Regent University
Health Plan

Optima Equity (HSA) Plan Option

Summary Plan Description
July 1, 2008

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ADMINISTRATIVE INFORMATION

NAME OF PLAN: **Regent University Health Plan**

ORIGINAL PLAN EFFECTIVE DATE: July 1, 1990

RESTATED PLAN EFFECTIVE DATE: July 1, 2008

TYPE OF PLAN: Welfare – group health plan.

IMPORTANT:

BENEFITS UNDER THIS PLAN WILL BE PAID ONLY IF THE PLAN ADMINISTRATOR DECIDES IN HIS/HER DISCRETION THAT THE COVERED PERSON IS ENTITLED TO THEM.

EXCEPT IN AN EMERGENCY, THE IN-NETWORK BENEFITS UNDER THE PLAN ARE AVAILABLE ONLY WHEN THE SERVICES ARE PROVIDED BY PLAN PROVIDERS.

IT IS THE COVERED PERSON'S RESPONSIBILITY TO BE FAMILIAR WITH THE PLAN'S COVERAGE AND TO UNDERSTAND BASED ON THE SERVICES BEING RENDERED AND THE PROVIDER USED BY THE COVERED PERSON WHETHER IN-NETWORK OR OUT-OF-NETWORK COVERAGE IS APPLICABLE.

PRE-AUTHORIZATION IS REQUIRED REGARDLESS OF THE NETWORK CHOSEN. IT IS THE COVERED PERSON'S RESPONSIBILITY TO MAKE SURE THAT PRE-AUTHORIZATION IS COMPLETED ACCORDING TO THE TERMS SET FORTH HEREIN.

THIS SUMMARY PLAN DESCRIPTION IS INTENDED TO HELP YOU UNDERSTAND THE MAIN FEATURES OF THE PLAN. IT SHOULD NOT BE CONSIDERED AS A SUBSTITUTE FOR THE PLAN DOCUMENT, WHICH GOVERNS THE OPERATION OF THE PLAN. THAT DOCUMENT SETS FORTH ALL OF THE DETAILS AND PROVISIONS CONCERNING THE PLAN AND IS SUBJECT TO AMENDMENT. IF ANY QUESTIONS ARISE THAT ARE NOT COVERED IN THIS SUMMARY PLAN DESCRIPTION OR IF THIS SUMMARY PLAN DESCRIPTION APPEARS TO CONFLICT WITH THE OFFICAL PLAN DOCUMENT, THE TEXT OF THE OFFICIAL PLAN DOCUMENT WILL DETERMINE HOW QUESTIONS WILL BE RESOLVED.

NAME AND ADDRESS OF COMPANY OR "PLAN SPONSOR":

Regent University
1000 Regent University Drive
Virginia Beach, Virginia 23464

NAME, ADDRESS AND BUSINESS TELEPHONE NUMBER OF PLAN ADMINISTRATOR :

Martha Smith, Vice President for Human Resources
Regent University
1000 Regent University Drive
Virginia Beach, Virginia 23464
(757) 352-4053

The Plan Administrator has authority to control and manage the operation and administration of the Plan.

EMPLOYER IDENTIFICATION NUMBER (EIN): 54-1061178

PLAN NUMBER: 503

WHO PAYS FOR COVERAGE PROVIDED BY THE PLAN (CONTRIBUTION SOURCE):

The health care coverage under the Plan is paid partly by funds contributed by the University and partly by contributions from You as Employee of the University.

METHOD OF CONTRIBUTION:

The University determines each Plan Year the amount of Employee Contribution required for each coverage tier (e.g., Employee Only, Employee plus Child, Employee plus Spouse, or Family) based on projected costs for the Plan Year. Contributions may be paid through payroll deduction, or through salary reduction under the University's Section 125 Cafeteria Plan.

PLAN YEAR:

The financial records of the Plan are kept on a Plan year basis, which is the twelve month period beginning July 1 and ending June 30.

PLAN PROVIDER COORDINATOR AND CLAIMS PROCESSING:

The Plan has contracted with Sentara Health Management ("Sentara"), a Virginia corporation located at 4417 Corporation Lane, Virginia Beach, Virginia 23462, (757) 552-7100, to provide certain claims processing, health care utilization review, and health care provider coordination services for the Plan Administrator.

The Plan has contracted with CIGNA for the administration of Dental Benefits available to Covered Persons under this Plan. Please refer to the Dental Benefits SPD for further information.

AGENT FOR LEGAL PROCESS:

For disputes arising under the Plan, service for legal process may be made to the Plan Administrator at the address shown above.

FUNDING FOR ACCUMULATION OF PLAN ASSETS:

The Plan utilizes a fund for the accumulation of assets through which benefits are provided. Benefits are payable directly from this fund, which is established and maintained solely by the Plan Sponsor.

The University contributes to such fund each Plan Year an amount which, when combined with Employee Contributions, is sufficient to pay all Plan expenses for that Plan Year.

ERISA NOTICE

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

Receive Information About Your Plan and Benefits

Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

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

Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

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

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you

should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 1996

Under federal law known as the "Newborns' and Mothers' Health Protection Act of 1996" (Newborns' Act) group health plans and health insurance issuers generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

The Women's Health and Cancer Rights Act of 1998 requires the Plan to notify you of your rights related to benefits provided by the Plan in connection with a mastectomy. Please retain this notice with your important health care records. If you have any questions regarding this Notice or the benefits you are entitled to under the Plan please call Member Services at the number listed on your Plan insurance identification card.

As a Cover Person of the Plan you have rights to coverage to be provided in a manner determined in consultation with your attending physician for:

- All stages of reconstruction of the breast on which the mastectomy was performed; and
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications of the mastectomy, including lymphedema.

These benefits are subject to the exclusions, limitations, and conditions including Deductibles and Coinsurance as set forth in this document.

HIPAA PRIVACY PRACTICES INFORMATION

The Health Insurance Portability and Accountability Act of 1996 (HIPPA) requires that health plans protect the confidentiality of your private health information. A complete description of your rights under HIPAA can be found in the Privacy Notice which was distributed to you upon enrollment and is available from the benefits manager.

This Plan, and the Plan Sponsor, will not use or further disclose information ("personal health information or PHI") that is protected by HIPAA except as necessary for treatment, payment, health plan operations and plan administration, or as permitted or required by law. By law, the Plan has required all of its business associates to also observe HIPAA's privacy rules. In particular, the Plan Sponsor will not, without authorization, use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit plan of the Plan Sponsor.

Under HIPAA you have certain rights to see and copy protected health information about you. You have the right to request an accounting of certain disclosures of the information and under certain circumstances, amend the information. You have the right to file a complaint with the Plan Sponsor or with the Secretary of the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated.

If you have any questions regarding your rights under HIPAA's privacy rules please consult the Privacy Notice. For a copy of the notice, or if you have questions about the privacy of your health information please contact: Brenda Robinson.

If you wish to file a complaint under HIPAA, please contact Martha Smith, Vice President for Human Resources.

Optima Equity Plan Option Overview and Schedule of Benefits

How the Plan Works

The Optima Equity Plan Option has two components to cover the cost of health care services under the Plan. The components include Preventive Care coverage and coverage from in- and out-of-network providers once the Plan Year Deductible has been met. In addition, the Optima Equity Plan Option is designed to be an IRS-qualified "High Deductible Health Plan (HDHP)" – enabling otherwise qualified employees to make contributions to a Health Savings Account (HSA).

Preventive Care

The Plan will cover the cost of Preventive Care as specified on the Plan's Schedule of Benefits. There is no deductible to meet. Please refer to Section 3.18 for those services that are Covered Preventive Care Services.

Plan Year Deductible

The Covered Person will be responsible for meeting the Plan Year Deductible amount before the Plan's health care coverage component is available.

Health Care Coverage

Once the Covered Person has met the Deductible, the Covered Person may access Covered Services under the health care coverage Component. You have the choice of using In-Network or Out-of-Network benefits for most benefits. All Covered Services received from Non Plan Providers will be covered under Out-of-Network benefits. All covered laboratory services received from Non Plan laboratories will be covered under Out-of-Network benefits. Covered Services received from Non Plan Providers while the Covered Person is receiving care at plan facilities will be covered under Out-of-Network benefits.

It is the Covered Person's responsibility to make sure the Pre-Authorization process is initiated and completed for those benefits requiring Pre-Authorization, regardless of the coverage chosen.

The following Schedule of Benefits is a brief outline of the benefits payable under the Plan. All benefits are subject to the definitions, conditions, limitations, exclusions, and provisions of the Plan set forth herein.

Regent University Health Plan
Optima Equity (HSA)
Schedule of Benefits

You have the choice of using In-Network or Out-of-Network benefits for most benefits. To use your In-Network benefits all covered services must be received from Plan Providers. All Covered Services received from Non-Plan Providers will be covered under Out-of-Network benefits. All covered laboratory services received from Non-Plan laboratories will be covered under Out-of-Network benefits. Covered Services received from Non-Plan Providers while a Covered Person is receiving care at plan facilities will be covered under Out-of-Network benefits.

	In-Network Coverage	*Out-of-Network Coverage*
Plan Lifetime Maximum	$2,000,000 combined for in-network and out-of network benefits.	
Deductible per Plan Year[2]	$1,500 – Employee Only coverage[2] $3,000 – for all Family coverages[2]	$1,500 – Employee Only coverage[2] $3,000 – for all Family coverages[2]
Maximum Out-of-Pocket Amount per Plan Year	$3,000 – for Employee Only coverage[3] $6,000 – for all Family coverages[3]	$6,000 – for Employee Only coverage[4] $12,000 – for all Family coverages[4]

OUTPATIENT PHYSICIAN SERVICES

Pre-Authorization is required for in-office surgery.[5]

	In-Network Coverage	*Out-of-Network Coverage*
Primary Care Physician (PCP) Office Visit	After Deductible covered at 80%[7]	After Deductible covered at 65%[AC]
Specialist Office Visit	After Deductible covered at 80%[7]	After Deductible covered at 65%[AC]

Preventive Care Visits	*In-Network Coverage*	*Out-of-Network Coverage*
Routine Annual Physical Exams **Well Baby Exams** **Annual Gyn Exams and Pap Smears** **PSA Tests** **Colorectal Cancer Tests** **Routine Adult and Childhood Immunizations** **Screening Colonoscopy** **Screening Mammograms** **Vaccines and Immunotherapeutic Agents** Preventive Care is not subject to the Plan's Deductible. Deductible and/or Coinsurance will apply to any diagnostic procedures performed during routine screenings.	Covered at 100%[7]	Covered at 65%[AC]

SHORT TERM OUTPATIENT THERAPY AND REHABILITATION SERVICES[5, 6]

Covered Services provided in a free-standing outpatient facility, hospital outpatient facility, a Physician's office, or in the Covered Person's home as part of Skilled Home Health Care Services benefit.

Outpatient Therapy Services	*In-Network Coverage*	*Out-of-Network Coverage*
Physical Therapy **Occupational Therapy** **Speech Therapy** **Pre-Authorization is required.**[5] Limited to a maximum combined benefit with In-Network and Out-of-Network benefits of 30 days per Plan Year. Day maximums are for all therapies combined.[6]	After Deductible covered at 80%[7]	After Deductible covered at 65%[AC]
Outpatient Rehabilitation Services	*In-Network Coverage*	*Out-of-Network Coverage*

Cardiac Rehabilitation **Pulmonary Rehabilitation** **Vascular Rehabilitation** **Vestibular Rehabilitation** **Pre-Authorization is required.**[5] Limited to a maximum combined benefit with In-Network and Out-of-Network benefits of 30 days per Plan Year. Day maximums are for all therapies combined.[6] Cardiac rehabilitation limited to 36 days maximum per Plan Year.[6]	After Deductible covered at 80%[7]	After Deductible covered at 65%[AC]

OTHER OUTPATIENT TREATMENTS[5, 6]

Covered Services provided in a free-standing outpatient facility, hospital outpatient facility, a Physician's office, or in the Covered Person's home as part of Skilled Home Health Care Services benefit.

Other Outpatient Treatments	*In-Network Coverage*	*Out-of-Network Coverage*
Chemotherapy **Radiation Therapy** **IV Therapy** **Inhalation Therapy** **Pre-Authorization is required for IV Therapy with medications and inhalation therapy.**[5]	After Deductible covered at 80%[7]	After Deductible covered at 65%[AC]

OUTPATIENT DIALYSIS SERVICES

	In-Network Coverage	*Out-of-Network Coverage*
Outpatient Dialysis Services	After Deductible covered at 80%[7]	After Deductible covered at 65%[AC]

OUTPATIENT SURGERY[5]

Services provided in a freestanding ambulatory surgery center or Hospital outpatient surgical facility.

	In-Network Coverage	*Out-of-Network Coverage*
Outpatient Surgery **Pre-Authorization is required.**[5]	After Deductible covered at 80%[7]	After Deductible covered at 65%[AC]

OUTPATIENT DIAGNOSTIC PROCEDURES[5]

Procedures performed in a free-standing outpatient facility or lab, or a hospital outpatient facility or lab.

	In-Network Coverage	*Out-of-Network Coverage*

Diagnostic Procedures **Pre-Authorization is required.[5]** **X-Ray** **Ultrasound** **Doppler Studies**	After Deductible covered at 80%[7]	After Deductible covered at 65%[AC]
Outpatient Lab Work	After Deductible covered at 80%[7]	After Deductible covered at 65%[AC]

OUTPATIENT ADVANCED IMAGING PROCEDURES

Covered Services provided in a free-standing outpatient facility, hospital outpatient facility or in a physician's office.

	In-Network Coverage	Out-of-Network Coverage
Pre-Authorization is required.[5] **Magnetic Resonance Imaging (MRI)** **Magnetic Resonance Angiography (MRA)** **Positron Emission Tomography (PET Scans)** **Computerized Axial Tomography (CT Scans)** **Computerized Axial Tomography Angiogram (CTA Scans)**	After Deductible covered at 80%[7]	After Deductible covered at 65%[AC]

MATERNITY CARE [5,9]

Coverage for any maternity related services for obstetrical, prenatal, perinatal, or post-partum care for a Dependent child is excluded from Coverage.

	In-Network Coverage	Out-of-Network Coverage
Maternity Care **Pre-Authorization required for prenatal services.** [5]	After Deductible covered at 80%[7]	After Deductible covered at 65%[AC]

INPATIENT SERVICES[5,6]

	In-Network Coverage	Out-of-Network Coverage
Inpatient Hospital Services **Pre-Authorization is required.**[5] **Transplants are covered at contracted facilities only.**	After Deductible covered at 80%[7]	After Deductible covered at 65%[AC]
Skilled Nursing Facilities/Services **Pre-Authorization is required.**[5] Following inpatient hospital care or in lieu of hospitalization. Covered Services include up to 90 days combined In- and Out-of-Network per Plan Year per illness or condition that in the Plan's judgment requires Skilled Nursing Facility Services. [6]	After Deductible covered at 80%[7]	After Deductible covered at 65%[AC]

AMBULANCE SERVICES [8]

For emergency transportation, or as Medically Necessary and Pre-Authorized by the Plan.

	In-Network Coverage	Out-of-Network Coverage

Ambulance Services **Pre-Authorization is required for use other than for emergency services.**	After Deductible covered at 80%[7]	After Deductible covered at 65%[AC]

EMERGENCY DEPARTMENT SERVICES [8]

Includes those Emergency Department facility, physician, and ancillary services that are rendered during an emergency visit.

	In-Network Coverage	*Out-of-Network Coverage*
Emergency Department Services **Pre-Authorization is not required.**	After Deductible covered at 80%[7] Benefit may be reduced for non-emergency use of facilities.	Same as In-Network Benefit

URGENT CARE CENTER SERVICES [8]

	In-Network Coverage	*Out-of-Network Coverage*
Urgent Care Center Services **Pre-Authorization is not required.** Includes urgent care center services, primary care and specialist physician services, and other ancillary services received at an Urgent Care center.	After Deductible covered at 80%[7]	After Deductible covered at 65%[AC] (for non-emergency services only)

MENTAL HEALTH CARE SERVICES

Includes inpatient and outpatient services for the treatment of mental health and biologically-based mental illnesses.

	In-Network Coverage	*Out-of-Network Coverage*
Inpatient Services **Pre-Authorization is required.[5]** Maximum benefit of 10 days per Plan Year Partial and residential care based on a ratio of 2:1	After Deductible covered at 80%[7]	After Deductible covered at 65%[AC]
Outpatient Services **Pre-Authorization is required for outpatient psychological testing.[5]** Maximum benefit of 30 visits per Plan Year	After Deductible covered at 80%[7]	After Deductible covered at 65%[AC]

OTHER COVERED SERVICES

	In-Network Coverage	Out-of-Network Coverage
Artificial Limb Services [5,6] **Pre-Authorization is required.** For adults 18 and over, artificial limbs, including repair and replacement, will be covered up to a $10,000 lifetime maximum. For children under age 18, artificial limbs, including repair and replacement, will be covered up to $10,000 per occurrence for a maximum of two occurrences.[6]	After Deductible covered at 80%[7]	After Deductible covered at 65%[AC]
Diabetic Supplies and Equipment Includes FDA-approved equipment and supplies for the treatment of diabetes, and in-person outpatient self-management training and education, including medical nutrition therapy. **Note**: Insulin, syringes, and needles are covered under the Plan's Prescription Drug Benefit for the applicable Coinsurance per 31-day supply. Diabetic equipment and supplies are covered when received from Plan Providers only. For convenience, a Covered Person may call Liberty Medical Supply at 1-866-691-9277 to arrange for supplies to be delivered to them at home.	After Deductible covered at 80%[7] for blood glucose monitoring equipment and supplies including home glucose monitors, lancets, blood glucose test strips, and insulin pump infusion sets. After Deductible covered at 100%[7] for insulin pumps. After Deductible covered at 100%[7] for outpatient self-management training and education, including medical nutritional therapy.	After Deductible covered at 65%[AC]
Chiropractic Care[6] **Administered by American Specialty Health Networks (ASHN)** To receive services, contact ASHN's Member Services at 1-800-678-9133. Representatives are available from 8 AM to 9 PM Monday-Friday. Maximum benefit of 30 visits per Plan Year. [6]	After Deductible covered at 80%[7]	Covered at 65%[AC] after deductible For providers not in the ASHN network the Covered Person will be responsible for payment of all charges in excess of ASHN's allowable charge in addition to any Coinsurance amount listed. Allowable charge is the lesser of the provider's actual charge or ASHN's in-network fee schedule for the same services.

OTHER COVERED SERVICES

	In-Network Coverage	Out-of-Network Coverage
Durable Medical Equipment (DME) and Supplies Covered Services include durable medical equipment, and repair and replacement. **Coverage is limited to $2,000 combined In-Network and Out-of-Network per Plan Year.[6]** **Pre-Authorization is required for single items over $750.[5]** **Pre-Authorization is required for all rental items.[5]** **Pre-Authorization is required for all repair and replacement.[5]**	After Deductible covered at 80%[7]	After Deductible covered at 65%[AC]
Orthopedic Devices and Prosthetic Appliances Covered Services include orthopedic devices, prosthetic appliances, colostomy, iliostomy, and tracheostomy supplies, and suction and urinary catheters, and repair and replacement. **Services are covered up to a maximum benefit of $3,500 per Plan Year[6].** **Pre-Authorization is required for single items over $750.[5]** **Pre-Authorization is required for all rental items.[5]** **Pre-Authorization is required for all repair and replacement.[5]**	After Deductible covered at 80%[7]	After Deductible covered at 65%[AC]
Early Intervention Services **Pre-Authorization is required.** Covered for Dependents from birth to age three who are certified as eligible by the Department of Mental Health, Mental Retardation and Substance Abuse Services. Covered Services include: Medically Necessary speech and language therapy, occupational therapy, physical therapy and assistive technology services and devices. **Coverage is limited to $5,000 per Plan Year.**	After Deductible covered at 80%[7]	After Deductible covered at 65%[AC]

OTHER COVERED SERVICES		
	In-Network Coverage	***Out-of-Network Coverage***
Home Health Care Skilled Services [5,6] **Pre-Authorization required** A Cover Person must be homebound and unable to receive services outside the home to receive care.	After Deductible covered at 80% [7] Maximum combined benefit with Out-of-Network benefit of 100 visits per Plan Year.	After Deductible covered at 65% [AC] Maximum combined benefit with In-Network benefits of 100 visits per Plan Year.
Hospice Care **Pre-Authorization is required.** [5]	After Deductible covered at 80% [7]	After Deductible covered at 65% [AC]
Reduction Mammoplasty **Pre-Authorization is required.** [5] Coinsurance will apply to all applicable services associated with Reduction Mammoplasty including but not limited to physician, facility, surgical, and/or diagnostic services. This does not include Reduction Mammoplasty procedures associated with reconstructive breast surgery following mastectomy.	After Deductible covered at 80% [7]	After Deductible covered at 65% [AC]

NOTES

The Covered Services herein are subject to the terms and conditions set forth in this Summary Plan Description.

1. Maximum benefits payable by the Plan.
2. Deductible means the dollar amount of covered medical expenses for which a Covered Person is responsible each Plan Year before benefits are payable by the Plan. If a Covered Person has Employee Only coverage he or she must satisfy the individual Employee Only deductible before coverage begins. If an Employee and his or her dependents have family coverage (Employee and Spouse, Employee and Child(ren), or Employee and Family) they must satisfy the Family Deductible. This Plan has an Aggregate Family Deductible when dependents are covered. This means that once the total Family Deductible is met, benefits are available for all covered family members, and the Family Deductible can be satisfied by any one or more of the covered family members. The Plan has separate individual and family deductibles for In-Network services and for Out-of-Network services. Deductible amounts are not be reimbursed by the Plan. The Deductible does not apply to Preventive Care Services. Amounts applied to an In-Network Deductible will only apply toward the Plan's In-Network maximum Out of Pocket amount. Amounts applied to an Out-of-Network Deductible will only apply toward the Plan's Out-of-Network maximum Out of Pocket amount.
3. The total maximum amount an Employee and/or Dependents will pay during a Plan Year for covered In-Network Services. The In-Network Deductible will apply toward the In-Network Out-Of-Pocket Maximum. Copayments or Coinsurance amounts which a Covered Person is required to pay for failure to comply with the Plan's Pre-Authorization and Utilization Management procedures do not count toward the In-Network Out-Of-Pocket Maximum and must continue to be paid after the Maximum has been met. The Out-Of-Network Deductible does not apply toward the In-Network Out-Of-Pocket Maximum. Coinsurance for Out-Of-Network Covered Services do not count toward the In-Network Out-Of-Pocket Maximum.
4. The total maximum amount an Employee and/or Dependents will pay during a Plan Year for covered Out-of-Network Services. The Out-Of-Network Deductible will apply toward the Out-Of-Network Out-Of-Pocket Maximum. Copayments or Coinsurance or amounts which a Covered Person is required to pay for failure to comply with the Plan's Pre-Authorization and Utilization Management procedures, or amounts which are in excess of the Plan's Allowable Charge do not count toward the Out-Of-Network Out-Of-Pocket Maximum and must continue to be paid after the Maximum has been met. The In-Network Deductible does not apply toward the Out-Of-Network Out-Of-Pocket Maximum. Coinsurance for In-Network Covered Services does not count toward the Out-Of-Network Out-Of-Pocket Maximum.
5. Pre-Authorization is required. A Covered Person's benefits under the Plan will be reduced, after any deductible amount, if he/she does not comply with the Plan's pre-authorization procedures. Details concerning the Plan's pre-authorization procedures, including possible benefit reductions for not following the requirements, are provided in this Summary Plan Description.
6. Maximum amounts are combined maximums of both In-Network and Out-Of Network Covered Services unless otherwise indicated. Amounts in excess of a benefit dollar limit and/or visit limit as stated in the Schedule of Benefits are excluded from Coverage.
7. Benefits are payable at the percent specified of the Plan's fee schedule.
8. All Emergency, Urgent Care, Ambulance and Emergency Mental Health Services may be subject to Retrospective Review to determine the Plan's responsibility for payment. If the Plan determines that the condition treated was not an emergency, the benefit will be reduced as specified in this Schedule of Benefits. Covered Persons who receive Emergency services from Non-Plan Providers may be responsible for charges in excess of what would have been paid had the emergency care been received from Plan Providers. In no event will the Plan be responsible for payment for services from Non-Plan Providers where the service would not have been covered had the Cover Person received care from a Plan Provider.
9. Coverage for obstetrical services as an inpatient in a general hospital or obstetrical services by a physician shall provide such benefits with durational limits, deductibles, and coinsurance percentages that are no less favorable than for physical illness generally.

AC Benefits for Covered Services performed by any provider who is not a Plan Provider will be based on either a negotiated or agreed upon reimbursement or on an allowable charge which is the lesser of the provider's actual charge or the Plan's in-network fee schedule for the same service performed by the same type of provider. The Covered Person will be responsible for payment of all charges in excess of the Plan's allowable charge in addition to any Deductible and Coinsurance amounts he/she is required to pay. Charges from non-Plan providers will generally exceed the Plan's Allowable Charge.

Regent University Health Plan
Optima Equity (HSA)
Prescription Drug Benefits

Subject to the conditions and limitations set forth herein (See Section IV, Outpatient Prescription Drugs), Covered Persons are entitled to receive Outpatient Prescription Drugs from a participating pharmacy or from a non-participating pharmacy that has agreed to accept as payment in full reimbursement from the Plan at the same level as the Plan gives to participating pharmacies. Recommendations on drug coverage are made by the Pharmacy and Therapeutics Committee composed of physicians and pharmacists. Selected drugs may require your physician to obtain Pre-Authorization from the Plan in order to be covered. The Pharmacy and Therapeutics Committee may establish monthly quantity limits for selected medications.

Deductibles

Covered Persons will responsible for meeting all applicable individual member or family medical deductibles as specified in the Schedule of Benefits.

Coinsurance

A Covered Person may receive up to a consecutive 31-day supply of a covered outpatient prescription drug at a retail pharmacy.

After Deductible Covered at 70%*

PLEASE NOTE: Prescription medications used to prevent any of the following medical conditions are **not** subject to the Plan Deductible.

Hypertension, high cholesterol, diabetes, asthma, osteoporosis, stroke, prenatal nutrient deficiency: Covered at 70%*, not subject to deductible.

*Benefits are payable at the percent specified of the Plan's fee schedule

SECTION I - DEFINITIONS

For purposes of this Summary Plan Description and any enrollment application, questionnaire, form or other document provided or executed in connection with coverage under this document, the following terms shall have the meanings given them in this Section unless the context requires otherwise:

1.1 **ACCIDENT/INJURY** means physical damage to a Covered Person's body caused by an unexpected event or trauma, independent of all other causes. Only a non-occupational Injury (i.e., one which does not arise out of or in the course of any work for pay or profit) is considered for benefits under the Plan.

1.2 **ADMISSION** means registration as a patient at a Hospital. For purposes of determining the applicability of deductibles and copayments, successive inpatient admissions for the same or a related cause will be considered one admission unless separated by a period of at least 30 days. In the case of inpatient admissions for mental health or substance abuse services, successive inpatient admissions for the same or related cause will also be considered one admission unless separated by a period of at least 30 days.

1.3 **ADVERSE BENEFIT DETERMINATION** means a denial, reduction, or termination of , or a failure to make payment (in whole or in part) for , a benefit based on a Covered Person's eligibility to participate in the Plan, a Utilization Management decision, or failure to cover an item or service because the Plan considers it to be experimental, investigational, or not medically necessary.

1.4 **ALLOWABLE CHARGE** means benefits for Covered Services performed by a provider who is not a Plan Provider will be based on either a contractually agreed upon reimbursement or on an allowable charge which is the lesser of the provider's actual charge or the In-Network fee schedule for the same service performed by the same type of provider. The Covered Person will be responsible for payment of all charges in excess of the Allowable Charge in addition to any Deductible or Coinsurance amounts he/she is required to pay. Charges from Non-Plan Providers will generally exceed the Allowable Charge.

1.5 **CASE MANAGEMENT** means individual review and follow-up for ongoing specialized services.

1.6 **CLAIM** means a request for a Plan benefit or benefits made by a claimant in accordance with the Plan's reasonable procedure for filing claims.

1.7 **CLAIMANT** means a Covered Person or person authorized to act on his/her behalf in filing a request for Plan benefits.

1.8 **COBRA** means the Consolidated Omnibus Budget Reconciliation Act of 1985, Public Law No. 99-272, and any subsequent amendments thereto. COBRA provisions apply to groups of more than 20 employees.

1.9 **COINSURANCE** means amounts required to be paid by the Covered Person for certain services covered under this Plan. Coinsurance may be required to be paid to the provider of the service at the time service is received.

1.10 **CONCURRENT CARE CLAIM/DECISION** means a claim regarding a decision by the Plan to terminate or reduce benefits that it previously approved. Concurrent Claim also may be a request to extend the course of treatment already approved by the Plan.

1.11 **CONCURRENT REVIEW** means ongoing medical review of the Covered Person's care while hospitalized.

1.12 **COORDINATION OF BENEFITS** means those provisions of this Plan by which the Plan Provider or the

Plan either together or separately seek to recover costs of health care services provided to a Covered Person in connection with an incident of sickness or Accident, which may be covered by another group insurer, group service plan, or group health care plan, including coverage provided under governmental programs subject to any limitations imposed by this Plan.

1.13 COVERAGE means the right of the Covered Person to receive those health care benefits of the Plan he or she has chosen, as set forth herein.

1.14 COVERED PERSON means the Employee, and his/her Dependent(s) as defined in Section II, who meet the eligibility requirements of the Plan Sponsor, and who are enrolled hereunder.

1.15 COVERED SERVICES means those health services and benefits to which Covered Persons are entitled under the terms of this Plan which may be amended by the Plan Sponsor from time to time, and which are rendered while the Covered Person is under the direct care of a Physician.

1.16 CUSTODIAL CARE means treatment or services which could be rendered safely and reasonably by a person not medically skilled, regardless of who recommends them and where they are provided, and which are designed mainly to help the patient with daily living activities. Such activities include, but are not limited to:

- help in walking, getting in and out of bed, bathing, eating by spoon, tube or gastrostomy, exercising, dressing;
- preparing meals or special diets;
- moving the patient;
- acting as a companion or sitter; and
- supervising medication which can usually be self-administered.

"Custodial Care" includes the following care: (1) the provision of room and board, nursing care, or such other care which is provided to an individual who is mentally or physically disabled and who, per the attending Physician, has reached the maximum level of recovery; and (2) in the case of institutionalized person, room and board, nursing care or such other care which is provided to an individual for whom it cannot reasonably be expected that medical or surgical treatment will enable him to live outside an institution; and (3) rest cures, respite care and home care provided by family members. The Plan or its designee will determine if a service or treatment is Custodial Care.

1.17 DEDUCTIBLE means the means the dollar amount which a Covered Person is responsible to pay before benefits are payable under the Plan for Covered Services. Such amount will not be reimbursed under the Plan. After any applicable Deductible amount has been paid, benefits for Covered Services will be payable in accordance with the Coinsurance rates shown on the Schedule of Benefits.

1.18 DEPENDENT(S) means those Covered Persons of the Employee's family who meet the eligibility requirements of the Plan set forth in Section 2.1(B) and have been enrolled in the Plan by the Employee, and for whom any required contribution have been received by the Plan. A child shall not be eligible as a Dependent of more than one Employee under the Plan.

1.19 DIAGNOSTIC SERVICES means services ordered by a provider because of specific symptoms, to diagnose a definite condition or disease. Diagnostic Services include, but are not limited to: a) radiology, ultrasound, nuclear medicine, computer axial tomography (CT scan), and magnetic resonance imaging (MRI); b) laboratory and pathology; and c) EKGs, EEGs, and other electronic diagnostic tests. Diagnostic services do not include procedures ordered as part of a routine or periodic physical examination.

1.20 DRUG FORMULARY means a listing of prescription medications which are approved for coverage by the Plan subject to the Plan's established procedure, when dispensed by Plan Pharmacies to a Covered Person. When designated by the Plan, a generic equivalent shall be dispensed. The Drug Formulary shall be subject to periodic review and modification by the Plan.

1.21 DURABLE MEDICAL EQUIPMENT (DME) means equipment which is a) able to withstand repeated use; b) primarily and customarily used to serve a medical purpose; and c) not generally useful to a person in the absence of an illness or injury. Durable Medical Equipment includes, but is not limited to, renal dialysis equipment, hospital type beds, traction equipment, wheelchairs and walkers.

1.22 ENROLLMENT APPLICATION means an application furnished or approved by the Plan, executed by a person meeting the eligibility requirements of a Covered Person, pursuant to which such person applies on his or her own behalf and/or on behalf of eligible Dependents for coverage under the Plan.

1.23 EMERGENCY SERVICES means those health care services provided after the onset of an "Emergency" which is a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine to result in (a) serious jeopardy to the mental or physical health of the individual, or (b) danger of serious impairment of the individual's bodily functions, or (c) serious dysfunction of any of the individual's bodily organs, or (d) in the case of a pregnant woman, serious jeopardy to the health of the fetus. Examples of Emergencies include, but are not limited to, heart attacks, severe chest pain, cardiovascular accidents, hemorrhaging, poisonings, major burns, loss of consciousness, serious breathing difficulties, spinal injuries, shock, and other acute conditions as the Plan shall determine. All Emergency Services are subject to Retrospective Review.

1.24 EMPLOYEE means a person who meets all applicable eligibility requirements of Section 2.1(A), and whose enrollment form has been accepted by the Plan in accordance with the enrollment requirements of the Plan Document, and whose employee contribution, if any, has been received by the Plan.

1.25 EXPERIMENTAL/INVESTIGATIONAL. A drug, device, medical treatment or procedure may be considered experimental/investigational if:

- **A.** the majority of the medical community does not support the use of this drug, device, medical treatment or procedure; or
- **B.** the use of this drug, device, medical treatment or procedure may have been shown to be unsafe and/or of no or questionable use as reported by current scientific literature and/or regulatory agencies; or
- **C.** the research regarding this drug, device, medical treatment or procedure may be so limited than an evaluation of safety and efficacy can not be made; or
- **D.** the drug or device is not approved for marketing by the Food and Drug Administration (FDA); or
- **E.** the drug, device , or medical treatment is approved as Category B Non-experimental/Investigational by the FDA; or
- **F.** the drug, device, medical treatment or procedure is:
  - **1.** currently under study in a Phase I or II clinical trial or
  - **2.** an experimental study/investigational arm of a Phase III clinical study or
  - **3.** otherwise under study to determine safety and efficacy/compare its safety and efficacy to current standards of care.

1.26 HOME HEALTH CARE AGENCY means an agency or organization, or subdivision thereof, which:

- is primarily engaged in providing skilled nursing services and other therapeutic services in the patient's home;
- is duly licensed, if required, by the appropriate licensing facility;
- has policies established by a professional group associated with the agency or organization, including at least one physician and one registered graduate nurse (R.N.) to govern the services provided;
- provides full-time supervision of such services by a Physician or by a R.N.;
- maintains a complete medical record on each patient; and
- has a full-time administrator.

1.27 HOME HEALTH CARE PLAN means a program:

- for the care and treatment of the Covered Person in his or her home;

- established and approved in writing by his or her attending Physician;
- certified, by the attending Physician, as required for the proper treatment of the injury or illness, and
- in place of inpatient treatment in a Hospital or in a Skilled Nursing Facility.

1.28 HOME HEALTH SERVICES shall mean part-time or intermittent care or service provided by a Home Health Care Agency. Such services shall consist primarily of medical or therapeutic caring for the patient and shall provide for the care and treatment of the Covered Person in his or her home under a Home Health Care Plan.

1.29 HOSPICE SERVICES means a coordinated program of home and inpatient care including palliative and supportive physical, psychological, psychosocial and other Covered Services to individuals with a terminal illness, whose medical prognosis is death within six months.

1.30 HOSPITAL means an institution which:

- is accredited under one of the programs of the Joint Commission on Accreditation of Health Care Organizations; or
- is licensed as a hospital under the laws of the jurisdiction where it is located;
- is primarily engaged in providing, for pay and on its own premises, inpatient care and treatment of sick and injured persons through medical, diagnostic and major surgical facilities;
- provides 24-hour nursing service rendered or supervised by a an R.N.; and
- has facilities on its premises for major surgery (or a written contractual agreement with an accredited hospital for the performance of surgery).

"Hospital" does not include a facility, or part thereof, which is principally used as: a rest or custodial care facility, nursing facility, convalescent facility, extended care facility, or facility for the aged or for the care and treatment of drug addicts or alcoholics, unless specifically provided in the Plan and/or as mandated by state or Federal law. It does not mean any institution in which the Covered Person receives treatment for which he or she is not required to pay.

1.31 ILLNESS means a bodily disorder or infirmity that is not work-related, or a pregnancy. Only a non-occupational Illness (i.e., one that does not arise out of or in the course of work for pay or profit) is considered for benefits under the Plan.

1.32 IN-NETWORK SERVICES means the level of benefits a Covered Person uses when he or she seeks Covered Services from a Plan Provider.

1.33 INFERTILITY means that the Covered Person is unable to conceive or produce conception after one year of unprotected intercourse; or if older than age 35 the Covered Person is unable to conceive or produce conception after six months of unprotected intercourse; and/or in either of the above situations the Covered Person is unable to carry the fetus to term (e.g., three or more consecutive spontaneous miscarriages prior to 20 weeks gestational age).

1.34 MAXIMUM BENEFIT AMOUNT means the total amount of medical benefits payable at any time under this Plan.

1.35 MEDICAL DIRECTOR means a duly licensed Physician or his/her designee who has been appointed by the Plan to monitor the quality and delivery of health care to Covered Persons in accordance with the Plan Document and the accepted medical standards of the community.

1.36 MEDICALLY NECESSARY SERVICES AND/OR SUPPLIES means services or supplies as provided by a Hospital, Skilled Nursing Facility, Physician or other provider required to identify or treat a Covered Person's Illness or Injury and which, as determined by the Covered Person's Physician and the Plan, are: (1) consistent with the symptoms, diagnosis and treatment of the Covered Person's condition, disease, ailment or injury; (2) in

accordance with recognized standards of care for the Covered Person's disease, ailment or injury; (3) appropriate with regard to standards of good medical practice; (4) not solely for the convenience of the Covered Person, his or her Physician, Hospital, or other health care provider; and (5) the most appropriate supply or level of service which can be safely provided to the Covered Person. When specifically applied to an inpatient, it further means that the Covered Person's medical symptoms or condition requires that the diagnosis, treatment or service cannot be safely provided to the Covered Person as an outpatient.

1.37 **MEDICARE** means Title XVII of the Act and all amendments thereto.

1.38 **NON-PLAN PROVIDER** means any provider that is not a Plan Provider.

1.39 **OPEN ENROLLMENT PERIOD** means a period of time occurring at least once annually during which time any eligible Employee may join or transfer from once type of health care plan to another.

1.40 **OUT-OF-NETWORK SERVICES** means the level of benefits a Covered Person uses when he or she receives Covered Services from Non-Plan Providers.

1.41 **OUT-OF-POCKET MAXIMUM** means the total maximum amount a Covered Person pays during a Plan Year as described in the Schedule of Benefits.

1.42 **PHYSICIAN** means, a doctor of medicine or osteopathy who is duly licensed under the laws of the state where the health care service is rendered, is qualified to perform the particular medical or surgical service for which claim is made and who is practicing within the scope of such certification or licensure.

"Physician" does not include (1) an intern; or (2) a person in training.

1.43 **PLAN** means The Regent University Health Plan which arranges to provide to Covered Persons the health care benefits that are set forth herein.

1.44 **PLAN ADMINISTRATOR** means the individual or entity identified above who is responsible for the operation of the Plan.

1.45 **PLAN DOCUMENT** means this document issued by the Plan to Covered Persons, which describes the terms and conditions of the health care benefits provided by the Plan.

1.46 **PLAN PHARMACY** means a pharmacy which is licensed by the State and is under contract to provide covered prescription drugs to Covered Persons.

1.47 **PLAN PROVIDER** means a Physician, Hospital, Skilled Nursing Facility, laboratory, urgent care center, or any other duly licensed institution or health professional under contract to provide professional and hospital services to Covered Persons. A list of Plan Providers and their locations is available to each Employee upon enrollment or upon request. Such list shall be revised from time to time as necessary. A Plan Provider's contract may terminate, and a Covered Person may be required to utilize another Plan Provider. (See also **1.60 SERVICE AREA** below.)

1.48 **PLAN SPONSOR/COMPANY** means the employer, employee organization or other entity that established and maintains the Plan.

1.49 **POST-SERVICE CLAIM** means any Claim for a benefit under the Plan that is not a Pre-Service Claim.

1.50 **PRE-AUTHORIZATION** means an evaluation process which assesses the Medical Necessity of proposed

treatment to determine that the treatment is being provided at the appropriate level of care.

1.51 PRE-SERVICE CLAIM means any Claim for a benefit under the Plan for which the Plan requires approval before the Covered Person obtains medical care.

1.52 RETROSPECTIVE REVIEW means the review of the Covered Person's medical records and other supporting documentation by the Plan after services have been rendered to determine whether such services are Covered Services.

1.53 SENTARA (SHP) means Sentara Health Plans, Inc., which has been contracted by the Plan Sponsor to arrange and coordinate access to health benefits for Covered Persons of the Plan as set forth in the Plan Document.

1.54 SERVICE AREA means the geographic area within which the Plan shall arrange for the provision of Covered Services through Plan Providers. Services from Sentara/Optima Health Plan Providers are available only in the following cities and counties:
Counties – Accomack, Amelia, Brunswick, Caroline, Charles City, Chesterfield, Cumberland, Dinwiddie, Essex, Fluvanna, Gloucester, Goochland, Greensville, Hanover, Henrico, Isle of Wight, James City, King & Queen, King William, Lancaster, Louisa, Lunenburg, Mathews, Mecklenburg, Middlesex, New Kent, Northampton, Northumberland, Nottoway, Powhatan, Prince Edward, Prince George, Richmond, Southampton, Surry, Sussex, Westmoreland, York.
Cities – Chesapeake, Colonial Heights, Emporia, Farmville, Franklin, Hampton, Hopewell, Newport News, Norfolk, Petersburg, Portsmouth, Poqouson, Richmond, Suffolk, Virginia Beach, Williamsburg.

Provider Access for Virginia Residents in the Sentara/Optima Health Service Area

Please go to www.optimahealth.com, click on "Members" and near the center of the next page click on "Find a doctor", and fill in the answers to the self explanatory questions about the provider you are seeking. If you are looking for a facility for services such as diagnostic testing or blood work, continue down the same page and near the bottom, click on "Find a facility or Healthcare Service" which is underlined in blue. This facility page will look just like the "Find a Doctor" page with self explanatory identifying questions.

Provider Access for Residents Outside of Virginia or Traveling Outside of Virginia

In order to serve the needs of employees and family members living or traveling outside of the Sentara/Optima Health service area, the Plan Provider network has been expanded to include Private Healthcare Systems (PHCS). PHCS providers can be accessed by visiting www.phcs.com or by calling 1-888-817-7427. The extended provider network through PHCS can only be utilized for providers located outside of the Optima Health Service Area.

If you choose to search providers at www.phcs.com you will see "Multiplan" and "PHCS" at the top of the screen. Multiplan is another provider network that manages both PHCS and Multiplan. Click on the underlined, dark blue section "I'm a client looking for the PHCS Customer Access website". Click in the upper right hand corner where you see a magnifying glass in the green section showing "Search for a Doctor or Facility". This screen shows various PHCS logos. Please choose the PHCS logo that is identified on your Optima Health member identification card on the front, lower right corner.

Click "continue". From this screen click either "doctor" or "facility", then click "continue" again. Complete the answers to the self explanatory questions about the provider you are seeking. Click "continue" to see final screen giving you provider names, addresses, and telephone numbers. If there are no matches, try again by expanding your mile radius. When choosing a provider from the website it is recommended that you contact the provider to make sure the provider is still participating with PHCS before you make an appointment.

Please note that if a participating provider or facility is notated on the website with an "**" contact PHCS to ensure that this provider is not excluded from Optima Health's extended network.

Should you have any questions, please contact Member Services at 1-800-543-3359. This number is also listed on the back of your ID card.

1.55 SHORT-TERM THERAPY is defined as inpatient and/or outpatient services which, in the judgment of the Plan, can be expected to result in significant improvement of a specific bodily function lost or impaired due to an Injury or Illness in a period of ninety (90) days or less. If therapy is determined to be short-term, based upon diagnosis, coverage will be provided for up to ninety (90) consecutive days from the start of treatment per Injury or Illness as long as rehabilitative or therapeutic progress is demonstrated as determined by a Plan Physician. Short-term speech therapy is covered only to the extent of restoration to the level of the pre-trauma, pre-illness or pre-condition speech function, or following surgery to correct a congenital defect (if such surgery was performed while a Covered Person). Therapy for delayed or abnormal speech pathology is not covered.

1.56 SKILLED NURSING FACILITY means an institution which is licensed by the State and is accredited under one of the programs of the Joint Commission on Accreditation of Healthcare Organizations as a Skilled Nursing Facility; or is recognized by Medicare as an extended care facility; and furnishes room and board and 24-hour-a-day skilled nursing care by, or under the supervision of, an R.N.; and, other than incidentally, is not a clinic, a rest facility, a home for the aged, a place for drug addicts or alcoholics, or a place for custodial care.

1.57 URGENT CARE CLAIM means any Claim for medical care or treatment where (1) if the Plan were to use its normal Pre-Service standards for making a coverage decision or a decision on appeal it would seriously jeopardize the life or health of the Covered Person or the ability of the Covered Person to regain maximum function; or (2) in the opinion of a physician with knowledge of the Covered Person's medical condition, following the Plan's normal appeal procedure would subject the Covered Person to sever pain that cannot be adequately managed without the care or treatment that is the subject of the Claim. A prudent layperson standard applies when determining what is an urgent care claim, except where a physician with knowledge of the Covered Person's medical condition determines that the claim is urgent.

1.58 URGENT CARE SERVICES means those outpatient Covered Services which are Medically Necessary in order to prevent a serious deterioration of the Covered Person's health that results from an unforeseen non-life threatening Illness or Injury. Urgent Care Services are subject to Retrospective Review.

1.59 USUAL AND CUSTOMARY CHARGES means the lower of the rate which a Provider usually charges for furnishing a treatment, service or supply; or the charge determined to be the general rate charged by others who render or furnish such treatments, services or supplies to persons: (1) who reside in the same area; and (2) whose injury or illness is comparable in nature and severity. When applied to a Plan Provider, "Usual and Customary Charges" means the compensation agreed to by the Plan Provider in its contract with respect to Covered Persons. Usual and Customary Charges shall be determined by the Plan.

1.60 YOU/YOUR means the Covered Person.

SECTION II - ELIGIBILITY, ENROLLMENT, AND EFFECTIVE DATE

2.1 ELIGIBILITY FOR COVERAGE

Eligibility for benefits under this Plan Document is to be determined by the Plan Sponsor in accordance with the terms herein. A person may not be eligible for benefits under this Plan Document unless he/she is:

A. Employees. Employees shall be eligible for benefits if employed by the University on a regular full-time basis, are actively at work at least thirty (30) hours per week, or are a phased retiree age 60 with at least 10 years of service.

Coverage for Employees is effective on the first day of the month coinciding with or next following the date of employment, provided that a completed enrollment application has been received by the Plan from the Employee or on the Employee's behalf.

If an eligible employee is no longer actively at work because of one of the following circumstances, and the group's coverage remains in effect, coverage may continue if premiums are being paid on the employee's behalf:

1. For an approved short term leave of absence coverage will continue for not longer than 3 months.

Coverage may be retained if Employee continues to pay premium contributions.

2. For an employee who is totally disabled, coverage will continue for a period of not longer than 6 months. The Plan may require certification of disability from the employee.

Coverage may be retained if Employee continues to pay premium contributions.

3. The Family and Medical Leave Act (FMLA). FMLA requires employers of 50 or more employees to give up to 12 weeks of unpaid, job-protected leave to eligible employees for the birth, or adoption of a child or for the serious illness of the employee or a spouse, child or parent.

Coverage may be retained if Employee continues to pay premium contributions.

4. The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). According to USERRA any employee called to Active Duty can continue the health care coverage they have for themselves and/or any family members covered under the Plan for up to 24 months.

Coverage may be retained if Employee continues to pay premium contributions.

B. Dependents. Dependents must be chiefly dependent upon the Employee for support. To be eligible for coverage as a Dependent, a person must be:

1. An Employee's lawful spouse;

2. Any unmarried child (including step-child, legally adopted child, child placed for adoption, as well as natural child) of the Employee, who is under age nineteen (19), who is chiefly dependent upon the Employee for support. "Placed for adoption" means the assumption and retention by the Employee of a legal obligation for total or partial support of such child in anticipation of adoption of such child. The child's placement with the Employee terminates upon the termination of such legal obligation. "Chiefly dependent" means: (a) living with the employee for more than one-half of the Calendar Year; and (b) providing less than one-half of his/her own support. A Dependent shall also include a child for whom the Employee is a court appointed legal guardian, provided proof of such guardianship is

submitted with the prospective Dependent's enrollment form and provided the above criteria are satisfied. Coverage for Dependents will continue until the end of the Calendar Year in which they turn 19.

3. Any such unmarried child as defined in subsection (2) above, who is between nineteen (19) and twenty-three (23), provided the child is a full-time student in an accredited educational institution. Upon the request of the Plan, the Employee agrees to provide proof of full-time student status. The Employee must notify the Plan when a Dependent is no longer a full-time student. If a Dependent is no longer a full-time student, and proper notice is not provided, the Plan shall have the right to retroactively terminate Coverage on the date full-time student status ceased and to recover an amount equal to the Usual and Customary Charge for services provided to the ineligible person following the date full-time student status ceased. Coverage for full-time student Dependents will continue until the end of the calendar month in which they turn 23.

4. Coverage will continue for Dependents currently enrolled in the Plan who are nineteen (19) years or older but incapable of self-sustaining support because of mental retardation or physical handicap and is dependent upon the Employee for support and maintenance. A subsequent recertification may be required by the Plan, but not more frequently than annually following the Dependent's twenty-first birthday. Such certification is subject to review and approval by the Plan and consists of a statement by a licensed psychologist, psychiatrist, or other Physician to the effect that such Dependent is incapable of self-sustaining employment by reason of mental retardation or physical handicap. The Plan uses Social Security's definition for "disability" in determining eligibility under this subsection (4). Thus, a Covered Person will be considered disabled if he or she is unable to perform any gainful work found in the national economy. The Covered Person's inability to work is also expected to last for at least a year or to result in death. If for any reason, voluntary or involuntary, the Employee disenrolls, and the incapacitated Dependent reaches the limiting age during the period of disenrollment, then the incapacitated Dependent is no longer eligible upon re-enrollment of the Employee.

5. Coverage for a newborn child of an Employee will begin at birth if the newborn is added to the Employee's coverage within thirty-one (31) days of birth. The Employee must submit a completed enrollment form for the newborn and the full applicable contribution, if any, for the month in which the child is born. If an enrollment application and applicable fees are not submitted within thirty-one (31) days of birth, the newborn may not be enrolled until the Plan's next Open Enrollment Period, subject to Section 2.2(E) below.

6. If a Qualified Medical Child Support Order (QMCSO), as defined by federal law, is issued for your child, coverage will begin on the effective date of the court order if the request is made and an enrollment application is submitted within thirty-one (31) days of the order. A Qualified Medical Child Support Order is a judgment, decree or order (including approval of a settlement agreement) or administrative notice, which is issued pursuant to a state domestic relations law (including a community property law), or to an administrative process, which provides for child support or provides for health benefit coverage to such child and relates to benefits under the group health plan, and satisfies all of the following: 1. the order recognizes or creates a child's right to receive group health benefits for which a participant or beneficiary is eligible; 2. the order specifies your name and last known address, and the child's name and last known address, except that the name and address of an official of a state or political subdivision may be substituted for the child's mailing address; 3. the order provides a description of the coverage to be provided, or the manner in which the type of coverage is to be determined; 4. the order states the period to which it applies; and 5. if the order is a National Medical Support Notice completed in accordance with the Child Support Performance and Incentive Act of 1998, such Notice meets the requirements above. The QMCSO may not require the health insurance policy to provide coverage for any type or form of benefit or option not otherwise provided under the policy, except that an order may require a plan to comply with State laws regarding health care coverage. Any payment of benefits in reimbursement for Covered Expenses paid by the child, or the

child's custodial parent or legal guardian, shall be made to the child, the child's custodial parent or legal guardian, or a state official whose name and address have been substituted for the name and address of the child.

C. **Changes in Eligibility.** It is the Employee's responsibility to notify the Plan of any change (i.e., Dependent loses full-time student status; divorce) in the eligibility status of himself/herself or of a Dependent

1. Verification of Eligibility. It is the responsibility of the Employee to verify the eligibility of the Employee and any Dependents enrolled in the Plan or applying for coverage under the Plan. The Plan reserves the right to request or review at any time, at its sole and absolute discretion, proof of eligibility of any Employee or Dependent. Should the Plan discover at any time that any Employee or Dependent is not eligible for coverage, never was eligible for coverage, and/or submitted false proof of eligibility for coverage, then the Employee's/Dependent's coverage may be canceled. Disenrollment of an Employee or Dependent due to ineligibility for coverage may result in the reversal and/or denial of claims during the period of ineligibility. The Employee/Dependent may be held responsible for any charges for claims for services during the period of ineligibility.

2. Changes in Eligibility. It is the Employee's responsibility to notify the Plan of any change in the eligibility status of himself/herself or a Dependent. Coverage for Dependent children ends when a Dependent child reaches the limiting age as specified in this document. Coverage for full-time students ends the last day of the month in which the student reaches the limiting age as specified in this document, or the last day of the month in which they stop going to school full-time, whichever occurs first. If the Employee fails to notify the Plan of such changes, upon learning of the change in eligibility the Plan will retroactively terminate Coverage on the last day of the month in which eligible status ceased. The Plan may also seek to recover the usual and customary charge for services provided following such date. The Employee must notify the Plan of a divorce so that the Employee's spouse may exercise COBRA rights, if applicable. Disenrollment of an Employee or Dependent due to ineligibility for coverage may result in the reversal and/or denial of claims during the period of ineligibility. The Employee/Dependent may be held responsible for any charges for claims for services during the period of ineligibility.

D. **Permissible Family Status Changes.** You may make a change in the coverage of Dependents between Open Enrollment Periods under certain circumstances. You are not permitted to change to another Plan or to drop any other benefit in force. Subject to Section 2.2(E), You may only change coverage with respect to your Dependents if one of the following events occurs:

1. Change in legal marital status including marriage, death of spouse, divorce, legal separation, and annulment;
2. Change in number of dependents including birth, death, adoption, placement for adoption or court appointed legal guardianship;
3. Change in employment status, including a change in worksite; a switch between hourly and salaried status, and any other employment status change resulting in a gain or loss of eligibility of the employee, spouse, or dependent;
4. Change in dependent's eligibility for coverage;
5. Change in residence of employee, spouse, or dependent that affects eligibility.

In order for one of these events to qualify as an occasion for changing your coverage under the Plan, it must have a direct effect on your present coverage. For example, marriage is a permissible reason to change from Employee Only coverage to Family coverage. On the other hand, the death of a child has no effect on your coverage, if you had a spouse and another child and Family coverage is in effect. All modifications due to a Permissible Family Status Change must be submitted to the Plan Administrator within 31 days of the event.

2.2 ENROLLMENT

A. Initial Enrollment. During the initial Plan Open Enrollment Period, each eligible Employee shall be entitled to apply for coverage for himself or herself and for eligible Dependents who must be listed on the enrollment form provided by the Plan.

B. Newly Eligible Employee. Each new Employee entering employment after the Plan's initial effective date shall be permitted to apply for coverage for himself or herself and eligible Dependents, within thirty-one (31) days of becoming eligible.

C. Newly Eligible Dependents. Any person attaining eligibility to become a Dependent may be enrolled by the Employee by completing and submitting to the Plan a signed change of enrollment request form within thirty-one (31) days of the Dependent's attaining eligibility.

D. Plan Open Enrollment. A Plan Open Enrollment Period shall be held at least once annually at which time eligible Employees and their eligible Dependents may enroll under the Plan.

E. HIPAA Special Enrollment Provisions.

The Plan shall provide special late enrollment periods during which eligible, but non-erolled Employees or Dependents, may enroll under the Plan. To be eligible to enroll during a special enrollment period Employees and Dependents must fall into the following categories:

1. **Late enrollees with other coverage.** Employees or Dependents who initially decline coverage because they have other health insurance will be allowed to enroll late without evidence of insurability if the following conditions are met:
   a) The Employee and/or Dependent must be eligible under the Plan’s terms; and
   b) The Employee or Dependent was covered under a group plan or had insurance when coverage was previously offered to that person; and
   c) The employee stated in writing at the time coverage was previously offered that another source of coverage was the reason for declining coverage. This paragraph (c) shall apply only if the Plan required such a statement at the time coverage was previously offered to the Employee and Dependent and provided the Employee with notice of such requirement (and the consequences of such requirement) at that time;
   d) The Employee's or Dependent's coverage described in (b) above:

      (i.) was under a COBRA continuation provision and the coverage under such provision was exhausted, or

      (ii.) was not under a COBRA provision and either the coverage was terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment) or employer contributions toward such coverage were terminated; and

   e) The employee requests enrollment within thirty-one (31) days after the date of exhaustion of coverage described in (d)(i) above or termination of coverage or employer contribution described in (d)(ii).

2. **Late enrollees due to marriage, birth, adoption, or placement for adoption.** An eligible Employee who could have applied for coverage during a Plan Open Enrollment Period or when first satisfying the requirements to be a Covered Person, but did not do so, may enroll himself or herself and his or her eligible Dependents under this Plan Document when an individual becomes the Employee’s Dependent

through marriage, birth, adoption or placement for adoption. In the case of birth or adoption of a child, the spouse of the Employee may be enrolled as a Dependent if such spouse is otherwise eligible for coverage. The Employee must request enrollment under this paragraph 2. for himself or herself and his or her Dependents within thirty-one (31) days from the date of the marriage, birth, adoption or placement for adoption.

The Plan is not required to allow special enrollment if the employee or dependent lost eligibility for prior coverage because of failure to pay premiums on a timely basis or was terminated for cause (such as making a fraudulent claim or intentionally misrepresenting a material fact in connection with coverage). The Plan shall request information from the insurance issuer for the prior group health plan or other insurance and may terminate the Covered Person immediately if loss of eligibility or coverage was due to such causes.

2.3 EFFECTIVE DATE OF COVERAGE

Subject to the Plan's receipt of an enrollment application, any required coverage contribution, and the provisions of this Plan Document, coverage shall become effective on the earliest of the following dates:

A. Employees Coverage. When an Employee makes written application for coverage **on or prior to** the date he/she satisfies the eligibility requirements, coverage shall be effective as of the date the eligibility requirements are satisfied. When an Employee makes written application for coverage **after** the date he/she satisfies the eligibility requirements above, coverage will be effective as of the first day of the calendar month following the month in which such application is received by the Plan.

B. Effective Date of Dependent Coverage. Coverage under the Plan for eligible Dependents will become effective on the later of: the date the Employee's coverage becomes effective provided that the eligible dependent was included on the enrollment form completed by the Employee; or on the date the Employee acquires eligible Dependents, provided notification to the Plan is within enrollment guidelines and any required coverage contribution has been paid on their behalf.

C. Newborn Children. A newborn child of the Employee will be covered from the moment of birth if the newborn is added to the Employees' coverage within thirty-one (31) days of birth.

D. Adopted Children. Coverage for a child adopted by the Employee or placed for adoption with the Employee will become effective from the effective date of the adoption or placement for adoption if the child is added to the Employees coverage within thirty-one (31) days of adoption or placement for adoption.

E. HIPAA Special Enrollment Period. Notwithstanding Sections A through D above, if the enrollment form is received during a special enrollment period pursuant to Section 2.2(E), then coverage shall be effective on the following dates:

1. For individuals described in subsections (1) through (3) of Section 2.2(E), on the first day after coverage under subsection (1) was exhausted; or

2. For individuals described in subsection (4) of Section 2.2(E).

a) in the case of marriage, not later than the first day of the first month beginning after the completed request for enrollment is received;

b) in the case of a dependent's birth, as of the date of such birth; or

c) in the case of a dependent's adoption or placement for adoption, the date of such adoption or placement for adoption.

SECTION III – COVERED SERVICES

HOW BENEFITS ARE PAYABLE

The Plan Administrator, or parties acting for it, shall have the authority to make all determinations that are required for administration of this Plan, and to construe and interpret the Plan Document whenever necessary to carry out its intent and purpose and to facilitate its administration. All such determinations, constructions and interpretations made by the Plan shall be binding upon the Covered Person.

All benefits for Covered Services are subject to the Pre-authorization procedures, exclusions, limitations, and conditions including Deductible and/or Coinsurance set forth herein.

Covered Persons may choose to receive Covered Services under:

- the Plan's In-Network Level from Plan Providers

or

- the Plan's Out-of-Network Level from Non-Plan Providers.

IN-NETWORK COVERAGE

All Covered Services must be received from Plan Participating Providers, including but not limited to Physicians, Hospitals, and other Ancillary Facilities, in order to be covered at the In-network level of benefits. All services must be deemed to be or have been Medically Necessary and all benefits are subject to the Pre-authorization procedures, exclusions, limitations, and conditions including Deductible and/or Coinsurance set forth herein.

Composition of Provider Network
Plan participating providers included Primary Care Physicians, specialist physicians, facilities, and ancillary providers who contract with the Plan to provide Covered Services.

A list of Plan Providers and their locations is available to each Covered Person without charge upon enrollment or upon request. Such list shall be revised from time to time as necessary. A Plan Provider's contract may terminate, and a Covered Person may be required to utilize another Plan Provider.

OUT-OF-NETWORK COVERAGE

Covered Persons may receive Covered Services from Non-Plan Providers at the Out-Of-Network level of benefits subject to the exclusions, limitations, and conditions including Deductible and/or Coinsurance set forth herein.

Covered medical expenses are the Usual and Customary Charges for Medically Necessary treatment, services and supplies as follows:

Benefits will be payable at the coinsurance rate of the Usual and Customary and/or Allowable fee charge as defined herein, after any applicable bridge/deductible, as shown in the Schedule of Benefits. All benefits are subject to the Definitions, Benefit Limitations and Exclusions in this document. Covered Services are subject to all applicable Utilization Management requirements. In the absence of due proof to the contrary, when a single charge is made for a series of services, each service will be considered to bear a pro rata share of the charge.

Please refer to the Schedule Of Benefits for applicable Deductible and Coinsurance requirements.

PRE EXISTING CONDITIONS AND WAITING PERIODS

There are no preexisting condition waiting periods.

DEDUCTIBLES

The Deductible means the means the dollar amount which a Covered Person is responsible to pay before Covered Services are payable under this Plan. Such amount will not be reimbursed under the Plan. After any applicable Deductible amount has been paid, benefits for Covered Services will be payable in accordance with the Coinsurance rates shown on the Schedule of Benefits.

The Deductible applies to all covered medical expenses unless otherwise noted. Amounts which a Covered Person is required to pay for preventive vision, dental, vision materials, amounts which are in excess of usual and customary charges, or amounts required as a result of a benefit reduction due to failure to comply with the Plan's Utilization Management program will not be used to satisfy any Deductible amount in the Plan.

The Deductible under this Plan is found in the Schedule of Benefits. If an Employee has individual coverage he or she must satisfy the individual coverage deductible before Covered Services are payable. If an Employee and his or her dependents have any type of dependent coverage they must satisfy the family coverage deductible. Only when the total family coverage deductible is met will benefits be payable for any and all covered family members. This is sometimes referred to as an "Aggregate Family Deductible."

The Plan has separate Deductibles for In-Network services and for Out-of-Network services.

Amounts applied to an In-Network Deductible will apply toward the Plan's In-Network Maximum Out-of-Pocket amount. Amounts applied to an Out-of-Network Deductible will apply toward the Plan's Out-of-Network Maximum Out-of-Pocket amount.

MAXIMUM BENEFIT

Maximum Benefit means the total amount of benefits payable at any time after the Restated Plan Effective Date under this Plan, even if the Covered Person's coverage is interrupted, or terminated and subsequently reinstated, or if the Covered Person changes his or her benefit selection under the Plan.

Any unused portion of the Maximum Benefit is only payable for expenses incurred while the Covered Person: (1) is eligible for the coverage while this Plan is in force; or (2) is eligible for coverage under the extended benefits provision of this Plan.

The Maximum Benefit under this Plan is found on the Schedule of Benefits.

OUT-OF-POCKET MAXIMUM

Out-of-Pocket Maximum means the total amount a Covered Person pays during a Plan Year. The Plan maintains a record of payments made by the Covered Person. Once a Covered Person's payments reach the maximum amount for a Plan Year, no further payments will be required for that year except as indicated below. The Plan will notify the Covered Person approximately 31 days after the Out-of-Pocket Maximum has been reached. Any charges paid by the Covered Person after the Covered Person has reached the maximum amount will be refunded. The Out-of-Pocket Maximum under the Plan is listed on the Schedule of Benefits. There is a separate Out-of-Pocket Maximum for In-Network services and Out-of-Network services.

The Out-of-Pocket Maximum for In-Network Services is the total amount an Employee and/or Dependents will pay during a Plan Year for covered In-Network Services. The In-Network Deductible will apply toward the In-Network Out-of-Pocket Maximum. Coinsurance or amounts which a Covered Person is required to pay for failure to comply with the Plan's Pre-Authorization and Utilization Management procedures do not count toward the In-Network Out-of-Pocket Maximum and must continue to be paid after the Maximum has been met. The Out-of-Network

Deductible does not apply toward the In-Network Out-of-Pocket Maximum. Coinsurance for Out-of-Network Covered Services do not count toward the In-Network Out-of-Pocket Maximum.

The Out-of-Pocket Maximum for Out-of-Network Services is the total amount an Employee and/or Dependents will pay during a Plan Year for covered Out-of-Network Services. The Out-of-Network Deductible will apply toward the Out-of-Network Out-of-Pocket Maximum. Coinsurance or amounts which a covered person is required to pay for failure to comply with the Plan's Pre-Authorization and Utilization Management procedures, or amounts which are in excess of the Plan's Allowable Charge do not count toward the Out-of-Network Out-of-Pocket Maximum and must continue to be paid after the maximum has been met. The In-Network Deductible does not apply toward the Out-of-Network Out-of-Pocket Maximum. Coinsurance for In-Network Covered Services do not count toward the Out-of-Network Out-of-Pocket Maximum.

PRE-AUTHORIZATION, AND UTILIZATION MANAGEMENT PROCEDURES FOR CLAIMS FOR COVERED SERVICES.

Pre-Authorizations are based on current medical practice and guidelines and not on incentives or bonus structures.

Utilization Management.

The Plan's Medical Care Management Department uses Pre-Authorization, Concurrent Review, Retrospective Review, and Case Management to manage utilization of Covered Services and to make coverage determinations on Pre-Service, Post-Service, Concurrent, and Urgent Care claims.

Compliance with any of the review processes under the Plan's Utilization Management Program is not a guarantee of benefits or payment under the Plan.

Pre-Authorization.

Pre-Authorization is an evaluation process which assesses the Medical Necessity and coverage of proposed treatment, and checks to see that the treatment is being provided at the appropriate level of care.

Pre-Authorization is certification by the Plan of Medical Necessity and not a guarantee of payment by the Plan. Payment by the Plan for Covered Services is contingent on the Covered Person's eligibility status on the date the Covered Service is received by the Covered Person. The Covered Person will be responsible for any applicable Coinsurance or Deductible as specified in the Schedule of Benefits. Covered Services are subject to all exclusions and limitations under the Plan.

The Plan has policies and procedures in place that tell Physicians which Covered Services require Pre-Authorization. The Plan informs your Physician of the proper procedures for obtaining Pre-Authorization through the Physician's contract, provider manual, and newsletters.

Your Physician must obtain Pre-Authorization from the Plan for the following treatment, services, and supplies: Scheduled Ambulance Transport, Outpatient Surgery/Services, Surgery done in the Physician's Office, Inpatient Hospitalization, Inpatient Surgery/Services, Single items of Durable Medical Equipment and Orthopedic and Prosthetic Appliances over $250, all rental items of Durable Medical Equipment and Orthopedic and Prosthetic Appliances, and all repair and replacement items of Durable Medical Equipment and Orthopedic and Prosthetic Appliances, Artificial Limbs, Prenatal Maternity Services, Prosthetic/Orthopedic Appliances, Home Health Care, Skilled Nursing Facility Care, Services for Short Term Therapy (physical, occupational, and speech therapy, and cardiac, pulmonary, and vascular rehabilitation),IV therapy with medications, Inhalation therapy, Early Intervention Services, Clinical Trials for Treatment Studies on Cancer, Hospice Services, Oral Surgery, TMJ Services, Tubal Ligation, Hospitalization and Anesthesia for Dental Procedures, Treatment of Lymphedema, Positron Emission Tomography Scans (PET), Magnetic Resonance Angiography (MRA) , Magnetic Resonance Imaging (MRI), Computerized Axial Tomography (CT) Scans, and Transplant Services.

Mental Health Services. All inpatient and outpatient Mental Health services must be Pre-Authorized by Sentara Behavioral Health Services, Inc. Subject to all provisions of this Plan, when the Pre-Authorization requirements are properly followed and the applicable medical care is certified, Covered Service will be processed as described in the Schedule of Benefits.

Penalty for failure to follow the Plan's Pre-Authorization Procedures.
If a Covered Person does not properly follow the Plan's Pre-Authorization procedures and ensure that the provider/physician has obtained Pre-Authorization when it is required, and the Plan determines through Retrospective Review that the Covered Service was Medically Necessary, the Plan will apply a $500 fee which will be offset against any benefit owed by the Plan. The penalty fee with not count toward any Plan Deductible or Out-of-Pocket Maximum amounts.

Pre-Service Claims Coverage Decisions.

The Plan will make coverage decisions on Pre-Service Claims within 15 days from receipt of request for the service. The Plan may extend this period for another 15 days if we determine it to be necessary because of matters beyond our control. If an extension is necessary, the Covered Person will be notified prior to the end of the initial 15 day period. If the extension is necessary due the Plan not having enough information to make the initial coverage decision the Covered Person/Provider will be notified of the specific information missing and the timeframe within which the information must be provided. The Plan will make its decision within 2 business days of receiving the medical information needed to process the Claim.

When the Plan has made a decision on services requiring Pre-Authorization, the Plan will sent the Covered Person and treating Physician written notice of the Plan's decision.

Expedited Approval for Urgent Care Claims.

Urgent Care Claim means any request or claim for medical care or treatment that, if the Plan's normal Pre-Authorization standards are applied, would seriously jeopardize the life or health of the Covered Person or the ability of the Covered Person to regain maximum function; or in the opinion of a Physician with knowledge of the Covered Person's medical condition, would subject the Covered Person to severe pain that cannot be adequately managed without the care or treatment that is the subject of the Claim.

For Urgent Care Claims, the Plan will notify the Covered Person of the Plan's decision not later than 72 hours from receipt of the claim. If the Plan requires additional information, the Covered Person/Physician will be notified within 24 hours of receipt of the claim of the specific information that is missing and the applicable timeframes within which to respond to the Plan.

For review determination relating to prescriptions for the alleviation of cancer pain, the Plan will notify the Covered Person/Physician of its decision within 24 hours of receipt of the claim.

Approval Of Care Involving Ongoing Course Of Treatment.

Concurrent Review means ongoing medical review of the Covered Person's care during Hospital and Skilled Nursing Facility confinements. Concurrent Review may also be performed for Home Health Care Treatment Plans, and therapy and rehabilitative treatment plans. For Concurrent Claims the Plan will notify the Claimant prior to the benefit being reduced or terminated and early enough to allow for an appeal of the decision.

Plan Providers must follow certain procedures to ensure that if a previously approved course of treatment or hospital stay needs to be extended, the extension is requested in time to minimize disruption of needed services. The Plan will notify the Covered Person of its coverage decision within 24 hours of the request. Notification will include information on how to appeal an Adverse Benefit Determination prior to services being discontinued. Requests for

extensions of therapy or rehabilitative treatment plans must be made 7 days prior to the end of the authorized timeframe to avoid disruption of care or services.

Retrospective Review of Post-Service Claims.

Retrospective Review means the review by the Plan of the Covered Person's medical records and other supporting documentation after services have been rendered to determine if the services were Medically Necessary and the Plan's liability for payment.

The Plan will make coverage decisions on Post-Service Claims within 30 calendar days from receipt of request for the service. The Plan may extend this period for another 15 days if we determine it to be necessary because of matters beyond our control. If an extension is necessary, the Covered Person will be notified prior to the end of the initial 30 day period. If the extension is necessary due the Plan not having enough information to make the initial coverage decision, the Covered Person/Provider will be notified of the specific information missing and the timeframe within which the information must be provided. The Plan will make its decision within 2 business days of receiving the medical information needed to process the claim. The Plan will provide the Covered Person and Physician written notice of its decision.

Adverse Benefit Determinations.

An Adverse Benefit Determination means a denial, reduction, or termination of, or a failure to make payment (in whole or in part) for a benefit based on a Covered Person’s eligibility to participate in the Plan; a Utilization Management Decision; or failure to cover an item or service because the Plan considers it to be experimental, investigational, or not medically necessary.

The Plan will provide written notice of an Adverse Benefit Determination within the determination timeframe depending upon the type of Claim under review. Urgent claim notification may be provided orally and then confirmed in writing up to three days after the oral notice. Written notification will include the following:

1. The specific reason or reason for the adverse benefit determination;
2. Reference to the specific Plan provisions on which the determination is based;
3. A description of the Plan’s appeal process and applicable time limits. For Urgent Care Claims it will include a description of the expedited appeals process.

The Covered Person is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and all other information relevant to the Claim for benefits. This includes copies of any internal rule, guideline, protocol, or other criteria relied upon in making the Adverse Benefit Determination. For denials due to Medical Necessity, experimental treatment, or similar exclusion or limit, the Covered Person is entitled to receive, upon request and free of charge, an explanation of the scientific or clinical judgement for the determination applying the terms of the Plan to the Covered Person’s medical circumstances.

Please refer to the Plan’s Appeal Procedure for Adverse Benefit Determinations in this document.

COVERED SERVICES

Please refer to your Schedule of Benefits of this document for applicable Deductibles and/or Coinsurance.

3.1 PHYSICIAN'S SERVICES

Professional services of Physicians, including medical, surgical, diagnostic, therapeutic and preventive services which are performed, prescribed or directed, according to the Plan's Pre-authorization procedures. The following services are subject to any applicable Deductible and/or Coinsurance:

- Physician's office visits for the diagnosis and treatment of Illness, Injury or preventive care.

- Office visits for elective physical examinations (including X-rays and laboratory tests), well-baby care, pediatric and adult immunizations and inoculations when prescribed.
- Routine annual GYN exam covered once per calendar year.
- Diagnostic and laboratory procedures.
- Specialist care and consultations when Medically Necessary.
- Surgical care (inpatient and outpatient).
- Pre and postnatal care.
- In-hospital medical care.
- Physician's home visits.
- The following Short-Term Therapy: physical, speech and occupational therapy, cardiac, vascular and pulmonary rehabilitation.
- Anesthesia services.
- Allergy care. Refer to Section 3.2.
- Hearing screening and audiometric testing by a Physician or when performed by a specialist approved by the Plan.
- Family Planning. Refer to Section 3.7.
- Non-routine foot care, including, but not limited to an operation which involves the exposure of bones, tendons, or ligaments for the treatment of tarsalgia, metatarsalgia, or bunions.
- Routine visual screening by a Physician for children up to age 18, or as indicated under Section 3.14.
- Oral surgery is covered for: (1) surgical procedures required to repair accidental injuries to the jaws; mouth, lips, tongue or hard and soft palates for which medical treatment is requested within 48 hours of the injury; (2) treatment of fractures of the facial bones; (3) excision including diagnostic biopsy of malignant and/or symptomatic tumors and cysts of the jaws, gums, cheeks, lips, tongue, hard and soft palates, and salivary glands; or (4) orthognathic surgical procedures such as osteotomy or other reconstruction of the jaws and/or facial bones (when associated with severe malocclusion) that are necessary to restore and maintain function.
- Services and supplies necessary for the treatment of temporomandibular joint (TMJ) syndrome are covered if medically indicated. Excluded are orthodontia, extractions, repositioning or any other service dental in nature.
- Therapeutic injections.

3.2 ALLERGY CARE

The following allergy care services are provided in accordance with your Schedule of Benefits:

- Allergy Testing - This includes the performance and evaluation of scratch, puncture or prick allergy tests.

- Allergy Administration - Coverage is limited to professional services related to allergy injections.

- Allergy Serum is covered.

3.3 HOSPITAL SERVICES (Except Mental Health)

Those inpatient or outpatient services include:

- Room and board in semi-private room (including an observation room) unless private room is ordered by the Physician for Medically Necessary reasons and authorized by the Plan.
- General nursing care.
- Meals and special diets.
- Use of operating room and related facilities.
- Use of intensive care or cardiac care units and services.
- Laboratory and other diagnostic tests.
- X-ray facilities (Diagnosis and Therapy).
- Drugs, medications and biologicals.

- Anesthesia and oxygen services.
- Inhalation therapy.
- Administration of whole blood and blood products.
- Initial surgically implanted prosthetic devices.
- Outpatient ambulatory surgical and/or other services.
- A minimum stay in the Hospital of not less than forty-eight (48) hours for a patient following a radical or modified radical mastectomy and not less than twenty-four (24) hours of inpatient care following a total mastectomy or a partial mastectomy with lymph node dissection for the treatment of breast cancer. Nothing in this provision shall be construed as requiring the provision of the total hours referenced when the attending physician, in consultation with the patient, determines that a shorter period of Hospital stay is appropriate.

3.4 ANESTHESIA SERVICES

These Hospital or outpatient facility services may include but are not limited to general, regional, supplementation of local anesthesia, or other supportive services in order to afford the patient the anesthesia care deemed optimal by the anesthesiologist during any procedure. These services include the usual preoperative and postoperative visits, the anesthesia care during the procedure, the administration of fluids, and/or blood and the usual monitoring services.

3.5 DIRECT ACCESS TO OBSTETRICIAN-GYNECOLOGISTS

Routine annual GYN exam covered for female Covered Persons age 13 and over once per calendar year. Coverage includes routine health care services incidental to and rendered during the annual visit. Additional health care services may be provided by the OB/GYN, subject to the following : (1) consultation by the OB/GYN with the Plan, for follow-up care or subsequent visits; (2) all Plan Pre-authorization requirements apply (3) all inpatient hospitalizations and outpatient surgery/services must be pre-authorized by the Plan. Health care services related to this benefit means Medically Necessary services provided by the OB/GYN in the care of or related to the female reproductive system and breasts. Services related to infertility are not considered routine.

3.6 MATERNITY SERVICES

Covered Services include full care for the Covered Person before, during and after delivery. Included are:

- Obstetrical, prenatal and postnatal care and all related inpatient and outpatient Hospital services and professional services.
- Counseling and diagnostic services regarding genetic problems and birth defects.
- All care and services related to a miscarriage.
- Any services in connection with prenatal, perinatal, or postpartum care for a Dependent child is excluded.

Newborns and Mothers Health Protection Act. Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

3.7 FAMILY PLANNING

The following family planning services are covered:

- Gynecological examinations.
- Counseling and education regarding birth control methodology.
- Tubal Ligation services. Pre-Authorization Required.

- Vasectomy services.
- Depro-provera or Lunelle injections.
- Intrauterine Devices (IUDs) and cervical caps and their insertion.

3.8 SKILLED NURSING FACILITY CARE

Care rendered in a Skilled Nursing Facility, when ordered by the Plan Physician and arranged and authorized as a supplement to or substitution for inpatient hospitalization, is covered up to a maximum of one hundred (100) days per calendar year. Any care extending beyond one hundred (100) days or any care which is classified as "custodial" rather than "skilled nursing" is not covered.

3.9 SKILLED HOME HEALTH SERVICES

Services will be provided at the Covered Person's home including provision of medical supplies and nursing services subject to all limitations and exclusions of this Plan, if the services are ordered by a Plan Physician and pre-approved by the Plan. Such services must be determined by the Plan to be Medically Necessary and be expected to result in the significant improvement of the Covered Person's condition. Oxygen, when Medically Necessary, is covered. All services must be pre-authorized by the Plan. Hospice Care is covered when the Covered Person has a life expectancy of six (6) months or less as determined by the Covered Person's attending Physician.

3.10 DURABLE MEDICAL EQUIPMENT

Pre-authorization is required for items over $250. Pre-authorization is required for all rental items. Pre-authorization is required for all repair and replacement.

The Plan will provide benefits in connection with the rental or purchase by the Covered Person of Durable Medical Equipment provided that such rental or purchase is authorized and arranged for by the Plan. **It is the Covered Person's responsibility to make sure that the certification process is initiated and completed before receiving equipment.** Equipment must be prescribed by the Physician and determined to be Medically Necessary by the Plan. Covered Services under the DME benefit also include colonostomy, iliostomy, and tracheostomy supplies, and suction and urinary catheters. The option of purchasing or renting the equipment will be determined by the Plan.

Excluded are:

A. Equipment and appliances which are not uniquely relevant to the treatment of disease;
B. Disposable medical supplies including but not limited to medical dressings, disposable diapers, etc;
C. More than one item of equipment for the same or similar purpose;
D. Durable Medical Equipment (DME) services for use in altering air quality or temperature or for exercise or training including, but not limited to: air conditioners, humidifiers, dehumidifiers, exercise bicycles, whirlpool baths, sun or heat lamps, or heating pads.
E. DME primarily for the comfort and well-being of the affected person.

3.11 ORTHOPEDIC AND PROSTHETIC APPLIANCES

Pre-authorization is required for all rental items. Pre-authorization is required for all repair and replacement. **It is the Covered Person's responsibility to make sure that the pre-authorization process is initiated and completed before receiving covered appliances.**

Orthopedic appliances (initial device only) such as customized splints and customized braces are covered when determined Medically Necessary and pre-authorized by the Plan.

Prosthetic appliances: For prosthetic devices other than artificial limbs, coverage is provided for the initial purchase and subsequent purchases due to physical growth. The initial surgically implanted prosthetic device will be covered when determined to be Medically Necessary. The replacement of prosthetic devices for infants/children up to age 18

due to growth or surgical revision of amputation are covered when determined to be Medically Necessary, even if the infant's/child's condition resulted from an Injury or Illness which occurred prior to becoming a Covered Person under this Plan.

3.12 AMBULANCE SERVICE

Ambulance service is covered in an Emergency or when arranged by the Plan. Emergency ambulance service will be covered from the site of the Injury or onset of symptoms to the closest facility. Any transport between facilities must be pre-authorized by the Plan.

3.13 EMERGENCY SERVICES

An Emergency means the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine to result in (a) serious jeopardy to the mental or physical health of the individual, or (b) danger of serious impairment of the individual’s bodily functions, or (c) serious dysfunction of any of the individual’s bodily organs, or (d) in the case of a pregnant woman, serious jeopardy to the health of the fetus. Examples of Emergency Services include, but are not limited to, heart attacks, severe chest pain, cardiovascular accidents, hemorrhaging, poisonings, major burns, loss of consciousness, serious breathing difficulties, spinal injuries, shock, and other acute conditions as the Plan shall determine.

For payment determination, all emergency care is subject to Retrospective Review to determine if an Emergency did exist.

After Hours Nurse Triage Program

The After Hours Nurse Triage Program is an additional benefit to give the Covered Person access to a professional nurse who can help find the most appropriate care in the most appropriate setting. With the After Hours Nurse Triage Program, professional nurses will listen to concerns, analyze the situation, and advise the Covered Person where to get medical care on evenings and weekends when the doctor's office is closed. If Medically Necessary, the Covered Person will be directed to an emergency room or Urgent Care center where he/she can get appropriate treatment.

When the Covered Person calls the After Hours nurse he/she should have his/her Plan ID card ready and be prepared to describe the immediate medical situation in as much detail as possible so the After Hours nurse can offer the best direction possible. The Covered Person should make sure to include information about any other medical problems for which treatment is currently being received.

In severe situations, the After Hours nurse may instruct the Covered Person to call 911 and will follow the case until the Covered Person receives care and notifies the Hospital emergency room in advance that the Covered Person is on his/her way. If it is not possible to call the Covered Person's Physician or After Hours nurse due to a life threatening situation, the Covered Person should call 911 or proceed to the nearest emergency room. **NOTE:** the After Hours nurse cannot diagnose your medical condition or write prescriptions.

The After Hours Nurse Triage Program is available Monday through Friday from 5:00 p.m. to 8:00 a.m., and 24 hours on Saturday, Sunday and Holidays. The After Hours Nurse Triage Program can be reached by calling 552-7250 or 1-800-394-2237.

For Emergency Services rendered by non-Plan Providers, the Plan's financial responsibility shall be limited to paying or reimbursing the Usual and Customary Charges for the Medically Necessary services provided.

All Emergency Services will be subject to Retrospective Review. If the Plan determines that the condition treated was not an Emergency, benefits may be reduced for such non-emergency treatment.

3.14 MENTAL HEALTH SERVICES

Mental health care services are administered for the Plan by Optima Behavioral Health. Emergency mental health services must receive authorization by Optima Behavioral Health. Optima Behavioral Health may be reached by calling 552-7174 or 1/800/648-8420. Subject to the Schedule of Benefits, each Covered Person is eligible to receive the following services each calendar year, if Medically Necessary:

- Outpatient mental health care.
- Diagnosis, medical treatment and referral services, including referral services to appropriate ancillary services.
- Inpatient mental health care, according to medical necessity. (Inpatient days may be converted to partial days on a 1:2 basis.)
- Partial hospitalization means a licensed or approved day or evening treatment program that includes the major diagnostic, medical, psychiatric and psychosocial rehabilitation treatment modalities designed for patients with mental, emotional, or nervous disorders who require coordinated, intensive, comprehensive and multi-disciplinary treatment. Such a program shall provide treatment over a period of six or more continuous hours per day to individuals or groups of individuals who are not admitted as inpatients. Such term shall also include intensive outpatient programs which provide treatment over a period of three or more continuous hours per day to individuals or groups of individuals who are not admitted as inpatients.
- Psychiatric Emergency Services are those services identified by Optima Behavioral Health in accordance with the medical community's accepted standards. All emergency room visits are subject to Retrospective Review. Medical problems related to a psychiatric condition which result in an emergency room visit are covered under medical Emergency Services. Optima Behavioral Health is also available to provide information on alternatives to emergency room visits.

Only those services described hereunder and authorized by Optima Behavioral Health are covered by the Plan. Nonmedical ancillary services for which the Covered Person is referred are not covered. These include, but are not limited to, vocational rehabilitation services, employment counseling, marriage counseling, expressive therapies and health education.

PLEASE REFER TO YOUR SCHEDULE OF BENEFITS.

3.15 EARLY INTERVENTION SERVICES

Early Intervention Services means Medically Necessary speech and language therapy, occupational therapy, physical therapy and assistive technology services and devices for Dependents from birth to age three (3) who are certified by the Department of Mental Health, Mental Retardation, and Substance Abuse Services as eligible for services under Part H of the Individuals with Disabilities Education Act. Medically Necessary Early Intervention Services for the population certified by the Department of Mental Health , Mental Retardation, and Substance Abuse Services shall mean those services designed to help a Covered Person attain or retain the capability to function age-appropriately within his/her environment, and shall include services that enhance functional ability without effecting a cure. Coverage is limited to a benefit of $5,000 per Covered Person per Plan Year. Pre-authorization is required.

The cost of Early Intervention Services shall not be applied to any lifetime maximum benefit under this Plan Document.

3.16 ARTIFICIAL LIMB SERVICES

Pre-Authorization is required. For adults18 and over, artificial limbs, including repair and replacement, will be covered up to a $10,000 lifetime maximum. For children under age 18, artificial limbs, including repair and replacement, will be covered up to $10,000 per occurrence for a maximum of two occurrences.

3.17 RECONSTRUCTIVE BREAST SURGERY

Women's Health and Cancer Rights Act of 1998. The Plan provides benefits for the mastectomy related services listed below in a manner determined in consultation with the attending physician and the Covered Person. For each Covered Person who has had a mastectomy as a result of breast cancer, the Plan will cover (1) all stages reconstruction of the breast on which the mastectomy has been performed; (2) surgery and reconstruction of the unaffected breast to produce a symmetrical appearance; (3) prostheses and physical complications of all stages of mastectomy, including lympedemas.

3.18 PREVENTIVE CARE SERVICES

The following preventive care services are covered in accordance with professional standards adopted by the Plan:

1. One routine physical exam each year.

2. For females 13 years or older one routine annual GYN exam each calendar year. Coverage includes routine health care and services incidental to and rendered during the annual visit. Routine health care and services as related to this benefit means Medically Necessary services provided by the OB./GYN in the care of or related to the female reproductive system and breasts. Services related to infertility and high risk OB are not considered routine. Additional health care services may be provided subject to the following:
   - **a)** Consultation by the OB/GYN with the Plan for follow-up care or subsequent visits;
   - **b)** All inpatient hospitalizations and out-patient surgery services must be pre-authorized by the Plan.

3. Routine mammogram including one screening mammogram to persons age 35 to 39 and annually to persons age 40 and over;

4. Pap smears;

5. One PSA test in a 12-month period and digital rectal examinations for persons over age 50 and persons over 40 who are at high risk for prostate cancer;

6. Routine and necessary immunizations for each newborn child from birth to thirty-six months of age, including diphtheria, pertussis, tetanus, polio, hepatitis B, measles, mumps, rubella.

7. Colorectal cancer screening including annual occult blood test, flexible sigmoidoscopy or colonoscopy, or in appropriate circumstances radiologic imaging, in accordance with most recently published recommendations established by the American College of Gastroenterology, in consultation with the American Cancer Society , for the ages, family histories, and frequencies referenced in such recommendations.

8. One annual routine hearing test.

9. Well-baby care including routine care and periodic review of a child's physical and emotional status subject to the following:
   - **a)** Services include a history; complete physical examination, development assessment, anticipatory guidance, appropriate immunizations, and laboratory tests in keeping with prevailing medical standards;
   - **b)** Benefits will be provided at approximately birth, 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, 18 months, 2 years, 3 years, 4 years, 5 years, and 6 years.
   - **c)** Well-baby services which are rendered during a periodic review will be covered to the extent that such services are provided by or under the supervision of a single Physician during the course of one office visit.

3.20 DIABETIC EQUIPMENT AND SUPPLIES

Coverage includes benefits for equipment, supplies and outpatient self-management training and education. Please refer to the Schedule of Benefits for any applicable Deductible and/or Coinsurance. **Note: Insulin, syringes, needles and lancets are covered under the Plan's outpatient prescription drug benefit subject to the applicable prescription drug Coinsurance and dispensing limitations.**

3.21 LYMPHEDEMA

Coverage includes benefits for equipment, supplies, complex decongestive therapy, and outpatient self-management training and education for the treatment of lymphedema, if prescribed by a health care professional legally authorized to prescribe or provide such items under law.

3.22 REDUCTION MAMMOPLASTY

Covered Services include all applicable services associated with Reduction Mammoplasty including but not limited to physician, facility, surgical, and/or diagnostic services. This does not include reduction mammoplasty procedures associated with reconstructive breast surgery following mastectomy covered under the Plan's benefits for Reconstructive Breast Surgery.

3.23 TRANSPLANT SERVICES

Pre-Authorization is required. The Plan covers the following human organ transplants, provided they are Medically Necessary, non-experimental, and meet all Plan criteria: Kidney; Heart; Cornea; Liver; Lung; Heart-lung; Kidney-pancreas; Bone marrow transplants for leukemia, Hodgkin's disease, non-Hodgkin's lymphoma, severe combined immunodeficiency disease, aplastic anemia and Wiskott-Aldrich syndrome; Dose-intensive chemotherapy/autologous bone marrow transplants or stem cell transplants for the treatment of breast cancer.

At the discretion of the Plan, this list may be amended in accordance with accepted medical and community standards.

All transplant services will be provided at contracted Plan facilities only.

SECTION IV - OUTPATIENT PRESCRIPTION DRUGS

Subject to the conditions and limitations set forth herein, Covered Persons are entitled to receive Outpatient Prescription Drugs from a participating pharmacy or from a non-participating pharmacy that has agreed to accept as payment in full reimbursement from the Plan at the same level as the Plan gives to participating pharmacies. Recommendations on drug coverage are made by the Pharmacy and Therapeutics Committee composed of physicians and pharmacists. Selected drugs may require your physician to obtain Pre-Authorization from the Plan in order to be covered. Cover Persons will be responsible for all applicable Deductibles and/or Coinsurance.

All covered outpatient drugs must have been approved by the Food and Drug Administration and require a prescription either by State or Federal Law.

All compounded prescriptions must contain at least one prescription ingredient.

The Pharmacy and Therapeutics Committee may establish monthly quantity limits for selected medications. Please call Member Services with any questions about any applicable quantity limits. This information is also available at the Plan's website www.optimahealth.com.

A Covered Person may receive:

- Up to a consecutive 31-day supply of a covered outpatient drug. Where covered outpatient drugs are pre-packaged by the manufacturer and Pharmacists or other dispensing agents do not customarily divide such packaging (i.e. blister packs), the covered drug will be dispensed and charged Coinsurance per <u>each</u> package (dose). Covered Persons pay Coinsurance per vial, per tube of ointment/cream, per 8 ounces of oral liquid, per box, per blister pack, or per 31day supply of loose pills.
- Two vials of insulin. Covered Persons may obtain up to a 31-day supply of insulin at one time, but must remit the appropriate Coinsurance.
- One rescue inhaler
- Two maintenance/steroidal inhalers
- Up to a 31-day supply of insulin syringes, insulin needles, or disposable insulin syringes with needles. (Limited to a Maximum of 100.)
- Up to a 31-day supply of disposable blood, urine, glucose/acetone testing agents.
- Up to a 3-cycle supply of oral contraceptives.
    - 1 diaphragm.

Norplant (levonorgestral implants) is not covered.

Covered Persons will be reimbursed for outpatient prescription drugs obtained from pharmacies other than the Plan Pharmacies, when they are: 1) ordered in connection with an out-of-area Emergency or 2) ordered by a Provider for immediate use because of a Medical Necessity and because no Plan Pharmacy was open for business at that time. Reimbursement will be limited to a quantity sufficient to treat the acute phase of the Illness. Upon approval and verification of the Covered Person's out-of-network claim, the Covered Person will be reimbursed the cost of the prescription, less the applicable Coinsurance amount.

Coverage includes participation in the Plan's Mail Order Drug Program. Cover Persons may purchase a 90-day supply of maintenance drugs (limited to manufacturer's packaging). If a Cover Person has a question about the Mail Order Prescription Drug Program or about whether his or her prescription is available through the program, he or she may call Caremark at: 1-888-766-5495 or write to:

Caremark
P.O. Box 94467
Palatine, IL 60094-4467

EXCLUSIONS:

- All other drugs and over-the-counter medications, even if written on a prescription blank
- Non-durable disposable medical supplies and items such as bandages, cotton swabs, diabetic supplies (other than those listed as covered), hypodermic needles, and durable medical equipment, etc.
- Prescription or over the counter appetite suppressants and any other prescription or over the counter medication for weight loss.
- Compound prescription medications with ingredients not requiring a Physician's authorization by State or Federal Law.
- Immunization agents, biological sera, blood or blood products.
- Infertility drugs.
- Injectables (other than those self-administered and insulin).
- Medication which is to be taken or administered to the Covered Person (including by the Physician or in the Physician's office) in whole or in part, while he/she is a patient in a licensed Hospital, rest home, sanatorium, extended care facility, convalescent Hospital, nursing home, or similar institution which operates on its premises a facility for dispensing pharmaceuticals).
- Investigational or experimental medications.
- Medications for cosmetic purposes only.
- Medications for smoking cessation, including gum, spray, or patches.
- Medications for experimental indications and/or dosage regimens determined by the Plan to be experimental.
- Medications with no approved FDA indications.
- Over-the-counter (OTC) medications that do not require a Physician's authorization by State or Federal law and any prescription that is available as an OTC medication.
- Replacement prescriptions resulting from loss, theft or breakage.
- Therapeutic devices or appliances, including but not limited to, support stockings and other nonmedical items or substances, regardless of their intended use;
- Drug charges exceeding the cost for the same drug in a conventional packaging (i.e., convenience packages, unit doses, blister packs, etc.);

SECTION V - EXCLUSIONS AND LIMITATIONS

The services or items listed below are either not covered by the Plan or coverage is limited as follows:

A

Abortions- Elective abortion services are excluded unless medically necessary to save the mother's life.
Acupuncture – is excluded from coverage.
Adaptations to the Home – are excluded from coverage. Examples include but are not limited to, handrails, ramps, escalators, elevators, or other disability modifications.
Allergy Testing – Food allergy ingestion testing, IGE immunoassays for quantitative Invitro allergy testing for diagnosis of allergic rhinitis, including but not limited to, RAST is excluded from coverage.
AMA – Against Medical Advice – Failure to comply with recommended treatment is an option for the Covered Person. In such cases, the Plan will not assume any further liability for the particular condition ***unless*** the Covered Person later decides to follow prescribed treatment under the care of the ordering physician and subject to the terms of your coverage.
Ambulance Services – are excluded from coverage unless authorized by the Plan.
Ancillary Services – non-medical ancillary services for which the Covered Person is referred are excluded from coverage. These include, but not limited to, vocational rehab services, employment counseling, marriage counseling, expressive therapies and health education.
Aromatherapy – is excluded from coverage.
Autopsies – are excluded from coverage.

B

Batteries - Batteries for repair or replacement are excluded from coverage. This does not apply to batteries for motorized wheelchairs.
Biofeedback - is excluded from coverage except when authorized by the Plan.
Blood Pressure Monitors - are excluded from coverage unless authorized by the Plan.
Blood and Blood Products - are excluded from coverage. The cost of securing the services of blood donors are excluded from coverage.
Bone Densitometry - studies done more frequently than once every two years are excluded from coverage unless authorized by the Plan.
Botox injections - are excluded from coverage unless approved by the Plan. Botox injections for the following are excluded from coverage: headaches, cosmetic procedures, bone and joint conditions, and writers' cramp.
Breast Augmentation/Mastopexy - Procedures requested for the purpose of correction of cosmetic physical imperfections, except as required by applicable law regarding breast reconstruction and symmetry following mastectomy are excluded from coverage.
Breast Ductal Lavage - is excluded from coverage.

C

Chelation Therapy – is excluded from coverage for other than arsenic, copper, iron, gold, mercury or lead poisoning.
Circumcision - is excluded from coverage for non-medically indicated reasons after six weeks of age.
Cold Therapy Machine - is excluded from coverage.
Contact Lenses – or eyeglasses or the fitting thereof are excluded from coverage, except for the first pair of lenses (this may include contact lens, or placement of intraocular lens or eyeglass lens only) following cataract surgery.
Cosmetic Surgery – Emotional conflict or distress does not constitute medical necessity**.** The following are excluded from coverage:

- Any cosmetic surgery or any hospital, physician, or other health service related thereto, except to the extent Medically Necessary to restore function.
- Treatment or services resulting from complications due to cosmetic and/or experimental procedures.

- Tattoo removal
- Keloid removal as a result of the piercing of any body part
- Consultations and/or office visits for the purpose of obtaining cosmetic and/or experimental procedures.
- Penile implants.

Covered Services by Another Payor – the cost of services, which are covered through a group insurance mechanism or governmental program, such as Workers Compensation, occupational disease laws and other employers' liability laws, are excluded from coverage. The Plan will not cover the cost of services that were denied by the above insurance programs for failure to meet administrative or filing requirements.
Crime – Expenses incurred for an illness or injury suffered in connection with illegal activities, including but not limited to the commitment of or intent to commit a crime and driving while intoxicated are excluded from coverage. The Plan will not deny benefits that would otherwise be covered if an injury results from an act of domestic violence, or a physical or mental health condition.
Custodial Care – or domiciliary care, rest cures, or any examination and/or care ordered by a court of law, which has not received prior authorization by the Plan and has been arranged through, or provided at, a participating Plan facility is excluded from coverage.

D

Dentistry/Oral Surgery – **the following is a listing of specific dental and oral surgery exclusions, including:**

1. **Dentistry**
    - For or in connection with treatment of the teeth or periodontium unless such expenses are incurred for charges made for a continuous course of dental treatment started within six months of an Injury to sound natural teeth;
    - Services to restore appearance or for cosmetic purposes;
    - Dental services performed in a hospital or any outpatient facility except as described in the Covered Services under "Hospitalization and Anesthesia for Dental procedures" are excluded from coverage.
    - Dental implants and any preparation work for implants.

2.Oral Surgery – the following are excluded from coverage:
- Oral surgery which is part of an orthodontic treatment program;
- Orthodontic treatment prior to orthognathic surgery;
- Dental implants and any preparation work for implants;
- Extraction of wisdom teeth.

3.Dental Care
- Dental care, treatment, supplies, orthodontia, extractions, repositioning, X-rays, periodontal work, or any other services dental in nature.

NOTE: Please refer to The CIGNA dental coverage document, included by reference as part of this SPD, for dental benefit information.

Digital Mammograms – are excluded from coverage unless approved by the Plan.
Disposable Medical Supplies - are excluded from coverage. This includes, but is not limited to, medical dressings, disposable diapers any over the counter supplies, such as bandages, tape, gauzepads, alcohol, iodine, peroxide.
Driver Training - is excluded from coverage.
Durable Medical Equipment (DME) - The rental, purchase, repair and replacement of durable medical equipment are limited to the level of coverage indicated on the Schedule of Benefits. DME and surgical equipment benefits are excluded for:
- More than one item of equipment for the same or similar purpose.
- An amount that exceeds the cost of a similar supply that would have been sufficient to safely and adequately treat the Cover Person's physical condition.
- Equipment and appliances which are not uniquely relevant to the treatment of disease.
- Disposable medical supplies and medical equipment are excluded from coverage. This includes, but is not limited to, medical dressings, disposable diapers any over the counter supplies, such as bandages, tape, gauzepads, alcohol, iodine, peroxide.

- DME for use in altering air quality or temperature or for exercise or training.
- DME primarily for the comfort and well being of the Covered Person.
- Batteries for repair or replacement. This does not apply to batteries for motorized wheelchairs.
- Blood Pressure Monitors unless authorized by the Plan.

E

Educational/Teacher Services/Evaluations – educational, tutorial, evaluation, testing, screening and any other services relating to school or classroom performance are excluded from coverage.
Enteral or Parenteral Feeding – Supplements and/or supplies are excluded from coverage unless it is used as the sole source of nutrition. No over the counter supplements are covered.
Exercise Equipment – including, but not limited to bicycles, treadmills or stairclimbers are excluded from coverage.
Experimental Treatment and Procedures – are excluded from coverage. A drug, device, medical treatment or procedure may be considered experimental or investigative if:

- The majority of the medical community does not support the use of this drug, device, medical treatment or procedure; or
- The use of this drug, device, medical treatment or procedure may have been shown to be unsafe and/or of no or questionable use as reported by current scientific literature and/or regulatory agencies; or
- The research regarding this drug, device, medical treatment or procedure may be so limited that an evaluation of safety and efficacy cannot be made; or
- The drug or device is not approved for marketing by the Food and Drug Administration (FDA); or
- The drug, device, medical treatment or procedure is currently under study in a Phase I, Phase II clinical trial, an experimental study/investigational arm of a Phase III clinical study, or otherwise under study to determine safety and efficacy or to compare its safety and efficacy to current standards of care.
- Medical services classified by the FDA as a Category B Non-experimental/investigational drug, device medical treatment or procedure are excluded from coverage.

Eye Examination – or any corrective eyewear required by an employer as a condition of employment is excluded from coverage.
Eye Glasses – or contact lenses or the fitting thereof are excluded from coverage, except for the first pair of lenses (This may include contact lens, or placement of intraocular lens or eyeglass lens only.) following cataract surgery.
Eye Movement Desensitization and Reprocessing Therapy - is excluded from coverage.
Eye Surgery – is excluded from coverage, including, but not limited to, Radial Keratotomy, PRK and LASIK.

F

Food Allergy Testing – is excluded from coverage.
Foot Care – The following are excluded from coverage:

- Routine foot care such as the removal of corns or calluses and the trimming of nails (except for an operation which involves the exposure of bones, tendons, or ligaments for the treatment of tarsalgia, metatarsalgia or bunions) except as approved by the Plan for Covered Persons with diabetes.
- Treatment and services related to flat-feet, fallen arches, routine bunionectomy or chronic foot strain.

Foot Orthotics – of any kind are excluded from coverage, including, but not limited to, customized or non-customized shoes, boots, and inserts, except as medically necessary and approved by the Plan for Covered Persons with diabetes.

G

Genetic Testing – including screening and counseling are excluded from coverage, except for amniocentesis, HLAB 27, infant chromosomal analysis, BRAC1, BRAC2, and FAP or AFAP for colorectal cancer when Pre-Authorized by the Plan.
GIFT (Gamete Intrafallopian Transfer) programs - are excluded from coverage.
Growth Hormones - are covered only as indicated under Outpatient Prescription Drugs.

H

Hearing Aids – are excluded, including but not limited to, fittings, molds and/or supplies, e.g., batteries.
Heart – Artificial and/or mechanical heart placement and other related expenses are excluded from coverage.
Home Births – are excluded from coverage.
Home Health – the following are excluded from coverage:

- Services or supplies which are not specified in home health care plans;
- Services for any Covered Person who is not home-bound as determined by the Plan;
- Custodial care; or
- Transportation services

Hypnotherapy – is excluded from coverage

I

IGE – IGE immunoassays for quantitative Invitro allergy testing for diagnosis of allergic rhinitis, including but not limited to, RAST is excluded from coverage.
Immunizations - as related to foreign travel and/or employment are excluded from coverage.
Implants – Breast implants, except after mastectomy for breast cancer to produce symmetry, are excluded from coverage.
Incarceration - Services and treatments required or performed while the Cover Person is incarcerated in a Local, State, Federal or Community Correctional Facility are excluded from coverage.
Infertility - All services, tests, medications, and treatments in connection with the diagnosis or treatment of Infertility, and all services, tests, medications, and treatments that aid in or diagnose potential problems with conception are excluded from coverage, including, but not limited to:

- In-Vitro Fertilization programs, Artificial insemination or any other types of artificial or surgical means of conception including any drugs administered in connection with these procedures;
- GIFT programs;
- Reproductive material storage;
- Treatment related to sexual organ function, dysfunction or inadequacies, including but not limited to, impotency;
- Semen recovery or storage, or sperm washing;
- Infertility Services needed due to a reversal of sterilization;
- Services to reverse voluntary sterilization;
- Semen analysis;
- Sims-Huhner test (smear);
- Drugs used to treat infertility.

Influenza Vaccines– Flu-mist vaccines are excluded from coverage unless authorized by the Plan

J

K

Keyloids – the treatment of keyloids as a result of body piercing or pierced ears is excluded from coverage.

L

Laboratory Services – Laboratory services received from Non-Plan Providers or laboratories are covered under Out-of-Network benefits only, regardless of ordering physician.
Laser Treatment – for inflammatory skin disease (psoriasis) is excluded from coverage.
Lung Cancer Screening Helical CT Scans – are excluded from coverage.
Lyme Disease – vaccination and vaccine for Lyme Disease are excluded from coverage.

M

Magnetic Resonance Spectroscopy – is excluded from coverage.
Massage Therapy – is excluded from coverage.
Maternity Services – the following are excluded from coverage:

- Coverage for any maternity related services for obstetrical, prenatal, perinatal, or post partum care for a dependent child.
- Coverage for a newborn or other child of a dependent child.

Maximum Benefit – Amounts in excess of a benefit limit as stated in this document are excluded from coverage.
Medically Necessary Treatments – Any service, supplies, treatment, or procedure not specifically covered in your Plan's coverage or determined not to be Medically Necessary are excluded from coverage.
Medical Equipment and Supplies –

- Any disposable or convenience medical equipment, appliances, devices, and/or supplies are excluded from coverage, including but not limited to: exercise equipment, air conditioners, purifiers, humidifiers and dehumidifiers, whirlpool baths, hypoallergenic pillows or bed linens, telephones, handrails, ramps, elevators and stair glides, orthotics, changes made to vehicles, residences or places of business, adaptive feeding devices, adaptive bed devices, water filters or purification devices and other similar equipment and supplies.
- Disposable Medical Supplies are excluded from coverage, including, but not limited to, medical dressings, disposable diapers any over the counter supplies, such as bandages, tape, gauzepads, alcohol, iodine, peroxide.

Membership Fees - to health and/or athletic clubs are excluded from coverage.
Mental Health Services - The following mental health and substance abuse services are excluded from coverage:

- Medically Necessary Treatments - Any services, supplies or treatments not specifically listed as covered as well as services and any other procedures determined not to be Medically Necessary are excluded from coverage.
- All services, other than emergency services, that have not been authorized by Sentara Behavioral Health Services, Inc.
- Non-medical ancillary services are not covered including but not limited to vocational rehabilitation services, employment counseling, marriage counseling, expressive therapies, and health education.
- Psychological examinations, testing or treatment for the purpose of obtaining or maintaining employment or insurance, or related to judicial or administrative proceedings.
- Court ordered examinations or care unless medically necessary.
- Psychiatric treatment for sexual dysfunction or sexual therapy, mental retardation or learning disabilities.
- Psychoanalysis to complete degree or residency requirements.
- Pastoral counseling, marital or relationship counseling.
- Psychological testing for educational purposes.
- Residential level of care or treatment.
- Other non-covered services listed in this document that could be deemed mental health services.
- Sex Change Operations and any medical treatment of gender identity disorders.

Morbid Obesity – Morbid obesity surgeries, services and drugs used in connection with morbid obesity.
Motorized or Power Operated Vehicles – including **a**ny adaptations to motorized or power operated vehicles and/or chair lifts.

N

Neuro-cognitive therapy – Following a neurological event or to restore cognitive deficits in neuro-cognition is excluded.
Neuropsychiatric Testing - is excluded from coverage, including, but not limited to, psychological examinations, testing or treatment for the purpose of obtaining or maintaining employment or insurance, or related to judicial or administrative proceedings, or not authorized by the Plan.
Newborn Coverage – for the newborn or other child of a dependent child is excluded.

O

Obstetrical Care – the following are excluded:

- Coverage for any maternity related services for obstetrical, prenatal, perinatal, or post partum care for a dependent;
- Coverage for the newborn or other child of a dependent child;
- Home births.

Oral Surgery

- Dental implants, and any preparation work for implants or dentures are excluded from coverage
- Extraction of wisdom teeth is excluded from coverage.
- Oral surgery, which is part of an orthodontic treatment program, is excluded from coverage.
- Orthodontic treatment prior to Orthognathic surgery is excluded from coverage.

Orthoptics – or vision/visual training and any associated supplemental testing are excluded from coverage.
Out Of Network Medical and Laboratory Services – any services other than emergency care received from Non-Plan Providers, irrespective of any referral or direction by a provider, will be processed under the Plan's Out-of-Network benefit unless Pre-authorized by the Plan.

P

Paternity Testing – is excluded from coverage.
Penile Implants – are excluded from coverage.
Personal comfort items – which include, but are not limited, to telephones, televisions, extra meal trays and personal hygiene items including, but not limited to, underpads, diapers, icebags, chairs, air conditioners, water purifiers, humidifiers, dehumidifiers, saunas, swimming pools or hot tubs are excluded from coverage.
PET Scans - Positron Emission Tomography(PET) Scans are excluded from coverage unless authorized by the Plan.
Physician Examinations –

- Physicals for employment, insurance or recreational activities are excluded from coverage.
- Executive physicals are excluded from coverage.
- School physicals are excluded from coverage, except when a Cover Person has not had a health assessment with his or her physician during the calendar year.
- A second opinion is covered when authorized by the Plan.
- Services or supplies not prescribed, performed, or directed by a provider licensed to do so.

Physician's clerical charges – for no show appointments, telephone calls, completion of forms, transfer of medical records, the cost of copying medical records or the generation of correspondence to other parties are excluded from coverage.
Prescription Drug Exclusions – Any drugs not specifically listed as covered and all other drugs and over-the-counter medications, even if written on a prescription blank, are excluded. For a full listing of excluded outpatient prescription drugs, please reference the Plan's Pharmacy Exclusions (Section IV).
Private Duty Nursing – is excluded from coverage.

Q

R

RAST Testing – IGE immunoassays for quantitative Invitro allergy testing for diagnosis of allergic rhinitis, including but not limited to RAST, is excluded from coverage.
Reconstructive surgery – is not covered unless such services follow trauma which causes anatomic functional impairment and if such trauma occurred on or after the effective date of the Covered Person's coverage or is needed to correct a congenital disease or anomaly which has resulted in a functional defect. If the trauma occurred before the Covered Person's effective date of coverage, the reconstructive surgery is covered subject to the Plan's pre-existing condition exclusion provisions and medical necessity determination. Emotional conflict does not constitute medical necessity.
Note: Breast reconstruction following mastectomy is covered.

Remedial Education and/or Programs – including services which are extended beyond the period necessary for the evaluation and diagnosis of learning and behavioral disabilities or for mental retardation or for autism disabilities are excluded from coverage.
Routine Disposable Medical Supplies - are excluded from coverage. This includes, but is not limited to, medical dressings, disposable diapers, any over the counter supplies, such as bandages, tape, gauzepads, alcohol, iodine, peroxide.

S

Saliva Tests – are excluded from coverage.
Services – the following services are excluded from coverage:

- Services for which a charge is not normally made;
- Services or supplies not prescribed, performed or directed by a provider licensed to do so;
- Services if they are for dates of service before the Covered Person's effective date under the Plan or after the Covered Person's coverage under the Plan ends;
- Telephone consultations, charges for missed appointments, charges for completing forms, or charges associated with copying medical records.
- Services not specifically listed or described as covered under this Plan.

Non-medically necessary complications of non-covered services including medical, mental health, and surgical services related to the complication.
Sex Change Operations – and any treatment of gender identity disorders are excluded from coverage..
Smoking Cessation – including the drugs and treatment associated with smoking cessation are excluded from coverage.
Sterilization Reversal – Reversal of voluntary sterilization and infertility services required because of such reversal is excluded from coverage.
Substance Abuse – services are excluded from coverage.
Supplies - Disposable medical supplies are excluded from coverage. This includes, but is not limited to, medical dressings, disposable diaper, any over the counter supplies, such as bandages, tape, gauzepads, alcohol, iodine, peroxide.

T

Therapies – Physical, speech and occupational therapies will be covered only to the extent of restoration to the pre-trauma or pre-illness level.

- Therapies will be covered only to the extent of restoration to the level of the pre-trauma, pre-illness or pre-condition status;
- Therapies for developmental delay or abnormal speech pathology are not covered except as covered through Early Intervention Services;
- Therapies which are primarily educational in nature, including but not limited to, special education or lessons in sign language are excluded from coverage;
- Therapies performed to correct an impairment resulting from a functional nervous disorder (i.e. stuttering, stammering) are excluded from coverage;
- Therapies to maintain current status or level of care are excluded from coverage;
- Restorative therapies to maintain chronic level of care are excluded from coverage;
- Therapies which are available in a school program or similar programs available through state and local funding are excluded from coverage;
- Recreation therapies including art, dance, music, exercise or sleep therapies are excluded from coverage.
- Driver Training is excluded from coverage;
- Functional capacity testing to return to work is excluded from coverage;
- Work hardening programs are excluded from coverage.

Transplant Services – Any organ or tissue transplant services not specifically listed as covered by the Plan are excluded from coverage, including, but not limited to:

- Services received from Non-Plan Providers unless Pre-authorized by the Plan;

- Services and supplies associated with screenings, searches and registries;
- Organ and tissue transplants that are considered experimental or investigative are excluded from coverage;
- Organ and tissue transplants that are not medically necessary are excluded from coverage.

Travel and Transportation – expenses are excluded except for medically necessary transport and ambulance services which must be approved and authorized by the Plan.

U

Urea Breath Testing - is excluded from coverage unless approved by the Plan.

V

Vaccines - Flu-mist vaccines are excluded from coverage.
Virtual Colonoscopy - is excluded from coverage.
Vision Materials – Any vision supplies or materials not specifically listed as covered are excluded from coverage.

W

Wigs – or cranial prostheses as a result of hair loss for any reason are excluded from coverage.
Wisdom Teeth - extraction of wisdom teeth is excluded from coverage.

X

Y

Z

SECTION VI - TERMINATION OF COVERAGE

6.1 TERMINATION OF EMPLOYEE COVERAGE

Except as provided below and under "Continuation of Coverage," an Employee's coverage under this Plan will terminate on the first of the following:

A. the date this Plan terminates;

B. the date the Maximum Benefit amount under this Plan has been paid to or on behalf of the Employee;

C. the last day of the month in which the Employee ceases to be an Eligible Employee, employed by the Plan Sponsor or otherwise covered pursuant to an employment contract or a separation or settlement agreement arising from, or in accordance with, the Employee's employment as an otherwise Eligible Employee;

D. the date the Employee contribution, if any, for Plan Coverage cease due to non-payment by the Employee;

E. the date any Employee fails to pay, have paid on his or her account or for his or her benefit, or make satisfactory arrangements to pay any Deductible, Coinsurance, or any other required contributions for coverage under the Plan; or

F. the date the Employee dies.

6.2 TERMINATION OF DEPENDENT COVERAGE.

Except as provided below and under "Continuation of Coverage," a Dependent's coverage under this Plan will terminate on the first of the following:

A. the date this Plan terminates;

B. the date the Maximum Benefit amount under this Plan has been paid to or on behalf of the Dependent;

C. the date any Covered Person fails to pay, have paid on his or her account or for his or her benefit, or make satisfactory arrangements to pay any Deductible, Coinsurance, or any other required contributions for coverage under the Plan;

D. the date the Employee's coverage under this Plan terminates;

E. the date a spouse or child ceases to satisfy the Plan's definition of an Eligible Dependent; or

F. the date the spouse or child becomes covered as an Employee under this Plan.

6.3 EXCEPTIONS TO TERMINATION PROVISIONS - EXTENSION OF ACTIVE SERVICE (DURING ABSENCE FROM EMPLOYMENT)

If cessation of active service is due to one of the following circumstances, coverage may continue until the end of the following time period stipulated below, **provided the Plan is in force**:

A. For an approved leave of absence, coverage will continue for a period of not longer than three (3) months.

Coverage may be retained during such period if Employee continues to pay premium contributions.

B. For an Employee who is unable to work due to total disability, coverage will continue for a period not longer than six (6) months.

Coverage may be retained during such period if Employee continues to pay premium contributions.

C. The Family and Medical Leave Act (FMLA). FMLA requires employers of 50 or more employees to give up to 12 weeks of unpaid, job-protected leave to eligible employees for the birth, or adoption of a child or for the serious illness of the employee or a spouse, child or parent.

Coverage may be retained during such period if Employee continues to pay premium contributions.

D. The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). According to USERRA any employee called to Active Duty can continue the health care coverage they have for themselves and/or any family Covered Persons covered under the Plan for up to 24 months.

Coverage may be retained during such period if Employee continues to pay premium contributions.

Coverage continued under this provision is in addition to coverage continued under the Plan's COBRA continuation provisions.

6.4 ADDITIONAL TERMINATION PROVISIONS

In addition to the termination provisions above, a Covered Person's coverage under the Plan will terminate as follows:

A. Misuse of Plan Identification Card. If the Covered Person permits the use of his or her or any other Covered Person's Plan identification card by any other person, or uses another person's card, the card may be retained by the Plan and coverage of the Covered Person may be terminated effective upon written notice. Both the Employee and the Dependent shall be liable to the Plan for all costs incurred as a result of the Dependent's misuse of the identification card.

B. Unsatisfactory Physician-Patient Relationship. If, after reasonable efforts, a Plan Physician is unable to establish or maintain a satisfactory physician-patient relationship with a Covered Person, coverage of the Covered Person may be terminated upon written notice. Examples of unsatisfactory physician-patient relationships include, but are not limited to, abusive or disruptive behavior in a Physician's office, and repeated refusals by the Covered Person to accept procedures or treatment recommended by a Plan Physician.

C. Fraud or Misrepresentation. If a Covered Person, on behalf of himself/herself or another Covered Person, knowingly causes or allows incorrect or incomplete information to be furnished to the Plan which constitutes a material misrepresentation, then the coverage of the Covered Person who either furnished such information or on whose behalf such information was furnished, may be voided immediately upon written notice. In addition, such Covered Person shall be responsible for all costs incurred by the Plan for such Covered Person.

D. Failure to Cooperate. If a Covered Person fails to cooperate in the Plan administration of the Double Coverage, Coordination of Benefits or Subrogation provisions set forth herein, respectively, then the coverage of such Covered Person may be terminated upon written notice by the Plan.

E. Failure to Pay Deductibles, Premiums, etc. If a Covered Person fails to pay, or arrange for payment of any Deductible or other required contribution for coverage under the Plan, coverage will terminate upon written notice by the Plan.

SECTION VII - DOUBLE COVERAGE

7.1 WORKERS' COMPENSATION

The benefits under this Plan Document for Covered Persons eligible for Workers' Compensation are not designed to duplicate any benefit to which such Covered Persons are eligible under the Workers' Compensation Law. All sums payable pursuant to Workers' Compensation for services provided hereunder to Covered Persons are payable to and retained by the Plan. It is understood that coverage hereunder is not in lieu of, and shall not affect, any requirements for coverage under Workers' Compensation.

7.2 MEDICARE

Except as otherwise provided by applicable federal law that would require the Plan to be the primary payor, the benefits under this Plan Document for Covered Persons aged sixty-five (65) and older, or Covered Persons otherwise eligible for Medicare, do not duplicate any benefit to which such Covered Persons are eligible under the Medicare Act, including Part B of such Act. In cases where the Plan has paid for services covered hereunder, but Medicare is the responsible payor, the Plan will pursue all sums payable pursuant to the Medicare program, and such sums shall be payable to and retained by the Plan. In all other cases, all sums payable pursuant to the Medicare program for services provided hereunder are payable up to the amount of the secondary payor's liability.

7.3 OTHER GOVERNMENT PROGRAMS

Except as otherwise provided by applicable law that would require the Plan to be the primary payor, the benefits under this Plan Document shall not duplicate any benefits to which Covered Persons are entitled or for which they are eligible under any other governmental program. To the extent that the Plan has duplicated such benefits, the Plan will pursue all sums payable pursuant to the government program and such sums shall be payable to and retained by the Plan. In all other cases, all sums payable pursuant to the government program for services provided hereunder are payable up to the amount of the secondary payor's liability.

7.4 COVERED PERSON'S COOPERATION

Each Covered Person shall complete and submit to the Plan such consents, releases, assignments and other documents as may be requested the Plan in order to obtain or assure reimbursement under Medicare, Workers' Compensation or any other governmental program. Any Covered Person who fails to so cooperate will be responsible for the Usual and Customary Charge for services subject to this section and coverage may be terminated.

SECTION VIII - COORDINATION OF BENEFITS

8.1 APPLICABILITY

A. This Coordination of Benefits ("COB") provision applies to This Plan when a Covered Person has health coverage under more than one Plan. "Plan" and "This Plan" are defined below.

B. If this COB provision applies, the order of benefit determination rules should be looked at first. Those rules determine whether the benefits of This Plan are determined before or after those of another plan. The benefits of This Plan:

1. Shall not be reduced when, under the order of benefit determination rules, This Plan determines its benefits before another plan; but

2. May be reduced when, under the order of benefits determination rules, another plan determines its benefits first. The above reduction is described in the Section, "Effect on the Benefits of This Plan."

8.2 DEFINITIONS

A. "Plan" is any of these which provides benefits or services for, or because of, medical care or treatment:

1. Group insurance or group-type coverage, whether insured or uninsured. This includes prepayment or group practice coverage. It also includes coverage other than school accident-type coverage.

2. Coverage under a governmental plan, or coverage required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended from time to time).

3. Medical benefits coverage of group and group-type contracts, except for mandated coverage under personal Injury protection insurance.

Each contract or other arrangement for coverage under (1), (2) or (3) is a separate plan. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate plan.

B. "This Plan" is the part of this Document that provides benefits for health care expenses.

C. "Primary Plan/Secondary Plan:" The order of benefit determination rules state whether This Plan is a Primary Plan or Secondary Plan as to another plan covering the person.

When This Plan is a Primary Plan, its benefits are determined before those of the other plan and without considering the other plan's benefits.

When This Plan is a Secondary Plan, its benefits may be reduced and it may recover from the Primary Plan the reasonable cash value of benefits provided by this Plan.

When This Plan is a Secondary Plan, its benefits are determined after those of the other plan and may be reduced because of the other plan's benefits.

D. "Allowable Expense" means the Usual and Customary Charge for an item of expense for health care, when the item of expense is covered at least in part by one or more plans covering the person for whom the claim is made. The difference between the cost of a private Hospital room and the cost of a semi-private Hospital room is not considered an Allowable Expense under the above definition unless the patient's stay in a

private Hospital room is Medically Necessary either in terms of generally accepted medical practice, or as specifically defined in the plan.

When a plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid.

When benefits are reduced under a Primary Plan because a covered person does not comply with the plan provisions, the amount of such reduction will not be considered an Allowable Expense. Examples of such provisions are those relating to services provided without required pre-authorizations by the Plan.

E. "Claim Determination Period" means a calendar year. However, it does not include any part of a year during which a person has no coverage under This Plan, or any part of a year before the date of this COB provision or a similar provision takes effect.

8.3 ORDER OF BENEFIT DETERMINATION RULES

A. General. When there is a basis for a claim under This Plan and another plan, This Plan is a Secondary Plan which has its benefits determined after those of the other plan, unless:

1. The other plan has rules coordinating its benefits with those of This Plan; and

2. Both those rules and This Plan's rules, in subparagraph B below, require that This Plan's benefits be determined before those of the other plan; or

3. The other plan is a governmental plan and federal law requires This Plan to be the Primary Plan.

B. Rules. This Plan determines its order of benefits using the first of the following rules which applies:

1. Non-Dependent/Dependent. The benefits of the plan which covers the person as an Employee (that is, other than as a Dependent) are determined before those of the plan which covers the person as a Dependent.

2. Dependent Child/Parents not Separated or Divorced. Except as stated in subparagraph 3 below, when This Plan and another plan cover the same child as a Dependent of different persons, called "parents:"

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

b) If both parents have the same birthday, the benefits of the plan which covered the parent longer are determined before those of the plan which covered the other parent for a shorter period of time.

However, if the other plan does not have the rule described in (a) immediately above, but instead has a rule based upon the gender of the parent, 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.

3. Dependent Child/Separated or Divorced. If two or more plans cover a person as a Dependent child of divorced or separated parents, benefits for the child are determined in this order:

a) First, the plan of the parent with custody of the child;

b) Then, the plan of the spouse of the parent with custody of the child; and

c) Finally, the plan of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expense of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. The plan of the other parent shall be the Secondary Plan. This paragraph does not apply with respect to any Claim Determination Period or Plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.

4. Active/Inactive Employee. The benefits of a plan which covers a person as an Employee who is neither laid off nor retired (or as that Employee's Dependent) are determined before those of a plan which covers that person as a 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 (4) is ignored.

5. Longer/Shorter Length of Coverage. If none of the above rules determines the order of benefits, the benefits of the plan which covered an Employee longer are determined before those of the Plan which covered that person for the shorter term. Two consecutive Plans shall be treated as one plan if the claimant was eligible under the second Plan within twenty-four (24) hours after the termination of the first Plan.

The start of a new plan does not include:

a) A change in the amount or scope of a Plan's benefits;

b) A change in the entity paying, providing or administering Plan Benefits; or

c) A change from one type of Plan to another (e.g., single employer to multiple employer plan).

6. **Continuation Coverage.** If an individual is covered under a continuation plan as a result of the purchase of coverage as provided under federal or state law, and is also covered under another group health plan, the following shall be the order of benefit determination:

a) First, the benefits of a plan covering the person as an employee (or as that employee’s dependent);

b) Second, the benefits of coverage purchased under the continuation plan.

If the other plan does not have the rule described above, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

8.4 EFFECT ON THE BENEFITS OF THIS PLAN

A. When This Applies. This Section applies when, in accordance with the Section titled, "Order of Benefit Determination Rules," This Plan is a Secondary Plan as to one or more other plans. In that event the benefits of This Plan may be reduced under this section. Such other plan or plans are referred to as "the other plans" in B immediately below.

B. Reduction in This Plan's Benefits. The benefits of this Plan will be reduced when the sum of:

1. The benefits that would be payable for the Allowable Expenses under This Plan in the absence of this COB provision; and

2. The benefits that would be payable for the Allowable Expenses under the other plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made; exceeds those

Allowable Expenses in a Claim Determination Period. In that case, the benefits of This Plan will be reduced so that they and the benefits payable under the other plans do not total more than those Allowable Expenses.

When the benefits of This Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of This Plan.

8.5 RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION.

Certain facts are needed to apply these COB rules. The Plan has the right to decide which facts it needs. It may get needed facts from or give them to any other organization or person. The Plan need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give the Plan any facts it needs to pay the claim.

8.6 FACILITY OF PAYMENT

A payment made under another plan may include an amount which should have been paid under This Plan. If it does, this Plan may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under This Plan. The Plan will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

8.7 RIGHT OF RECOVERY

If the amount of the payments made by the Plan is more than it should have paid under this COB provision, it may recover the excess from one or more of:

A. The persons it has paid or for whom it has paid;
B. Insurance companies; or
C. Other organizations.

The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services. Nothing in this Section shall be interpreted to require the Plan to reimburse a Covered Person in cash for the value of services provided by a plan which provides benefits in the form of services.

SECTION IX SUBROGATION AND REIMBURSEMENT

If a Covered Person is injured or becomes ill through the act of a third party, the Plan shall provide Covered Services in connection with the care for such Injury or Illness. As a condition to receiving any benefit under this Plan for any illness or injury sustained by the Covered Person due to the acts of a third party, Covered Person agrees that the Plan shall be subrogated to all of the Covered Person's rights to recover damages for such benefits. Acceptance of any benefit under this Plan by Covered Person will constitute consent to all provisions of this section.

The Plan shall have a right of reimbursement from any recovery by judgment, settlement or otherwise, which the Covered Person may receive or be entitled to receive from any source, including but not limited to, liability or other insurance covering the third party, uninsured or underinsured motorist insurance, medical payment or personal injury protection insurance and no-fault insurance.

If such Covered Person receives payment from a third-party suit, settlement or otherwise, such payment shall be deemed to be for medical services and supplies received by the Covered Person from the Plan with respect to such Illness or injury, and the Covered Person is hereby obligated to reimburse the Plan for all expenses incurred by the Plan for such services and supplies up to the amount received from such third-party suit, settlement or otherwise.

By accepting benefits the Covered Person, or his or her legal representative, gives the Plan a priority lien on all funds recovered by Covered Person up to the total amount of expenses incurred by the Plan for the services and supplies provided to the Covered Person. The Plan Administrator or his/her/its designee may give notice of that lien to any party who may have contributed to the loss. This lien is binding on any attorney, insurance company, or other party who agrees or becomes obligated to make payment to or on behalf of Covered Person as compensation for any damages suffered. The Plan's rights to reimbursement shall not be reduced by any reason whatsoever, including but not limited to the made-whole doctrine, the equitable distribution doctrine, the minor's doctrine, or the attorney fund doctrine. The Plan shall be repaid in full regardless of whether the settlement or judgment specifically designates the recovery or a portion thereof as including medical expenses. The Plan will not pay attorney fees or costs associated with you or your dependent's claim or lawsuit without the express written authorization of the plan administrator or its authorized agent. If Covered Person fails or refuse to reimburse the Plan, Covered Person agrees to reimburse the plan for attorneys fees and costs which it incurs in enforcing this provision.

If the Plan so decides, it may be subrogated to the Covered Person's rights to the extent of the benefits received under this Plan Document. This includes the Plan's right to bring suit against the third party in the Covered Person's name.

Covered Person or Covered Person’s legal representative shall do nothing to prejudice the plan's rights hereunder and agree to cooperate with the plan by furnishing such information and assistance, and executing such instruments as the Plan may require to facilitate enforcement of its rights under this provision. Entering into a settlement agreement with a party without the plan’s prior written consent will be deemed to prejudice the plan’s rights. Any Covered Person who fails to cooperate in the Plan's administration of this Section shall be responsible for reimbursing the Plan for expenses incurred by it for services subject to this Section (including any legal expenses incurred by the Plan to enforce its rights under this Section), and coverage of such Covered Person may be terminated in accordance with provisions herein.

SECTION X - CLAIMS FOR REIMBURSEMENT

10.1 PLAN PROVIDERS

Requests for benefits for services received from a Plan Provider shall be made to the Plan Provider by the Covered Person presenting his/her Plan identification card at the time such services are initiated. Plan Providers are responsible for submitting to the Plan all bills for services rendered to Covered Persons.

10.2 NON-PLAN PROVIDERS

Claims for Covered Services rendered by non-Plan Providers should be sent to the Plan c/o Sentara Health Management, 4417 Corporation Lane, Virginia Beach, VA 23462 for payment consideration. If a charge is made to a Covered Person for any service that is reimbursable under this Plan Document, written proof of such charge shall include an itemized statement plus diagnosis and must be submitted to the Plan within ninety (90) days after the delivery of the service. Failure to furnish such documentation within the specified period shall not invalidate nor reduce any such claim if for good reason it was not possible to submit the claim within the specified period, provided such proof is produced on a timely basis.

10.3 PAYMENT BY PLAN

The Plan may make payment to the person or institution providing the services. However, if the Covered Person furnishes evidence satisfactory to the Plan that payment has been made to such person or institution for the service covered, reimbursement will be made to the Covered Person after deducting any payment made by the Plan before receipt of such evidence.

SECTION XI - CONTINUATION OF COVERAGE – COBRA

** CONTINUATION COVERAGE RIGHTS UNDER COBRA**

Introduction

You are receiving this notice because you have recently become covered under a group health plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan as a "dependent child."

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: Brenda Robinson, Regent University Human Resources Department.

How is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep Your Plan Informed of Address Changes

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

Plan Contact Information

Brenda Robinson, Regent University Human Resources Department
1000 Regent University Drive
Virginia Beach, VA 23464
Phone: 757-352-4021

SECTION XII - COMPLAINT AND ADVERSE BENEFIT DETERMINATION APPEAL PROCEDURE

The Plan would like Covered Persons to be completely satisfied with the benefits they receive. Therefore, if a Covered Person has a problem or complaint concerning the operation of the Plan, any service received under the Plan, or the denial of a claim or service, a procedure has been developed for Covered Persons to register a complaint or appeal so these issues can be resolved in a fair and consistent manner in accordance with the Plan Document and Plan policies and procedures.

Should a problem or an incident cause dissatisfaction, it is hoped that it can be resolved informally between the Covered Person and the Plan staff or provider involved. If the problem is not resolved to the Covered Person's satisfaction, the following information describes the steps that the Covered Person must take to seek formal resolution of his or her problem or complaint. All claims against the Plan must be processed through the appeals procedure before the initiation of a lawsuit.

COMPLAINT PROCESS

A Covered Person may file a complaint in writing or verbally regarding a problem, complaint or concern regarding Plan benefits or provider services. The Covered Person will be notified of the receipt of the concern, and upon research and investigation, the Plan will notify the Covered Person of the resolution to their concern, including a clinical review of any quality of care issues.

ADVERSE BENEFIT DETERMINATION APPEAL PROCESS

An Adverse Benefit Determination means a denial, reduction, or termination of, or a failure to make payment (in whole or in part) for, a claim for a Covered Service based on:

- A Covered Person's eligibility to participate in the Plan;
- A Utilization Management decision; or
- Failure to cover an item or service because the Plan considers it to be Experimental, Investigational, or not Medically Necessary.

<u>The Plan's Appeals Process</u>

When the Plan makes an Adverse Benefit Determination, the Covered Person has the right to a full and fair review of the Plan's determination in accordance with the Plan's appeal procedure.

The Covered Person has 180 calendar days from the date he/she receives notice of the Plan's Adverse Benefit Determination in which to request an appeal in writing. Appeal forms and written appeal procedures will be available at the Covered Person's request.

The Covered Person has the right to designate an authorized representative, such as a physician or family Covered Person, to act on his or her behalf in filing an appeal of an Adverse Benefit Determination.

The Covered Person must complete the appeal process before seeking any alternative remedies available.

The appeal review takes into account all comments, documents, records, and other information submitted by the Covered Person relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination. Covered Persons may submit new information to the Plan in writing or in person. The review will not take the initial Adverse Benefit Determination into consideration, and the individual reviewing the appeal will not have participated in the original decision.

If the Adverse Benefit Determination under appeal relates in whole or in part to a medical judgment, including determinations regarding whether a particular treatment, drug, or other service is experimental, investigational, or not Medically Necessary or appropriate, a peer of the treating health care provider who specializes in a discipline pertinent to the issue under review, and who has not participated in the Adverse Benefit Determination or any prior reconsideration, will review the decision.

When the Plan completes its review of an Adverse Benefit Determination it will give the Covered Person written notification of the outcome. If the Plan does not reverse its decision the written notice will include:

- The specific reason or reasons for the Plan's Adverse Benefit Determination;

- Reference to the specific plan provisions on which the Plan based its determination; and
- Any further appeal rights available to the Covered Person.

Upon request, the Covered Person is entitled to the following free of charge:
- reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits.
- Copies of any internal rule, guideline, protocol, or other criteria relied upon in making the adverse decision;
- For denials due to medical necessity, experimental treatment, or a similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination applying the terms of the plan to the Covered Person's medical circumstances.

Types Of Claims.
The type of claim under review will determine what process the Covered Person or his or her designated representative must follow to request an appeal.

Pre-service claim means any claim for a benefit under the Plan for which the Plan requires approval before the Covered Person obtains medical care. An example would be obtaining Pre-Authorization for a diagnostic test or medical procedure. To appeal the Plan's decision on a Pre-Service claim the Covered Person must follow the Appeal Procedure for Pre- and Post-Service Claims explained below.

Urgent Care Claim means any claim for medical care or treatment where (1) if the Plan were to use its normal Pre-Service standards for making a coverage decision or a decision on appeal it would seriously jeopardize the life or health of the Covered Person or the ability of the Covered Person to regain maximum function; or (2) in the opinion of a physician with knowledge of the Covered Person's medical condition, following the Plan's normal appeal procedure would subject the Covered Person to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. A prudent layperson standard applies when determining what is an urgent care claim, except where a physician with knowledge of the Covered Person's medical condition determines that the claim is urgent. To appeal any denial of an Urgent Care Claim the Covered Person must follow the Appeal Procedure for Expedited Appeals.

Post-Service Claim means any claim for a benefit that is not a Pre-Service Claim; for example a claim for reimbursement for a diagnostic test already performed. To appeal a Post-Service Claim the Covered Person must follow the Appeals procedure for Pre- and Post-Service claims.

Concurrent care decision/claim means a Claim regarding a decision by the Plan to terminate or reduce benefits that it previously approved. Concurrent Claim also may be a request to extend the course of treatment already approved by the Plan. An example is where the Plan reviews an inpatient hospital stay approved for five days on the third day to determine if the full five days is appropriate. To appeal a Concurrent Care Decision/Claim the Covered Person must follow the procedure for expedited appeals.

Expedited Appeals Of Urgent Care Claims And Concurrent Care Decisions/Claims

The Covered Person or treating physician may request an expedited appeal by telephone, facsimile, or letter, and must explicitly state "expedited appeal" in the request to initiate this process. To Contact the Plan with a request for an expedited appeal:

By Phone: Call Covered Person Services at the number on the ID card
By Facsimile: at 757-687-6232
By Mail: send requests for an appeal to:

Sentara Health Management
APPEALS DEPARTMENT
P.O. Box 62876

Virginia Beach, VA 23466-2876

The Plan will consider an expedited appeal and notify the Covered Person of its decision as soon as possible, but not later than one business day after it receives all necessary information and not later than 72 hours from the receipt of the request.
Expedited appeals relating to a prescription to alleviate cancer pain shall be decided not more than twenty-four hours from receipt of the request.

Appeals Of Pre-Service Or Post-Service Claims Following An Adverse Benefit Determination By The Plan.

Requesting an Appeal.
To request forms to initiate a written appeal, please contact the Plan:
By Phone: Call Covered Person Services at the number on the ID card
By Facsimile: 757-687-6232
By Mail send requests to: Sentara Health Management
APPEALS DEPARTMENT
P.O. Box 62876
Virginia Beach, VA 23466-2876

The Covered Person must complete the information in the packet provided by the Plan to him or her and return it to the Plan. The Covered Person should provide to the Plan any new information for the Plan to consider when deciding the appeal. When completing the appeals forms, the Covered Person should make sure to include the following:
The Covered Person's name, address, telephone number, Covered Person number, and group number;
The date of service, place of service, provider and charge related to the service;
Any additional written comments, documents, records, or other information necessary to make a determination,
For Pre-Service Claims, the appeal decision will be completed and the Covered Person notified of the Plan's decision within 30 calendar days of the Plan's receipt of written request for the appeal.

For Post-Service Claims, the appeal decision will be completed and the Covered Person notified of the Plan's decision within 60 calendar days of the Plan's receipt of written request for the appeal.

Sources For Additional Information

You may also contact the nearest office of the U.S. Department of Labor, Employee Benefits Security Administration listed in your telephone directory or visit their website at www.dol.gov.

SECTION XIII - MISCELLANEOUS

13.1 MAJOR DISASTERS AND OTHER CIRCUMSTANCES BEYOND THE PLAN'S CONTROL

In the event that circumstances not within the Plan's or its designee's control including, but not limited to, a major disaster, epidemic, or civil insurrection, results in the facilities, personnel or resources used by the Plan or its designee being unable to provide or arrange for the benefits and services it has agreed to provide, the Plan shall make a good faith effort to arrange for an alternative method of providing such care and services insofar as practical and according to its best judgment. In such circumstances, however, neither the Plan, its designee nor Plan Providers shall incur any liability or obligation for delay, or failure to provide or arrange for such benefits and services.

13.2 SEVERABILITY

In the event that any provision of this Plan Document is held to be invalid or unenforceable for any reason, the invalidity or unenforceability of that provision shall not affect the remainder of this Plan Document, which shall continue in full force and effect in accordance with its remaining terms.

13.3 POLICIES AND PROVISIONS

The Plan may develop and adopt policies, procedures, rules and interpretations to promote orderly, equitable, and efficient administration of coverage.

13.4 NAMED FIDUCIARY AUTHORITY

In addition to those powers, rights and duties delegated to it elsewhere in the Plan, and the extent that the authority is not delegated to another person under this Plan, the Named Fiduciary shall have the authority to:

A. Interpret the Plan, decide all questions of eligibility and determine the amount, manner and time of payment of any benefits;
B. Adopt rules of procedures and regulations that it determines may be necessary for the proper and efficient administration of the Plan in a manner consistent with the provisions of the Plan;
C. Appoint individuals to assist in the administration of the Plan and any other agents it deems advisable including legal, accounting, and actuarial services.

13.5 ASSIGNMENT

No person other than Covered Person is entitled to receive Covered Services under this Plan Document. Such right to Covered Services is not transferable.

13.6 RELATIONSHIP OF PARTIES

A. **Independent Contractors.** Plan Providers are not agents or employees of the Plan, Sentara or SMHM, nor is the Employer, the Plan, Sentara or SMHM, or any employee of the Employer, the Plan, or Sentara, an employee or agent of Plan Providers. The Employer, the Plan, Sentara and SMHM shall not be liable for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries suffered by the Covered Person while receiving care from any Plan Provider or in any Plan Provider's facilities.

B. **Patient/Provider Relationship.** Plan Providers maintain the provider-patient relationship with Covered Persons and are solely responsible to Covered Persons for all health services. Certain Covered Persons may, for personal reasons, refuse to accept procedures or treatment by Plan Physicians. Plan Physicians may regard such refusal to accept their recommendations as incompatible with continuance of the

physician-patient relationship and as obstructing the provision of proper medical care. Plan Physicians shall use their best efforts to render all Medically Necessary Services and Supplies in a manner compatible with a Covered Person's wishes, insofar as this can be done consistently with the Plan Physician's judgment as to the requirements of proper medical practice. If a Covered Person refuses to follow a recommended treatment or procedure, and the Plan Physician believes that no professionally acceptable alternative exists, such Covered Person shall be so advised. In such case, neither the Plan, nor any Plan Provider, shall have any further responsibility to provide care for the condition under treatment. The continued refusal by the Covered Person to follow the recommended treatment or procedure(s) may result in termination of the Covered Person's coverage pursuant to provisions herein.

13.7 IDENTIFICATION CARD

Cards issued by the Plan to Covered Persons pursuant to this Plan Document are for identification only. Possession of a Plan identification card confers no right to services or other benefits under this Plan Document. To be entitled to such services or benefits, the holder of the card must, in fact, be a Covered Person. Any person receiving services or other benefits to which he or she is not then entitled pursuant to the provisions of this Plan Document will be liable for the actual cost of such services or benefits.

13.8 AUTHORIZATION TO EXAMINE HEALTH RECORDS

Each Covered Person consents to and authorizes a Physician, Hospital, Skilled Nursing Facility or any other provider of care to permit the examination and copying of any portion of the Covered Person's Hospital or medical records or claims information, when requested by the Plan or its designee. Information from such records of Covered Persons and information received from Physicians or Hospitals incident to the Physician-patient relationship or Hospital-patient relationship or claims information shall be kept confidential and, except for use reasonably necessary in connection with government requirements established by law or the administration of this Plan Document, may not be disclosed without the consent of the Covered Person. The Covered Person agrees that medical and Hospital records and claims information may be reviewed by the Plan Administrator and Sentara and may be shared between the Plan Administrator and Sentara for program audit and other purposes not inconsistent with applicable law.

13.9 MODIFICATIONS OF BENEFITS AND RIGHT TO TERMINATE

In accordance with this Plan Document, the Plan Sponsor makes coverage available to persons who are eligible under the Section titled, "Eligibility, Enrollment, and Effective Date." The Plan Sponsor reserves the right to amend, modify or terminate the Plan at any time. No change may be made to the Plan unless made in writing by the Plan Administrator with notice to Covered Persons in accordance with applicable federal law. This Plan Document shall be subject to amendment, modification, and termination by the Plan Sponsor without the consent or concurrence of any Covered Persons.

13.10 LIMITATION ON BENEFITS OF THIS PLAN

No person or entity other than the Plan Sponsor, Sentara and Covered Persons hereunder is or shall be entitled to bring any action to enforce any provision of the Plan against the Plan Sponsor, Sentara or Covered Persons hereunder, and the covenants, undertakings, and agreements set forth in the Plan shall be solely for the benefit of, and shall be enforceable only by, the Plan Sponsor, Sentara and the Covered Persons.

13.11 GOVERNING LAWS

The Plan shall be administered according to the laws of the Commonwealth of Virginia to the extent that such laws are not preempted by the laws of the United States of America.

13.12 PLAN NOT A CONTRACT OF EMPLOYMENT

The Plan does not constitute a contract of employment and participation in the Plan will not give any Employee the right to be retained in the employment of the Employer.