.
- n. **Reimbursement from Other Plans** - Charges that are covered under a health plan that reimburses a greater amount than this Plan.
- o. **Replacement of Lenses and Frames** - Charges for replacement of lenses and frames furnished under this Plan which are lost or broken, except at the normal intervals when services are provided under the Plan.
- p. **Self-Inflicted** - See Military Injury.
- q. **Services by an Optician** - Charges for services by an optician unless they are prescribed by an optometrist or an ophthalmologist.
- r. **Sunglasses, Safety Lenses or Goggles** - Charges for sunglasses, plain or prescription, or safety lenses or goggles.
- s. **War** – See Military.
- t. **Worker's Compensation** - Charges for treatment of a Sickness or Injury for which Benefits are or, upon compliance with all applicable laws, would be provided under Worker's Compensation Law; or charges for treatment of a Sickness or Injury occurring during or arising from secondary employment for wage or profit.

Re-enrollment of Coverage. If an Employee chooses to drop vision coverage for self or covered Dependents, the Employee and/or covered Dependents will not be able to re-enroll in the Vision Plan for a minimum of five (5) years. If after the five (5) years the Employee chooses to re-enroll and add Dependents formerly on the Plan, a one (1) year Pre-Existing Restriction Condition limitation will be imposed. This means, you and/or your Dependents cannot re-enroll in the vision Plan within five (5) years from the date the coverage ended.

APPENDIX C RETIRED EMPLOYEE COVERAGE

This Retired Employee Coverage Appendix applies only to former Employees who have coverage under the Plan on account of their status as Retired Employees (as defined in this Appendix). The purpose of this Appendix is to describe differences between the coverage provided to Employees and their Dependents, and the coverage provided to Retired Employees and their Dependents.

Where the terms of this Appendix expressly describe a Benefit, right, responsibility or limitation applicable to a Retired Employee, which contradicts a Benefit, right, responsibility or limitation (as described in the preceding pages of this booklet) applicable to an Employee, the provisions of this Appendix override, with respect to anyone covered as a Retired Employee, such provision to the contrary in the preceding pages of this booklet. Similarly, where the terms of this Appendix expressly describe a Benefit, right, responsibility or limitation applicable to a Dependent of a Retired Employee, which contradicts a Benefit, right, responsibility or limitation (as described in the preceding pages of this booklet) applicable to a Dependent of an Employee, the provisions of this Appendix override, with respect to anyone covered as a Dependent of a Retired Employee, such provision to the contrary in the preceding pages of this booklet. *Otherwise, the preceding pages of this booklet describing the Benefits, rights, responsibilities and limitations applicable to covered Employees and their Dependents apply as well to covered Retired Employees and their Dependents, respectively.*

Definitions. This Appendix includes the following definitions:

Retirement Date. The day immediately following your last date of employment as an Employee, if on such day you are a Retired Employee.

Retired Employee. You are a Retired Employee if you are employed for a minimum of six (6) years with Daytona State College in a benefits-eligible position. Additionally, you are a Retired Employee if you terminate employment with Daytona State College while covered by this Plan, and at the time you so terminate your employment to meet the following requirements for retiree coverage under the Plan:

- The Employee is eligible for and shall begin drawing Florida Retirement System (FRS) Benefits immediately upon retirement.
- The Employee is eligible for a retirement program offered by Daytona State College and shall apply for Benefits immediately upon retirement.

Temporary reappointment of retired personnel does not negate a member's option to return to their retiree status once the appointment ends, if the member has maintained continuous coverage under the Plan.

Contributions to the Plan. As a covered Retired Employee or covered Dependent of a Retired Employee, you may be required to make contributions to the Plan, as a condition of continuing your coverage, that are different from the contributions made by Employees and their Dependents.

Eligibility and Effective Date of Coverage as a Retired Employee or Dependent of a Retired Employee.

Retired Employee Eligibility. In order to be eligible for coverage under the Plan under the provisions of this Appendix, you must be a Retired Employee. You are eligible to continue coverage as a Retired Employee if you apply for Retired Employee coverage during the 60-day window ending on your Retirement Date, and are a Retired Employee on your Retirement Date. If you apply for coverage as a Retired Employee during this 60-day window and are a Retired Employee on your Retirement Date, your coverage as a Retired Employee will begin on your Retirement Date. For example, if your retirement date is August 31st and you submitted your last paid premium on July 31st (as an active Employee), you will then begin paying retiree premiums on August 1st and your retiree coverage will begin on September 1st (your coverage as an active employee ceases August 31st). If you fail to apply for coverage during this 60-day window or you are not a Retired Employee on your Retirement Date, you will not be enrolled as a Retired Employee upon your Retirement Date and you will be ineligible for coverage under this Plan (except under the Plan's COBRA Continuation Coverage provisions, if applicable) on and after your Retirement Date unless you again become an Employee and again qualify for coverage under the Plan as an Eligible

Employee. There is no periodic “open enrollment period” for Retired Employees other than as described in this paragraph, and no “late enrollment” rights.

Eligibility of a Dependent of a Retired Employee. Your Dependents are eligible for coverage under this Appendix on the date you become eligible for Retired Employee coverage, or the date on which the Dependents become your Dependents, whichever occurs last. *However, under no circumstances may you enroll your Dependents under this Appendix if you are not also enrolled under this Appendix.* If both you and your spouse are Retired Employees, and both are eligible for Dependent coverage, either you or your spouse, but not both, may elect Dependent coverage for your other eligible Dependents (e.g., Dependent Children). No person may be covered under this Appendix as both a Retired Employee and as a Dependent.

Special Enrollment Events. As a Retired Employee you are not eligible for special enrollment rights, described in the section of this booklet titled, *Effective Date of Coverage*, attributable to the loss of other coverage or to acquisition of a new Dependent (that is, you are not entitled to a special enrollment right to enroll yourself because you will not be an eligible Retired Employee if you do not enroll as described above, in the paragraph titled, *Retired Employee Eligibility*). If you are covered as a Retired Employee, however, your Dependents are eligible for special enrollment rights as described in the section of this booklet titled, *Effective Date of Coverage*.

Termination of Retired Employee Coverage and Coverage of Dependents of a Retired Employee.

Retired Employee Coverage Termination. Except as otherwise provided in this Appendix, your coverage as a Retired Employee will terminate on the earliest of the following dates:

- If you fail to remit required contributions for your coverage when due, the date which is the end of the period for which the last timely contribution was made.
- The last day of the month you enter the military, naval or air force of any country or international organization on a full-time basis other than scheduled drills or other training not exceeding one month in any Benefit Period.
- The date you die.
- The date the Plan is terminated or coverage for Retired Employees (or the class of Retired Employees to which you belong) is terminated.
- The last day of the month in which you request your coverage to be terminated.
- The date the Plan Sponsor determines, in its sole discretion that you knowingly filed or knowingly assisted with the filing of a fraudulent claim for Benefits.
- The date you reach the Plan’s Lifetime Maximum; provided, however, that you may choose to maintain your enrollment in the Plan notwithstanding the fact that you have reached the Plan’s Lifetime Maximum (for example, you may wish to choose to maintain your enrollment so that the coverage of your Dependent(s) can continue under the Plan).

Termination of Coverage for Dependent of Covered Retired Employee. Except as provided in this Appendix, your coverage as a covered Dependent of a covered Retired Employee will terminate on the earliest of the following dates:

- The date your sponsor’s (the Eligible Employee’s) coverage terminates.
- If required contributions for your coverage are not remitted when due, the date which is the end of the period for which the last timely contribution was made.
- The last day of the month you enter the military, naval or air force of any country or international organization on a full-time basis other than scheduled drills or other training not exceeding one month in any Benefit Period.
- The last day of the month you cease to meet the definition of “*Dependent*”, or the date Dependent coverage (for all Dependents or for Dependents of Retired Employees) is discontinued under the Plan.
- The date the Plan is terminated or the date coverage of Retired Employees is terminated.
- The date the Plan Sponsor determines, in its sole discretion that you knowingly filed or knowingly assisted with the filing of a fraudulent claim for Benefits.
- The date you reach the Plan’s Lifetime Maximum.

Coordination of Benefits - Medicare Reduction/Coordination

Retired Employee or Dependent of Retired Employee Entitled to or Eligible for Medicare Due to Age or Disability (Other than ESRD). If you are covered under this Plan due to your or someone else's status as a Retired Employee, and are also entitled to Medicare on account of age or disability (other than end-stage renal disease), Medicare is the primary payer and this Plan pays second, after Medicare. If you are eligible for Medicare due to age or disability (other than ESRD) but not enrolled in Medicare, this Plan will deem you to be enrolled in Medicare Parts A, B and D, and coordinate its Benefit payments as though Medicare had paid first.

Retired Employee or Dependent of Retired Employee Entitled to or Eligible for Medicare Due to End-Stage Renal Disease. If you are covered under this Plan due to your or someone else's status as a Retired Employee, and are also eligible for Medicare on account of end-stage-renal disease (ESRD), then this Plan will be primary to Medicare for up to 30 months (called the "coordination period"); after that, the Plan becomes the secondary payer (assuming you're still eligible for coverage), and Medicare is the primary payer. The coordination period begins on the first day of the month for which you are eligible for Medicare benefits on account of your ESRD, and ends not later than 30 months later (it might end earlier in some cases, such as when your coverage ends under this Plan). If at the time you become eligible for Medicare benefits due to ESRD you are already entitled to Medicare benefits on account of age or disability, and Medicare is the primary payer (and this Plan is secondary), then Medicare remains the primary payer, even after you become eligible for Medicare benefits due to your ESRD. Please note that for purposes of this provision, the coordination period begins in the month you are merely eligible for Medicare benefits due to ESRD, whether or not you actually enroll in Medicare then.

Reduced Medicare Part B Premium. The reduced Medicare Part B premium is not automatic. To apply for the Medicare Part B premium, you must provide the Employee Benefits Department with a copy of your signed Medicare Health Insurance card. Your card must show that you have enrolled in Medicare Part B and the effective date of coverage. Credit for any over deductions will only be reimbursed back to the date your card is received by the Employee Benefits Department.

APPENDIX D

EPIC HEARING AID BENEFITS

This Plan includes a benefit that will allow Covered Persons to access discounted hearing aids and related testing and fitting. This benefit is being offered under the Plan by EPIC Hearing Healthcare.

This benefit may be accessed under the Plan by calling EPIC on its toll free number: **1 (866) 956-5400**.

Once contacted, one of EPIC's hearing professionals will coordinate the Covered Person's care and direct them to the nearest appropriate provider.

The hearing aid benefit being provided through EPIC consists of discounted hearing aids and related testing and fitting. EPIC discounts may be as much as 50% below manufacturer's suggested retail prices and up to 35% lower than most discount offers. EPIC will require that the Covered Person pay for his or her hearing aids and other services out-of-pocket prior to the delivery of services.

Because this Plan does not have additional hearing benefits, Covered Persons should not submit a claim for reimbursement to the Plan for EPIC products or services. Covered Persons who utilize the EPIC discounts should communicate directly with EPIC to obtain the discount. In the event that a Covered Person submits a claim for reimbursement, the claim will be denied because the Plan does not provide additional coverage beyond the EPIC discounts for these products and services.

In the event that You have questions or complaints about the hearing aid products or services offered under the Plan, You should contact EPIC directly at their toll free number or write to them at:

**EPIC Hearing Services,
17870 Castleton Street, Suite 320,
City of Industry, CA 91748.
1 (866) 956-5400**