Ball State University of Muncie, Indiana, hereby establishes a plan for payment of certain expenses for the benefit of its eligible participants to be known as the Ball State University Employee Benefit Plan.

The Plan assures its covered participants that during the continuance of the Plan all benefits hereinafter described shall be paid to or on behalf of them in the event they become eligible for benefits.

The Plan is subject to all terms, provisions, and conditions recited on the following pages.

This plan is not in lieu of and does not effect any requirements for coverage by worker's compensation insurance.

Ball State University has caused this Ball State University Employee Benefit Plan to take effect as of 12:01 a.m. standard time on July 1, 2011 at Muncie, Indiana.

Ball State University

_____

Authorized Signature

_____

Attest

_____

Date

Ball State University

Employee Benefit Plan

Plan Document

Ball State University

Table of Contents

Plan Specifications

Company	Ball State University
Plan Administrator, Plan Fiduciary, and Agent for Process of Legal Service	Ball State University 2000 University Avenue Muncie, IN 47306 (765) 285-8461
Plan Name	Ball State University Low Deductible PPO Health Care Plan
Plan Supervisor	Key Benefit Administrators, Inc. P. O. Box 55210 Indianapolis, IN 46205 (317) 284-7100
Type of Administration	Contract Administration
Participant	Employees of Ball State University as defined in the Plan
Updated Effective Date	July 1, 2011
End of Plan Fiscal Year	June 30th of each year
Group Number	9009
Employer Identification Number	35-6000221
Plan Number	502

How to File a Claim

Instructions for filing a claim for yourself and/or your dependents are as follows if your physician or hospital is unwilling to do so for you:

1. The initial report of a claim should be done on the benefit request claim form that you can get from your employer. You should complete the patient information section. If you wish your medical benefits paid directly to your benefit providers, sign in item 13. A separate form should be submitted for each family member.

2. Have your physician give you a complete itemized bill that you can attach to the benefit request claim form. An itemized bill is one that shows a patient's name, relationship to the plan participant, date of service, the type of service rendered, and the nature of the accident or illness being treated. If this information is missing, please write it on the bill yourself and sign your name.

3. Send the completed benefit request claim form and the itemized bill directly to the Plan Supervisor at the address shown on the plan specifications of this document. Please note that if additional information is needed for payment of a claim, the Plan Supervisor will need to request this information before your claim can be processed.

Time Limit for Filing a Claim

You must submit claims for benefits under this plan within one year from the date that you received the service or supply. Claims submitted after this one-year period will not be payable under the Plan.

Ball State University

Schedule of Benefits – Low Deductible PPO Plan

Patient Protection and Affordable Care Act ("PPACA") Compliance

The Plan will at all times be in compliance with PPACA rules and regulations. PPACA requires that benefits that are offered by the Plan that are "Essential Health Benefits" as defined by the United States Department of Health And Human Services may not be restricted to less than a certain annual amount. If a major medical benefit of the Plan has an annual maximum below that amount, the Plan will continue to pay benefits for the Essential Health Benefit components of that benefit even though such payments would exceed the annual maximum for that benefit, but only until the annual Major Medical Calendar Year Maximum of the plan is paid.

Managed Care Program

Requires a participant or covered dependent to call a toll-free number upon learning of a future hospital admission, or within 48 hours after an emergency admission. If this provision is not followed, then hospital charges will be reduced by 50% per admission in addition to any deductible or coinsurance which might apply. Services rendered for Hospice Care must be precertified this includes services for inpatient or outpatient care. These services are subject to the 50% per admission penalty. This penalty does not apply toward the deductible or out of pocket maximum.

The following services require precertification:

- Inpatient hospital stay
- Non-Emergency MRI and CT Scans
- Outpatient orthopedic shoulder and knee surgeries
- Hospice
- Skilled Nursing

The Plan is subject to the utilization management program offered by the American Health Data Institute ("AHDI"). The bonus payment set out in the Schedule of Benefits will be paid when a covered person receives covered services from a participating provider with AHDI endorsement. A listing of participating providers with AHDI endorsement may be obtained from the AHDI web site that has been made available to the Plan. For the purposes of this plan, the term 'participating provider' is defined as a provider in the Encore network.

Preferred Provider Network

Benefits at an Encircle participating facility will be paid at 80%, benefits at a participating facility will be paid at 70%, benefits at an inpatient non-participating facility will be paid at 50%, and benefits at an outpatient non-participating facility will be paid at 60%. Benefits at a participating provider will be paid at 70%, while benefits at a non-participating provider will be paid at 60%. Benefits for an endorsed provider will receive a 10% bonus, resulting in a benefit of 80%. Benefits are paid subject to the coinsurance maximums as indicated below in the Schedule of Benefits.

If a participant or covered dependent receives ancillary and physician services, (i.e., anesthesiologists, radiologists, emergency room physicians, pathologists, etc.,) at a participating provider, the services provided by the non-participating provider will be paid at the AHDI endorsed participating provider benefit level. Also, if a participating provider refers the participant or covered dependent to a non-participating provider, services rendered by the non-participating provider will be paid at the AHDI endorsed participating provider level.

If a condition requires treatment from a specialist and there is no such specialist within a 30-mile radius of your home address, benefits will be paid at the AHDI endorsed participating provider level subject to the coinsurance maximum indicated below.

Integrated Deductible and Out-of-Pocket Maximums

The benefit deductible and out-of-pocket maximums of the Low Deductible PPO, High Deductible Wellness PPO, and the High Deductible HSA Qualified Health benefit plans will be integrated. A participant and/or dependent who switches coverage between the health benefit plans will have their benefit and out-of-pocket maximums, which are met under one plan, count toward the benefit and out-of-pocket maximums of the other plan. Participants are not to switch plans more than once every 3 years, unless otherwise directed by the Plan Administrator.

Major Medical Benefits

Note: All services are subject to the deductible and out-of-pocket maximums noted in this Schedule of Benefits unless otherwise stated.

Individual Deductible	$350 per person per calendar year
Family Deductible (**Employee plus Children or Employee plus Spouse/Domestic Partner or Employee plus Spouse/Domestic Partner and Children**)	$875 per family per calendar year The combined medical expenses of all covered family members can be applied to the $875 aggregate.

Individual Coinsurance	
Encircle Participating Hospital/Facility	80% of eligible charges paid by the Plan, unless otherwise stated, after satisfying the deductible When the out-of-pocket maximum per person per calendar year has been reached, then the Plan pays 100% thereafter for the remainder of the calendar year.
Participating Hospital/Facility	70% of eligible charges paid by the Plan, unless otherwise stated, after satisfying the deductible When the out-of-pocket maximum per person per calendar year has been reached, then the Plan pays 100% thereafter for the remainder of the calendar year.
Participating Physician with AHDI Endorsement	80% of eligible charges will be paid by the Plan, unless otherwise stated, after satisfying the deductible and includes a 10% bonus for AHDI endorsed providers When the out-of-pocket maximum per person per calendar year has been reached, then the Plan pays 100% thereafter for the remainder of the calendar year.
Participating Physician with no AHDI Endorsement	70% of eligible charges will be paid by the Plan, unless otherwise stated, after satisfying the deductible When the out-of-pocket maximum per person per calendar year has been reached, then the Plan pays 100% thereafter for the remainder of the calendar year.
Non-Participating Provider	60% of eligible charges will be paid by the Plan, unless otherwise stated, after satisfying the deductible When the out-of-pocket maximum per person per calendar year has been reached, then the Plan pays 100% thereafter for the remainder of the calendar year.

Non-Participating Inpatient Hospital/Facility	50% of eligible charges paid by the Plan, unless otherwise stated, after satisfying the deductible When the out-of-pocket maximum per person per calendar year has been reached, then the Plan pays 100% thereafter for the remainder of the calendar year.
Out-of-Pocket Maximums	
	Individual Maximum
Encircle Participating Hospital/Facility and Participating Provider with AHDI Endorsement	$1,725 per covered person per calendar year, **not including the deductible** Benefits paid at the 80% coinsurance rate are subject to this out of pocket maximum amount unless specifically noted.
Participating Hospital/Facility and Participating Provider with no AHDI Endorsement	$2,600 per covered person per calendar year, **not including the deductible** Benefits paid at the 70% coinsurance rate are subject to this out of pocket maximum amount unless specifically noted.
Combined Out-of-Pocket Maximum for Encircle Participating Hospital/Facility and Participating Hospital/Facility/ Participating Provider with AHDI Endorsement and no AHDI Endorsement	$2,600 per covered person per calendar year, **not including the deductible** Benefits paid at the 80% or 70% coinsurance rate are subject to this out of pocket maximum amount unless specifically noted.
Non-Participating Hospital/Facility and Provider	$3,450 per covered person per calendar year, **not including the deductible** Benefits paid at the 50% and 60% coinsurance rates are subject to this out of pocket maximum amount unless specifically noted.

Inpatient Hospital/Facility Services, including Intensive Care Unit	
Encircle Participating Hospital/Facility	80% of eligible charges, **subject to the deductible**
Participating Hospital/Facility	70% of eligible charges, **subject to the deductible**
Non-Participating Hospital/Facility	50% of eligible charges, **subject to the deductible** and subject to an additional per admission $2,000 penalty The penalty does not apply toward the deductible or maximum out of pocket expense.
Routine-Wellness Immunization Benefit	
Participating Provider with AHDI Endorsement	10% bonus for a total of 80% of eligible charges, **not subject to the deductible**
Participating Provider	70% of eligible charges, **not subject to the deductible**
Non-Participating Provider	60% of eligible charges, **subject to the deductible**
Nurse Practitioner/ Routine-Wellness Immunization Benefit	80% of eligible charges, **not subject to the deductible.**

Certified Nurse Midwife Routine-Wellness Immunization Benefit	
Participating Provider	80% of eligible charges, **not subject to the deductible**
Non-Participating Provider	60% of eligible charges **subject to the deductible**
Routine-Wellness Pap Smears/Mammograms/ PSA Tests/Colonoscopy/ Sigmoidoscopy	
Encircle Participating Hospital/Facility/Participating Provider with AHDI Endorsement	10% bonus for a total of 80% of eligible charges, **not subject to the deductible**
Participating Hospital/Facility/ Participating Provider	70% of eligible charges, **not subject to the deductible**
Non-Participating Hospital/Facility/ Non-Participating Provider	60% of eligible charges, **subject to the deductible**
Nurse Practitioner Routine-Wellness Pap Smears/ Mammograms/ PSA Tests	80% of eligible charges, **not subject to the deductible.**

Certified Nurse Midwife Routine-Wellness Pap Smears/ Mammograms/ PSA Tests	
Participating Provider	80% of eligible charges, **not subject to the deductible**
Non-Participating Provider	60% of eligible charges **subject to the deductible**
Nurse Practitioner Wellness Office Visits Associated with Wellness (Physical Exam)	Limited to maximum payment of $200 per visit. 80% of eligible charges, **not subject to the deductible.**
Certified Nurse Midwife Routine-Wellness Office Visits Associated with Wellness (Physical Exam)	Limited to maximum payment of $200 per visit
Participating Provider	80% of eligible charges, **not subject to the deductible**
Non-Participating Provider	60% of eligible charges **subject to the deductible**
Routine-Wellness Office Visits Associated with Wellness (Physical Exam)	Limited to maximum payment of $200 per visit
Participating Provider with AHDI Endorsement	10% bonus for a total of 80% of eligible charges, **not subject to the deductible**
Participating Provider	70% of eligible charges, **not subject to the deductible**
Non-Participating Provider	60% of eligible charges, **subject to the deductible**

Physician Office Diagnostic Visits (Exam Charge Only)	
Participating Provider with AHDI Endorsement	10% bonus for a total of 80% of eligible charges, **subject to the deductible**
Participating Provider	70% of eligible charges, **subject to the deductible**
Non-Participating Provider	60% of eligible charges, **subject to the deductible**
Nurse Practitioners Diagnostic Visit (Office Exam Charge Only)	80% of eligible charges, **not subject to the deductible.**
Chronic Disease Benefit	Refer to Section 2.30 for a list of chronic diseases. This benefit includes the exam charge and lab and EKG services related to the office visits.
Participating Provider with AHDI Endorsement	10% bonus for a total of 80% of eligible charges, **not subject to the deductible**
Participating Provider	70% of eligible charges, **not subject to the deductible**
Non-Participating Provider	60% of eligible charges, **subject to the deductible**

Birth Control Devices and Injections (Physician's Office)	
Participating Provider with AHDI Endorsement	10% bonus for a total of 80% of eligible charges, **not subject to the deductible**
Participating Provider	70% of eligible charges, **not subject to the deductible**
Non-Participating Provider	60% of eligible charges, **subject to the deductible**
Birth Control Devices and Injections (Other Locations)	
Encircle Participating Hospital/Facility	80% of eligible charges, **not subject to the deductible**
Participating Hospital/Facility	70% of eligible charges, **not subject to the deductible**
Non-Participating Hospital/Facility	60% of eligible charges, **subject to the deductible**
Nurse Practitioner Office Injections for Illness/Accident in the Office Note: Chemotherapy Injections in the Office are subject to the deductible	80% of eligible charges, **not subject to the deductible.**

Office Injections for Illness/Accident in the Physician's Office Note: Chemotherapy Injections in the Office are subject to the deductible	
Participating Provider with AHDI Endorsement	10% bonus for a total of 80% of eligible charges, **subject to the deductible**
Participating Provider	70% of eligible charges, **subject to the deductible**
Non-Participating Provider	60% of eligible charges, **subject to the deductible**
Ball State Employee Quick Care Clinic	100% of eligible charges, **not subject to the deductible**
Diabetic Education	100% of eligible charges, **not subject to the deductible** Services must be prescribed by a physician and provided by a certified diabetic educator.
Asthma Education	100% of eligible charges, **not subject to the deductible** Services must be prescribed by a physician and provided by a certified asthma educator.

Nutrition Counseling	100% of eligible charges, **not subject to the deductible** Services must be prescribed by a physician for diabetes, pre-diabetes, hypertension and/or hyperlipidemia and provided by a registered dietician.
Emergency Room Illness and Accident Benefit	
Hospital/Facility Charges	80% of eligible charges, **not subject to the deductible**
Physician Charges	80% of eligible charges, **not subject to the deductible**
Ambulance Benefit	80% of eligible charges, **subject to the deductible**
Pre-Admission Testing Benefit – Facility	To be performed within 72 hours prior to the individual's admission to the hospital, subject to the deductible
Encircle Participating Hospital/Facility	80% of eligible charges, **subject to the deductible**
Participating Hospital/Facility	70% of eligible charges, **subject to the deductible**
Non-Participating Hospital/Facility	60% of eligible charges, **subject to the deductible**

Pre-Admission Testing Benefit – Physician	To be performed within 72 hours prior to the individual's admission to the hospital, **subject to the deductible**
Participating Provider with AHDI Endorsement	10% bonus for a total of 80% of eligible charges, **subject to the deductible**
Participating Provider	70% of eligible charges, **subject to the deductible**
Non-Participating Provider	60% of eligible charges, **subject to the deductible**
In-hospital Visits – Physician	
Participating Provider with AHDI Endorsement	10% bonus for a total of 80% of eligible charges, **subject to the deductible**
Participating Provider	70% of eligible charges, **subject to the deductible**
Non-Participating Provider	60% of eligible charges, **subject to the deductible**
Surgical Expenses Facility	
	Inpatient Surgery
Encircle Participating Hospital/Facility	80% of eligible charges, **subject to the deductible**
Participating Hospital/Facility	70% of eligible charges, **subject to the deductible**
Non-Participating Hospital/Facility	50% of eligible charges**, subject to the deductible**

	Outpatient Surgery
	For surgery performed in a hospital outpatient department, physician's office, or an ambulatory surgical center
Encircle Participating Hospital/Facility	80% of eligible charges, **subject to the deductible**
Participating Hospital/Facility	70% of eligible charges**, subject to the deductible**
Non-Participating Hospital/Facility	60% of eligible charges, **subject to the deductible**
Surgical Expenses Physician	
	Inpatient Surgery
Participating Provider with AHDI Endorsement	10% bonus for a total of 80% of eligible charges, **subject to the deductible**
Participating Provider	70% of eligible charges, **subject to the deductible**
Non-Participating Provider	60% of eligible charges, **subject to the deductible**
	Outpatient Surgery
	For surgery performed in a hospital outpatient department, a physician's office or an ambulatory surgical center
Participating Provider with AHDI Endorsement	10% bonus for a total of 80% of eligible charges, **subject to the deductible**
Participating Provider	70% of eligible charges, **subject to the deductible**
Non-Participating Provider	60% of eligible charges, **subject to the deductible**

	Assistant Surgeons Charges are limited to a maximum benefit of 20% of the surgeon's allowable fee.
Participating Provider with AHDI Endorsement	10% bonus for a total of 80% of eligible charges, **subject to the deductible**
Participating Provider	70% of eligible charges, **subject to the deductible**
Non-Participating Provider	60% of eligible charges, **subject to the deductible**
LabCorp, Quest Diagnostic/LabCard, and American Health Network	100% of eligible charges, **not subject to the deductible** This benefit is for laboratory charges only**.**
Diagnostic X-ray Expenses- Physicians	
Participating Provider with AHDI Endorsement	10% bonus for a total of 80% of eligible charges, **subject to the deductible**
Participating Provider	70% of eligible charges, **subject to the deductible**
Non-Participating Provider	60% of eligible charges, **subject to the deductible**
Diagnostic X-ray Expenses- Facility	
Encircle Participating Hospital/Facility	80% of eligible charges, **subject to the deductible** All services will be subject to the Encircle Participating Hospital/Facility out of pocket maximum.
Participating Hospital/Facility	80% of eligible charges**, subject to the deductible** All services will be subject to the Participating Hospital/Facility out of pocket maximum.
Non-Participating Hospital/Facility	60% of eligible charges, **subject to the deductible**

Diagnostic for Routine-Wellness/Accident/Illness Laboratory Expenses - Physicians	
Participating Provider with AHDI Endorsement	10% bonus for a total of 80% of eligible charges, **subject to the deductible** All services will be subject to the Participating Provider with AHDI endorsement out of pocket maximums.
Participating Provider	80% of eligible charges, **subject to the deductible** All services will be subject to the Participating Provider out of pocket maximum.
Non-Participating Provider	80% of eligible charges, **subject to the deductible** All services will be subject to the Non-Participating Provider out of pocket maximum.
Diagnostic for Routine-Wellness/Accident/Illness Laboratory Expenses - Facility	
Encircle Participating Hospital/Facility	80% of eligible charges, **subject to the deductible** All services will be subject to the Encircle Participating Hospital/Facility out of pocket maximum.
Participating Hospital/Facility	80% of eligible charges**, subject to the deductible** All services will be subject to the Participating Hospital/Facility out of pocket maximum.
Non-Participating Hospital/Facility	80% of eligible charges, **subject to the deductible** All services will be subject to the Non-Participating Provider out of pocket maximum.

Substance Abuse Benefit	Payable as any other illness Note: All mental health and substance abuse providers are to be paid as AHDI Endorsed network providers. M.D. and facilities are not included in this exception. All services will be subject to the Encircle participating facility out of pocket maximum.
Mental Health Benefit	Payable as any other illness Note: All mental health and substance abuse providers are to be paid as AHDI Endorsed network providers. M.D. and facilities are not included in this exception. All services will be subject to the Encircle participating facility out of pocket maximum.
Chiropractic Services	80% of eligible charges, **subject to the deductible.**
Skilled Nursing Facility	**Pre-Certification required**
Encircle Participating Hospital/Facility	80% of eligible charges, **subject to the deductible**
Participating Hospital/Facility	70% of eligible charges, **subject to the deductible**
Non-Participating Hospital/Facility	50% of eligible charges, **subject to the deductible**

Hospice Care	**Pre-Certification and Case Management required**
Encircle Participating Hospital/Facility	80% of eligible charges, **subject to the deductible**
Participating Hospital/Facility	70% of eligible charges, **subject to the deductible**
Non-Participating Hospital/Facility (not including inpatient care)	60% of eligible charges, **subject to the deductible**
Inpatient Non-Participating Hospital/Facility	50% of eligible charges, **subject to the deductible** and subject to an additional per admission $2,000 penalty. The penalty does not apply toward the deductible or out pocket maximum.
Certified Nurse Midwife	See Section 4.38.
Participating Provider	80% of eligible charges, **subject to the deductible**
Non-Participating Provider	80% of eligible charges, **subject to the deductible**
Home Health Care	80% of eligible charges, **subject to the deductible**
Temporomandibular Joint Syndrome (TMJ)	80% of eligible charges, **subject to the deductible**

Organ Transplants-Facility	See Section 2.24
Encircle Participating Hospital/Facility	80% of eligible charges, **not subject to the deductible**
Participating Hospital/Facility	70% of eligible charges, **not subject to the deductible**
Outpatient Non-Participating Hospital/Facility	60% of eligible charges, **not subject to the deductible**
Inpatient Non-Participating Hospital/Facility	50% of eligible charges, **not subject to the deductible** and subject to an additional per admission $2,000 penalty. The penalty does not apply toward the deductible or out pocket maximum.
Organ Procurement	100% of eligible charges, **not subject to the deductible**
Transportation	100% of eligible charges, **not subject to the deductible**
Organ Transplants-Physician	See Section 2.24
Participating Provider with AHDI Endorsement	10% bonus for a total of 80% of eligible charges, **not subject to the deductible**
Participating Provider	70% of eligible charges, **not subject to the deductible**
Non-Participating Provider	60% of eligible charges, **not subject to the deductible**
Organ Procurement	100% of eligible charges, **not subject to the deductible**
Transportation	100% of eligible charges, **not subject to the deductible**

Physical, Speech and Occupational Therapy	80% of eligible charges, **subject to the deductible**
Durable Medical Equipment, Prosthetics and Orthotics	80% of eligible charges, **subject to the deductible**
Biomed Drugs	Biomed drugs must be purchased through the Medco's specialty drug pharmacy - Accredo.
Services for Nicotine Abuse from Tobacco	80% of eligible charges, **not subject to the deductible**
Accident Dental Benefit	80% of eligible charges, **subject to the deductible**
All Other Services – Facility Charges	
Encircle Participating Hospital/Facility	80% of eligible charges, **subject to the deductible**
Participating Hospital/Facility	70% of eligible charges, **subject to the deductible**
All Non-Inpatient Non-Participating Hospital/Facility	60% of eligible charges, **subject to the deductible**
Inpatient Non-Participating Hospital/Facility	50% of eligible charges, **subject to the deductible**

All Other Services – Physician Charges	
Participating Provider with AHDI Endorsement	10% bonus for a total of 80% of eligible charges, **subject to the deductible**
Participating Provider	70% of eligible charges, **subject to the deductible**
Non-Participating Provider	60% of eligible charges, **subject to the deductible**
Pregnancy	Covered the same as any other illness for the participant or covered dependent except that there is no pre-existing exclusion period which applies to maternity
Effective Date of Coverage	Eligible for coverage immediately upon date of hire
Dependent Child Maximum Age	A child of a participant is eligible for coverage under the plan until age 26 at which time coverage will end. This plan qualifies as a "grandfathered health plan" under section 1251 of the Affordable Care Act (generally, a plan that was in existence as of March 23, 2010). A child who is eligible to enroll in a health plan sponsored by his employer or the employer of his spouse is not eligible for coverage under this plan. This requirement will end as of the renewal of the plan that occurs in 2014.
Major Medical Lifetime Maximum	Unlimited

Prescription Drug Card	The prescription drug portion is carried with and administered by Medco. For questions, contact the Payroll and Employee Benefits Department at Ball State University.
	Mail Order Prescription Out-of-Pocket Maximum - $1,725 per person per calendar year
Generic Drugs	80% of eligible charges
Name Brand Drugs	70% of eligible charges
Maintenance Medications – Retail Refill Allowance Penalty	After the 3rd fill at a retail pharmacy, a 15% penalty is applied for maintenance medication refills.
Generic Drugs	65% of eligible charges
Name Brand Drugs	55% of eligible charges
Maintenance Medications – Medco Mail Order	
Generic Drugs	80% of eligible charges
Name Brand Drugs	70% of eligible charges

Other Important Considerations

Termination of Coverage	Refer to Section 1, Eligibility
Coverage after Termination	Refer to Section 1, Eligibility
Pre-Existing Condition Exclusion	Refer to Section 2, Comprehensive Major Medical

Medical Benefit Explanations and Exclusions

For a complete explanation of the aforementioned benefits, please refer to the rest of the document. For exclusions to the Plan, please refer to Section 3.

Dental	
Individual Deductible	$50 per person per calendar year, separate from medical
Family Deductible	$100 per family per calendar year, separate from medical
Dental Benefits	80% of reasonable and customary rate per calendar year
Preventive Dental	First $50 per calendar year paid at 100%, the balance paid at 80%.
Calendar Year Dental Maximum	$1,500 per person per calendar year

NOTE: Pediatric dental services are not subject to the above maximums for dependent children under age 18. This does not include Orthodontia.

Orthodontia	For participants and dependents
Individual Deductible	$50 per person per calendar year, separate from medical and common with dental
Family Deductible	$100 per family per calendar year, separate from medical and common with dental
Orthodontic Coinsurance	80% of reasonable & customary rate
Orthodontic Calendar Year Maximum	$500 per person per calendar year, separate from the dental maximum

Dental Benefit Explanations

For a complete explanation of the above benefits, please refer to section 6.

Section 1

Eligibility

1.00 Eligible Classes

Eligible persons include:

a) Regular full-time Faculty/Professional Personnel assigned half-time or more for the full academic year or at least for ten months of the fiscal year

b) Continuing Contract Professional Personnel assigned half-time or more for the full academic year or at least for ten months of the fiscal year

c) Coaches classified as full-time Professional Personnel hired under renewable term contracts which are one or more years in length

d) Contract full-time Faculty/Professional Personnel hired under renewable term contracts which are three or more years in length

e) Contract full-time Faculty/Professional Personnel assigned for no less than one academic year or one fiscal year

f) Contract full-time Faculty with the designation of Distinguished Professor, John R. Emens Distinguished Professor, or occupying endowed chairs provided such faculty are assigned for the full academic year

g) Contract part-time Faculty/Professional Personnel assigned at least half-time for no less than a full academic year

h) Regular full-time library Professional Personnel assigned on a fiscal year basis for at least 190 work days

i) Regular full-time Staff Personnel and Service Personnel assigned a normal work week of forty hours or more

j) Temporary Staff Personnel assigned a normal work week of forty hours or more on a fiscal year or other twelve-month basis

k) Contract full-time Doctoral Intern Counseling & Psychological Services Center Professional Personnel assigned on a fiscal-year basis

l) Eligible retirees of Ball State University

m) Contract full-time Faculty/Professional Personnel and temporary full-time Staff Personnel age and years of service eligible upon leaving the university

n) Dependents of all individuals in the foregoing items a) through m) inclusive, provided they qualify as a dependent as defined in the definitions section of the Plan

1.01 Enrollment

The employee may enroll in the Plan within 30 days of their employment date. If the employee does not enroll within this period they must wait for the period of open enrollment unless they qualify for a special enrollment.

All newborns will be covered for the first 30 days under the mother, or father if mother is not on the plan. To be eligible for coverage past the first 30 days the newborn must be enrolled in the plan within the first 30 days.

1.02 Effective Date of Coverage

Coverage under the Plan shall begin with the effective date of your employment provided you are actively at work. Coverage for your dependents begins with the effective date of your coverage. If the employee is not actively at work as of the date of the effective date, coverage for the employee and dependent(s) shall become effective as of the date the employee returns to work.

"Actively-at-work" means present and capable of carrying out the normal assigned duties on a scheduled workday unless the absence from work is health-related.

1.03 Special Enrollment

The Health Insurance Portability and Accountability Act of 1996 requires that group health programs allow certain individuals be covered by the Plan as ***special enrollees*** as follows:

A. If an otherwise eligible employee or dependent declined coverage under the Plan at the time of initial eligibility, and stated in writing at that time that coverage was declined because of other group health coverage, and that other group health coverage is subsequently lost, and that person makes application for coverage under the Plan within 30 days of the loss of the other health coverage, such individual shall be a ***special enrollee*** provided such person:

1. Lost the other health coverage as a result of loss of eligibility for the coverage (including as the result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment, but not including an increase in cost of the other coverage or reduction in benefits of the other coverage); or

2. Employer contributions toward such other coverage were terminated; or

3. If the eligible employee or dependent was covered under a COBRA continuation provision and the COBRA continuation period has been exhausted. Individuals who lose other health coverage due to non-payment of premium or for cause (e.g., filing fraudulent claims) shall not be a ***special enrollee*** under the Plan.

B. An otherwise eligible employee who is not covered by the Plan, an otherwise eligible employee and dependent who are not covered by the Plan, or a participant's dependent who is not otherwise covered by the Plan may apply for coverage under the Plan as a result of the acquisition of a new dependent by the participant through marriage and shall be a ***special enrollee*** provided such person is properly enrolled as a participant or dependent of the participant within 30 days of the acquisition of the new dependent.

C. A newborn child, a child placed for adoption, or a newly-adopted child of a covered participant will be covered from the moment of birth, placement for adoption, or adoption, including coverage for the necessary care or treatment of medically diagnosed congenital defects, birth abnormalities, or prematurity, provided the child is properly enrolled as a dependent of the participant within 30 days of the child's date of birth, adoption, or placement for adoption. To be covered beyond the first 30 days, the newborn must be added to your membership within the first 30 days.

D. Coverage for a ***special enrollee***, other than for a newborn, a child placed for adoption, or a newly-adopted child, shall be on the date of the qualifying event.

1.04 Open Enrollment

An open enrollment period shall be held at least 30 days prior to the beginning of each year for coverage to be effective the following July 1st . During this open enrollment period each employee shall have the opportunity to make changes to his coverage, i.e. enroll or drop himself or his dependents from the Plan by completing the required form and delivering it to the Plan Administrator.

1.05 Termination of Coverage

Termination of coverage of a participant will occur on the earliest of the following:

A. The provisions of the Plan for the coverage terminate,

B. His or her class is no longer included in the eligible coverage classes,

C. If the coverage is contributory, any contribution required of him or her for any coverage under the Plan is not made when due, or

D. Employment is terminated for any reason

Coverage terminates at 12:00 midnight on the last day of the month in which the termination event occurs.

The Plan Administrator will signify a participant's termination of employment by notifying the Plan Supervisor.

No contributory coverage may be continued beyond the end of the period for which the participant has made the required contributions to the Plan Administrator.

Any dependent coverage of a participant covered for dependent coverage will cease, regardless of continuation of other dependent coverage when one or more of the following apply:

A. The individual ceases to be a dependent as defined under the Plan,

B. The participant is no longer covered under this plan, and/or

C. The dependent becomes eligible for participant coverage in this plan

Coverage terminates at 12:00 midnight on the last day of the month in which the termination event occurs.

A child who has lost eligibility under the Plan may resume coverage if the child's reason for loss of eligibility no longer exists and the child otherwise meets the eligibility criteria of the Plan. Pre-existing rules apply as of the date of return to the Plan.

If a child who is a dependent as defined in the Plan is incapable of self-sustaining employment by reason of mental retardation or physical handicap and is chiefly dependent upon the participant for support and maintenance beginning prior to the end of the calendar year in which he or she turns the age specified in the Schedule of Benefits, coverage will continue for the dependent until the earliest of the following:

A. The participant discontinues his or her coverage under the Plan,

B. The participant is no longer considered an eligible participant,

C. The plan is cancelled, or

D. The disability no longer exists as determined by the Plan.

Satisfactory evidence of such disability and dependency is required by the Plan. Such evidence must be received within 120 days after the end of the calendar year in which the maximum age is attained. The Plan may require that the evidence of disability or dependency be updated annually.

1.06 Coverage After Terminations -- COBRA

All eligible participants and dependents covered under the Plan on the date before a qualifying event who would otherwise have lost coverage under the Plan as a result of any of the events listed below shall have the right to elect continuation coverage. Newborns and children placed for adoption with a person covered by COBRA continuation coverage may be added to their parent's coverage while the parent has coverage under COBRA if the Plan would otherwise allow such a child to be covered by the Plan. If a newborn child or child placed for adoption is added to the COBRA continuation coverage of the participant, such child shall be considered a qualified beneficiary under the Plan.

The company will notify the Plan Administrator of the participant's death, termination of employment, layoff or reduction of working hours, or when he or she becomes entitled to benefits under Title XVIII of the Social Security Act

within 30 days of the occurrence of any of these events. The participant or covered dependent must notify the Plan Administrator within 60 days of his or her divorce or legal separation or when a dependent child is no longer eligible for coverage as defined in the Plan, in order for continuation coverage to be offered to the dependent.

The Plan Administrator will notify the participant or covered dependent of his or her right to elect to continue coverage within 14 days from the date the Plan Administrator is first notified of any of the events described above. The election period shall begin not later than the date on which coverage terminates under the Plan due to any of the events listed below, shall be of at least 60 days duration, and shall end 60 days after the later of:

A. The date coverage terminates under the Plan due to any qualifying event listed below, or

B. The date the Plan Administrator sends notification to the participant or covered dependent of his or her rights under this provision as described above

Pursuant to the Trade Act of 1974, workers whose employment is adversely affected by international trade (increased imports or a shift in production to another country) may become entitled to receive Trade Act Assistance ("TAA") and may elect continuation coverage during a 60 day period that begins on the first day of the month in which he or she is determined to be a TAA eligible person. The person may elect coverage for himself or herself and his or her family. The election must be made not later than 6 months after the date of TAA related loss of coverage. Any continuation coverage elected during the second election period will begin with the first day of the second election period and not on the date which the coverage originally ended.

Benefits will be identical to those available under the Plan to all active participants and covered dependents who are similarly situated beneficiaries.

The Plan may require the participant and/or covered dependent pay for all or part of the cost for continuing his or her coverage, not to exceed 102% of the premium. If the participant or covered dependent is required by the Plan to pay the cost of continuing coverage, payment for the initial premium must be made within 45 days from the date of election. Payments must be made in monthly installments. Payments are due by the first day of the month for which coverage is being provided.

Covered dependent spouses and children are eligible for continuation of coverage for up to 36 months upon the occurrence of any of the following qualifying events which results in the loss of coverage under the Plan:

A. The death of the participant,

B. The divorce or legal separation of the participant from the covered dependent spouse,

C. The participant enrolls in Medicare, Part A, Part B, or both, or

D. With respect to a dependent child, the dependent child is no longer eligible for coverage as a dependent child as defined in the Plan

The participant and covered dependents shall be eligible for continuation of coverage for up to 18 months upon the occurrence of any of the following qualifying events which results in the loss of coverage under the Plan:

A. The participant's employment with the company terminates (except if due to the participant's gross misconduct), or

B. The participant is laid off or his or her working hours are reduced so as to render him or her ineligible for coverage as defined in the Plan

If the participant or covered dependent is disabled on or within 60 days of the initial qualifying event for continuation coverage due to termination of employment or reduction in hours, continuation coverage may be extended for all qualified beneficiaries within that family for up to 29 months from the qualifying event date rather than for only 18 months. The disabled person is subject to all of the following:

A. The Social Security Administration must make a determination that the person was disabled under Title II or XVI of the Social Security Act and that the disability began before or within 60 days after the qualifying event date;

B. The disability determination must be made by the Social Security Administration before the end of the original 18-month continuation of coverage period;

C. The person must notify the Plan Administrator within the later of 60 days after the disability determination has been made or the date of the qualifying event which results in a loss of coverage, and before the end of the original 18-month continuation of coverage period.

D. The person must notify the Plan Administrator within 30 days after the final determination is made that the person is no longer totally disabled; and

E. The cost for coverage for months one through 18 will be at the rate of up to 102% of the cost of the coverage, and the cost for months 19 through 29 will be at the rate of up to 150% of the cost of the coverage.

The continuation period will end when any of the following occur:

A. When the participant or dependent fails to make the required contribution (if any) to the Plan before the due date or within a grace period of 30 days;

B. When the participant or covered dependent first becomes covered by any other group health plan, except as described below, or first becomes entitled to Medicare benefits under Title XVIII of the Social Security Act;

C. When the company ceases to maintain any group health plan; or

D. In the case of a disabled participant and/or dependent who has been on continuation coverage for more than 18 months due to a disability, the month that begins more than 30 days after the date of the final determination under Title II or XVI of the Social Security Act that the person is no longer disabled

A retired participant and his or her spouse who would otherwise lose health coverage under the Plan after the employer files a Chapter 11 bankruptcy proceeding may continue coverage under the Plan until the death of the participant. Upon the death of the retired covered participant, his or her covered dependents shall be entitled to continuation coverage for a period of 36 months from the retiree's death.

If the participant or dependent first becomes covered under another group health plan or Medicare while covered under the Plan, continuation coverage may

continue only during the time that the new group health plan contains any exclusion or limitation which relates to a pre-existing condition of the participant or dependent. Normal payments for this coverage must be made in order for continuation coverage to remain in effect.

Any other group health plan will be considered the primary coverage and must always pay benefits before this plan will consider a claim for benefits. The only exception is that the Plan will remain primary if the COBRA covered person is covered by Medicare by reason of End Stage Renal Disease, and then only until the end of the first 30 months of Medicare coverage for that disease.

In no event shall coverage as provided in this provision be continued for more than 36 months. For example, if a dependent is receiving continuation of coverage benefits due to an 18-month qualifying event, and during the 18-month period, another qualifying event occurs which would entitle the person to 36 months of continuation coverage, that dependent shall be eligible for continuation of coverage for not more than a total of 36 months.

1.07 Family and Medical Leave Act Continued Coverage

All participants and their dependents covered under the Plan who are eligible for a leave of absence under the Family and Medical Leave Act of 1993 (i.e., FMLA) shall have the right to continue coverage under the Plan for the term of the leave of absence under the same terms, conditions, and coverage as enjoyed by all other participants.

If the Plan requires a contribution from the participant for normal coverage, those contributions must be paid by the participant during the term of the leave of absence in order for coverage under the Plan to continue.

If the leave of absence is a paid leave, normal contributions will be deducted from those payments. If the leave of absence is not a paid leave, the participant must pay the contribution to the Plan, through the company as the Plan Administrator, at the same time that contributions are normally taken from the company payroll. If a contribution is not made within 15 days of such date, coverage under the Plan for the participant and all covered dependents will end after a 15-day non-payment notice is given and payment is not received during the 15-day period. All eligible claims which are incurred during the 15 days will still be considered as eligible by the Plan. The company may withhold a delinquent contribution from any amount due the participant or may bring a legal action to recover the contribution if not paid by the participant.

If a participant returns to employment during or at the end of the FMLA leave of absence and during the leave the participant's coverage under the Plan has ended for any reason, the participant will be allowed to re-enter the Plan as of the date that the participant returns to work. The participant and those dependents who were previously covered by the Plan will not be subject to a new pre-existing condition waiting period. Coverage for new entrants at the time that the participant returns to work will be governed by the terms of the Plan.

The company may recover its contribution to the Plan for a participant who is on an unpaid FMLA leave of absence if the participant fails to return to work for at least 30 days after the FMLA leave has been exhausted or expires, unless the reason the participant does not return to work is due to one of the following:

A. The continuation, recurrence, or onset of a serious health condition which would entitle the participant to leave under the FMLA; or

B. Other circumstances beyond the participant's control.

The company may recover its contribution from any sums due the participant provided such deductions do not violate applicable federal or state wage payment or other laws. The company may also bring legal action against the participant to recover its share of the contribution.

If the participant elects or is required to substitute normal company paid leave (vacation, sick days, personal days, etc.) for part or all of a FMLA leave, the company may not recover its contribution for the period of the leave that is covered by the normal company paid leave.

1.08 Continuation of Coverage Under the Uniformed Services Employment and Re-employment Rights Act (USERRA)

Main point of the USERRA is to treat employees as if they have been continuously employed during the length of their military commitment for purposes of seniority, rights and benefits. This is for military leave that is 5 years in length or less, unless the employee is in the National Guard in which case the leave could be longer.
In order to receive certain benefits, the employee is required to file for re-employment within certain time frames upon their release from active military service. These time frames are as follows: For leave less that 31 days – return the next scheduled work day following an 8 hour period after return. For leave more than 30 days and less than 181 days – submit application for re-employment within 14 days. For leave more than 180 days – submit application for re-employment within 90 days.

Under this act employees are entitled to continue health benefits during their active military commitment. It has been determined that health benefits will be available to employees that ***enlist*** in any branch of the armed services which fall under this act as follows:

1) Leave less than 31 days, this may be continued at the employee rate.
2) Leave greater than 30 days, this may be continued for up to 24 months at a rate of 102% of the total premium (same as COBRA rate).

Employees are entitled to health benefits upon return following active military commitment. If health benefits are not continued during the leave or are exhausted during the leave, the Plan must permit re-enrollment as if the employee had not left employment. Pre-existing condition limits must be waived for any illness or injury excluding pre-existing conditions resulting from the military service.

Employees that are ***"called up"*** to active duty will receive the above health benefits with the following changes:

Health Care may be continued by the employee for the length of their military commitment at the regular employee share of the premium.

1.09 Compliance with Health Insurance Portability and Accountability Act of 1996

All provisions of the Plan are intended to bring the Plan into compliance with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Any provisions of the Plan which differ with the requirements of HIPAA are hereby amended so that the Plan shall at all times be in compliance with HIPAA and the Plan Administrator shall administer the Plan accordingly.

Pursuant to HIPAA, the Plan will at no time take into consideration any health status-related factors (including both physical and mental illnesses, prior receipt of health care, prior medical history, genetic information, evidence of insurability, conditions arising out of acts of domestic violence, or disability) which exist in relation to a person who is eligible for coverage under the Plan for purposes of determining the initial or continued eligibility of that person for coverage under the Plan, for determining the level of contribution of the person to plan funding, or for determining the level of benefits which will be made available to a person.

The Plan is a self-funded welfare benefit plan which provides medical benefits to covered persons. No benefits are payable by any insurance company. The company will provide all payments for the benefit plan. Employees may be required to pay a

contribution which will partially reimburse the employer for the cost of operating the Plan and for benefit payments.

All plan participants will be given written notice of any material reduction in benefits provided by the Plan within 60 days of the adoption of such material reduction.

Certificates of Prior Coverage Under the Plan

In 1996 the Health Insurance Portability and Accountability Act of 1996 (HIPAA) was passed by Congress. Under HIPAA, all employees and their dependents who are actually covered by the Plan will automatically receive a Certificate of Group Health Plan Coverage when they lose coverage under the Plan and upon the loss of coverage should continuation of coverage under COBRA be elected. Additionally, all employees and their dependents who lose coverage under the Plan may request a new certificate at any time during the 24 months which follow loss of coverage. The certificate will include information for both the covered employee and his dependents unless the information for a dependent is different from that of the covered employee, and in such case, a separate certificate will be issued for each such person.

The certificate will be issued free of charge to the employee or dependent and will show a new employer or group health plan the period that the employee or dependent was covered by the Plan, including the waiting period served prior to the effective date of coverage. A person who receives a certificate must provide the certificate to his new group health plan in order for the new group health plan to credit the period that the person was covered by the Plan against the pre-existing condition exclusion waiting period of the new group health coverage, if any.

1.10 Newborns' and Mothers' Health Protection Act of 1996

The Plan will at all times comply with the terms of the Newborns' and Mothers' Health Protection Act of 1996. The Plan will 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 normal vaginal delivery, or to less than 96 hours following a cesarean section.

The Plan will also not require that a provider obtain authorization from the Plan for the hospital stay of the mother or newborn child for the first 48 hours following a normal vaginal delivery or for the first 96 hours following a cesarean section.

Section 2

Comprehensive Major Medical Benefits

2.00 Eligible Expenses

The following services are eligible expenses for participants and dependents covered under this plan. Eligible expenses are subject to the deductible and coinsurance percentage as shown in the Schedule of Benefits and are limited by certain provisions listed in the general exclusions in Section 3 of this plan.

2.01 Pre-existing Condition Exclusion

Claims resulting from pre-existing conditions, as defined in the Plan, may receive up to $2,000 of benefits for a period of twelve (12) months from the enrollment date of the participant or dependent where the participant or dependent enrolls for coverage under the Plan when first eligible, pursuant to the requirements of the Plan for special enrollees.

If you previously had creditable health care coverage, the pre-existing condition waiting period will be reduced by the time you were covered under your previous health care plan(s), provided that coverage under your previous plan(s) and this plan is continuous without a break in coverage of 63 days or more. If your previous creditable health care coverage does not fully reduce the waiting period, the following benefit limitations apply during the pre-existing condition waiting period.

If a claim for benefits under the Plan is denied or reduced by operation of this provision, the covered person shall be entitled to appeal that decision and may provide additional evidence of prior creditable coverage pursuant to the normal procedure of the Plan for the appeal of any other coverage decision of the Plan.

The pre-existing condition provision for dependents or individuals under age 19 and who began coverage while under age 19 shall be waived.

2.02 Network

The Plan hereby includes the PPO Network. The Network consists of many of the full service hospitals in Indiana. Covered services provided by a participating provider will be payable at the normal percentage levels. Payments for covered services will be made directly to the participating hospital and payment for covered services by a physician or other provider of service, except a hospital, will be made to that provider unless designated by the participant. A list of participating providers and endorsed providers is available from your employer. Participating providers and endorsed providers may vary from one year to the next. Endorsed providers will receive a 10% bonus. Covered services provided by a non-participating provider will be subject to a penalty and paid at a lower percentage unless one of the following are applicable:

a) If a participating provider within a 30-mile radius of the employer is unable to provide the necessary care to the covered person, the penalty will not apply.

b) If the covered person resides outside of a 30-mile radius of a participating provider, the penalty will not apply.

c) If the covered person requires emergency medical treatment and is taken to the nearest appropriate hospital, the penalty will not apply. It will be considered emergency medical treatment when an accident is involved, when an illness is life threatening, or the covered person is not within a 30-mile radius of a participating provider when requiring medical treatment.

d) If the covered person is on vacation outside the state of residence, claims for medical emergencies will be paid at the participating level.

e) If a covered dependent attends school outside the state of the participant's residence, claims will be paid at the participating level.

f) If referred by an in-network provider to an out-of-network provider for anesthesiologists, emergency room physicians, pathologists, radiologists.

g) If the surgery center is in network but one of the providers is a non-participating provider.

2.03 Managed Care Program

The Managed Care Program is a health care benefit management program. It is a cost containment benefit built upon the components of pre-certification and case management.

I. PRE-CERTIFICATION PROCESS

Participants or their dependents with the benefit of a Managed Care Program must have every inpatient hospital stay certified. This is a participant driven and participant responsible program. The participant or agent for the participant may call, or have the admitting physician or hospital call to certify the stay. Medical, surgical, and psychiatric admissions must be certified prior to admission. Emergency admissions must be certified within forty-eight (48) hours of the admission.

The Plan will not require that a provider obtain authorization from the Plan for the hospital stay of the mother or newborn child for the first 48 hours following a normal vaginal delivery or for the first 96 hours following a cesarean section. If a newborn stays in the hospital longer than the mother, the newborn's hospital stay must be pre-certified.

At the time a medical, surgical, or psychiatric inpatient hospital admission **is planned** the participant or his or her dependent must let the physician know that the health care coverage includes the requirement of pre-certification.

If the Managed Care consultants find that the proposed care is medically necessary and the setting is appropriate, the medical consultants will certify the inpatient care and approve a length of stay.

If the Managed Care consultants find that the proposed inpatient care can be safely performed in an outpatient setting, the medical consultants will not certify the inpatient admission.

When certification is not obtained or the approved length of stay has been exceeded, payment for the hospital inpatient room and board, x-rays, laboratory, and drug portions of the care received without appropriate certification will be determined according to the following Benefits Calculation procedure:

a) Covered charges will be reduced by 50%.

b) Any applicable deductible will be subtracted from the remaining amount as determined in item a).

c) Any applicable coinsurance will be applied to the remaining amount as determined in item b) and the remainder will be paid.

d) Any inpatient charges for which benefits have not been paid due to item a) above are the covered person's responsibility and are not covered by any other portion of the Plan. They also will not apply to any deductible, nor will they accrue to any out-of-pocket maximum contained in the Plan.

Pre-certification is accomplished by telephoning a toll-free number on your I.D. card and providing the following information:

* Participant (Employee) Name

* Company Name

* Patient's name and age

* Admitting physician's name, address, and phone number

* Name of hospital and address

Calls received after hours will be recorded and the call will receive a response within one working day. In the case of emergency admissions, the call must be made within 48 hours or two (2) working days of the emergency admission.

II. CONCURRENT REVIEW

Inpatient care may be needed beyond the days initially certified. Days needed beyond those certified at admission must also be certified.

The Managed Care consultants will review the case and, if the physician can document the medical necessity for exceeding the approved length of stay, the medical consultants will certify additional days. At the time the certification is applied for, the medical consultants will also request information about all required tests. The medical consultants will not certify any extra inpatient days for tests that can be obtained on an outpatient basis prior to the inpatient admission.

III. APPEALS PROCEDURE

Upon request by a participant or provider, the Managed Care consultants will review an admission or length of stay which was not pre-certified. Upon the presentation of evidence of extraordinary circumstances or of medical information justifying the admission or length of stay which was not available to the participant or provider at the time of the initial request for certification, the Medical Consultants will certify that portion of the admission that is justified.

IV. CASE MANAGEMENT PROCESS

Case management is the process of assessing major or catastrophic illnesses and injuries and developing and coordinating a cost-effective alternative treatment plan. The process can be accomplished by utilizing current contract benefits or by proposing an exception to benefits. Additionally, case management monitors the quality of care in an appropriate place of service.

Clinical Case Managers who are all registered nurses, are responsible for identifying and carefully examining as early as possible every reasonable option in the care and treatment of patients suffering from a serious illness or injury. The clinical case managers then coordinate and facilitate a smooth transition to the alternate care setting. The case

management component is designed to help control the cost of treating victims of serious illnesses and injuries while monitoring for the highest quality of care.

The Managed Care Company has the authority to approve services which are not otherwise covered by the Plan if those services are as effective as a covered service but are less costly.

Coverage for alternative care is subject to the same contract maximum, deductible, and/or coinsurance requirements applicable to the medical care being replaced.

Examples of alternative means of care that may be offered are: skilled nursing facility, home health care, hospice care, or special medical equipment, such as ventilators and respirators.

2.04 Hospital Inpatient Expenses

Eligible Hospital Inpatient Expenses:

- Hospital daily services, including room, board and general nursing services and any flat charge for regular hospital services up to the limit shown in the Schedule of Benefits

- Hospital Room and Board is the eligible charge for an average semi-private room, unless the use of a private room is medically necessary, or the hospital only has private rooms; in such case, a private room will be paid the same as a semi-private room

- Hospital intensive care accommodation unit services, not to exceed the limitation for intensive care unit services shown in the Schedule of Benefits

2.05 Expenses In or Out of the Hospital

Including but not limited to the following:

- Operating room
- One admission kit per confinement
- Hospital Outpatient Services
- X-ray and laboratory services (including pathologist's and radiologist's charges)
- Surgery charges
- Anesthesia charges

- Radiation treatment of cancer and other abnormal growths

Services of other physicians including:

- Radiation therapy
- Pathological services
- Electrocardiograms
- Physical therapy
- Electroencephalograms
- Hospital visits
- Assistant surgeon charges
- Respiration/Inhalation Therapy
- Drugs and medicines

Other services:

- Nursing services (except those of a relative) performed by a registered nurse, nurse practitioner or a licensed practical nurse
- Medically necessary durable equipment, including purchase, repair and replacement. Routine maintenance is not covered. Deluxe items are limited to the cost of standard items. The eligible charge for rental equipment is limited to the purchase price of the equipment
- Orthopedic braces, crutches, and prosthetic devices, including purchase, fitting, repair and replacement
- Orthotic appliances including purchase, fitting, repair and replacement of braces, splints and other appliances used to support or restrain a weak or deformed part of the body see General Exclusions for more information
- Ambulance service when medically necessary to and from the medical facility rendering appropriate treatment, includes air and ground trips
- First pair of eyeglasses or contact lenses following cataract surgery
- Surgical dressings, cervical collar, colostomy bag, ileostomy supplies, catheters, insulin and syringes
- Blood and blood syringes
- Oxygen and its administration
- Speech therapy for children and adults for medically necessary treatment as a result of brain injury, birth defect, premature birth, mental and nervous disorders, cancer, dysphagia, aphasia or stroke
- Chiropractic services as indicated in the Schedule of Benefits
- Immunizations

- Immunizations and related office visit for the purpose of traveling outside the country
- Pap smears, mammograms, PSA testing, routine sigmoidoscopy, routine colonoscopy, routine immunizations and injections
- Diabetic education and training
- Asthma education
- Nutrition counseling.
- Home IV Therapy programs, if medically approved
- Mental health providers under the supervision of a physician or licensed psychologist
- Medically necessary occupational therapy performed by a state licensed occupational therapist is covered
- Dental services provided by a dentist, oral surgeon, or physician, including all related hospital outpatient charges, only as specifically provided in the Plan:
    - Treatment for accidental injuries to natural teeth
- Breast reconstruction in connection with a mastectomy:
    - Reconstruction of the breast on which the mastectomy has been performed
    - Surgery and reconstruction of the other breast to produce symmetrical appearance
    - Coverage for prostheses and physical complications of all stages of mastectomy, including lymphedemas, in a manner determined appropriate in consultation with the attending physician and the patient
- Any excise tax or surcharge imposed by a governmental entity for services, supplies and/or treatments rendered by a physician, hospital, facility or any other health care provider
- Voluntary bill audits, the Plan will provide payment for fees associated with bill discount programs

2.06 Expenses Out of the Hospital

Including but not limited to the following:

- Physician's office calls
- Physician's office surgery

2.07 Physician's In Hospital Visits

If a participant or dependent covered under this plan undergoes treatment by a physician, as defined in the Plan, during a period of hospital confinement of at least 15 hours because of injury or illness, the Plan shall pay the actual cost charged by the physician for such treatment up to the maximum as shown in the Schedule of Benefits. In determining the number of visits allowable, not more than one visit, per day, per diagnosis shall be considered. The total payment for all such charges for visits made during one period of hospital confinement shall not exceed the limits shown in the Schedule of Benefits.

2.08 Surgical Expense

Benefits paid for an assistant surgeon's surgery services are:

a. Subject to the deductible.

b. Payable at percentages indicated in the Schedule of Benefits.

c. Limited to a maximum of 20% of the primary physician's surgery allowable fee.

2.09 Diagnostic X-ray and Laboratory Benefit

Diagnostic x-ray and laboratory expense benefits provide payment for x-ray and laboratory tests and their interpretation. Benefits under this provision of the Plan are payable up to the limits as shown in the Schedule of Benefits for all injuries resulting from accident or illness in a calendar year.

Benefits are not payable for pre-marital laboratory tests, x-ray therapy, dentistry, eye refractions, expenses incurred while confined in a hospital, or x-ray or laboratory charges which would be considered under any other benefits of this plan.

2.10 Routine Immunization/Injection Benefit

The Plan will pay for immunizations/injections as indicated in the Schedule of Benefits per covered person.

2.11 Routine Mammograms, Pap Smears, and PSA Testing

Benefits are payable under the Plan for routine preventive expenses for mammograms, Pap smears, and PSA testing as shown in the Schedule of Benefits per covered person.

2.12 Routine Office Visits Associated with Wellness

Benefits are payable under the Plan for routine expenses associated with wellness up to the maximum benefit shown in the Schedule of Benefits per covered person per visit.

2.13 Emergency Room Benefit

If treatment is received for an illness or injury at a hospital outpatient emergency room department as shown in the Schedule of Benefits, the participant or dependent will be covered up to the eligible charge for all treatment related to the illness or injury.

2.14 Accidental Dental

Benefits paid for treatment of dental conditions caused by an accidental injury occurring after the insured's effective date by a provider facility and/or by a provider individual, including services in the provider individual's office are payable as shown in the Schedule of Benefits.

2.15 Pre-Admission Testing

The Plan will pay the amount as shown in the Schedule of Benefits for outpatient pre-admission testing. The testing must be performed within 72 hours prior to the individual's admission to the hospital. The testing must be necessary and consistent with the diagnosis and treatment of the condition for which the participant or covered dependent is being admitted to the hospital. Pre-Admission Testing does not include the following:

* Tests or studies performed to establish a diagnosis

* Tests or studies repeated when the covered person is admitted to the hospital as an inpatient

* Tests or studies if the covered person cancels or postpones the hospital inpatient admission

2.16 Individual Deductible

Participants and dependents covered under this plan must meet an amount of eligible expenses each calendar year equal to the deductible amount as shown in the Schedule of Benefits before major medical benefits can be paid.

If this plan replaces a prior plan during a calendar year, any deductible or coinsurance met during that calendar year shall apply toward the deductible and/or coinsurance described in this plan for the remainder of that calendar year.

The benefit deductible and out-of-pocket maximums of the Low Deductible PPO, High Deductible Wellness PPO and High Deductible HSA Qualified PPO health benefit plans will be integrated. A participant and/or dependent who switches coverage between the Low Deductible PPO, High Deductible Wellness PPO and High Deductible HSA Qualified PPO health benefit plans will have their benefit and out-of-pocket maximums, which are met under one plan, count toward the benefit and out-of-pocket maximums of the other plan.

2.17 Family Deductible

When covered family members have met an amount of eligible expenses equal to the Family Deductible amount shown in the Schedule of Benefits, the Individual Deductible for all other covered members in that family will be considered satisfied for the remainder of the calendar year.

The benefit deductible and out-of-pocket maximums of the Low Deductible PPO, High Deductible Wellness PPO and High Deductible HSA Qualified PPO health benefit plans will be integrated. A participant and/or dependent who switches coverage between the Low Deductible PPO, High Deductible Wellness PPO and High Deductible HSA Qualified PPO health benefit plans will have their benefit and out-of-pocket maximums, which are met under one plan, count toward the benefit and out-of-pocket maximums of the other plan.

2.18 Carryover Credit for Deductible

Eligible expenses that were incurred in October, November, and December of the calendar year and applied to the Individual or Family Deductible for that year shall apply to the next calendar year's Individual or Family Deductible. Deductibles satisfied because of a Common Accident provision shall not be considered eligible expenses as to the Carryover provision of this plan.

The benefit deductible and out-of-pocket maximums of the Low Deductible PPO, and High Deductible Wellness PPO health benefit plans health benefit plans will be integrated. A participant and/or dependent who switches coverage between the Low Deductible PPO, and High Deductible Wellness PPO health benefit plans will have their benefit and out-of-pocket maximums, which are met under one plan, count toward the benefit and out-of-pocket maximums of the other plan.

2.19 Common Accident Deductible

When two or more covered family members are injured in the same accident, only one deductible amount applies to all eligible expenses for treatment resulting from that accident.

2.20 Coinsurance Percentage

After eligible expenses incurred in a calendar year equal the deductible amount, eligible expenses incurred in the calendar year shall be paid at the coinsurance percentage as specified in the Schedule of Benefits.

2.21 Maximum Out-of-Pocket

When eligible charges incurred in a calendar year and paid under this plan reach the maximum out-of-pocket shown in the Schedule of Benefits, then eligible charges shall be paid at 100% for the remainder of that calendar year.

The benefit deductible and out-of-pocket maximums of the Low Deductible PPO, High Deductible Wellness PPO and High Deductible HSA Qualified PPO health benefit plans will be integrated. A participant and/or dependent who switches coverage between Low Deductible PPO, High Deductible Wellness PPO and High Deductible HSA Qualified PPO health benefit plans will have their benefit and out-of-pocket maximums, which are met under one plan, count toward the benefit and out-of-pocket maximums of the other plan.

2.22 Hospice Care – Pre-Certification and Case Management Required

Hospice Care coverage pays benefits for many of the charges incurred for the treatment of a terminally ill person while in a Hospice Care Program.

This care may be administered through either of the following:

A. Confinement in a hospital, or

B. A centrally administered, medically-directed, and nurse-coordinated program which provides a coherent system primarily of home care, is available 24 hours a day, seven days a week, and uses a Hospice team.

The program must meet standards set by the National Hospice Organization and approved by the Plan Supervisor. If such program is required by a state to be licensed, certified, or registered, it must also meet those requirements to be considered an eligible Hospice program.

Hospice Care Definitions

Counseling Services means supportive services provided after the death of the terminally ill person by members of the Hospice team in counseling sessions with the family unit.

Family Unit means the participant and his covered dependents.

Hospice means a free-standing or hospital-affiliated facility which provides short periods of stay for the terminally ill in a home-like setting for either direct care or respite. It must operate as an integral part of the Hospice Care Program.

Hospice Care Program means a formal program directed by a physician as defined in the Plan to help care for the terminally ill person.

Hospice Services means services and supplies furnished to a terminally ill person by the Hospice and/or the Hospice team.

Hospice Team means a group of professional and volunteer workers who provide care to as follows:

A. Reduce or abate pain or other symptoms of mental or physical distress, and

B. Meet the special needs arising out of the stresses of the terminal illness, dying, and bereavement. The team includes at least a physician and a

registered nurse. It could also include social workers, clergymen, counselors, volunteers, clinical psychologists, physiotherapists, and occupational therapists.

Remission means a halt in the progression of the disease that led to the terminal illness or an actual reduction in the extent to which the disease has already progressed.

Terminally ill means the primary attending physician who is treating the person has certified that the person's life expectancy is six months or less.

Hospice Care Benefits Other Than Bereavement Benefits

Benefits – The Plan will pay benefits up to the maximums shown in the Schedule of Benefits for any one period of care in a Hospice Care Program for charges incurred for the terminally ill person:

A. While not an inpatient in a hospice for Hospice services furnished under a Hospice Care Program, or

B. While an inpatient in a Hospice for hospice room and board and services for a Hospice Care Program.

Conditions for Benefits -- A terminally ill person must meet the following conditions:

A. Be in a Hospice Care Program, and

B. Have the primary attending physician furnish certification of the terminally ill status to the Plan Supervisor.

Further, the hospice services or stay must meet the following conditions:

A. Provided while the individual is covered under this plan,

B. Ordered by the supervising physician who is directing the Hospice Care Program,

C. Charged for by the Hospice Care Program, and

D. Provided within six months of the individual's entry, or re-entry after a period of remission, in the Hospice Care Program.

Hospice Care Exclusions

The following are not covered under this benefit:

A. Charges for services or supplies received as a result of an accident arising out of or in the course of work or an illness covered under Worker's Compensation or a similar law

B. Charges for services or supplies furnished by or for the U.S. government or for any other government, unless payment of the charge is required by law

C. Charges for services or supplies provided under any government program or law under which the individual is or could be covered

This exclusion does not apply to a state plan under Medicaid or to any law or plan which states that its benefits are in excess of those of any private insurance program or other non-governmental program.

D. Charges incurred during a remission period if the individual is discharged from the Hospice Care Program during that period

E. Charges for services provided by a close relative

F. Bereavement benefits

2.23 Convalescent Care

This provision shall provide benefits for expenses incurred during a covered convalescent confinement after a hospital stay of at least three consecutive days while covered under this plan. The confinement must start within 14 days of release from the hospital and be ordered by the attending physician for the condition necessitating the hospitalization. Refer to the Schedule of Benefits for further limitations.

The eligible expenses are the nursing home charges, up to the limits shown in the Schedule of Benefits, for the following services and supplies furnished while the patient is under continuous care of the attending physician and requires 24-hour care:

A. Room, board, and other services and supplies furnished by the facility for necessary care (other than personal items and professional services)

B. Use of special treatment rooms

C. X-ray and laboratory examinations

D. Physical, occupational and speech therapy, and/or

E. Oxygen and other gas therapy

2.24 Donor/Organ Transplant

Subject to the provisions of this benefit, a participant or covered dependent is entitled to the following transplant benefits when a Transplant Benefit Period begins while covered under this plan.

Transplant Procedure

A transplant procedure begins at the moment the incision is made in the recipient in order to implant the donated organs/tissue into the recipient's body. If the procedure does not progress to this step, no benefits will be paid under this provision for any services in preparation for, or incidental to, the transplant.

Pre-Notification

The Plan Supervisor or its designee must be notified before a covered transplant procedure is performed.

Transplant Services

Covered charges are all services, except procurement, transportation, lodging, and meals, furnished in connection with a heart, liver, pancreas, cornea, kidney, heart/lung or bone marrow transplant. Covered types of bone marrow transplants are limited to allogenic, autologous, and peripheral stem cell transplants, for treatment of leukemia, lymphoma, blood and genetic diseases, and solid tumors. Transplant services do not include bone marrow transplants for the treatment of diseases caused by, or infection from, any human T-cell leukemia virus.

Donor Organ or Tissue Procurement

Covered services are evaluation, surgical removal, storage costs, and transportation of a human organ or bone marrow used in a covered transplant procedure.

Benefits paid for procurement are 100% of covered charges.

Maximums:

$17,500 plan maximum per covered person for procurement, per transplant, for heart, liver, pancreas, kidney, cornea, and heart/lung transplants

$10,000 plan maximum per covered person for procurement, per bone marrow transplant

Transportation, Lodging, and Meals

Covered services are:

a) Transportation to and from the site of a transplant procedure for the recipient and/or the donor and one other individual; and

b) Up to $150 per day for lodging and meals for the individual accompanying the recipient and/or the donor

Exception:

If the recipient and/or the donor is under age 18 at the time of the transplant procedure, transportation, lodging, and meals for two individuals accompanying the recipient and/or the donor are covered charges, up to a total benefit of $150 per day for lodging and meals.

Benefits paid for transportation, lodging, and meals:

100% of actual charges up to the daily limit. Itemized bills for these charges must be furnished to the Plan Supervisor

Maximum:

$2,500 plan maximum for transportation, lodging, and meals, per heart, liver, pancreas, kidney, cornea, or heart/lung transplant

$10,000 plan maximum for transportation, lodging, and meals, per bone marrow transplant

If a covered transplant procedure is not done as scheduled due to the intended recipient's medical condition or death, benefits will still be paid as stated in this provision for donor organ or tissue procurement, transportation, lodging and meals.

Transplant Benefit Period

The benefit period per transplant is a period beginning 5 days before the date of the transplant and ending 18 months after the transplant is performed.

If two or more transplants are performed:

a) If they are due to unrelated causes, they will have separate transplant periods.

b) If they are due to related causes, they will have separate transplant benefit periods if:

- In the participant's case, they are separated by his or her return to active work; or
- In the case of a dependent, they are separated by at least 3 consecutive months

c) If they are due to related causes and not eligible for separation under b) above, they will have the same transplant benefit period.

2.25 Temporomandibular Joint Syndrome (TMJ)

The Plan provides benefits for expenses incurred for medical treatment of the Temporomandibular Joint (TMJ) and other jaw disorders and services directly attributable to the TMJ dysfunction. Benefits include but are not limited to office visits, diagnostic services, orthotic appliances, equilibrations and surgery.

Eligible charges are payable under the Schedule of Benefits for diagnostic services and surgery. Office visits, orthotic appliances and equilibrations are payable as shown in the Schedule of Benefits.

2.26 Pregnancy

Eligible charges include services for pregnancy, childbirth, complications of childbirth, abortion, and facility services for routine newborn nursery care.

Maternity is covered the same as any other illness for the participant and covered dependents.

2.27 Elective Sterilization

The Plan pays for certain elective sterilization procedures such as tubal ligations and vasectomies. These procedures shall be considered the same as any other illness only for covered participants and covered dependents.

Eligible expenses under this plan shall not include reversals or attempted reversals of these procedures.

2.28 Newborn Care

The benefits payable for eligible dependent children shall be paid for a sick or injured newborn infant of a member for the first 30 days of life under the mother, or father if mother is not on the plan. The coverage for the newborn infant consists of coverage of injury or sickness, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. This coverage includes, but is not limited to, benefits for inpatient or outpatient expenses arising from medical and dental treatment (including orthodontic and oral surgery treatment) involved in managing birth defects known as cleft lip and cleft palate.

To be covered beyond the first 30 days, the newborn must be added to your membership within the first 30 days.

All charges including hospital charges incurred by the newborn during the initial period of hospital confinement will be covered as charges of the mother or father if the mother is not covered under the Plan, but not to exceed 30 days. If the mother is not covered for the pregnancy, the child will still be eligible for coverage under this provision if the child is a dependent of the participant.

In addition, the following services will be covered during the same period:

A. Professional services, and/or

B. Circumcision

2.29 Physician Office Visit

The Plan will pay for physician office visits due to an accident or illness. The covered person pays the amount indicated in the Schedule of Benefits.

2.30 Chronic Disease Benefit

The Plan offers a Chronic Disease Benefit. The Chronic Disease Benefit includes the following diagnoses:

- Asthma
- Atherosclerosis
- Atrial Fibrillation
- Chronic Obstructive Pulmonary Disease (COPD)
- Chronic Renal Insufficiency
- Congestive Heart Failure (CHF)
- Coronary Artery Disease
- Depression
- Diabetes Mellitus
- Epilepsy
- Human Immunodeficiency Virus Infection
- Hyperlipidemia
- Hyperthyroidism
- Hypertension
- Hypothroidism
- Metabolic syndrome
- Multiple Sclerosis
- Parkinson's Disease
- Polymyalgia Rheumatica
- Pre-diabetes
- Pulmonary Hypertension
- Pulmonary Hypertension with COPD
- Rheumatoid Arthritis
- Schizophrenia
- Sleep Apnea
- Thrombo-embolic disease
- Ulcerative Colitis

The AHDI endorsed provider and participating provider deductibles will be waived on office visits for the specific chronic conditions and lab and EKG services related to the office visits.

The Plan offers a Chronic Disease Management Program. Persons who are covered by the Plan and identified as having specific chronic conditions will receive written communication from AHDI registered nurses. AHDI will offer confidential counseling and provide minimum care guidelines for the identified chronic disease(s).

2.31 Home Health Care Benefit

Charges made by a home health care agency for the following services and supplies furnished to a covered individual in his or her home for care in accordance with a home health care plan are included as covered medical expenses.

- Part-time or intermittent nursing care by a registered nurse or a licensed practical nurse if the services of a registered nurse are not available
- Part-time or intermittent home health aide services which consist primarily of caring for the individual
- Physical, occupational, and speech therapy
- Medical supplies, drugs, and medicines prescribed by a physician, and laboratory services provided by or on behalf of a hospital, but only to the extent that they would have been covered under this plan if the individual had remained in the hospital

Section 3

General Exclusions

General Exclusions to the Plan

Covered expenses do not include and no benefits are payable for the following:

3.00 Services and supplies for transplants, except as specifically stated

3.01 Services and supplies for artificial heart implants

3.02 Services and supplies for fertility treatment

3.03 Services and supplies for artificial insemination

3.04 Services and supplies for a sex change

3.05 Services and supplies for in vitro fertilization

3.06 Services and supplies for radial keratotomy

3.07 Services and supplies for gamete intra fallopian transfer (GIFT)

3.08 Charges for reversal of sterilizations

3.09 Services provided by a provider individual who is a member of the participant's immediate family

3.10 Eyeglasses, contact lenses, or examinations to prescribe or fit such items (eye refractions), except that the cost of the first pair of eyeglasses, contact lenses, or intraocular lenses required following cataract surgery are not excluded

3.11 Hearing aids or examinations to prescribe or fit them

3.12 Services, supplies, or hospital care which, in the judgment of KBA's medical consultants, are not medically necessary for the treatment of illness, injury, diseased condition, or impairment

3.13 Custodial care whose primary purpose is to meet personal rather than medical needs. Such care includes, but is not limited to, helping a patient walk, getting in or out of bed, or taking normally self-administered medicine. The Plan Administrator shall determine, based on reasonable medical evidence, whether care is custodial

3.14 Services and supplies for dental care, except as specifically stated under ***Dental*** in this Section or if due to an accident as stated in the Schedule of Benefits

3.15 Private duty nursing, except as specifically stated under *Comprehensive Major Medical Benefits*

3.16 Any experimental treatment, procedure, facility, equipment, drug, device, or supply

3.17 Treatment and care connected with or incidental to treatment that is intended primarily to improve the covered person's appearance regardless of whether such treatment is due to psychological reasons. However, benefits will be provided for treatment and care intended to restore bodily function or correct deformity resulting from disease, accidental injury, birth defects, or previous therapeutic process

3.18 Charges for services or supplies for occupational accidents and diseases which are or could have been paid for or are available under the requirements of Worker's Compensation and Occupational Disease Law except when Worker Compensation claims are denied by the Worker Compensation administrator, then the claim will be eligible to be paid through the medical plan

3.19 Preventive or routine care, including physicals and premarital examinations, and any other routine or periodic examinations, except as specifically stated under *Comprehensive Major Medical Benefits*

3.20 Services and supplies for research studies or screening examinations, except as specifically stated under *Comprehensive Major Medical Benefits*

3.21 Treatment of any injury or illness resulting from war, act of war, rebellion, or taking voluntary part in a riot

3.22 Services or supplies to the extent the participant has no legal obligation to pay

3.23 Expenses incurred before a participant's coverage begins or after it ends, except as specifically stated elsewhere in this plan document

3.24 Rest cures or sanatorium care

3.25 Services or supplies furnished by any person or institution acting beyond the scope of his/her/its license

3.26 Care or supplies to the extent the charge is a Medicare Part A or Part B liability or would be a Medicare Part A or Part B liability if the insured had enrolled in

Medicare. This exclusion does not apply to those employees of the University Medicare age or older, or to their spouses Medicare age or older, who have elected coverage under this plan as their primary coverage

3.27 Services or supplies received from a dental or medical department maintained by or on behalf of a group, a mutual benefit association, labor union, trust, or similar person or group

3.28 Services provided by any governmental agency to the extent provided without cost to the insured, except as this exclusion may conflict with federal or state law

3.29 Travel, whether or not recommended by a physician

3.30 Services or supplies not specifically stated as covered

3.31 Telephone consultations, charges for failure to keep a scheduled visit, or charges for completion of a claim form

3.32 Recreation or diversional therapy

3.33 Personal hygiene and convenience items, such as air conditioners, humidifiers, hot tubs, whirlpools, or physical exercise equipment, even if such items are prescribed by a physician

3.34 Hospitalization for environmental change and all related charges

3.35 Services and supplies, including surgical services and supplies, for the treatment of obesity and/or weight control

3.36 Dental services performed by a dentist in the participant's home or in a provider facility, except in connection with oral surgery or emergency care

3.37 Dental services or supplies furnished as a result of loss or theft of an artificial denture or orthodontic appliance

3.38 Supportive devices (orthotics) of the feet; care of flat feet, fallen arches, weak feet, or chronic foot strain; treatment of corns, bunions, calluses, or toenails; however, orthotics, care of corns, bunions, calluses, or toenails is covered when medically necessary because of diabetes or circulatory problems

3.39 Stand-by charges of a physician

3.40 Prescription drugs purchased at a retail pharmacy including biomed prescriptions

3.41 Foot support devices such as arch supports and corrective shoes unless they are an integral part of a leg brace, standard elastic stockings, garter belts, and other supplies not specially made or fitted are not covered services

3.42 Alternative medical treatment, services and supplies (including massage therapy) are excluded

3.43 Charges that are in excess of the reasonable and customary rates and/or that are not medically necessary for the treatment of the diagnosed illness or injury as determined by the Plan

Section 4

Definitions

4.00 Actively-at-Work

"Actively-at-work" means present and capable of carrying out the normal assigned duties on a scheduled workday unless the absence from work is health-related.

4.01 Chiropractic or Chiropractic Services

Chiropractic or Chiropractic Services means the diagnosis and analysis of any interference with normal nerve transmission and expression, the procedure preparatory to and complementary to the correction thereof by an adjustment of the articulations of the vertebral column, its immediate articulation, and includes other incidental means of adjustments of the spinal column and the practice of drugless therapeutics. However, chiropractic does not include any of the following:

a) Prescription or administration of legend drugs or other controlled substances;

b) Performing of incisive surgery or internal or external cauterization;

c) Penetration of the skin with a needle or other instrument for any purpose except for the purpose of blood analysis;

d) Use of colonic irrigations, plasmatics, ionizing radionics;

e) Conducting invasive diagnostic tests or analysis of body fluids except for urinalysis;

f) The taking of x-rays of any organ other than the vertebral column and extremities; and

g) The treatment or attempt to treat infectious diseases, endocrine disorders, or atypical or abnormal histology.

4.02 Clinical Laboratory

A laboratory that performs clinical procedures and is not affiliated or associated with a hospital, physician or other provider.

4.03 Coinsurance

The percentage of covered charges for which the insured is responsible under the terms of the Plan. Coinsurance takes effect after any deductible is met and before any out of pocket limit is reached.

4.04 Community Mental Health Center

A facility which offers a program of services approved by the Indiana Department of Mental Health, is organized for the purpose of providing multiple services for persons with mental illness, including substance abuse, and is operated by one or more of the entities named in I.C. 16-16-1-1.

4.05 Convalescent Facility

An institution, or a distinct part of an institution meeting all of the following tests:

a) It is licensed to provide and is engaged in providing, on an inpatient basis, for persons convalescing from injury or disease, professional nursing services rendered by a registered graduate nurse or by a licensed practical nurse under the direction of a registered graduate nurse, physical restoration services to assist patients to reach a degree of body functioning to permit self-care in essential daily living activities.

b) Its services are provided for compensation from its patients and which patients are under the full-time supervision of a physician or registered graduate nurse.

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

d) It maintains a complete medical record on each patient.

e) It has an effective utilization review plan.

f) It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, the mentally handicapped, custodial or educational care, or care of mental disorders.

4.06 Covered Services

Services or supplies specified in the Plan for which benefits will be paid when provided by a provider acting within the scope of the provider's license. In order to be considered a covered service, charges for that service must be incurred while the insured's coverage under the Plan is in force.

4.07 Custodial Care

Care for which the primary purpose is to meet personal rather that medical needs, designed to help meet daily living activities, which is not primarily provided for its therapeutic value in the treatment of an illness, disease, bodily injury, or medical condition, and which can be provided by persons with no special medical skills or training. Such care includes, but is not limited to, helping a patient walk, get in or out of bed, and take normally self-administered medicine. The Plan Supervisor will determine, based on reasonable medical evidence, whether care is custodial.

4.08 Deductible

The specified dollar amount of covered charges that must be incurred by an insured before the Plan will begin to pay benefits which are subject to the deductible. The deductible will apply to expenses for routine nursery care and supplies incurred by a newborn. If two or more persons, covered by the same membership, are injured in the same accident, only a single deductible will be applied to all covered charges that are related to that accident.

4.09 Dependent

The term dependent means the spouse of a participant, and the following unmarried children who qualify as the participant's dependent for Federal Income Tax purposes:

a) Natural children;

b) Stepchildren;

c) Legally adopted children;

d) Children for whom the person or the person's spouse is legal guardian;

e) Children for whom coverage must be provided pursuant to a divorce decree;

f) Grandchildren

The child shall remain a dependent under the Plan until:

a) Marriage;

b) Attaining the age specified in the Schedule of Benefits; or

b) Becoming eligible to obtain participant coverage under this plan

A child who has lost eligibility under the Plan may resume coverage if the child's reason for loss of eligibility no longer exists and the child otherwise meets the eligibility criteria of the Plan.

If a child who is a dependent as defined in this plan is incapable of self-sustaining employment by reason of mental retardation or physical handicap and is chiefly dependent upon the participant for support and maintenance beginning prior to the end of the calendar year in which he turns the age specified in the Schedule of Benefits, coverage will continue for the dependent until the earliest of the following:

a) The participant discontinues his coverage under the Plan;

b) The participant is no longer considered an eligible participant;

c) The plan is cancelled; or

d) The disability no longer exists as determined by the Plan

Satisfactory evidence of such disability and dependency is required by the Plan. Such evidence must be received within 120 days after the end of the calendar year in which the maximum age is attained. The Plan may require that the evidence of disability or dependency be updated annually.

Same-Sex Domestic Partners need to meet the following criteria under the Plan:

a) The employee and the domestic partner have shared the same residence and have been in an exclusive relationship for at least six (6) months;

b) Neither the employee nor the domestic partner is married or in a domestic partnership relationship with anyone else;

c) Both the employee and the domestic partner are at least eighteen (18) years of age and mentally competent to contact;

d) The employee and the domestic partner are not related by blood closer than would bar marriage in the state of Indiana by reason of blood relationship;

e) The employee and the domestic partner have agreed to be jointly responsible for each other's necessities, including without limitation food, clothing, housing, and medical care; and

f) The employee and the domestic partner must provide documentation of significant financial interrelationships, such as joint ownership or lease of a home, as well as other documentation such as establishing joint bank accounts, designating of each other as beneficiary of life insurance, retirement benefits, will, and any other binding contractual financial relationships.

4.10 Diagnostic Services

The following procedures ordered by a provider individual, because of specific symptoms, in order to determine a definite condition or disease:

1. Radiology, ultrasound, and nuclear medicine;
2. Laboratory and pathology;
3. EKG, EEG, and other electronic diagnostic medical procedures;
4. Psychological testing;
5. Neuropsychological testing

Diagnostic services are covered to the extent specified under the Schedule of Benefits section.

4.11 Donor

A donor is the person who provides the organ for the recipient in connection with organ transplant surgery. A donor may or may not be a participant or covered dependent covered under the provisions of this plan.

4.12 Effective Date

The effective date shall mean the first day this plan was in effect as shown in the plan specifications. As to the individual, it is the first day that coverage begins.

4.13 Eligible Charges

Eligible Charges means charges for services covered under the Plan. However, benefits will include only reasonable and customary charges based upon opinions rendered by medical professionals selected by the Plan Administrator.

4.14 Enrollment Date

The term "Enrollment Date" is defined as the first day of coverage.

For a person who is a Late Enrollee or who enrolls on a Special Enrollment date, the "Enrollment Date" will be the first date of actual coverage.

4.15 Experimental

The term ***experimental*** is if one or more of the following is true of a treatment, procedure, device, drug, or medicine:

- It cannot be lawfully marketed without U.S. Food and Drug Administration approval and approval for marketing for the condition treated has not been given at the time the device, drug, or medicine is furnished;

- Reliable evidence shows that to determine its maximum tolerated dose, toxicity, safety, efficacy (or efficacy as compared with the standard means of treatment or diagnosis):

  a. It is undergoing phase I, II, or III clinical trials or is under study; or

b. Further clinical trials or studies are needed, according to the experts' consensus of opinion

Reliable evidence means only published reports and articles in the authoritative medical and scientific literature or the written protocol or written informed consent used by the treating facility (or by another facility studying substantially the same treatment, procedure, device, drug, or medicine).

Experimental or ***investigational*** shall also mean:

- Any treatments, services, supplies or related expenses that are educational or provided primarily for research; or

- Treatments, procedures, devices, drugs or medicines, or other expenses relating to the transplant of non-human organs

4.16 Free Standing Dialysis Facility

A facility which is primarily engaged in providing dialysis treatment, maintenance, or training to patients on an outpatient or home care basis.

4.17 Gender

Whenever a personal pronoun in the masculine gender is used, it shall include the feminine also, unless the context clearly indicates the contrary.

4.18 Illness

An injury, sickness, a disease, a bodily or mental disorder, a pregnancy, or any birth defect of a newborn child. Conditions that exist and are treated the same time or are due to the same or related causes are considered to be one illness.

4.19 Incurred Charge

The charges for a service or supply is considered to be incurred on the date it is furnished. In the absence of due proof to the contrary when a single charge is made for a series of services, the date of service shall be considered the last date of service shown on the claim. To be considered an incurred charge under the Plan, the incurred date must be during the time period that the participant or dependent's coverage is in effect.

4.20 Identification Card

A card issued by the Plan Supervisor that bears the participant's name, identifies his or her group number, and may contain information about his or her coverage.

4.21 Injury

The term injury shall mean only bodily injury caused by an accident while the Plan is in force as to the covered person whose injury is the basis of the claim. Injury shall mean only those injuries which require treatment by a physician.

4.22 Late Enrollee

The term "Late Enrollee" means an Employee or Dependent who requests enrollment for coverage under the Plan other than during the period of initial eligibility or during a period of Special Enrollment.

4.23 Lifetime

Wherever the word ***lifetime*** appears in this plan document in reference to benefit maximums and limitations, it is understood to mean while covered under this plan, all of the Plan's coverage options combined together if more than one is offered, and all other health benefit plans offered by the employer, if any, unless such other health benefit plan specifically provides a lifetime maximum. Under no circumstances does lifetime mean during the lifetime of the covered person.

4.24 Medically Necessary

The term ***medically necessary*** refers to medical services and/or supplies which are absolutely necessary and essential, as determined by the Plan, to treat an illness or injury of a covered participant or dependent while covered by this plan. Such items are as follows:

- Consistent with the patient's diagnosis or symptoms; and
- Appropriate treatment according to generally accepted standards of medical practice; and
- Not provided only as a convenience to the patient or provider; and
- Not experimental or unproven; and
- Not educational, vocational, or provided primarily for medical or other research; and
- Not excessive in scope, duration, or intensity to provide safe, adequate, and appropriate treatment to the covered person

Any service or supply provided at a provider facility will not be considered medically necessary if the covered person's symptoms or condition indicate that it would be safe to provide the service or supply in a less comprehensive setting.

4.25 Medicare

The programs established by Title XVIII of the U.S. Social Security Act as amended and as may be amended, entitled Health Insurance for the Aged Act, and which includes Part A - Hospital Insurance Benefits for the Aged and Part B - Supplementary Medical Insurance Benefits for the Aged.

4.26 Occupational, Physical and Speech Therapy

Occupational, physical and speech therapies are the use of therapeutic activity designed to improve or restore functions which have been impaired due to a congenital disability, illness or injury, or where function has been permanently impaired or lost due to an illness or injury. These therapies are to improve an individual’s ability to perform activities for daily living.

Coverage for these therapies include, but are not limited to, the following criteria:

a) A written treatment plan must be submitted for approval;

b) Services must be part of a written treatment plan that is specific, goal-directed, includes timelines, and involves generally accepted modalities that are consistent with the patient's current and potential level of function;

c) The expectation is that services will result in practical improvement in the patient's level of functioning within a reasonable time frame, usually 90 days or less; and

d) The expected level of improvement in functioning/activities of daily living could not be accomplished in the absence of therapy.

For continuing therapy beyond 90 days, evidence must be submitted that significant practical improvement in the patient's conditioning as a result of the occupational, physical or speech therapy treatment plan.

4.27 Office Visit – Diagnostic

The Plan considers office visit diagnostic to be for an illness, injury and/or accident.

4.28 Office Visit – Routine/Wellness

The Plan considers routine office visits to be for Wellness/Preventive purposes and not related to illness or accident.

4.29 Open Enrollment Period

A period during which an individual may apply for or adjust coverage under the benefit plan(s) of the company. A person who enrolls in the Plan during an open-enrollment period shall be considered a "Late Enrollee" under the Plan.

4.30 Participant

An active employee or contract full-time Faculty/Professional Personnel or temporary full-time Staff Personnel of Ball State University or a retiree who has met the age and years of service eligible upon leaving the university requirements, as determined by Ball State University, who is entitled to participate in the Ball State Health Plan.

4.31 Plan Administrator

The person, group or organization responsible for the day to day functions and management of the Plan. The Plan Administrator may employ persons or firms to process claims and perform other plan connected services. The Plan Administrator is the company which is the named fiduciary.

4.32 Plan Document

The term "Plan Document" whenever used in the Plan shall mean the document held by the company which describes the terms and conditions of the benefits of the Plan.

4.33 Plan Supervisor

The person or group providing administrative services to the company in connection with the operation of the Plan and performing such other functions, including processing and payment of claims, as may be delegated to it.

4.34 Plan Year

The term "Plan Year" means an annual period beginning on the effective date of this plan and ending twelve (12) calendar months thereafter or upon termination of the Plan, whichever occurs earliest.

4.35 PPACA

Patient Protection and Affordable Care Act.

4.36 Pre-Existing Condition

A pre-existing condition is an illness, condition, or injury for which an insured received medical advice or treatment during the 180 days before the effective date of coverage. The waiting period before a pre-existing condition is covered by this plan is twelve months.

Pregnancy shall not be considered a pre-existing condition under the Plan.

A newborn child, a child placed for adoption, or a newly adopted child (under age 18) who begins dependent coverage under this plan within 30 days of birth, placement for adoption or adoption (or who has creditable coverage from birth, placement for adoption, or adoption without a significant break in coverage) shall not be considered to have any pre-existing conditions.

4.37 Provider Facilities

1. **Ambulatory Surgical Facility** – a facility that is so licensed by the state in which it operates. If that state does not issue such licenses, it means a facility with an organized staff of physicians which:

   a. has permanent facilities and equipment for the primary purpose of performing surgical procedures on an outpatient basis, and
   b. provides treatment by or under the supervision of physicians and nursing services whenever the patient is in the facility, and
   c. does not provide inpatient accommodation, and
   d. is not, other than incidentally, a facility used as an office or clinic for the purpose of practice of a provider individual, and
   e. has appropriate government planning approval, if required by its state law.

2. **Clinical Laboratory** – a laboratory that performs clinical procedures and is not affiliated or associated with a hospital, physician, or other provider.

3. **Community Mental Health Center** – a facility which offers a program of services approved by the Indiana Department of Mental Health, is organized for the purpose of providing multiple services for persons with mental illness, including substance abuse, and is operated by one or more of the entities named in I. C. 12-7-2-38 (Indiana Code).

4. **Freestanding Dialysis Facility** – a facility which is primarily engaged in providing dialysis treatment, maintenance, or training to patients on an outpatient or home care basis.

5. **Hospital** – a facility which is a short-term, acute care general hospital and which:

   a. operates as a duly licensed facility; and
   b. operates for compensation from its patients, is primarily engaged in providing inpatient diagnostic and therapeutic services for the diagnosis, treatment, and care of injured and sick persons by or under the supervision of physicians; and
   c. has organized departments of medicine and major surgery; and
   d. provides 24-hour nursing service by or under the supervision of RNs; and
   e. maintains daily medical records for each patient; and
   f. is an institution that qualifies as a hospital or a psychiatric hospital, and as a provider of services under Medicare, if such institution is accredited as a hospital by the Joint Commission of Accreditation of Hospitals; and
   g. is any hospital that meets the Medicare definition of a hospital if the participant is eligible for Medicare.

Hospital includes Community Mental Health Center, and Psychiatric Hospital. Hospital does not include any institution that is primarily a place for rest, a place for the aged, a nursing home or a place for custodial care.

6. **Outpatient Psychiatric Facility** – a facility which is licensed or certified by the state in which it operates as a provider of outpatient rehabilitation and therapeutic services for the treatment of mental illness.

7. **Pharmacy** – any facility so licensed by the state in which it operates.

8. **Psychiatric Hospital** – a facility licensed by the state in which operates to provide and therapeutic services for treatment of mental illness, including substance abuse, on an inpatient basis. If the state does not issue such licenses, it means a facility which is primarily engaged in providing diagnostic and therapeutic services for the inpatient treatment of mental illness and substance abuse, if such services are provided by or under the supervision of an organized staff of physicians and if continuous nursing services are provided by RNs.

9. **Free Standing Birthing Center** – must be licensed.

4.38 Provider Individuals

1. **Licensed Practical Nurse (LPN)** – a person who has graduated from a formal practical nursing education program and is licensed as such by appropriate state authority.

2. **Occupational Therapist** – a person who is licensed as such by the state in which he or she practices or, if that state does not issue such licenses, it means a person certified as such by an appropriate professional body.

3. **Physical Therapist** – a person who is licensed as such by the state in which he or she practices or, if that state does not issue such licenses, it means a person certified as such by an appropriate professional body.

4. **Physician** – a person who is performing services within the scope of his or her license who: (a) is a duly licensed Doctor of Medicine (MD) or a duly licensed Doctor of Osteopathy (DO); or (b) is a duly licensed dentist, podiatrist, optometrist, chiropractor, or a licensed psychologist who has been endorsed as a health service provider in psychology by the Indiana State Board of Examiners in psychology.

5. **Registered Nurse (RN)** – a person who has graduated from a formal program of nursing education (diploma school, associate degree, or baccalaureate program) and is certified as such by appropriate state authority.

6. **Respiratory/Inhalation Therapist** – a person who is licensed as such by the state in which he or she practices or, if that state does not issue such licenses, it means a person certified as such by an appropriate professional body.

7. **Mental health providers** under the supervision of a physician or Licensed Psychologist.

8. **Certified Nurse Midwife (CNM)** – All CNM services will be covered when performed in a hospital or freestanding state licensed birthing center.

9. **Certified Diabetic Educator** – one who shall have a CDE designation as certified by the National Certification Board for Diabetes Education.

10. **Certified Asthma Educator** – one who shall have an ACE designation as certified by the National Asthma Education Board.

11. **Certified Dietician** – one who shall meet the registration requirements to practice dietetics under Indiana law or its equivalence in another state.

12. **Speech Therapist** – a person who is licensed as such by the state in which he or she practices or, if that state does not issue such licenses, it means a person certified as such by an appropriate professional body.

4.39 Reasonable and Customary

A reasonable and customary charge shall be the usual charge made by a physician or supplier of services, medicines, or supplies and shall not exceed the general level of charges made by others rendering or furnishing such services, medicines or supplies within the area in which the charge is incurred for illness or injuries comparable in severity and nature to the illness or injury being treated. The term "area" as it would apply to any particular service, medicine, or supply means a county or such greater area as is necessary to obtain a representative cross section of level charges.

4.40 Recipient

The recipient is the person who receives the organ for transplant from the organ donor. The recipient shall be a participant or covered dependent covered under the provisions of this plan. Only those organ transplants **not** considered experimental in nature are eligible for coverage under this plan.

4.41 Room and Board Charges

The institution's charges for room and board and its charges for other necessary institutional services and supplies, made regularly at a daily or weekly rate as a condition of occupancy of the type of accommodations occupied.

4.42 Semi-Private Rate

The daily room and board charge which an institution applies to the greatest number of beds in its semi-private rooms containing 2 or more beds. If the institution has no semi-private rooms, the semi-private rate will be the lowest cost private room rate charged.

4.43 Significant Break in Coverage

The term "Significant Break in Coverage" means a period of 63 days or more during which an employee or dependent is not covered by any creditable coverage. Waiting periods are not included in the calculation of the break in coverage period.

4.44 Skilled Nursing Facility

A ***skilled nursing facility*** is an institution or a distinct part of an institution meeting all of the following tests:

A. It is licensed to provide and is engaged in providing, on an inpatient basis, for persons convalescing from injury or disease, professional nursing services, rendered by a registered graduate nurse or by a licensed practical nurse under the direction of a registered graduate nurse, and physical restoration services to assist patients to reach a degree of body functioning to permit self-care in essential daily living activities.

B. Its services are provided for compensation from its patients which are under the full-time supervision of a physician or registered graduate nurse.

C. It provides 24 hour per day nursing services by licensed nurses under the direction of a full-time registered graduate nurse.

D. It maintains a complete medical record on each patient.

E. It has an effective utilization review plan.

F. It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, the mentally handicapped, custodial or educational care, or care of mental disorders.

4.45 Special Enrollee

The term "Special Enrollee" means an employee or dependent who is entitled to, is qualified for, and who requests Special Enrollment under the Plan within 30 days of losing other health coverage or who is added to the Plan as a result of marriage, birth, placement for adoption or is a newly adopted child under the age of 18.

4.46 Spouse

The term ***spouse*** means a person who is legally married to the participant.

4.47 Surgical Procedure

A surgical procedure means cutting, suturing, treating burns, correcting a fracture, reducing a dislocation, manipulating a joint under general anesthesia, electrocauterizing, paracentesis, applying plaster casts, administering pneumothorax, endoscopy, injecting sclerosing solution, arthroscopic procedures, lithotripsy or urethral dilation.

4.48 Therapy Services

The following services and supplies ordered by a provider individual and used for the treatment of an illness or injury to promote the recovery of the covered person:

a) **Radiation Therapy** which is the treatment of disease by X-ray, radium, or radioactive isotopes.

b) **Chemotherapy** which is the treatment of disease by chemical or biological anti-neoplastic agents.

c) **Dialysis** treatment which is the treatment of acute renal failure or chronic irreversible renal insufficiency for removal of waste materials from the body, and includes hemodialysis or peritoneal dialysis.

d) **Physical Therapy** is the use of physical measure, activities, and devices, designed to reduce the incidence and severity of physical disability, bodily malfunction, and pain.

e) **Cardiac Rehabilitation** consists of exercise programs designed for secondary prevention or rehabilitation for covered persons with ischemic heart disease or recovering from myocardial infarction or cardiovascular surgery.

f) **Respiratory/inhalation Therapy** which is the introduction of dry or moist gases into the lungs for treatment purposes.

g) **Occupational Therapy** which is the purposeful activity designed to improve or restore functions which have been impaired due to congenital disability, illness, or injury; or, where the function has been permanently lost or reduced by illness or injury, to improve the individual's ability to perform those tasks required for independent functioning.

h) **Speech Therapy** for the treatment of disorders of speech language, voice, communication, and auditory processing when the disorder results from brain

injury, birth defect, premature birth, mental and nervous disorders, cancer, dysphagia, aphasia or stroke.

Benefits for provider facility radiation therapy, chemotherapy, dialysis treatment, physical therapy, cardiac rehabilitation, and respiratory/inhalation therapy services are paid as shown in the Schedule of Benefits.

Benefits for provider individual radiation therapy, chemotherapy, dialysis treatment, physical therapy, cardiac rehabilitation, and respiratory/inhalation therapy services are payable as shown in the Schedule of Benefits.

4.49 Treatment

Any service or supply used to evaluate, diagnose or remedy a condition of a participant or his covered dependents.

Section 5

General Claim Information

5.00 Medical Claim Payment and Appeals

Pre-Service Urgent Care Claims

When a request to review an "urgent" pre-service claim is submitted, the participant will be notified of the Plan's decision as soon as possible, but no more than 72 hours after the Plan receives the claim. If the treating physician classifies a claim as "urgent" the Plan will do so as well.

Extensions

If information to support a review of an "urgent" claim is incomplete the following will occur;

1. The Plan will notify the participant of the deficiency and specify what information is missing. This will be done within 24 hours after receipt of the claim.
2. The participant has 48 hours to provide the missing information or the review of the "urgent" pre-service claim will be closed.
3. The Plan will make its decision within 48 hours after it receives all necessary information. If a supplemental submission of information is deficient, the time frames begin again.

If a participant appeals the denial of a pre-service "urgent" claim, the Plan must render a review decision as soon as possible, but no more than 72 hours after receiving the appeal.

Concurrent Care Claims

Reduction or Termination of Coverage by the Plan

If the Plan has approved an on-going course of treatment and then determines that such treatment should be reduced or terminated, the Plan must notify the participant of this decision far enough in advance of the reduction or termination date to allow for an appeal and review of the decision.

However, this does not apply if the Plan has been amended to reduce or end coverage for the treatment, or when the Plan itself terminates.

Extensions of Treatment

When a participant requests an extension of an on-going course of treatment beyond that which the Plan has approved, the Plan must:

1. Make a decision about the extension as soon as possible; and
2. Notify the participant of the decision within 24 hours after receipt of the request, if the request was made at least 24 hours before the end of the treatment which had already been approved

Pre-Service Benefit Claim Review for Coverage

If the Plan requires that benefits for a service be predetermined prior to the service being provided, a request for that pre-service benefit claim review must be submitted to the Plan Supervisor by the participant or the health care provider. A decision for a pre-service benefit determination will be made within 15 days after receipt of the request.

Extensions

1. The 15-day period may be extended for another 15 days if it is necessary because of matters beyond the Plan's control, and if the Plan notifies the participant of those circumstances and the expected date of the decision before the end of the first 15-day period.
2. If the extension is necessary because insufficient information was submitted, the extension notice will describe the missing information and give the participant 45 days to submit such information.

Normal Post-Service Health Claims

A participant or health care provider must file a claim with the Plan Supervisor within the time frames set out in the Plan. A claim will be considered to have been filed upon receipt by the Plan Supervisor. The participant will be notified within 30 days of receipt of a claim by the Plan as to the benefits to be paid for that claim.

Extensions

1. The 30-day period may be extended for 15 days if it is necessary due to matters beyond the control of the Plan, but the Plan will notify the participant before the end of the 30-day period of those circumstances and the expected date of the decision.
2. If more information is necessary to properly process the claim, a notice will be

given within the 30-day period that the Plan can not meet the 30-day time frame. The notice will describe the missing information and give the participant at least 45 days to provide the missing information. Upon receipt of the missing information, the claim will be processed within the later of 45 days after the original receipt of the claim or within 15 days of receipt of the missing information.

If more information is necessary to properly process the claim and it is not received within the 45-day time frame, the claim will be denied. The claim may thereafter be re-submitted with the missing information as long as the re-filing is completed within the claim filing time limits set out in the Plan.

General Conditions

The period of time within which a benefit determination is required to be made shall begin at the time the claim is filed with the Plan, without regard to whether all the information necessary to make the benefit determination accompanies the filing. In the case of any extension of time to make a benefit determination which is based on a lack of submitted information necessary to determine a claim, the period for making the benefit determination shall stop running until the claimant responds to the request for additional information.

Any adverse determination shall set forth:

1. The specific reason or reasons for the adverse determination;
2. A reference to any specific plan provision on which the determination is based;
3. A description of any additional material or information necessary for the participant to make the claim payable and an explanation of why such material or information is necessary;
4. A description of the Plan's review procedures and the time limits which are applicable to such procedures, including a statement of the participant's right to bring a civil action under Section 502(a) of ERISA;
5 If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, the Plan will provide that criterion free of charge upon request, and
6. If the adverse determination is based on a medical necessity or experimental treatment or similar exclusion or limit, the Plan will provide an explanation of how it made that determination free of charge upon request.

Appealing An Adverse Decision

In order to appeal an adverse decision, the Plan will:

1. Allow a participant 180 days following receipt of a notification of an adverse benefit determination within which to file a written appeal to the Plan Administrator at the address found in the Summary Plan Description;
2. Allow a participant the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;
3. A participant shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information which is relevant to the participant's claim for benefits;
4. Provide for a review that takes into account all comments, documents, records, and other information submitted by the participant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination;
5. Provide a review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate fiduciary of the Plan who is neither the individual who made the original adverse benefit determination, nor the subordinate of such individual;
6. In deciding an appeal from an adverse benefit determination that is based in whole or in part on a medical judgment, the appropriate plan fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;
7. Identify medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination;
8. Provide that the health care professional engaged for purposes of a consultation as a part of the appeal of the benefit determination shall be an individual who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual, and
9. Notify the participant of the Plan's benefit determination on review within a reasonable time, but not later than 60 days after receipt of the participant's appeal, unless the Plan Administrator determines that special circumstances require an extension of time for processing the appeal. In such case the Plan Administrator shall give written notice to the participant prior to the end of the original 60 days that an extension of time is required and the reasons for the extension, but in no case will the extension be for more than 60 days.

5.01 Administration of the Group Medical Plan

The Plan is administered through the Plan Administrator. The services of an independent Plan Supervisor experienced in claims processing have been retained to process claims for the Plan.

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

The Plan Administrator, and all persons who are plan fiduciaries, are given the specific discretionary authority to determine eligibility for benefits or to construe terms of the Plan.

Benefits under this plan will be paid only if the Plan Administrator decides in its discretion that the applicant is entitled to them.

Amounts paid out under this plan shall be based solely upon the benefits in effect as of the date the services are rendered.

No payment will be made for services incurred before coverage is in effect or after coverage terminates for the patient receiving the services.

5.02 Conditions Precedent to the Payment of Benefits

The participant or dependent shall present the Plan identification card upon admission to a hospital or upon receiving service from a physician.

Forms are available through the Plan Supervisor and are required along with an itemized statement with a diagnosis, the participant's name, coverage identification number, and the name of the Plan Administrator.

The participant and all dependents agree that in order to receive benefits under this plan, any physician, nurse, hospital, or other providers of service, having rendered service or being in possession of information or records relating thereto, is authorized and directed to furnish the Plan Supervisor, at any time, upon request, any and all such information and records, or copies.

The Plan Administrator has the right to have a physician examine a participant or dependent as often as reasonably required during the pendency of a claim or to aid in the determination of whether services are medically necessary. The Plan Administrator will notify the participant or dependent in advance of the time and place for such examination and shall pay for the cost of the examination.

5.03 Privileges as to Dependents

The participant shall have the privilege of adding or withdrawing the name or names of any dependents to or from this coverage, as permitted by the Plan, by submitting to the Plan Administrator an application for reclassification, furnished by the Plan Supervisor. Each dependent added to the coverage shall be subject to all conditions and limitations contained in this plan.

5.04 Application and Identification Card

To obtain coverage, an eligible participant must complete and deliver to the Plan Administrator an application on a form supplied by the Plan Supervisor.

Acceptance of this application will be evidenced by the delivery of an identification card, showing the participant's name, by the Plan Supervisor to the Plan Administrator.

5.05 Cancellation

In the event of the cancellation of this plan, all participant and dependent coverage shall cease automatically without notice and these participants and dependents shall not be entitled to further coverage or benefits thereafter.

5.06 Assignment of Payment

Except where otherwise provided in this plan, the Plan will pay any benefits accruing under this plan to the participant unless the participant shall assign benefits to a hospital, physician, or other provider of service furnishing the services for which benefits are provided under the Plan. No assignment, however, shall be binding on the Plan unless the Plan Supervisor is notified in writing of such assignment prior to payment under the Plan.

5.07 Amendment of Plan Document

The company reserves the power at any time and from time to time (and retroactively, if necessary or appropriate to meet the requirements of the Internal Revenue Code or other applicable law) to modify, amend, or terminate in whole or in part, any or all provisions of the Plan, provided, however, that no modification, amendment, or termination shall deny a participant or covered dependent of a right to those benefits

to which he or she has become entitled under the Plan. Any amendment to the Plan may be effected by the Plan Administrator in writing at the direction of the company.

5.08 Notice

Any notice given under this plan shall be sufficient, if given to the Plan Administrator when addressed to it at its office; if given to the Plan Supervisor, when addressed to it at its home office; or if given to a participant, when addressed to the participant at his address as it appears on the records of the Plan Supervisor in the care of the Plan Administrator.

5.09 Coordination of Benefits

Definitions

The term ***allowable expense*** shall mean the amount of expenses, at least a portion of which is paid under at least one of any multiple plans covering the person for whom the claim is made.

The term ***order of benefits determination*** shall mean the method for ascertaining the order in which the Plan renders payment under the Plan. The principle applies when another plan has a coordination of benefits provision.

Application

Under the order of benefits determination method, the plan which is obligated to pay its benefits first is known as the primary plan. The plan which is obligated to pay additional benefits for allowable expenses not paid by the primary plan is known as the secondary plan. Where another plan contains a coordination of benefits provision, the following order of benefits determination will establish the responsibility for payment under the Plan:

A. If the patient has individual insurance coverage which covers medical expenses, that plan will be deemed the primary plan. If the patient does not have such individual insurance coverage, the health coverage which covers the patient as an employee shall be deemed the primary plan and is obligated to pay benefits before the health coverage covering the patient as a dependent.

B. The plan covering the patient as a dependent of a person whose birthday anniversary occurs earlier in the calendar year will be deemed

to be the primary plan and is obligated to pay before the plan covering the patient as a dependent of a person whose birthday anniversary occurs later in the calendar year. If the birthday anniversaries are identical, the plan which has been in force the longer period of time shall be deemed to be primary.

If either plan is lawfully issued in another state and does not have the coordination of benefits procedure regarding dependents based on birthday anniversaries as provided under the Plan, and as a result each plan determines its benefits after the other, the coordination of benefits procedure set forth in the plan which does not have the coordination of benefits procedure based on birthday anniversaries shall be deemed to be primary.

In the event of divorce or legal separation, the following order will establish responsibility for payment. If this order of benefit determination is not recognized by the plan being coordinated with, order will be determined at the option of the Plan Supervisor on a case-by-case basis.

A. If a court decree has determined financial responsibility for a child's health care expenses, the plan of the parent having that responsibility pays first.

B. The plan of the parent with custody of the child pays before the plan of the other parent or the plan of any stepparent.

C. The plan of the stepparent married to the parent with custody of the child pays before the plan of the parent not having custody.

D. Where the order of payment cannot be determined in accordance with the provisions above, the primary plan shall be deemed to be the plan which has covered the patient for the longer period of time.

In the case of an 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 is ignored.

If a person, whose coverage is provided under a right of continuation pursuant to federal or state law, is also covered under another plan, the benefits of the plan covering the person as an employee (or as the employee's dependent) will be determined first and the benefits under the continuation coverage will be determined second.

As the primary plan, the Plan will provide payment in accordance with the provisions of this plan.

As a secondary plan, the Plan will provide payment for allowable expenses and services of hospitals and physicians, but only to the extent that payment for such hospital services and services of physicians are not provided by the primary plan or other secondary plans.

In no event will total payment by the Plan exceed the amount which would have been paid as primary plan.

The Plan shall be considered to be the secondary plan when the other plan does not contain a coordination of benefits provision. The total payment by the Plan for hospital services and physician services shall not exceed the amount which would have been paid as a secondary plan.

5.10 Subrogation

If the Plan receives claims for expenses that were either the result of the alleged negligence of another person, or which arise out of any claim or cause of action which may accrue against any third party responsible for injury or death to the covered employee or dependent of the covered employee (hereinafter named the covered person) by reason of their eligibility for benefits under the Plan, the Plan has no duty or obligation to pay these claims.

The Plan may choose to advance benefits. If the Plan advances benefits, the covered person, by accepting benefits agrees to the following terms and conditions.

The covered person agrees that the Plan will be reimbursed out of any recovery by the covered person for all benefits paid by the Plan. The covered person agrees that the Plan has a secured proprietary interest in any settlement proceeds that the covered person receives or may have an entitlement to receive. The covered person confesses that the Plan is entitled to a constructive trust interest in the proceeds of any settlement or recovery. The covered person consents to the position of said trust, the funding of said constructive trust using any settlement proceeds and the payment of said funds held in said trust directly to the Plan or its authorized representative. The Plan will be reimbursed in full prior to the covered person receiving any monies recovered from any party or their insurer as a result of judgment settlement or otherwise. The duty and obligation to reimburse the Plan also applies to any money received from any underinsured or uninsured motorist policy of insurance. The

obligation to repay the Plan remains in force even if the covered person is not fully compensated or made-whole from any settlement or verdict or judgment.

The Plan has the right to the covered person's full cooperation in any matter involving the alleged negligence of a third party. In such cases, the covered person is obligated to provide the Plan with whatever information, assistance, and records the Plan may require to enforce the rights in this provision. The covered person further agrees that in the event that the Plan has reason to believe that the Plan may have a subrogation lien, the Plan may require the covered person to complete a subrogation questionnaire, sign an acknowledgement of the Plan's subrogation rights and an agreement to provide ongoing information, before the Plan considers paying, or continuing to pay, any claims. Upon receipt of the requested materials from the covered person, the Plan may commence or may continue advancing claims payments according to its terms and conditions provided that said payment of claims in no way prejudices the Plan's rights to recovery.

The covered person agrees to include the Plan's name as a co-payee on any settlement check.

The Plan may, but is not obligated to, take any legal action it sees fit against the third party or the covered person, to recover the benefits the Plan has paid. The Plan's exercise of this right will not affect the covered person's right to pursue other forms of recovery, unless the covered person and his legal representative consent otherwise.

The Plan retains the right to employ the services of any attorney to recover money due to the Plan. The covered person agrees to cooperate with the attorney who is pursuing the subrogation recovery. The compensation that the Plan's attorney receives will be paid directly from the dollars recovered for the Plan.

The Plan specifically states that it has no duty or obligation to pay a fee to the covered person's attorney for the attorney's services in making any recovery on behalf of the covered person. The covered person consents to this provision and by accepting any advance of benefits agrees to instruct their attorney to not assess any fees against the Plan in the event of settlement or recovery.

The covered person is obligated to inform their attorney of the subrogation lien and to make no distributions from any settlement or judgment which will in any way result in the Plan receiving less than the full amount of its lien without the written approval of the Plan. The covered person agrees that they will instruct their attorney to reimburse the Plan out of any sums the attorney holds or may hold in his trust account.

The covered person agrees that he will not release any party or their insured without prior written approval from the Plan, and will take no action which prejudices the Plan's subrogation right.

The covered person agrees to refrain from characterizing any settlement in any manner so as to avoid repayment of the Plan's lien or right to reimbursement.

The Plan Administrator retains discretionary authority to interpret this and all other plan provisions and the discretionary authority to determine the amount of the lien.

The Plan pays secondary as to any and all PIP, Med-Pay or No-Fault coverage. The Plan has no duty or obligation to pay any claims until PIP, Med-Pay or No-Fault coverage is exhausted. In the event that the Plan pays claims that should have been paid by PIP, Med-Pay or No-Fault coverage under this provision, then the Plan has a right of recovery from the PIP, Med-Pay or No-Fault carrier.

In the event that the covered person receives any form or type of settlement and either fails or refuses to abide by the terms of this agreement, in addition to any other remedies the Plan may have, the Plan retains a right of equitable offset against future claims.

5.11 Medicare

To the extent allowable under applicable law, if the participant or his or her dependents are eligible to be covered under Medicare, coverage under the Plan will be secondary to coverage provided by Medicare. If the Plan is primary to Medicare and if the participant or his or her dependents are eligible to be covered by Medicare and incur a claim, coverage under the Plan will be paid as usual for eligible charges, subject to any applicable deductible and any applicable co-pay, exclusion, and any other limitations as set forth in the Plan.

The following rules apply:

- When the employer has less than 20 employees, Medicare is the primary coverage. In that situation participants and covered dependents must inform their health care providers that Medicare is the primary coverage.

- When the employer has more than 20 employees, the benefit plan is primary and Medicare is the secondary coverage for active employees and their dependents regardless of age.

- Medicare is the primary coverage for retirees over age 65 and for over age 65 dependents of retirees, unless the spouse is an active employee of another group health plan of more than 20 employees.

- The benefit plan is primary and Medicare is the secondary coverage for the first 30 months of Medicare eligibility due to End Stage Renal Disease. After the first 30 months, Medicare is the primary coverage. This applies if the person is covered due to active employment, being the dependent of an active employee, or covered due to COBRA continuation coverage.

- COBRA always pays secondary to Medicare except in the case of the first 30 months of Medicare eligibility due to End Stage Renal Disease.

- When the employer has less than 100 employees and Medicare coverage for an active employee or dependent is due to disability, Medicare is the primary coverage. When the employer has more than 100 employees, the benefit plan is primary. When the employee is no longer an active employee, Medicare is primary.

If the participant or his or her dependents choose not to be covered by the Plan and choose to be covered primarily by Medicare, Medicare will provide coverage and coverage under this plan will terminate. The participant or his or her dependents are considered eligible for Medicare for the purposes of the Plan during any period the participant or his or her dependents have coverage under Medicare or, while otherwise qualifying for coverage under Medicare, do not have such coverage solely because the participant or his or her dependents refused, discontinued, or failed to make any necessary application for Medicare coverage.

5.12 Facility of Payment

If, in the opinion of the Plan Supervisor, a valid release cannot be rendered for the payment of any benefit payable under this plan, the Plan Supervisor may, at its option, make such payment to the individuals as have, in the Plan Supervisor's opinion, assumed the care and principal support of the covered person and are therefore equitably entitled thereto. In the event of the death of the covered person prior to such time as all benefit payments due him or her have been made, the Plan Supervisor may, at its sole discretion and option, honor benefit assignments, if any, prior to the death of such covered person.

Any payment made by the Plan Supervisor in accordance with the above provisions shall fully discharge the Plan to the extent of such payment.

5.13 Misrepresentation

Any fraudulent or material misrepresentation on the part of a participant or dependent in making application for benefits, or any application for reclassification thereof, or for any claim for benefits hereunder may result in rescission of coverage back to the original effective date or termination of ongoing coverage after a 30 day notice is given to the covered individual.

5.14 Inadvertent Error

Inadvertent error by the Plan Administrator or Plan Supervisor in the keeping of records or the transmission of participants' applications shall not deprive any participant or dependent of benefits otherwise due.

5.15 Choice of Physician

You may select any physician who is a member of the portion of the managed care network selected by the participant for your medical benefits to be considered at the maximum benefit percentage shown in the Schedule of Benefits. If services are not received from such a participating provider, or if one of the exceptions does not apply, the penalty shown in the Schedule of Benefits will apply. Benefits will then be paid at the lesser benefit percentage.

5.16 Not Liable for Acts of Hospitals or Physicians

Nothing contained in the Plan shall confer upon a participant or dependent any claim, right, or cause of action, either at law or at equity, against the Plan for the acts of any hospital in which he receives care, or for the acts of any physician from whom he receives service under this plan.

5.17 Right of Recovery

Whenever payments have been made by the Plan in excess of the maximum amount of payment necessary at that time to satisfy the intent of this plan, the Plan shall have the right to recover such payments, to the extent of such excess, from among one or more of the following as the Plan Supervisor shall determine: any persons to or for, or with respect to whom such payments were made, and/or any insurance companies or other organizations.

5.18 Plan Administration

The Plan Administrator shall be responsible for compliance by the Plan with all requirements of Part 1, Subtitle B or Title 1 of the Employee Retirement Income Security Act of 1974 (ERISA).

5.19 Plan Is Not a Contract

The Plan shall not be deemed to constitute a contract between the Plan Administrator and any participant or to be a consideration for, or an inducement or condition of, the employment of any participant. Nothing in the Plan shall be deemed to give any participant the right to be retained in the service of the Plan Administrator or to interfere with the right of the Plan Administrator to discharge any employee at any time; provided, however, that the foregoing shall not be deemed to modify the provisions of any collective bargaining agreements which may be made by the Plan Administrator with the bargaining representative of any participants.

5.20 Fiduciary Operation

Except as may be otherwise specifically provided in the Plan or in any benefit contract or policy, the Plan Administrator or its designee shall have full discretionary authority to enable it to carry out its duties under the Plan, including, but not limited to, the authority to determine eligibility under the Plan and to construe and interpret the terms of the Plan and to determine all questions of fact or law arising under the Plan and to authorize coverage in a manner which is cost effective under the Plan. All such determinations and interpretations shall be final, conclusive, and binding on all persons affected thereby.

The Plan Administrator or its designee shall have full discretionary authority to correct any defect, supply any omission or reconcile any inconsistency, and resolve ambiguities in the Plan in such manner and to such extent as it may deem expedient, and subject to the above, the Plan Administrator or its designee shall be the sole and final judge of such expediency. Each fiduciary shall discharge his or her duties with respect to the Plan solely in the interest of the participants and beneficiaries:

A. For the exclusive purposes of providing benefits to participants and their beneficiaries and defraying reasonable expenses of administering the Plan;

B. With care, skill, prudence, and diligence under the circumstances then prevailing that a prudent person acting in a like capacity and familiar

with such matters would use in the conduct of an enterprise of a like character and with like aims; and

C. In accordance with the documents and instruments governing the Plan to the extent that they are consistent with the provisions of the Employee Retirement Income Security Act of 1974

5.21 Contributions and Funding

The Plan is a self-funded welfare benefit plan which provides medical benefits to covered persons. No benefits are payable by any insurance company. The company will provide all payments for the benefit plan. Employees may be required to pay a contribution which will partially reimburse the employer for the cost of operating the Plan and for benefit payments.

Employer Contributions: The employer shall pay such amounts needed to provide plan benefits.

Participant Contributions: Upon election to participate, each participant must contribute such amounts as may be required by the employer toward the cost of benefits.

Authorization: An employee shall authorize the deduction from earnings for required contributions in writing at the time of application to participate. The employee may revoke the authorization for deduction at any time, which will cause coverage to end. See Eligibility.

Funding: Benefits provided under the Plan are paid out of the general assets of the employer and authorized earnings deductions withheld from employee from an account maintained by the employer.

All funds are applied to benefit payments, insurance costs and reasonable expenses for administration or plan maintenance. The order of priority for payment is as follows:

A. First from authorized earnings deductions withheld from employees

B. Second from employer contributions

5.22 The Use and Disclosure of Protected Health Information

A. Use and Disclosures of Protected Health Information (PHI)

The Plan will use protected health information (PHI) to the extent of and in accordance with the uses and disclosures permitted by the Health Insurance Portability and Accountability act of 1996 (HIPAA). Specifically, the Plan will use and disclose PHI for purposes related to health care treatment, payment for health care and health care operations.

Payment includes activities undertaken by the Plan to obtain premiums or determine or fulfill its responsibility for coverage and provision of plan benefits that relate to an individual to whom health care is provided. These activities include, but are not limited to, the following:

- determination of eligibility, coverage and cost sharing amounts (for example, cost of a benefit , plan maximums and coinsurance as determined for an individual's claim);
- coordination of benefits;
- adjudication of health benefit claims (including appeals and other payment disputes);
- subrogation of health benefit claims;
- establishing employee contributions;
- risk adjusting amounts due based on enrollee health status and demographic characteristics;
- billing, collection activities and related health care data processing;
- claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes and responding to participant inquiries about payments;
- obtaining payment under a contract for reinsurance (including stop-loss and excess of loss insurance);
- medical necessity reviews or reviews of appropriateness of care or justification of charges;
- utilization review, including pre-certification, pre-authorization;
- disclosure to consumer reporting agencies related to the collection of premiums or reimbursement (the following PHI may be disclosed for payment purposes: name and address, date of birth, Social Security number, payment history, account number and name and address of the provider and/or health plan); and
- reimbursement to the Plan

Health Care Operations include, but are not limited to, the following activities:

- quality assessment;
- population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting health care providers and patients with information about treatment alternatives and related functions;
- rating provider and plan performance, including accreditation, certification, licensing or credentialing activities;
- underwriting, premium rating and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing or placing a contract for reinsurance of risk relating to health care claims (including stop-loss insurance and excess of loss insurance);
- conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;
- business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the Plan, including formulary development and administration, development or improvement of payment methods or coverage policies;
- business management and general administrative activities of the Plan, including, but not limited to:
  (a) management activities relating to the implementation of and compliance with HIPAA's administrative simplification requirements, or
  (b) customer service, including the provision of data analyses for policyholders, plan sponsors or other customers;
  (c) resolution of internal grievances; and
  (d) due diligence in connection with the sale or transfer of assets to a potential successor in interest, if the potential successor in interest is a "covered entity" under HIPAA or, following completion of the sale or transfer, will become a covered entity

B. The Plan Will Use and Disclose PHI as Required by Law and as Permitted by Authorization of the Participant or Beneficiary

With an authorization, the Plan will disclose PHI to the pension plan, disability plan, EAP plan, Section 125 Cafeteria plan, Workers' Compensation plan, and other benefit plans established by the Plan Sponsor for the purposes related to administration of these plans.

C. For Purposes of this Section Ball State University Is the Plan Sponsor

The Plan will disclose PHI to the Plan Sponsor only upon receipt of a certification from the Plan Sponsor that the plan documents have been amended to incorporate the following provisions.

D. With Respect to PHI, the Plan Sponsor Agrees to Certain Conditions

The Plan Sponsor agrees to:

- not use or further disclose PHI other than as permitted or required by the plan document or as required by law;
- ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;
- not use or disclose PHI for employment-related actions and decisions unless authorized by an individual;
- not use or disclose PHI in connection with any other benefit or employee benefit plan of the Plan Sponsor unless authorized by an individual;
- report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which it becomes aware;
- make PHI available to an individual in accordance with HIPAA's access requirements;
- make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;
- make available the information required to provide an accounting of disclosures;

- make internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the HHS Secretary for the purposes of determining the Plan's compliance with HIPAA; and
- if feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form, and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible).

E. Adequate Separation Between the Plan and the Plan Sponsor Must Be Maintained

In accordance with HIPAA, only the following employees or classes of employees may be given access to PHI:

- the Benefits Manager; and
- staff designated by the Benefits Manager

F. Limitations of PHI Access and Disclosure

The persons described in section E may only have access to and use the disclosed PHI for plan administration functions that the Plan Sponsor performs for the Plan.

G. Non-compliance Issues

If the persons described in section E do not comply with this plan document, the Plan Sponsor shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

Electronic Protected Health Information

Electronic Protected Health Information – The term "Electronic Protected Health Information" has the meaning set forth in 45 C.F.R. § 160.103, as amended from time to time, and generally means protected health information that is transmitted or maintained in any electronic media.

Security Incidents – The term "Security Incidents" has the meaning set forth in 45 C.F.R. § 164.304, as amended from time to time, and generally means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operations in an information system.

Where Electronic Protected Health Information will be created, received, maintained, or transmitted to or by the Plan Sponsor on behalf of the Plan, the Plan Sponsor shall reasonably safeguard the Electronic Protected Health Information as follows:

- Plan Sponsor shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic Protected Health Information that Plan Sponsor creates, receives, maintains, or transmits on behalf of the Plan;

- Plan Sponsor shall ensure that the adequate separation that is required by 45 C.F.R. § 164.504(f)(2)(iii) of the HIPAA Privacy Rule is supported by reasonable and appropriate security measures;

- Plan Sponsor shall ensure that any agent, including a subcontractor, to whom it provides Electronic Protected Health Information agrees to implement reasonable and appropriate security measures to protect such information; and

- Plan Sponsor shall report to the Plan any Security Incidents of which it becomes aware as described below:

  a. Plan Sponsor shall report to the Plan within a reasonable time after Plan Sponsor becomes aware, any Security Incident that results in unauthorized access, use, disclosure, modification, or destruction of the Plan's Electronic Protected Health Information; and

  b. Plan Sponsor shall report to the Plan any other Security Incident on an aggregate basis annually, or more frequently upon the Plan's request

Section 6

Dental Benefits

6.00 Dental Benefits

For eligible participants and their eligible dependents covered under this section, the Plan will pay the dental benefits listed in the Plan. Benefits in this section are also subject to the maximums shown in the Schedule of Benefits and limitations shown in the Plan.

6.01 Pre-determination of Dental Benefits

A pre-determination of dental benefits is not required but may be obtained by contacting the Plan Supervisor at the number on your medical coverage identification card.

6.02 Description of Dental Benefits

If covered dental expenses are incurred during a calendar year by a covered family member for treatment of a disease or injury, the Plan will pay a benefit equal to the applicable coinsurance percentage for type A, B, and C expenses which exceed in total the family member's deductible for the calendar year, subject to any maximum shown in the Schedule of Benefits.

6.03 Covered Dental Expenses

Covered dental expenses are the dentist's charges for the services and supplies listed below which meet both of the following tests:

A. They are necessary and customarily employed nationwide for the treatment of the dental condition, and

B. They are appropriate and meet professionally recognized national standards of quality

6.04 Alternative Dental Treatment

If alternate services or supplies are used to treat a dental condition, covered dental expenses will be limited to the services and supplies which are customarily employed nationwide to treat the disease or injury and which are recognized by the profession to be appropriate methods of treatment in accordance with broadly accepted national standards of dental practice, taking into account the family member's total current oral condition.

6.05 Covered Expenses

A. Oral examinations, including prophylaxis (scaling and cleaning of the teeth)

B. Topical application of sodium or stannous fluoride

C. Space maintainers

D. Dental x-ray:

1. Charges for full mouth x-rays performed as a part of a routine dental checkup

2. Charges for bite wing x-rays performed as a part of a routine dental checkup

3. Charges for x-rays when used in connection with oral surgery or other dental services

E. Emergency treatment for temporary relief of pain

F. Charges for simple extraction or surgical extraction of one or more teeth

G. Oral surgery to include root scaling, planing, and other scraping procedures

H. Fillings, consisting of silver amalgam, silicate, and plastic restorations

I. General anesthetic when medically necessary and administered in connection with oral surgery or other covered dental expenses

J. Treatment of periodontal and other diseases of the gums and tissues of the mouth

K. Endodontic treatment, including root canal therapy

L. Injection of antibiotic drugs

M. Repair or re-cementing of crowns, inlays, bridgework or dentures, or relining of dentures

N. Initial installation of partial or full removable dentures (including adjustments for the 6 month period following installation) to repair one or more natural teeth

O. Inlays, or crowns (including precision attachments for dentures), to replace one or more natural teeth extracted while covered under this plan

P. Initial installation of fixed bridgework (including inlays and crowns as abutments) to replace one or more natural teeth extracted while the individual is covered

Q. Replacement of an existing partial or full removable denture or fixed bridgework by new bridgework, or the addition of teeth to existing fixed bridgework

R. Coverage for apicoectomies, management of acute infections, oral lesions and osseous surgery

S. Dental implants

Dental Benefits are optional for Medicare eligible retirees of Ball State University and their spouses.

6.06 Individual Dental Deductible

The deductible for covered dental expenses is shown in the Schedule of Benefits. This amount must be satisfied before dental benefits under this section are payable.

6.07 Family Dental Deductible

When covered family members have met an amount of eligible expenses equal to the Family Deductible amount shown in the Schedule of Benefits, the Individual Deductible for all other covered members in that family will be considered satisfied for the remainder of the calendar year.

6.08 Carryover Deductible

Eligible expenses that were incurred in October, November, and December of the calendar year and applied to the Individual or Family Deductible for that year shall apply to the next calendar year's Individual or Family Deductible. Deductibles satisfied because of a Common Accident provision shall not be considered eligible expenses as to the carryover provision of this plan.

6.09 Calendar Year Dental Maximum

No more than the calendar year maximum shown in the Schedule of Benefits is payable under this section for all dental expenses incurred by an individual in a calendar year, regardless of any interruption in coverage.

6.10 Exclusions to the Dental Plan

Covered dental expenses do not include and no benefits are payable for the following:

A. Charges for any dental services and supplies which are covered expenses in whole or in part under any other part of this plan, or under any other plan of group benefits provided by the company, whether or not benefits are payable under such section or plan as to such charges

B. Charges for treatment by other than a dentist except that scaling or cleaning of teeth and topical application of fluoride may be performed by a licensed dental hygienist if the treatment is rendered under the supervision or the direction of the dentist

C. Charges for services or supplies that are cosmetic in nature, including charges for personalization or characterization of dentures

D. Charges for the replacement of a lost, missing, or stolen prosthetic device

E. Charges for any service or supplies which are for orthodontic treatment, except as specifically provided

F. Charges for precision or other elaborate attachments for any appliance

G. Charges for sealants

H. Services and supplies to treat or diagnose temporomandibular joint dysfunction, including but not limited to occlusal adjustments, joint manipulations, splints, and appliances

I. Charges that are in excess of reasonable and customary

J. Charges for services provided by a provider facility, except as medically necessary at which time it would be covered under the medical plan

K. Charges for athletic mouth guard

6.11 Dental Benefits after Termination of Coverage

When coverage under the Plan terminates for a participant and/or eligible dependent(s) by reason of the participant's termination of employment with the university or an eligible dependent child reaching the limiting age, dental treatment that was started prior to such termination will continue to be covered under the Plan as follows:

1. For dental treatment other than orthodontia, until the earliest of:

   a. three (3) months following termination of coverage;

   b. the calendar year dental maximum is reached; or,

   c. the treatment is completed

2. For orthodontia treatment, until the earliest of :

   a. three (3) months following termination of coverage;

   b. the orthodontia or dental maximum is reached; or,

   c. the course of treatment is completed

6.12 Orthodontic Benefit

Orthodontia is appliance, surgical, or functional/myofunctional treatment of dental irregularities resulting from the anomalous growth and development of dentition and its related anatomic structures or from an injury requiring repositioning (except preventative treatment) of teeth to establish normal occlusion.

The maximum benefit payable for all orthodontic treatment rendered to a covered individual will not exceed the orthodontic calendar year maximum amount shown in the Schedule of Benefits, regardless of any interruption in coverage.

If other dental services are performed in connection with orthodontic treatment, those other services will be considered under the dental benefit and not under the orthodontic benefit.