Summary Plan Description

For The

University Health Plan

Effective: January 1, 2014

Version 1724373: March 14, 2014

Notices

Lifetime Limits:

Lifetime and annual benefit limits have been eliminated. Individuals whose coverage ended by reason of reaching a lifetime limit under the plan are eligible to enroll in the plan. Individuals have 30 days from the date on which this notice was first given to such individual to request enrollment. For more information contact UHP at 314-977-5666

Adult Child Dependent Coverage:

Individuals whose coverage ended, or who were denied coverage (or were not eligible for coverage), because the availability of dependent coverage of children ended before attainment of age 26 are eligible to enroll. Individuals may request enrollment for such children for 30 days from the date of this notice or until the current open enrollment period ends on February 14, 2011, whichever is later. Enrollment will be effective retroactively to January 1, 2011. For enrollment information contact the UHP at 314-977-5666.

Patient Protections:

The UHP allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Coventry Health Care of Missouri Customer Services at 1-800-775-3540. For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from UHP or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Coventry Health Care of Missouri Customer Services at 1-800-775-3540.

Children's Health Insurance Program:

See notice of Children's Health Insurance Program attached as Exhibit 3.

TABLE OF CONTENTS

SUMMARY OF THE PLAN

I. Introduction

This document ("Summary Plan Description") is a summary of the University Health Plan (the "Plan") sponsored by Saint Louis University (the "University"). The Plan provides you with comprehensive health benefits. This Summary Plan Description is intended to be a summary of the benefits under the Plan in effect as of January 1, 2014. If any provision in this Summary Plan Description conflicts with the Plan, the terms of the Plan shall govern.

The University, as Plan Administrator, has complete authority and discretion to interpret and administer the provisions of the Plan (and this Summary Plan Description and its attachments) and determine who is eligible for coverage under the Plan and determine the coverage for which an eligible and enrolled individual is entitled to under the Plan.

II. Eligibility

Nothing in this Section II should be construed as establishing criteria based on individual health status, medical condition, receipt of health care, medical history, genetic information, or evidence of insurability.

A. Eligible Participants

As long as you meet the participation requirements below, you are eligible to participate in the Plan as a "Participant" at the time of your admission to (or, where applicable, registration at) the University and its undergraduate or graduate programs (hereinafter referred to as "Program"). For purposes of eligibility, you are considered admitted to the University as of your first day of orientation or your "letter of appointment" date. To be eligible for the Plan, you must be one of the following:

1. an undergraduate student admitted to the University with a minimum of 12 credit hours per semester in an undergraduate Program;

2. a graduate student admitted to the University with a minimum of 6 credit hours per semester or, as determined by the Plan Administrator, a full-time student in a graduate, professional or law school Program;

3. a graduate assistant receiving a "letter of appointment" from a graduate Program of the University; or

4. a medical or graduate student admitted to, or registered in, the University M.D. or graduate medical Program, or a resident, sub-specialty resident or fellow admitted to, or registered in, the University's School of Medicine.

There are no waiting periods in the Plan and the Plan does not have any pre-existing condition exclusions.

B. Eligible Dependents

To have dependent coverage under the Plan, your dependent(s) must be eligible and enrolled. The following individuals are eligible for coverage as dependents:

1. your lawful Spouse;

2. your Child less than 26 years of age; and

3. your Child with a mental or physical disability who is over the age limit if the Child becomes and remains disabled while covered under the Plan or was covered under a prior plan that this Plan replaces, and, in either case, all of the following conditions are met: (a) the Child has not been married; (b) the Child cannot hold a self-supporting job due to the disability; and (c) the Child depends on you for main support and care. First proof of incapacity must be given to the Plan Administrator (at your expense) within 31 days of the Child's 26th birthday. You must request a/an "Disabled/Incapacitated Dependent" form from the Plan Administrator.

Eligible dependents become eligible for coverage: (i) on the date you become eligible; or (ii) if later, on the date the person became eligible as a dependent as defined above (for instance, a child was born or you marry). No person may be covered as a Dependent of more than one Participant. A Participant may not be covered as a Dependent.

C. Defined Terms for Eligibility

For purposes of this Summary Plan Description, the following terms have the meanings set forth below.

"Child" means your natural child; an adopted child; a child who has been placed for adoption with you; a child for whom you have been appointed legal guardian; a stepchild; and a child who is recognized under a qualified medical child support order as having a right to enrollment under the Plan ("QMCSO-child"). In all cases a child over age 26 must depend upon you for his or her main support and care. However, when a court recognizes a child as a QMCSO-child, the child will be considered an eligible dependent regardless of whether the child is living with you or receiving his or her main support and care from you. A grandchild is not an eligible dependent unless the grandchild otherwise meets the requirements of this paragraph. A foster child is not an eligible dependent.

"Covered Individual" means a Participant or Dependent.

"Dependent" means an Eligible Dependent who is enrolled in the Plan as provided in Section III.

"Eligible Dependent" means an individual who is eligible to participate as a "Dependent" as set forth in Section II.B.

"Eligible Participant" means an individual who is eligible to participate as a "Participant" as set forth in Section II.A.

"Participant" means an Eligible Participant who is enrolled in the Plan as provided in Section III. A Participant is also sometimes referred to herein as "you" or "your".

"Spouse" means the person to whom you are currently married as determined under the law of the State of Missouri. Ex-spouses, common-law spouses, domestic partners or anyone else to whom you are not married as determined under the law of the State of Missouri, or any same-sex spouse regardless of whether the law in the State of Missouri or any other state or jurisdiction recognizes such marriages, cannot be covered as a spouse.

III. When Coverage Begins

A. Enrollment

Enrollment forms will be made available by the Plan Administrator. Except as provided below, to have coverage in effect, an enrollment form for each Eligible Participant and Eligible Dependent must be completed and returned to the Plan Administrator within the applicable time periods set forth in this Section III.

At the time of your enrollment, you must select one of the Plan membership types offered (e.g., Individual Membership, Individual Membership Plus One or Family Membership, each as referenced below).

1. "Individual Membership" is comprised of the individual (one person) who has been duly accepted for coverage as a Participant of the Plan.

2. "Individual Membership Plus One" is comprised of a Participant and one (1) Dependent.

3. "Family Membership" is comprised of a Participant and more than one (1) Dependent.

Certain students and trainee group members are required to have health insurance, and the Plan is the default health insurance coverage for these students and trainee group members of the University. If approved by the Plan Administrator, such students and trainee group members may decline coverage so long as evidence of coverage under another group or individual plan and a request, in writing, to decline coverage is provided to and accepted by the Plan Administrator. Requests to decline coverage must be returned to the Plan Administrator within 31 days of admission to the University, within an Open Enrollment Period or within a Special Enrollment Period. If you decline coverage, you will not be able to enroll until the next Open Enrollment Period unless a Special Enrollment Period applies as discussed below in Section III.D.

Students and trainee group members who are required to have coverage and who do not receive approval from the Plan Administrator to decline the Plan coverage, may be automatically enrolled under the Plan by the Plan Administrator even if they fail to complete the required enrollment form. In such instances, the default membership type for such students and trainee group members will be the Individual Membership.

B. For Eligible Participants

Except as otherwise provided in Section III.A, you must complete an enrollment form and return it to the Plan Administrator within the applicable time periods set forth in this Section III.B. to have coverage in effect.

An enrollment form must be completed and returned to the Plan Administrator within 31 days of admission to the University to have coverage in effect on the date of admission to the University. In order to have coverage in effect on the first day of the Open Enrollment Period, an enrollment form must be completed and returned to the Plan Administrator within the Open Enrollment Period for your Program.

In order to have coverage in effect on the first day of the Special Enrollment Period, an enrollment form must be completed and returned to the Plan Administrator within a Special Enrollment Period. Special Enrollment Periods are discussed further in Section III.D below.

You may be required to make contributions for the cost of your coverage.

C. For Eligible Dependents

You must be covered under the Plan in order to cover your Eligible Dependents. You must complete an enrollment form for each Eligible Dependent and return it to the Plan Administrator within the applicable time periods set forth in this Section III.C to have coverage in effect.

Such enrollment form must be completed and returned to the Plan Administrator within 31 days of your admission to the University to have coverage in effect on the date of admission to the University. In order to have coverage in effect on the first day of the Open Enrollment Period, such enrollment form must be completed and returned to the Plan Administrator within the Open Enrollment Period for your Program.

In order to have coverage in effect on the first day of the Special Enrollment Period, such enrollment form must be completed and returned to the Plan Administrator within a Special Enrollment Period. If you do not enroll your Eligible Dependents within the applicable Special Enrollment Period, you will not be able to enroll them until the next Open Enrollment Period for your Program. Special Enrollment Periods are discussed further in Section III.D below. You must make arrangements with the Plan Administrator to pay the cost of your Dependents' coverage. You will receive information on payment as applicable.

D. Enrollment Periods

The Plan Administrator sets the Open Enrollment Period for different groups of Participants, which vary by Program. Each Eligible Participant and their Eligible Dependents may enroll for health care coverage under the Plan, or decline coverage (or seek approval to decline coverage, if applicable), during the Open Enrollment Period. At a minimum, an Open Enrollment Period will be held once each year for each Program. The Plan Administrator will notify Eligible Participants of the applicable Open Enrollment Period, and the date coverage will be effective, for their respective Program.

Each Eligible Participant and their Eligible Dependents may also enroll during a Special Enrollment Period. A Special Enrollment Period exists under the following circumstances:

1. Loss of other coverage. If an Eligible Participant or an Eligible Dependent were covered under another group health plan (including COBRA continuation) or had other medical insurance coverage at the time enrollment was declined, and has lost or will lose coverage under the other plan as a result of loss of eligibility (due to such reasons as death of a spouse, divorce, legal separation, termination of employment or reduction in the number of hours of employment or, cessation of the employer's contributions to such coverage or change in enrollment status at an academic institution) or exhaustion of COBRA continuation coverage, the Eligible Participant or an Eligible Dependent must enroll (complete and return to the Plan Administrator an enrollment form) within 31 days after loss of coverage. Coverage will be effective as of the date coverage was lost.

2. New dependents. If you acquire an Eligible Dependent through marriage, birth, adoption or placement for adoption while you are eligible for the Plan, you (if you originally declined coverage when you became eligible) and your newly acquired Eligible Dependent(s) must (1) enroll (complete and return to the Plan Administrator an enrollment form) within 31 days of the date of marriage, birth, adoption or placement for adoption for coverage to be in effect as of the date of marriage, birth, adoption or placement for adoption and (2) make arrangements with the Plan Administrator to pay the cost of any additional and applicable premium starting from the date of birth or placement for adoption. In the case of the birth, adoption or placement for adoption of a Child, your Spouse may also be enrolled as your Eligible Dependent if otherwise eligible for coverage.

A child born to a Participant or Dependent Spouse will be provided coverage for 31 days from the date of birth. No additional premium will be assessed for these 31 days of coverage. To extend coverage past the 31 day period, you must (1) enroll (complete and return to the Plan Administrator an enrollment form) the child within 31 days of the birth and (2) make arrangements with the Plan Administrator to pay the cost of any additional and applicable premium.

3. CHIPRRA. Under the Children's Health Insurance Program Reauthorization Act of 2009 ("CHIPRA"), an Eligible Participant and his or her dependent(s) who are eligible, but not enrolled, will be allowed to enroll for coverage if either of the two following events occur:

(a) the Eligible Participant or his or her dependent(s) who is covered under a Medicaid plan or under a State Child Health Plan (SCHIP) and coverage of the Eligible Participant or dependent(s) under such plan is terminated as a result of loss of eligibility, may request coverage under the Plan no later than 60 days after the date of termination of coverage; or

(b) the Eligible Participant or his or her dependent(s) who becomes eligible for premium assistance under Medicaid or SCHIP, with respect to group health coverage, may request coverage under the Plan no later than 60 days after the date of eligibility determination.

If you do not enroll yourself or your Eligible Dependents during the applicable Special Enrollment Period, neither you nor your Eligible Dependents may be enrolled unless you experience another circumstance that entitled you to a Special Enrollment Period or until the next Open Enrollment Period for your Program.

If a Covered Individual enrolls in another group or individual plan during the other plan's "special enrollment" or "open enrollment period" as the result of a significant change in Covered Individual, guardian/parent or spouse employment status including commencement of employment, return from leave of absence or change from part-time to full-time status, or change in enrollment status at an

academic institution, the Covered Individual may request a termination of his or her coverage under the Plan prior to the expiration of the current Benefit Period. To request an early termination of coverage, written documentation supporting the change in employment or academic status and related new coverage effective dates must be submitted to the Plan Administrator within 31 days of the change in employment or academic status. If accepted by the Plan Administrator, coverage will terminate on the effective date of the new coverage.

Becoming eligible for another group, individual, or government health insurance program does not, in itself, provide a Covered Individual with the right to request a termination of coverage under the Plan.

If you were previously enrolled in the Individual Membership and desire to add one (1) or more Eligible Dependents during the Open Enrollment Period or during any Special Enrollment Period, then you will be required to select either the Individual Membership Plus One or Family Membership. You will be responsible for paying the increased premiums associated with the new membership type elected and in effect as of the date of the new coverage.

E. Qualified Medical Child Support Orders

If required by a qualified medical child support order ("QMCSO"), you (if you declined coverage when you became eligible) and your QMCSO-child (as described in Section II) will be enrolled in the Plan in accordance with the terms of the order. You will be required to make contributions for the cost of this coverage. You may obtain, without charge, a copy of the Plan's procedures governing QMCSO determinations.

F. Medicaid

In enrolling an individual as an Eligible Participant or Eligible Dependent or in determining or making any payments for benefits, the fact that the individual is eligible for or is provided benefits through Medicaid shall not be taken into account. In addition, payment of benefits will be made in accordance with any assignment of rights made by or on behalf of an Eligible Participant or Eligible Dependent under the Plan as required by Medicaid.

IV. Benefits

A. Benefit Levels

Except for retail prescription drugs, three different levels of Benefits are being provided under the Plan:

1. The "1st Tier" Benefit level will be payable for Medically Necessary covered services or supplies rendered or provided by a SLUCare Participating Provider or a University Participating Provider;

2. The "2nd Tier" Benefit level will be payable for Medically Necessary covered services or supplies rendered or provided by a Coventry Health Care of Missouri Participating Provider that is not also a SLUCare Participating Provider or a University Participating Provider; and

3. The "Out-of-Network" Benefit level will be payable for Medically Necessary covered services or supplies rendered or provided by a provider who is not a Participating Provider. Out-of-Network Benefits will be limited to the Usual and Customary Charge for the particular service.

Retail prescription drugs are covered Benefits only as described in Exhibit 1 attached hereto.

Provider directories listing the SLUCare, University and Coventry Health Care of Missouri Participating Providers will be made available to you by the Plan Administrator or its designee, at no cost. You may access the lists of SLUCare and Coventry Health Care of Missouri Participating Providers on Coventry Health Care of Missouri website at www.chcmissouri.com. Notwithstanding the inclusion of a provider in any provider directory, the Covered Individual shall be responsible for verifying with the Plan that: (i) any particular provider is a Participating Provider at the time any Benefit is provided or rendered in order to receive 1st Tier or 2nd Tier Benefits; and (ii) any particular pharmacy is a Participating Pharmacy at the time any prescription drug Benefit is provided.

B. Choosing a Primary Care Physician

You should choose a Primary Care Physician for yourself and each of your Dependents. Your Primary Care Physician will provide your primary health care and coordinate health care provided to you by Specialists. You do not need to select a Primary Care Physician in order to receive health care Benefits under the Plan.

For Adults: You may select your Primary Care Physician from the Student Health and Counseling Center Physicians as described in the list of Participating Providers. You may also choose from one of the University Medical Group, General Internal Medicine and Family Medicine faculty physicians at Des Peres Medical Arts Pavilion or Family Practice Center at St. Elizabeth Hospital in Belleville, Illinois.

For Children: You may select a Dependent's Primary Care Physician from one of the pediatricians in the Medicine/Pediatrics faculty group of the Saint Louis University School of Medicine/SLUCare University Medical Group Building, the Department of Pediatrics and Adolescent Medicine at the University Pediatrics Office located at Cardinal Glennon Children's Hospital, the Family Practice faculty at Des Peres Medical Arts Pavilion or Family Practice Center at St. Elizabeth Hospital in Belleville, Illinois.

C. Disclosure of Arrangements with Providers and Others

Some of the contracts that the Plan Administrator has with Providers, vendors, administrators and other service providers allow for allowances, fees, incentives, adjustments, settlements, discounts and rebates to be paid to the Plan Administrator. These amounts are for the sole benefit of the Plan Administrator and may be used to help offset administrative costs. When a claim is received, the Plan Administrator calculates the amounts of your responsibility (such as Copayments, etc.) without regard to such allowances, fees, incentives, adjustments, settlements, discounts and rebates.

In particular, with respect to prescription drugs, the Plan Administrator may enter into agreements with certain entities in order to obtain cost savings on prescription drugs for the benefit of the Plan, you, and others. In connection with such agreements, the Plan Administrator may receive rebates and other compensation directly or indirectly from such entities based on the number of prescription drugs purchased under the Plan, and other services, activities or information provided to or for such entities

or in connection with the Plan. The Plan and you understand, acknowledge and agree that any such rebates and compensation received will be retained by the Plan Administrator. Savings accrue to the Plan and you only from the point of sale transaction. The compensation and savings resulting from rebates and other compensation, which are a consequence of, among other things, services or activities provided (e.g., formulary compliance programs), will accrue to the Plan Administrator. The Plan and you understand, acknowledge and agree that amounts that are your responsibility are calculated without regard to any rebate or other compensation received by the Plan Administrator.

Provider agreements may also include financial incentives to promote effective medical management practices. Under these incentive agreements, the payments made to Providers may be partially based on how well they manage patient care. Factors that may be considered include patient satisfaction surveys, quality performance measures and the number of services provided to Covered Individuals.

D. Overview

1. Covered Benefits in General. The Plan provides comprehensive health care to Covered Individuals, consisting of the Benefits listed in the attached Prescription Drug and Medical Coverage summaries, in accordance with the procedures and subject to the limitations and exclusions specified in this Summary Plan Description. Further, the Plan pays only for eligible Medically Necessary covered services or supplies performed or provided by qualified providers (Hospitals, Physicians, etc.) as determined by the Plan. All providers must be certified or licensed by the applicable state law to render specific services as well as perform those services within the legal scope of such license as defined herein. Notwithstanding anything in this Summary Plan Description to the contrary, the following services, treatments, items, care and procedures are not covered by the Plan (a) services, treatments, items, care and procedures performed by non-qualified providers, (b) services, treatments, items, care and procedures performed outside the "legal scope" of a provider's license, (c) services, treatments, items, care and procedures performed by any provider which are not Medically Necessary, and (d) services, treatments, items, care and procedures not included as Benefits, whether or not the same are Medically Necessary.

Notwithstanding anything in this Summary Plan Description to the contrary, lifetime limits on the dollar amount of essential health benefits available to you under the terms of the Plan are no longer permitted, and any annual dollar limit applicable to the essential benefits listed below is no longer applicable. Essential health benefits include the following: ambulatory patient services; emergency services, hospitalization; maternity and newborn care, mental health and substance use disorder services (including behavioral health treatment); prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

2. Mental Health and Substance Abuse. The Plan has an additional and a separate telephone number indicated on the Summary of Coverage and Benefits to assist you in accessing these services under the 1st Tier Benefit. The Plan has also arranged for a separate Mental Health/Substance Abuse Assistance Hotline ("MH/SA Hotline") to assist you in accessing these services under the 2nd Tier Benefit. You may reach the MH/SA Hotline by calling the MH/SA telephone number on your identification card. The MH/SA Hotline is staffed by Mental Health Professionals who are available twenty-four (24) hours, seven (7) days a week to discuss with Covered Individuals their particular concerns and provide referrals to: (i) the type(s) of Mental Health Professionals and/or facilities who or which could best serve the Covered Individual; and (ii) the appropriate level of care and/or setting.

Mental health and substance abuse services, including outpatient psychiatric and psychological care, and Alcoholism and Chemical Dependency treatment, are provided as 1st Tier, 2nd Tier and Out-of-Network Benefits. The Saint Louis University Student Health and Counseling Center and Saint Louis Behavioral Medicine Institute are available to all Eligible Participants and their Eligible Dependents. This includes short-term confidential crisis intervention, and confidential assessment and management of alcohol or substance abuse related disorders.

3. Maternity Services. Maternity services for Covered Individuals under this Plan consist of Medically Necessary medical and hospital services and such maternity services are covered as any other non-occupational Illness. Benefits include prenatal and post-natal care. Maternity Benefits are extended to include a minimum of 48 hours of Inpatient care following a vaginal delivery for the mother and the newborn and a minimum of 96 hours of Inpatient care following a delivery by caesarian section for the mother and newborn. **Note:** You must complete an enrollment form for each Eligible Dependent (including a newborn) and return it to the Plan Administrator within applicable time period to have coverage in effect. Special Enrollment Periods are discussed in Section III.D above.

A shorter length of hospital Inpatient stay for maternity and newborn care may be covered if the attending Physician (after consultation with the mother) determines the mother and newborn meet protocols and guidelines developed by the American College of Obstetricians and Gynecologists or the American Academy of Pediatrics. If the attending Physician recommends the shorter length of a stay, the Covered Individual must approve it. Furthermore, a post-discharge office visit or in-home visits to verify the condition of the infant must be available in the first 48 hours after discharge.

Post-discharge care consists of a minimum of two visits, at least one of which must be in the home, in accordance with accepted maternal and neonatal physical assessments by a registered professional nurse with experience in maternal and child health nursing, or a Physician. The attending Physician determines the location and schedule for the post-discharge visits. Services provided by a registered professional nurse or Physician include, but shall not be limited to, physical assessment of the newborn and mother, parent education, assistance and training in breast or bottle feeding, education and services for complete childhood immunizations, the performance or any necessary and appropriate clinical tests and submission of a metabolic specimen outlined in the most current version of the "Guidelines for Perinatal Care" prepared by the American Academy of Pediatrics and the American College Obstetrician and Gynecologist, or similar guidelines prepared by another nationally recognized medical organization. Any abnormality, in the condition of the mother or child, observed by the nurse must be reported to the attending Physician as medically appropriate.

For the purposes of this Section IV.D.3 only, "attending Physician," means the attending obstetrician, pediatrician or other Physician attending the mother or newly born child.

STERILIZATION, REVERSAL OF STERILIZATION, FERTILITY AND ABORTION SERVICES ARE NOT COVERED BENEFITS.

4. Certain Other Covered Benefits.

(a) Hospitalization. Prior to Admission as an Inpatient for elective hospitalization, the Physician **must obtain pre-Admission certification from the Plan**. This is described in further detail in Section IV.I below. Coverage for any Emergency Medical Condition hospitalization does not

require prior authorization. However, any Emergency Medical Condition hospitalization will require notification to the Plan within 48 hours of Admission, or as soon as reasonably possible.

(b) Mastectomy Benefits. Pursuant to the Women's Health and Cancer Rights Act of 1998, Covered Individuals receiving Plan Benefits in connection with a mastectomy will receive the following services:

1. reconstruction of the breast on which a mastectomy has been performed;
2. surgery and reconstruction of the other breast to produce a symmetrical appearance;
3. prostheses or prosthetics necessary to restore symmetry; and
4. coverage for physical complications for all states of a mastectomy, including lymphedemas (swelling associated with the removal of lymph nodes).

Coverage for breast reconstruction and related services will be subject to Deductibles and Copayment amounts that are consistent with those that apply to other Benefits. The Plan will continue to determine the manner of coverage in consultation with the attending physician and patient.

(c) Second Opinion. The Plan will arrange for a referral to a Physician with the necessary expertise to provide a second opinion or consultation when you choose to seek a second medical opinion. If there is no Participating Provider Physician with the necessary expertise, the Plan will arrange for a referral to a Physician with the necessary expertise to provide a second opinion or consultation. This covered Benefit is provided to Covered Individuals at no greater cost than if the Benefit were obtained from a Participating Provider Physician.

(d) Child Health Supervision. Child health supervision services include coverage from the moment of birth through the age of twelve (12) years, and are subject to the same durational limits, dollar limits, Copayments and Coinsurance as other Benefits. A single Physician conducts the review. Benefits for these services are provided at approximately the following age intervals: birth, two months, four months, six months, nine months, twelve months, eighteen months, two years, three years, four years, five years, six years, eight years, ten years and twelve years.

(e) Anesthesia for Dental Care. The Plan will provide coverage for administration of general anesthesia and hospital charges for dental care provided to the following Covered Individuals:

1. a child under age five (5) years;
2. a person severely disabled, as determined by the CMO or his/her designee; or
3. a person who has a medical or behavioral condition which requires hospitalization or general anesthesia when dental services are provided, such as hemophilia, as determined by the CMO or his/her designee.

Coverage shall be provided for administration of general anesthesia and Hospital or office charges for treatment rendered by a dentist, regardless of whether the services are

performed in a Hospital, surgical center, or Physician office setting. This service, however, must be rendered at a facility that is a Participating Provider.

(f) Hearing Screening. Coverage is provided for newborn hearing screening, necessary rescreening, audiological assessment and follow-up.

E. Summary of Medical Coverage and Benefits See Exhibit 2 attached to this Summary Plan Description.

F. Deductibles, Copayments, Coinsurance, and Out-of-Pocket Maximum

1. Deductibles. There is no Deductible for 1st Tier Benefits.

There are Deductibles for 2nd Tier and Out-of-Network Benefits. Such Deductibles are the amounts of Eligible Charges you and/or your Dependents must incur and pay during each calendar year before the Plan will consider any additional Eligible Charges for reimbursement. The 2nd Tier Deductible for each Covered Individual is $100. The 2nd Tier Deductible for a Family is $200. The Out-of-Network Benefits Deductible for each Covered Individual is $500. The Out-of-Network Benefits Deductible for a Family is $1,000. After the Deductible has been paid toward Eligible Charges for two or more Covered Individuals in a Family, no further Deductible applies to any Covered Individual in the Family for that calendar year.

2. Copayments. Copayments are also required each time you or your Dependents receive certain services. These Copayment amounts are in addition to and do not count toward the Deductibles. Copayments may be a flat dollar amount or a percentage of covered expenses, as shown in the Summary of Coverage and Benefits set forth above.

3. Coinsurance. Coinsurance is the percentage of Eligible Charges that you pay for certain Benefits specified in the Description of 1st Tier, 2nd Tier and Out-of-Network Benefits below. For example, if your covered medical care is provided by a non-Participating Provider (i.e., the services are Out-of-Network Benefits), then your Coinsurance is 35% of the Eligible Charges after you satisfy the Deductible and the Plan pays the remaining 65% of the Eligible Charges. Any amount charged by the Provider in excess of the "Eligible Charge" is your responsibility.

4. Out-of-Pocket Maximum. The amount of Copayments and Coinsurance for 1st Tier Benefits that you have to pay for a Covered Individual in a calendar year is limited. The out-of-pocket maximum is $1,100 for each Covered Individual, or $3,300 for a Family. Once covered Copayments and Coinsurance for a Covered Individual reach $1,100, the Plan will pay 100% of that Covered Individual's covered expenses for 1st Tier Benefits for the remainder of that calendar year.

The amount of Copayments, Coinsurance and Deductibles for 2nd Tier Benefits that you have to pay for a Covered Individual in a calendar year is limited. The out-of-pocket maximum is $1,500 for each Covered Individual or $4,000 for a Family. Once covered Copayments, Coinsurance and Deductibles for a Covered Individual reach $1,500, the Plan will pay 100% of that Covered Individual's covered expenses for 2nd Tier Benefits for the remainder of that calendar year.

There is no out-of-pocket maximum for Out-of-Network Benefits.

G. Description of 1st Tier, 2nd Tier and Out-of-Network Benefits

This Section IV.G. describes the Benefits listed in the Summary of Medical Coverage and Benefits in greater detail. Any services or supplies expressly excluded in Section IV.H, or otherwise not specifically listed in the Summary of Medical Coverage and Benefits and this Section IV.G will not be treated as a Benefit under the Plan.

1. Medical Services.

(a) Services and Supplies. Medically Necessary services and supplies, including medications, ordered by and provided by or under the direction of a Physician in the Physician's office, including medications administered in the office, whether orally or by injection; provided, however, a Covered Individual must obtain **prior authorization** from the Plan's CMO for an office visit to a Physician (Primary Care Physician or Specialist) who is a Non-Participating Provider. 1st Tier and 2nd Tier Benefits include preventive medical care such as pap smears, pelvic, prostate and colorectal exams, prenatal care, well-baby care, physical examinations, hearing and vision screening, blood pressure testing, testing for lead poisoning, treatment of osteoporosis, and cancer screenings in accordance with the current American Cancer Society guidelines.

(b) Surgical Services and Other Medical Care; Surgery Performed in a Physician's Office. Medically Necessary surgical services and other medical care (including anesthesia and Hospital visits) ordered by and provided by or under the direction of a Physician in a Hospital, Skilled Nursing Facility, Outpatient Facility, or other Provider location. This includes surgery performed in a Physician's office.

(c) Immunizations. Routine immunizations for Dependent children from birth to five (5) years provided by a Participating Provider as recommended by the CDC for residents of the United States.

Travel immunizations are covered at the 1st Tier Benefit level; provided, however, that Covered Individuals who require travel immunizations must obtain preauthorization for such immunizations from the Plan by calling (314) 977-5666. If approved, Covered Individuals must pay at the time of service and subsequently request reimbursement from the Plan. There are no 2nd Tier Benefits or Out-of-Network Benefits for travel immunizations.

(d) Allergy Services. Medically Necessary allergy services, which include Primary Care Physician and Specialist office visits and injections and serum, treatment, or testing (when no charge is made for Physician services).

(e) Lab and X-Ray. Medically Necessary laboratory, medical diagnostic testing services, x-ray, and other services are covered only when ordered by and provided under the direction of a Participating Provider.

(f) Maternity. Maternity services, including routine and high-risk care deemed Medically Necessary during pregnancy and prenatal through postpartum (including fetal death) follow-up care. This includes office visits and laboratory and diagnostic testing services such as sonograms ordered during or related to a pregnancy, except that only two sonograms are covered during a normal pregnancy. **STERILIZATION, REVERSAL OF STERILIZATION, FERTILITY AND ABORTION ARE NOT COVERED BENEFITS.**

2. Inpatient Hospital Services. Those Medically Necessary services prescribed by and under the direction of a Physician in a Hospital or other Provider which shall include: Semi-Private Room and Board, general nursing care, ancillary services and supplies, operating room, private room (in certain instances), intensive care and related services, obstetrical care, newborn nursery, special diet, medications and medical supplies.

3. Outpatient Services. Those Medically Necessary services ordered by and provided under the direction of a Physician in a Hospital or another Provider when the Covered Individual is not an Inpatient which shall include: general nursing care, ancillary services and supplies, operating room, special diet, medications and medical supplies.

(a) Emergency Care. Medically Necessary services and supplies, including any medications administered as part of such care (and not intended primarily for home use), associated with an Emergency Medical Condition at a Hospital or other Provider. Coverage for any Emergency Medical Condition hospitalization does not require prior authorization. However, the Plan must be notified no later than 48-hours after service or as soon as reasonably possible to receive authorization for Benefits after stabilization to continue. Full details of the Emergency Care received shall be made available at the request of the Plan. The Emergency Care Copayment will be waived when Inpatient Admission for the same condition occurs within 24 hours. You will be responsible for the applicable Coinsurance for any continuation of care provided after stabilization by or through a non-Participating Provider. The Emergency Care Copayment is waived if the Covered Individual is admitted to an observation, outpatient surgery, outpatient procedure, or Inpatient care setting. The alternate Copayment or Coinsurance will apply. If the Covered Individual is hospitalized in connection with Emergency Care, a Participating Provider Physician may transfer the Covered Individual to a Participating Provider Hospital, upon the Covered Individual's request, as soon as it is medically appropriate in the opinion of the attending Physician.

(b) Non-Emergency Services.

(i) Outpatient Surgery. Medically Necessary services and supplies, including medications administered as part of a patient's care (and not intended primarily for home use) for outpatient surgery provided under the direction of a Physician at a Hospital or Outpatient Facility; excluding elective cosmetic surgery and other surgeries listed in Section IV.H. The outpatient surgery Copayment (but not Coinsurance) is waived if the Covered Individual is admitted to an Inpatient care setting.

(ii) Outpatient Hospital Procedures. Coverage is available for Medically Necessary procedures provided in the outpatient Hospital setting. This coverage includes but is not limited to invasive testing such as myelograms, venograms, arteriograms, endoscopic procedures (diagnostic sigmoidoscopies do not require a Copayment at the 1st Tier or 2nd Tier Benefit Level), urodynamic studies, pain management procedures (not related to a specific surgical procedure), and hysteroscopies unless otherwise referenced in this Summary Plan Description. The outpatient procedure Copayment (but not Coinsurance) is waived if outpatient surgery is performed during the same visit, or if the Covered Individual is admitted to an Inpatient care setting.

(c) Urgent Care. At the direction of a Participating Physician, Medically Necessary services; and supplies, including medications associated with the provision of Urgent Care at an Outpatient Facility.

(d) Outpatient Rehabilitative Therapy Services. Coverage maximum for up to sixty (60) visits per calendar year for an acute Injury or Illness for which therapy is reasonably expected to result in a material improvement in the physical condition of the Covered Individual. Rehabilitative therapy services include physical, speech, or occupational therapy. Medically Necessary rehabilitative therapy services are covered when ordered by or monitored by a Physician at a Provider **and approved in advance by the CMO or designee**. The sixty-visit limit includes all visits for any therapy whether services are provided in the outpatient Hospital setting, or a free-standing rehabilitation center. The sixty (60) visit limit is not renewable. Home rehabilitation services are limited to the Homebound patient and considered separately under the Home Health Benefit. Inpatient rehabilitation is covered under Section IV.G.2 above. Rehabilitative therapy services that are considered Maintenance Services, Developmental Services or Educational Services are not covered Benefits. The coverage maximum for cardiac and pulmonary rehabilitation is one cycle up to 36 visits within a 12 week period per year when services are considered Medically Necessary **and approved in advance by the CMO or designee**.

(e) Observation. Coverage is available for care provided in the Observation setting for up to 48 hours. Observation services are those services furnished by a Hospital on the Hospital's premises, including use of a bed and periodic monitoring by a Hospital's nursing or other staff, that are reasonable and necessary to evaluate an outpatient's condition or determine the need for a possible Admission to the Hospital as an Inpatient. Most observation services do not exceed one (1) day. Some patients, however, may require a second day of outpatient observation services. Covered Individuals may be admitted as observation status to beds in the emergency room, an observation unit, the intensive care unit, or a regular floor. If a Covered Individual is admitted under an observation status that results in a conversion to an Inpatient Admission, then the observation Copayment (but not Coinsurance) will be waived. The alternate Copayment will apply.

(f) Nutritional Counseling. Nutritional counseling that is appropriately included as part of the course of treatment based on the efficacy of the diet and lifestyle and treatment of the disease states, in accordance with Plan policies and procedures, which are subject to change. Expenses for nutritional counseling for up to three (3) visits in a calendar year are covered if recommended by a Provider and provided by a registered dietician at a Hospital or other Provider.

4. Mental Health/Alcoholism/Chemical Dependency Services. Mental health, Alcoholism and Chemical Dependency services include the following Medically Necessary services: Outpatient mental health, diagnostic crisis intervention, and therapeutic services; Inpatient services; Outpatient therapeutic Alcoholism and Chemical Dependency services; and Inpatient Alcoholism and Chemical Dependency services.

5. Other Benefits. Benefits will include the following Medically Necessary services, supplies, medications, rental, or purchase of equipment, if provided under the direction of a Physician who is a Participating Provider (or non-Participating Provider, unless excluded from Out-of-Network Benefits) and provided or obtained from a Participating Provider (or non-Participating Provider, unless excluded from Out-of-Network Benefits).

(a) Home Health Provider Services. Medically Necessary services of a Home Health Provider in a Covered Individual's home for the care and treatment of an Injury or Illness of the Homebound Covered Individual, which would otherwise require Inpatient confinement in a Hospital or Skilled Nursing Facility. Services will include periodic, intermittent nursing care by, or under the supervision of, a registered nurse, licensed practical nurse, as authorized in advance by the Plan. **This**

service may be subject to advance approval by the Plan's CMO. Coverage for up to a maximum of sixty (60) visits per calendar year.

(b) Skilled Nursing Facility Services. Coverage for up to a maximum of sixty (60) days per calendar year for Medically Necessary Room and Board, services and supplies, including medications provided under the direction of a Physician in a Skilled Nursing Facility for the care and treatment of an Injury or Illness which would otherwise require Inpatient confinement in a Hospital.

(c) Hospice Care Services. Services provided either on an Inpatient or an outpatient basis, based on approved acceptable medical practices of the Plan's CMO or designee. Generally, this Benefit is available once per lifetime for a terminally ill person with a life expectancy of less than six months.

(d) Ambulance. Medically Necessary ambulance service, either by motor vehicle or by air ambulance, to the most appropriate Hospital where Emergency Care can be provided in the case of an Emergency Medical Condition and Medically Necessary transportation, either by motor vehicle or air ambulance, when recommended by a Physician, provided, however, **use of air ambulance, except in cases of an Emergency Medical Condition, must be authorized in advance by the CMO of the Plan**. This excludes evacuation from foreign countries, even in emergency situations.

(e) Prosthetic Devices. When ordered or provided by a Physician and obtained from a Provider, the purchase, fitting, necessary adjustment of prosthetic devices which replace or repair all or part of a limb including tissue, or replace all or part of the function of a permanently inoperative or malfunctioning body organ is a covered benefit. This includes limbs, eyes, and prosthetic lenses when the organic lens is missing, breast prostheses (including a post-mastectomy brassiere). Supplies, adjustments, and repair or replacement of these devices, necessary to maintain their effective use, is provided when needed due to loss, irreparable damage, normal wear or a change in the patient's condition, and when ordered by a Physician and deemed Medically Necessary by the Plan. Even when the device has been in use prior to the users enrollment, so long as the device remains Medically Necessary, it will be covered. Cases suggestive of malicious damage, culpable neglect, or wrongful disposition will be investigated and may result in the dismissal of the Covered Individual from the Plan. Dentures are not covered, except when part of a covered prosthesis required to replace a missing part of the palate or other maxillofacial part.

A covered prosthetic device is the standard, basic equipment necessary to continue average daily activities. The following devices and related services are not covered as prosthetic devices Benefits:

- All mechanical organs.
- Computer assisted devices.
- Dental and TMJ appliances.
- Devices employing robotics.
- Electrical continence aids, anal or urethral.
- Implants for cosmetic or psychological reasons.
- Investigational or obsolete devices and supplies.
- Remote control devices.
- Replacement of cataract lenses necessary after cataract surgery.

(f) Orthotic Equipment. Covered orthotic equipment is the standard, basic equipment necessary to continue average daily activities.

The following items are covered when ordered and provided by a Physician and obtained from an orthotic Provider:

- Braces/support
- Trusses
- Splints
- Collars

Foot orthotics are a covered treatment for the following conditions:

- Neuropathy or severe vascular insufficiency due to diabetes, neurologic or vascular disease;
- Correction of demonstrable anatomic defect secondary to trauma, neuromuscular disease or deforming arthritis; or
- Correction of structural congenital or developmental defect or abnormality.

Please see the additional exclusions and limitations relating to orthotic equipment in Section IV.H.

(g) Durable Medical Equipment ("DME") and Supplies. Equipment prescribed by a Physician, which meets all of the following conditions: (a) standard and basic hospital-type equipment that is primarily used to serve a medical need; (b) it is able to withstand repeated use; (c) it is primarily and customarily used in the therapeutic treatment of Illness or Injury and Medically Necessary for the condition; (d) it is generally not useful to a person in the absence of an Illness or Injury; (e) it is not primarily a device for enhancing the environmental setting in which the patient is placed or altering air quality or temperature; (f) it is not used for exercising or training; or (g) equipment used for monitoring health conditions; (h) not primarily used for the convenience of the person caring for the patient; and (h) equipment which meets the medical need for: oxygen and the equipment necessary for its administration; a wheelchair or hospital-type bed; mechanical equipment required for the treatment of a chronic or acute respiratory illness or failure, such as asthmatic equipment; or ambulatory dialysis.

In no event shall orthodontic braces, humidifiers, air conditioners, dehumidifiers or similar personal comfort items be treated as DME for purposes of this Plan. DME in excess of $500.00 must be approved in advance by the CMO.

In addition, DME is not modified, repaired, or replaced unless necessitated by the Covered Individual's medical condition. The Plan may replace an item because of severe damage or loss through no intentional act of the Covered Individual, however, an item is not replaced more frequently than once per calendar year. DME may be purchased or rented based on approved acceptable medical practices of the Plan.

(h) Surgical Implants. Medically Necessary surgical implants, whether inserted in the Inpatient, outpatient, or office setting, including pacemakers, stints, and other implantable devices or treatments.

(i) Diabetes Services. Medically Necessary equipment, supplies and self-management training for the management and treatment of diabetes. Services are provided for persons with gestational, type I or type II diabetes.

(j) Transplant Services. Transplant services Benefits under this section require a second opinion and no Benefits shall be payable under this Plan with respect to expenses Incurred for or in connection with organ transplants unless rendered by a Board Certified Specialist who is a Participating Provider, who is not associated with the initial Participating Provider Physician and who will not be performing the surgery, confirming the organ transplant is Medically Necessary.

The surgery must be performed within 12 months of the date that the original recommendation for the surgery was made, except when the 12-month time period is exceeded for reasons beyond the Covered Individual's control (charges for any duplicated diagnostic testing or ancillary services will not be covered).

In addition, transplant services **must be approved in advance by the Plan** and are designated by the Plan to be performed at a Hospital that is a Participating Provider or other approved Hospital.

Transplant services are limited to transplantation of kidney(ies), cornea(s), pancreas, heart, lung, heart/lung, liver (but only in the case of end stage liver disease, or for children with biliary atresia), bone marrow (including those performed pursuant to nationally accepted peer review protocols utilized by breast cancer treatment centers experienced in dose-intensive chemotherapy/autologous bone marrow transplants stem cell transplants), intestinal and autologous transplants for testicular and other germ cell tumors, or kidney/pancreas.

There are no Out-of-Network Benefits for Transplant Services.

(k) Dialysis. Medically Necessary dialysis is a covered Benefit when provided by a Participating Provider. There are no Out-of-Network Benefits for Dialysis.

(l) Mammography. Low-dose mammography screening for non-symptomatic Covered Individuals is a covered Benefit, which includes the following:

- A baseline mammogram for female Covered Individuals ages thirty-five (35) to thirty-nine (39), inclusive;
- A mammogram every year for female Covered Individual's age forty (40) and over; and
- A mammogram for any female, upon the recommendation of her Physician who is a Participating Provider, where such female, her mother, or sister has prior history of breast cancer.

(m) Routine Eye Care Services. Expenses for one (1) eye exam and/or eye refraction per calendar year performed by an ophthalmologist or Optometrist. When services are

received for routine eye care and/or the correction of refractive errors, visual fields, gonioscopy, and other services are not covered.

(n) Nutritional Supplements. Coverage for formula and low protein modified food products recommended by a Physician for the Medically Necessary treatment of a Dependent Child with phenylketonuria (PKU) or any inherited disease of amino and organic acids who is less than six (6) years of age.

(o) Accidental Dental. Expenses Incurred in connection with an Injury to Sound Natural Teeth of the Covered Individual. Coverage is limited to damage from external trauma to face and mouth only, not for cracked or broken teeth, which result from biting or chewing. This coverage does not include Benefits for the repair or replacement of dental prosthetics, including, but not limited to, bridges, dentures, crowns, implants, braces and retainers. Dental implants and associated procedures and supplies are not covered by the Plan. All services in connection with an Injury of this nature must be provided to an eligible Covered Individual within the six (6) month period from the date of the Injury. The treating Provider must certify in writing that the teeth were injured as a result of an Injury. Dental x-rays and narrative report for independent dental consultant review may be required.

(p) Injectables. Up to a maximum of $100 per injection, injectables (not to include immunizations) provided by a Provider regardless of place of service. Injectable Copayments apply in addition to place of service (e.g., medical services, Home Health Provider services, etc.) Copayments.

(q) Human Leukocyte Antigen Testing (Bone Marrow Transplantation). Coverage is provided for human leukocyte antigen testing, also referred to as histocompatibility locus antigen testing for A, B, and DR antigens for utilization in bone marrow transplantation. Testing must be performed in an appropriate facility. A Covered Individual is limited to one such testing per lifetime, whether provided by a Participating Provider or non-Participating Provider.

(r) Natural Family Planning Services. Services provided by a Participating Provider for natural family planning, including but not limited to, the Creighton Model (CrM) ovulation method for natural family planning.

(s) Smoking Cessation Services. Benefits are available for up to one smoking cessation group support program per calendar year at a Plan-approved Participating Provider. Participating Providers generally offer up to five (5) American Lung Association certified sessions per program. The applicable Copayment applies to each program. There are no Out-of-Network Benefits for smoking cessation services.

H. Exclusions

Notwithstanding any of the foregoing, the following services and/or supplies listed below shall not be treated as Benefits under the Plan, even if recommended by a Participating Provider or other Provider.

(a) Medical care, services and supplies for which no charge is made or for which the Covered Individual is not, in the absence of this coverage, legally obligated to pay.

(b) To the extent permitted by law, medical care, services and supplies which are furnished by a Hospital or facility operated by or at the direction of the United States government or any authorized agency thereof, or furnished at the expense of such government or agency, or by a Provider

employed by such a Hospital or facility, unless (i) the treatment is of an emergency nature, and (ii) the Covered Individual is not entitled to such treatment without charge by reason of status as a veteran or otherwise.

(c) Care for an Injury or Illness resulting from participation in, or in consequence of having participated in an illegal occupation or the commission of an assault or felony.

(d) Eye glasses, contact lenses, or the fitting of eye glasses or contact lenses (except for one (1) pair of eyeglasses or contact lenses prescribed following cataract surgery, up to a maximum of a $300.00 benefit every twenty-four (24) month period), eye exercises or any medical care (including surgical procedures), services or supplies related to treatment of refractive disorders (including LASIK and radial keratotomy).

(e) Hearing aids, cross hearing aides or the fitting of hearing aids.

(f) Cosmetic or reconstructive surgery, including dermabrasions, chemical peels, or other procedures associated with the removal of scars, keloids, tattoos, and/or acne, and reduction mammoplasty, correction of asymmetric breasts or abnormal nipple-areolar complexes and protruding ears, unless a functional deficit is specifically documented, except when such cosmetic or reconstructive procedures are for: (i) medical care and treatment to restore or improve an Injury within the six (6) month period from the date of the Injury; (ii) reconstructive breast surgery performed post-mastectomy; (iii) functionally needed medical care and treatment to restore or improve a structurally abnormal congenital or developmental defect or abnormality in a Covered Individual under age twenty-six (26).

(g) Medical care or treatment for an Illness or Injury covered by workers' compensation law, occupational disease law, or laws of a similar character.

(h) Medical care or treatment for an Illness or Injury arising out of or in the course of any occupation or employment for compensation, profit or gain, regardless of whether or not such Illness or Injury is covered by workers' compensation law, occupational disease law, or laws of a similar character

(i) Work place evaluations and work hardening treatment.

(j) Injury or Illness resulting from any catastrophic act or incident of war, whether declared or undeclared, insurrection or any atomic explosion or other release of nuclear energy (except only when being used solely for medical treatment of an Injury or Illness), whether in peacetime or in wartime and whether intended or accidental.

(k) Services and supplies intended primarily or partially for the treatment of obesity/morbid obesity, including but not limited to, stomach stapling, jaw wiring, gastric banding, gastric balloon or bypass surgery, dietary/nutritional supplements, behavioral/community support programs, exercise programs, and medical testing, medications, and office visits associated with any weight loss program unless otherwise noted in this document or an attached benefit rider.

(l) Services and expenses associated with nutritional-based therapy for alcoholism or chemical dependency.

(m) Transportation expenses, other than ambulance services described in Section IV.G.5(d).

(n) All prescription and non-prescription drugs (including contraception medication and devices and smoking cessation products) not prescribed for use while the Covered Individual is an Inpatient at a Participating Provider Hospital, other than (i) retail prescription drugs described in Exhibit 1 attached hereto, and (ii) contraception medication and devices for women that constitute "preventive health services" as defined in 29 C.F.R. §2590-.715-2713.

(o) Services and supplies associated with any organ transplant not specifically described elsewhere in Section IV, and services and supplies related to the removal of an organ from a Covered Individual for the purpose of transplantation into another individual not covered under the Plan.

(p) Service in connection with treatment of Mental Illness not classified in the International Classification of Diseases of the U.S. Department of Health and Human Services; or for Mental Illness, which is not normally susceptible to favorable modification, in accordance with generally accepted practice standards; or services utilizing methadone treatment as maintenance.

(q) Unless covered by the Benefit described in Section IV.G.5(o), exclusion (pp), or otherwise specified below, services in connection with the care or treatment of teeth, gums, or alveolar process, including but not limited to dental surgery, services for overbite or underbite, services related to surgery for cutting through the lower or upper jaw bone, maxillary and mandibulary osteotomies and services for the treatment of temporomandibular joint syndrome, whether the services are considered to be medical or dental in nature; removal of teeth (other than those in the port of radiation therapy), dental x-rays, supplies and appliances, dental implants, braces, and occlusal splints and all associated expenses arising out of such dental services including hospitalizations and anesthesia, except as might otherwise be required for direct treatment of acute traumatic injury or cancer. Exceptions include charges for professional services of a Participating Provider in rendering any of the following:

(1) Surgical correction of cleft lip, cleft palate, or mid-face deformities associated with either of these two conditions. This does not include coverage for related orthodontic services.

(2) Treatment of head and neck cellulitis and other infection, as well as treatment of diseases of salivary glands and ducts.

(3) Excision of tumors, neoplastic tissues, and bony cysts, except when associated with endodontic surgery. In addition, surgical excision of the normally occurring dental follicular sac that accompanies impacted teeth does not qualify as cyst removal and therefore is not a benefit. Cysts that are expansive and destructive in nature, and as verified by diagnostic means, including but not limited to radiography and histopathological examination, may be considered for coverage.

(4) Oral surgery required to repair accidental injuries of the jaw, cheek, lips, tongue, roof, and floor of the mouth.

(r) **STERILIZATION, REVERSAL OF STERILIZATION AND ABORTION SERVICES.**

(s) **SERVICES PROVIDED IN CONNECTION WITH TREATMENT OF INFERTILITY (INCLUDING, BUT NOT LIMITED TO, MEDICAL CARE OR PRESCRIPTION DRUGS USED TO STIMULATE OVULATION) OR ASSISTED REPRODUCTIVE TECHNOLOGY (ART)**. ART includes any combination of chemical and/or

mechanical means of obtaining a mature male or female reproductive cell and placing it into a medium (whether internal or external to the human body) to enhance the chance reproduction will occur. Examples of ART include, but are not limited to, artificial insemination, in vitro fertilization, gametic intra fallopian transfer, zygote intra fallopian transfer, pronuclear state tubal transfer and surrogate pregnancy.

(t) Custodial care. Custodial care means the care and services, wherever furnished and by whatever name called, which do not require technical skills or professional training of medical and/or nursing personnel in order to be safely and effectively performed and which are designed primarily to assist a Covered Individual, whether or not Totally Disabled, in the activities of daily living, including, but not limited to: bathing, dressing, feeding, preparation of special diets, assistance in walking or in getting in and out of bed, acting as a companion or a sitter and supervision regarding medication which can normally be self-administered. For an institutionalized individual, custodial care includes Room and Board, non-skilled care, or such other care that is provided to an individual who cannot reasonably be expected to live outside an institution. Rest care, respite care, and home care provided by a family member (including a spouse, sibling, child, or parent of the Covered Individual) is also considered custodial care.

(u) Examinations or treatments not otherwise covered by the Plan received for the purpose of obtaining or maintaining any license, or which relate to employment and/or insurance; or an examination or treatment required prior to engaging in recreational activities, or by court order.

(v) Charges which do not meet the Plan's definition of a Benefit, or which are not otherwise described as a Benefit in this Summary Plan Description.

(w) Any artificial, mechanical or cross-species organ or tissue transplant.

(x) Services, including transplants, which are Experimental or Investigational or educational in nature or any treatment (including pharmacological regimes) not recognized as generally accepted medical practice by the medical profession. Procedures in question for their Experimental or Investigational nature will be reviewed by appropriate members of the medical profession for recommendation. Final decisions regarding coverage under the Plan will be based on approved acceptable medical practices of the Plan's CMO.

(y) Services provided or ordered by a Covered Individual his/herself, a Covered Individual's relative, including spouse, sibling, parent, or child, or any person living in the same household, even if such individual is a Provider.

(z) Charges made for completion of forms and/or filing of claims in connection with the Benefits provided under the Plan.

(aa) Charges made by a Hospital for telephone, television, private Hospital rooms, and other similar personal comfort items.

(bb) Charges Incurred prior to the Covered Individual's Effective Date of coverage under the Plan, or after such individual's coverage terminates, in accordance with Sections VIII and/or XI of this Summary Plan Description.

(cc) Services provided in connection with the treatment of corns, calluses or toenails, unless the charges are for the removal of a nail or root in connection with the treatment of a metabolic or peripheral-vascular disease or infection.

(dd) Services or supplies, including orthotics, orthopedic shoes, and other supportive appliances for feet provided in connection with conditions of the feet, including but not limited to painful feet, flat feet, fallen arches, metatarsalgia, plantar fascitis, or varus or valgus deformities unless otherwise noted in this Summary Plan Description.

(ee) Services or supplies that cannot reasonably be expected to lessen a Covered Individual's disability, and enable him/her to live outside an institution.

(ff) Services provided in connection with treatment or surgery to change gender or restore sexual function.

(gg) All Educational Services, including treatment of learning disorders, nutritional counseling and other Hospital-based educational programs except where otherwise specified in this Summary Plan Description.

(hh) Services or supplies not specifically listed in this Section IV, including but not limited to the following:

- Air conditioner, humidifiers, dehumidifiers, purifiers, tanning booths, etc.
- Bath chairs
- Breast pumps
- Exercise equipment
- Incontinence supplies, including diapers
- Lift Seat
- Over-the-counter orthopedic or corrective shoes.
- Raised toilet seats
- Whirlpools, saunas, and hot tubs
- Wigs

(ii) Charges for supplies for use beyond the first twenty-four (24) hours following discharge from the Hospital as an Inpatient or following the provision of Emergency Care, including any prescription drugs intended primarily for home use.

(jj) Vitamins (other than those prenatal vitamins prescribed for a Covered Individual who is then pregnant), including megavitamin therapy (for any purpose), when not confined in a Hospital.

(kk) Charges Incurred for broken appointments with a Provider.

(ll) Private duty nursing. Private duty nursing is defined as one-on-one care provided on an individual basis either in an institution or in a patient's home. Private duty skilled nursing care can be considered custodial after non-professional personnel repetitively performs the care, making continuous attention by a health professional no longer necessary, and is therefore not a covered Benefit.

(mm) Charges in excess of the Usual and Customary Charge charged by a Provider.

(nn) Chiropractic services.

(oo) Nutritional supplements, except as stated in Section IV.G.5(n), ordered by a Participating Physician in connection with home care, which requires the Covered Individual to have a feeding tube, or those which are expressly authorized in advance by the Plan's CMO.

(pp) Dental implants and associated oral surgery and supplies, even if the service is related to Accidental Dental Services. This includes but is not limited to any enabling procedures for implants, as well as placement, maintenance, restoration, and removal of dental implants. Any prosthetic superstructure fabricated upon a dental implant is also excluded.

(qq) Devices used specifically for safety purposes (examples include ear molds and helmets). Devices and supplements that affect performance in sports-related activities; or expenses related to physical conditioning programs, including but not limited to, athletic training, bodybuilding, and exercise and fitness programs. Exercise equipment including but not limited to parallel bars, weights, bicycles, rowing machines, and treadmills.

(rr) Massage therapy, homeopathy, acupuncture, orthoptic exercises, herbal remedies, and ayurvedic therapies.

(ss) Speech, physical, occupational, and other rehabilitative services solely for speech/language delay or articulation disorders or other developmental delay, regardless of origin. Speech therapy for central processing disorders, dyslexia, attention deficit disorder or other learning disabilities, stammering, stuttering, conceptual handicap, psychosocial speech delay, and voice therapy for vocational or avocational singers, and procedures that may be carried out effectively by the patient, family, or caregivers are not covered Benefits.

(tt) Augmentative communication devices, including but not limited to hearing aids, computer assisted speech devices, speech teaching machines, telephones, TDD equipment, Braille teaching texts, computers, and telephone alert systems. Exceptions include basic, non-digital voice systems, such as the Electro-Larynx, post-radical neck or other invasive surgery that interferes with laryngeal function.

(uu) Automated travel devices (motor scooters) and chair lifts and other transfer devices.

(vv) Water exercise and other exercises not under the supervision of a physical therapist

(ww) Injury or Illness incurred while incarcerated in any local, municipal, state or federal facility.

(xx) Devices that are primarily non-medical in nature or used primarily for comfort, including but not limited to bed boards, carafes, elevators, emesis basins, foam pads, maternity belts, heating pads, bathtub seats, beds other than standard, single hospital beds, overbed tables, standing tables, toilet seats, etc.

(yy) Chair lifts, bathtub lifts, bed lifter, and other similar devices.

(zz) Hygienic items, including but not limited to shower chairs, commodes (unless the individual is confined to room or bed), raised toilet seats, sauna baths, incontinence pads, bed baths, etc. Whirlpools, whirlpool pumps, hot tubs, and related items.

(aaa) Devices and equipment that is not normally appropriate outside of a Hospital (or other Provider) setting, including but not limited to blood glucose analyzers, diathermy machines, esophageal dilators, and paraffin bath units. Home monitoring devices and supplies are not covered, except Medically Necessary cardiac monitoring devices (such as halter monitors and event recorders), home prenatal monitoring and associated nursing support, apnea monitors, glucometers, and related supplies.

(bbb) Non-reusable disposable supplies including but not limited to bandages, wraps, tape, disposable sheets and bags, fabric supports, surgical face masks, incontinent pads, irrigating kits, pressure leotards, surgical leggings, and support hose. Over-the-counter medications and supplies. Exceptions include diabetic and osteomy supplies and supplies associated with equipment and home care services that have been provided in accordance with Plan policies and procedures.

(ccc) Equipment primarily used to alter the environment, including but not limited to air filters and other air cleaners, electrostatic machines, humidifiers, lights/lighting, air conditioners, portable room heaters, grab bars, etc. (see hh)

(ddd) Psychological Testing. Cognitive therapy as a medical treatment (non-mental health) unless provided as a treatment for brain injury. Neuropsych testing to assist in planning educational and vocational programs, for the purpose of disability determinations, and/or for forensic determinations is not a covered benefit. Neuropsych testing, for an individual who has suffered a brain injury (including cognitive degeneration as seen in individual's with Alzheimers), is covered when:

(1) results of the assessment will significantly alter the treatment plan;
(2) this type of assessment is the least intrusive, as well as most time and resource efficient method of meeting treatment goals for; and
(3) the testing is not used to confirm previous testing/diagnostic result

I. Utilization Review

"Utilization Review" means the review and determination as to whether the health care services, supplies, equipment and facility charges rendered qualify as approved Benefits under the Plan, including whether such services and supplies were Medically Necessary. Utilization Review is an important part of quality health care. You may contact your Plan's services staff at 1-866-785-5848. If you are not satisfied with the determination made under Utilization Review, please consult the information in the Benefit Claims and Appeals Procedures in Section XII.

1. Prospective Utilization Review: If any Admission, procedure or service must be pre-authorized or approved in advance, initial authorization or approval must be obtained prior to the proposed Admission, procedure or service. If a determination is made to approve the Admission, procedure, or service, the Plan will make reasonable efforts to notify you or your Dependent and the applicable Provider, via telephone, within twenty-four (24) hours of the decision. In the case of adverse determination, the Plan will make reasonable efforts to notify you or your Dependent and the applicable Provider, via telephone, within twenty-four (24) hours of the adverse decision. This will be

followed by written confirmation to you or your Dependent and the applicable Provider within one (1) working day of the adverse determination.

2. Concurrent Utilization Review: Review of a concurrent case will be made within one (1) working day after all of the necessary information has been obtained. If a determination is made to approve continued care, the Plan will make reasonable efforts to notify your Provider, via telephone, within twenty-four (24) hours of the decision. This will be followed by written confirmation to you or your Dependent and the applicable Provider within one (1) working day of the initial approval. In the case of an adverse determination, the Plan will make reasonable efforts to notify your Provider, via telephone, within twenty-four (24) hours of the adverse decision. This will be followed by written confirmation to you or your Dependent and the applicable Provider within one (1) working day of the adverse determination. The service will be continued without liability to you or your Dependent until you or your Dependent, as appropriate, have been notified of the determination.

3. Retrospective Review: The Plan will make retrospective determinations within thirty (30) days of receiving all necessary information and will communicate its decision, in writing, within such thirty (30) day period.

OUT-OF-NETWORK BENEFITS ARE SUBJECT TO A NON-COMPLIANCE PENALTY UNLESS THE COVERED INDIVIDUAL COMPLIES WITH THE UTILIZATION MANAGEMENT PROGRAM SET OUT BELOW.

4. Utilization Management Program. Compliance with the Utilization Management Program is required for Inpatient Admissions to a Hospital that is a non-Participating Provider and those other Out-of-Network Benefits specifically set out in this Section IV.I.4. Failure to comply with the Utilization Management Program will result in the applicable Non-Compliance Reduction, specified below. The amount of such reduction shall be subtracted from the Usual and Customary Charge for the covered Benefits rendered and shall not count toward satisfying the Covered Individual's Deductible.

(a) Pre-Certification Review of Non-Emergency Services: Except as specified below, **notification to the Plan is required three (3) days in advance** of any non-emergency Admission to a non-Participating Provider Hospital or other non-emergency services in order to facilitate pre-certification review. In the event that it is not possible to contact the Plan three (3) days in advance, due to the nature of the service or the expediency within which the service must be delivered, then you or your Dependent **must obtain pre-certification review** as soon as reasonably practical prior to the provision of the service and in no event less than one (1) business day prior to the provision of the service. You or your Dependent is responsible for contacting the Plan to obtain pre-certification. Failure to comply with this requirement will result in a Non-Compliance Reduction of 50% of Eligible Charges.

Care rendered in connection with a pregnancy will be treated as an exception to the three (3) day prior notice requirement described immediately above. The Pre-Certification Review requirement will be treated as satisfied if proper notice is given by you or your Dependent no later than the fifth (5^{th}) month of the pregnancy and you or your Dependent notifies the Plan within one (1) business day after Admission to the non-Participating Provider Hospital for delivery.

(b) Concurrent Review: The Plan will also conduct a review of the health services and supplies listed in Section IV.I.4(d) below during a course of treatment. The Plan will remain in

contact with the Provider to review extensions of treatment or additional treatments. Each request for an extension or additional services or supplies will be reviewed on a case by case basis.

(c) Second Opinion: A second opinion may be required by the Plan from a Physician selected by the Plan prior to a scheduled Inpatient Admission or surgery, whether scheduled as an Inpatient or outpatient procedure. If such a second opinion is required by the Plan, and you or your Dependent fails to receive the second opinion, then failure to comply with this requirement will result in a Non-Compliance Reduction of 50% of the Eligible Charges relating to the facility fee associated with the Inpatient Admission and the professional fees associated with the surgery for which a second opinion was not obtained.

(d) Services and Supplies Subject to Pre-Certification Review and Non-Compliance Reduction:

1.	Inpatient hospitalization	50% Reduction in Eligible Charges.
2.	Outpatient surgical procedures	50% Reduction in Eligible Charges (the Reduction applies to both the facility and the professional charges (except office surgery)).
3.	Health services provided during confinement.	50% Reduction in Eligible Charges (the Reduction applies to both the facility and the professional charges (except office surgery)).
4.	Home health care.	50% Reduction in Eligible Charges.
5.	MRI, RAST tests and CAT scans.	50% Reduction in Eligible Charges.
6.	Prosthetics.	100% Reduction in Eligible Charges; No Benefit Payable.
7.	Durable medical equipment.	100% Reduction in Eligible Charges; No Benefit Payable.
8.	Physical Therapy, Occupational Therapy and Speech Therapy	100% Reduction in Eligible Charges; No Benefit Payable.
9.	Orthotics	100% Reduction in Eligible Charges; No Benefit Payable.
10.	Skilled Nursing Facility	100% Reduction in Eligible Charges; No Benefit Payable.
11.	Inpatient rehabilitation	50% Reduction in Eligible Charges.

Note: It is your or your Dependent's responsibility to verify that the required certification has been given by the Plan. If certification is not given, or you or your Dependent fails to comply with the requirements stated in this Section IV.I.4, Eligible Charges will be subject to the Non-

Compliance Reduction and the amount of the reduction will not apply toward the applicable Deductible.

V. Your Benefits and Medicare

This section applies to a Covered Individual who is eligible for Medicare coverage. It provides rules for determining the order of benefit payments between coverage under this Plan and the coverage of Medicare. The intent of this section is to conform the Plan to the requirements of the federal Medicare Secondary Payer law. Accordingly, the section and its stated rules will be adjusted, if the Plan deems necessary, so that the Plan's liability for Benefit payment is neither greater nor less than those required under the law.

1. If, pursuant to the rules:

   a. this Plan is determined to be secondary to Medicare, it will pay secondary to and coordinate its Benefits with Medicare;
   b. this Plan is determined to be primary to Medicare, it will pay Benefits without regard to Medicare benefits.

2. The order of benefit payments rules are outlined below.

   a. Rules applicable to a person covered under the Plan by virtue of that person's "Current Employment Status" with an employer or as a dependent of such person:

Basis of Medicare Eligibility:	**This Plan Will:**
- Old-Age (attaining age 65)	Be primary.
- Disability (other than ESRD)	Be primary.
- End Stage Renal Disease (ESRD)	Be primary for the first 30 months of ESRD Medicare coverage; be secondary thereafter.
- Old-Age or Disability, preceding or beginning concurrently with ESRD	Continue to be primary until the end of the first 30 months of ESRD Medicare coverage; be secondary thereafter.

b. Rules applicable to a person covered under the Plan on any basis other than those stated in 2.a. above:

Basis of Medicare Eligibility:	**This Plan Will:**
- Old-Age (attaining age 65)	Be secondary.
- Disability (other than ESRD)	Be secondary.
- End Stage Renal Disease (ESRD)	Be primary for the first 30 months of ESRD Medicare coverage; be secondary thereafter.
- Old-Age or Disability, preceding ESRD	Continue to be secondary.

For purposes of this section, "Current Employment Status" means a person is considered to have Current Employment Status with an employer if the person is an employee, is the employer (including a self-employed person), or is associated with the employer in a business relationship.

REMEMBER: The Medicare section outlined above applies from the date a Covered Individual is first ELIGIBLE for Medicare (either part A or part B), whether or not the Covered Individual is enrolled and is receiving Medicare benefits.

Each Covered Individual should enroll in Medicare Part A and Part B as early as possible to minimize non-Covered Expenses. This Plan assumes you are enrolled in Medicare A and B if you are eligible to enroll, even if you have not actually enrolled.

VI. Coordination of Benefits

A. Coordination of Benefits

The Plan is designed to help you receive - but not exceed – a certain level of Benefits. If you or a Dependent is covered under another group health plan, you or your Dependents may be eligible to receive benefits from more than one plan. This is where Coordination of Benefits (COB) is applied. COB allows the various plans to collectively pay as much as 100% of the benefits.

Under the COB provisions, benefits are paid by primary and secondary plans. The primary plan covers you other than as a dependent - it pays first. The secondary plan covers you as a dependent - it pays second. For example, let's assume your spouse works for Employer X:

IF THE CLAIM IS FOR YOU	THEN THIS PLAN IS PRIMARY	AND	EMPLOYER X PLAN IS SECONDARY
IF THE CLAIM IS FOR SPOUSE	THE EMPLOYER X PLAN IS PRIMARY	AND	THIS PLAN IS SECONDARY

If you or one of your Dependents is covered under a plan that does not have COB, the plan without COB would be primary, and this Plan would be secondary.

With respect to children, the plan covering the parent whose birthday (month and day) falls earlier in the year is primary, and the plan covering the parent whose birthday (month and day) falls later in the year pays as secondary. If both parents have the same birthday, the plan that has covered the parent longer pays first. However, if either parent's plan does not follow the "birthday" rule, then the father's plan will be primary and the mother's plan will be secondary.

When the parents are separated or divorced, the plan of the parent with custody of the children will be considered primary and pay first. This is true regardless of whether that parent remarries.

Also, the benefits of a plan which covers a person as a participant who is not laid off, retired, graduated or dismissed are determined before those of a plan which covers that person as a person who has been laid off, retired, graduated or dismissed.

If none of the above positions determines order of benefit payment, COB provides that the primary plan will be the plan that has covered the patient for the longest period of time. In all cases though, if there is a court decree which mandates that one parent maintains coverage for the children, that parent's coverage will always pay first.

For the purpose of applying and implementing the terms of this provision of this Plan or any provision of a similar plan, the Plan may, without the consent of or notice to any person, release to or obtain from any insurance provider or organization or person any information which the Plan deems to be necessary for such purposes. Any person claiming benefits under this Plan shall, as a condition to receiving those benefits, furnish to the Plan such information as may be necessary to implement this provision.

The actual benefit amounts available are determined by each plan's benefit provisions. Benefits payable under this Plan will never exceed the amount which would have been paid if there were no other plans involved. If Benefit payments under this Plan are reduced by COB, only the reduced amounts will be charged against your Plan maximums.

B. Right of Recovery

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

- the person it has paid or for whom it has paid
- insurance companies, or
- other organizations.

C. Payment Adjustments

Whenever payments which should have been made under this Plan in accordance with this Section have been made under any other plan, the University shall have the right, exercisable alone and in its sole discretion, to pay over to any organization making such other payments, any amounts it shall determine to be warranted in order to satisfy the intent of this Section, and amounts so paid shall be

deemed to be "Benefits" paid under this Plan, and to the extent of such payments, the University shall be fully discharged from liability under this Plan.

VII. Subrogation Rights

If you or a Dependent incur medical expenses which are covered by the Plan, a third party may be liable for those expenses. In this case, the Plan Administrator may advance you amounts to cover your Benefits on a conditional basis. If you receive these payments, you will be required to sign an agreement that acknowledges the conditional payments and that the Plan has a right of subrogation of these benefits.

The Plan is entitled to recover the cost of any Benefits it has provided for you or an Dependent as a result of an Injury caused by a third party out of the proceeds of any judgment or settlement that you or an Dependent receives from the third party, the third party's insurer, or from any insurer providing you or an Dependent with indemnity against acts of third parties. The Plan may recover any amounts owed to it either from third-party funds received by you, regardless of whether you have been fully indemnified for losses sustained at the hands of the third party, or the Plan may pursue its recovery rights as your subrogee against the third party.

The Plan will be subrogated to all claims, demands, actions and right of recovery against any entity, including third parties and insurance companies, to the fullest extent of the Plan's right of recovery. Any funds received by you, your Dependent, an attorney and/or any other person or entity on behalf of, or for the benefit of, you or an Dependent or as a result of your or an Dependent's Illness or Injury, from any source for any purpose shall be held in constructive trust by such person or entity for the benefit of the Plan until such time as this obligation under the Plan's subrogation provision is fully satisfied.

You or an Dependent must notify the Plan Administrator, in writing, of whatever Benefits are paid under this Plan that may be subject to subrogation by the Plan. You also must keep the Plan Administrator informed in advance of any settlement proposals advanced or agreed to by the third party or the third party's insurer.

VIII. Termination of Coverage

A. When Your Coverage Ends

Your coverage will end on the earliest of the following dates:

- the last day of the month for which your contributions for coverage have been made;
- the last day of the Benefit Period in which you voluntarily notify the Plan Administrator, in writing, of your election to cancel coverage and, if required by the Plan Administrator, you provide evidence of coverage under another group or individual plan;
- the date on which you are no longer an Eligible Participant;
- the date you have performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of this Plan; or

- the date this Plan is terminated.

B. When Your Dependents' Coverage Ends

Your Dependents' coverage will end on the earliest of the following dates:

- the date your coverage ends;
- the last day of the month for which the contributions for their coverage have been made;
- the last day of the Benefit Period in which you or the Dependent voluntarily notify the Plan Administrator, in writing, of your election to cancel coverage for the Dependent(s);
- the date on which they are no longer an Eligible Dependent;
- the date they have performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of this Plan; or
- the date this Plan is terminated.

IX. Student Continuation Coverage

This Section contains important information about student continuation coverage which is a temporary extension of coverage under the Plan. This continuation coverage can become available when coverage under the Plan would otherwise end for a Participant who is not a Covered Employee and who no longer meets the eligibility requirements set forth in Section II. Events such as graduation from a Program, approval of withdrawal from the University, approval of a leave of absence, death or divorce or legal separation from a Participant who is not a Covered Employee are examples of when continuation coverage may become available. Depending on the type of event and at the discretion of the Medical Director of the Plan, continuation coverage may also be available to Dependents. The continuation coverage, if elected, is the same coverage that the Plan gives to other similarly situated Covered Individuals under the Plan who are not receiving continuation coverage. If the coverage for Covered Individuals is modified, the continuation coverage will be modified in the same manner.

The Plan allows for continuation coverage not to exceed six months from the date a Covered Individual no longer meets eligibility requirements.

To request continuation coverage, one must:

1. submit to the Medical Director of the Plan a written request to continue coverage within 60 days of the date an individual becomes ineligible under the Plan; and

2. select an initial coverage period of either (1) six months from date you are no longer eligible or (2) period between the date you are no longer eligible and the start date of the next Open Enrollment Period for your Program, if applicable; and

3. submit any supporting documentation such as an approved Change of Registration form or an approved Request for Leave of Absence form as requested by the Medical Director; and

4. be in good standing with the University; and

5. not be eligible for COBRA continuation coverage; and

6. not meet any eligibility requirements outlined in Section II; and

7. provide payment for the initial length of continuation coverage requested.

If the initial length of continuation coverage selected is less than six months, coverage may be extended for a limited period of time by making subsequent monthly payments to the Plan Administrator. Subsequent monthly payments are due on the first of each month, with a grace period of 30 days for each payment. Continuation coverage will be available for each month as long as payment for that month is made before the end of the grace period for that payment. You will not be billed for such payment by the University, but must pay the applicable amount in full by the due date. Continuation coverage is not available beyond six months from the date a Covered Individual no longer meets eligibility requirements.

If any of the above requirements are not met, an individual will lose continuation rights and coverage under the Plan.

The charge for continuation coverage under this Section may differ from the Covered Individual's regular charge for coverage, but typically will not exceed 150% of the regular charge for coverage in effect for the Covered Individual.

X. Covered Employee Continuation Coverage Rights

A. Overview

This Section X only applies to Covered Employees and their Dependents. This Section X contains important information about the rights of a Covered Employee and his or her Dependents to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available when coverage under the Plan would otherwise end because of a life event known as a "qualifying event." COBRA continuation coverage must be offered to each Covered Employee and his or her Dependents who is a "qualified beneficiary." A qualified beneficiary is someone who will lose coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, Dependent spouses and children of Covered Employees may be qualified beneficiaries under the Plan. Qualified beneficiaries who elect COBRA continuation coverage must pay the entire cost of the coverage.

COBRA continuation coverage, if elected, is the same coverage that the Plan gives to other similarly situated Covered Individuals under the Plan who are not receiving COBRA continuation coverage. This means that if the coverage for similarly situated Covered Individuals is modified, COBRA continuation coverage for qualified beneficiaries will be modified in the same manner. Each qualified beneficiary who elects COBRA continuation coverage will have the same rights under the Plan as other Covered Individuals under the Plan, except as otherwise provided herein.

Note: Most students (even those employed by the University) are covered under the Plan based on admission to a Program (i.e., their status as a student, and not by virtue of the performance of services for the University) and, as such, are not eligible for COBRA continuation coverage. See Section IX for student continuation coverage.

B. Qualifying Events

A Covered Employee will become a qualified beneficiary if he or she will lose coverage under the Plan because any of the following qualifying events happens:

- a voluntary or involuntary termination of the Covered Employee's employment for any reason other than Covered Employee's gross misconduct;
- reduction in a Covered Employee's hours of employment to non-eligible status. In this regard, a qualifying event occurs whether or not Covered Employee actually works and may include absence from work due to a disability, temporary layoff or leave of absence where Plan coverage terminates but termination of employment does not occur.

A Dependent spouse of a Covered Employee will become a qualified beneficiary if he or she will lose coverage under the Plan because any of the following qualifying events happens:

- the Covered Employee dies;
- the Covered Employee becomes enrolled in Medicare; or
- divorce or legal separation from the Covered Employee.

Dependent children of a Covered Employee will become qualified beneficiaries if they will lose coverage under the Plan because any of the following qualifying events happens:

- the Covered Employee-parent dies;
- the Covered Employee-parent becomes enrolled in Medicare;
- the parents become divorced or legally separated; or
- the child stops being eligible for coverage under the Plan as a "Dependent Child."

C. Required Notifications

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the death of the Participant, commencement of a proceeding in bankruptcy with respect to the University or enrollment of the Participant in Medicare, no notice from you is required. **For other qualifying events (divorce or legal separation or a dependent child's losing eligibility for coverage as a Dependent child), you must notify the Plan Administrator. The Plan requires you to notify the Plan Administrator with 60 days after the qualifying event occurs. Failure to provide timely notice to the Plan Administrator will cause you to lose the ability to elect COBRA continuation coverage.**

D. Duration of Coverage

COBRA continuation coverage is a temporary continuation of coverage for up to 18 months. When the qualifying event is the death of the Covered Employee, enrollment of the Covered Employee in Medicare, divorce or legal separation from the Covered Employee, or a dependent child losing eligibility as a Dependent child, COBRA continuation coverage lasts for up to 36 months.

COBRA continuation coverage will be terminated before the end of the maximum period if any required premium is not paid on time, if a qualified beneficiary becomes covered under another group health plan that does not impose any pre-existing condition exclusion for a pre-existing condition of the qualified beneficiary, if a qualified beneficiary enrolls in Medicare, or if the University ceases to provide any group health plan. Continuation coverage may also be terminated for any reason the Plan would terminate coverage of a Covered Employee not receiving COBRA continuation coverage (such as fraud).

E. Electing Coverage

Each qualified beneficiary has an independent right to elect COBRA continuation coverage. Parents may elect to continue coverage on behalf of their Dependent children only. A qualified beneficiary must elect coverage within 60 days of the date coverage would otherwise end, or the date the qualified beneficiary is notified, whichever is later. Failure to do so will result in loss of the right to elect continuation coverage under the Plan. A qualified beneficiary may change a prior rejection of continuation coverage any time until that date.

F. Paying for Coverage

Generally, each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount a qualified beneficiary may be required to pay may not exceed 102 percent of the Plan's full cost of coverage for similarly situated Covered Individuals who are not receiving continuation coverage.

First Payment for COBRA Continuation Coverage

If a qualified beneficiary elects COBRA continuation coverage, the first payment must be made within 45 days after the date of the election. If the first payment for continuation coverage is not made within that 45 days, the qualified beneficiary will lose all continuation coverage rights under the Plan. The first payment must cover the cost of COBRA continuation coverage from the time coverage under the Plan would have otherwise terminated up to the time the first payment is made. The qualified beneficiary is responsible for making sure that the amount of the first payment is enough to cover this entire period.

Subsequent Payments

After the first payment for COBRA continuation coverage is made, the qualified beneficiary will be required to pay for each subsequent month of coverage. These payments are due on the first of each month. Although the payments are due on the first of each month, the qualified beneficiary will be given a grace period of 30 days for each payment. COBRA continuation coverage will be provided for each month as long as the payment for that month is made before the end of the grace period for that payment. If the qualified beneficiary fails to make a monthly payment before the end of the grace

period for that payment, the qualified beneficiary will lose all rights to COBRA continuation coverage under the Plan.

XI. FMLA and USERRA Leave

Leave Taken Under the FMLA. If you are a Covered Employee and take leave under the Family and Medical Leave Act of 1993, as amended (FMLA), you and your Dependents' coverage will continue under the Plan to the extent required by the FMLA (that is, the University will continue to pay its share of the contributions required and you must continue to make your contributions). If your coverage ceases during the FMLA leave (for example, because you opted not to continue coverage or due to nonpayment of your contributions), you may resume your coverage upon return from FMLA leave on the same terms as before the leave was taken, or as otherwise required by the FMLA. Under special rules that apply if you do not return to work at the end of an FMLA leave, some individuals may be entitled to elect COBRA continuation coverage even if they weren't covered under the Plan during the leave. Please contact the Plan Administrator for more information about these special rules.

Leave Taken Under the USERRA. If you are a Covered Employee and going into or returning from military service, you will have certain rights mandated by the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended (USERRA). As used herein, military service means service in the Armed Forces, the Army National Guard, and the Air National Guard, when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or national emergency.

The Plan allows for the continuation of coverage for a military leave of absence, covered by USERRA. Coverage may be continued until the earlier of :

- twenty-four months after your absence from work begins; or
- the day after the date on which you fail to timely apply for or return to employment as required under USERRA.

If you elect to continue coverage, you must timely notify the Plan Administrator of your election to continue coverage. If your military service is less than 31 days, you are required to pay only your normal share of the contribution for such coverage. If the length of your military service extends past 31 days, the Plan Administrator may require you to pay up to 102% of the contribution cost for Plan coverage for similarly situated Covered Individuals who are not serving in a military service. Your election and payment are due within 31 days after coverage would have been terminated (if you receive prior notification of the right to continue coverage) or 31 days following notification if you receive notification of the right to continue coverage after coverage is terminated. These rights apply only to Covered Individuals covered under the Plan before leaving for military service.

Plan exclusions may be imposed for any Illness or Injury determined by the Secretary of Veterans Affairs to have been Incurred in, or aggravated during, military service.

If you are called to active military duty, you and your Dependents may be eligible for coverage under TRICARE, the military service's health plan. You and your Dependents may also elect to continue benefits under the Plan if you were covered by the Plan at the time you were called to military duty.

If you choose not to continue coverage under the Plan during your military service, you and your Dependents are eligible for reinstatement of coverage on the date you return with reemployment rights guaranteed under USERRA. As permitted by USERRA, your coverage will not include any Illness or Injury determined by the Secretary of Veteran Affairs to have been Incurred in, or aggravated during, performance of military service. Any other such Illness or Injury will be covered by the Plan, subject to all otherwise applicable conditions and limitations of the Plan.

The continuation of coverage ends at the earliest of the following: when the you become covered under another group health plan without pre-existing condition limitation; upon the expiration of the continued period of coverage as set forth herein; when the required payments are not received on a timely basis; or when this Plan is terminated and not replaced by the University with another health plan.

After your USERRA continuation coverage expires, you will not thereafter receive continuation of coverage under COBRA (see Section X). However, if your USERRA coverage expires prior to the expiration of the continuation of coverage under COBRA (e.g., because you do not return to employment), you may be eligible for continuation of coverage under COBRA for the remainder of the original COBRA coverage period.

The above is only a summary of the FMLA and USERRA rights and limitations. If you wish to elect FMLA or USERRA coverage or obtain more detailed information, please contact the Plan Administrator.

XII. Benefit Claims and Appeals Procedure

Claims for care, services, supplies, equipment and facility charges must be submitted by the Covered Individual to the appropriate Claims Administrator. The Claims Administrator has complete authority and discretion to make all decisions with respect to claims for benefits and appeals of denied claims under the Plan.

Claims should be filed with the appropriate Claims Administrator within 90 days of the date charges for the care, services, supplies, equipment and facility charges were Incurred. Benefits are based on the Plan's provisions at the time the charges were Incurred. Claims filed later than that date may be declined or reduced unless:

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

(b) the claim is submitted within 180 days from the date Incurred. This 180 day period will not apply when the person is not legally capable of submitting the claim.

The Claims Administrator will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested from the Covered Individual or claimant.

A. Claims Denied

The Claims Administrator will notify you of the decision on your claim within the following time periods, depending on how your claim is classified:

Urgent Care Claim – An Urgent Care Claim is a claim for care or treatment in which failure to make a decision within a short period of time could seriously jeopardize your life, health or ability to regain maximum function or, in the opinion of your Physician, would result in severe pain which cannot be adequately managed without the care or treatment.

Pre-Service Claim – A pre-service claim is a claim that requires approval, in whole or in part, before you obtain care or treatment (such as preadmission certification for hospitalization).

Post-Service Claim – A post-service claim is a claim that does not require approval before you obtain care or treatment (that is, for reimbursement after services have been rendered).

Concurrent Care Claim – A concurrent care claim is a claim to extend an ongoing course of treatment provided over a period of time or a number of treatments that was previously approved.

The Claims Administrator will generally determine whether a claim is an urgent care claim, based on information provided by or for you, by applying the judgment of a prudent person with an average knowledge of health and medicine. A claim will also be treated as an urgent care claim if your Physician determines that it is. Regardless of whether you have given notice to the Claims Administrator, your Physician or any other provider with knowledge of your medical condition may act as your authorized representative in filing an urgent care claim. The Claims Administrator will notify you of the decision on an urgent care claim as soon as possible in light of medical demands, but no later than 72 hours after receipt of the claim, unless you have failed to submit information required to determine whether benefits are covered or payable. In that case, the Claims Administrator will then notify you of the decision as soon as possible but no later than 24 hours after receipt of the claim. You will have a reasonable period of time, but not less than 48 hours, to provide the information. The Claims Administrator will then notify you of the decision as soon as possible, but no later than 48 hours after receiving the information or, if earlier, the deadline established by the Claims Administrator for providing it.

The Claims Administrator will notify you of the decision on a pre-service claim within a reasonable period of time appropriate to the medical circumstances, but no later than 15 days after receipt of the claim. In special circumstances beyond the control of the Claims Administrator, this period may be extended for up to 15 days. If an extension is needed, you will be notified before the end of the first 15-day period why the extension is needed and when a decision is expected.

If the post-service claim is denied in whole or in part, the Claims Administrator will notify you within a reasonable period of time, but no later than 30 days after receipt of the claim. In special circumstances beyond the control of the Claims Administrator, this period may be extended for up to 15 days. If an extension is needed, you will be notified before the end of the 30-day period why the extension is needed and when a decision is expected.

The Claims Administrator will notify you of the decision on a concurrent care claim that involves urgent care within 24 hours after receiving the claim, provided the claim was made at least 24 hours before the course of treatment ends. If a concurrent care claim does not involve urgent care, it will be subject to the time limits for pre-service or post-service claims, whichever applies. In addition, if an ongoing course of treatment will be reduced or terminated before the end of the approved period of time or number of treatments (other than by amendment or termination of the Plan), the Claims

Administrator will give you sufficient advance notice to request a review and obtain a decision on appeal before the reduction or termination.

If you contact a person who normally handles benefit matters for the Claims Administrator to request approval of a pre-service or urgent care claim for a specified individual, medical condition and treatment, but you fail to follow the procedures for filing claims established by the Claims Administrator, you will be notified orally (or, at his or her request, in writing) of the failure and the proper procedures. This notice will be given as soon as possible, but no later than five days after the initial contact in the case of a pre-service claim or 24 hours in the case of an urgent care claim.

If an extension for a pre-service or post-service claim is needed because information required to decide the claim was not submitted, the notice will describe the required information, you will be given at least 45 days to provide the information and the extension will not begin until the date you respond or, if earlier, the deadline established by the Claims Administrator for providing the information.

If the claim is denied in whole or in part, the Claims Administrator will notify you in writing or electronically. Oral notice of denial of an urgent care claim may initially be given, followed by written or electronic notice within three days. The notice of claim denial will give specific reasons for the denial, refer to the specific plan provisions on which the denial is based, describe any additional material or information necessary to grant the claim and explain why it is necessary, describe the appeals procedures and the applicable time limits, include a statement of your right to bring a civil action under Section 502(a) of ERISA following denial of an appeal and, if applicable, describe the expedited appeal procedures for urgent care claims. If the Claims Administrator relied on a rule, guideline, protocol or similar criterion in denying the claim, the notice will either include a copy or state that it was relied on and will be provided upon request, without charge. Notice of a denial based on medical necessity, experimental treatment or a similar exclusion or limit will either explain the scientific or clinical judgment for the decision as applied to the medical circumstances or state that an explanation will be provided upon request, without charge.

B. Internal Claims Appeal Procedures and Notification

Within 180 days of the date of notice of a claim denial including any recission of coverage whether or not there is an adverse effect on any particular benefit at that time, you may submit a request for review of the denial. The request must be made in writing, except that a request for review of an urgent care claim may be made orally. If the request is not submitted during this 180-day period, you will be barred from challenging the Claims Administrator's decision denying the claim. The decision on review will be made independently by individuals other than those who denied the claim or their subordinates. You may submit written comments, documents, records and other information and evidence relating to the claim, all of which will be taken into account in the review, whether or not previously submitted or considered. You will be provided upon request, without charge, access to and copies of any other relevant documents, records and information. For this purpose, documents, records or information are considered relevant if they (1) were relied on in making the decision on the claim, (2) were submitted, considered or generated in the course of making that decision, (3) demonstrate that the decision was made in accordance with applicable Plan documents in a manner that applies Plan provisions consistently to similarly situated individuals (but excluding files on claims made by those individuals) or (4) constitute a statement of policy or guidance concerning the denied benefit. In addition, we will provide you, free of charge, copies of any new or additional evidence considered, relied upon or generated in connection with the claim. Such additional information, as well as any new or additional rationale for the denial, will be provided as soon as possible and sufficiently in advance in order to give

you a reasonable opportunity to respond prior to the date on which a notice of final internal adverse benefit determination is to be made. You may also request that any medical or vocational experts who advised the Claims Administrator regarding the claim be identified. In the case of an urgent care claim, all information will be transmitted by telephone, facsimile or similar means. If the claim was denied on the basis of a medical judgment (including the determination of whether a particular treatment, drug or other item is Experimental or Investigational, Medically Necessary or appropriate), the Claims Administrator will consult a health care professional with appropriate training and experience. Any health care professional who was consulted in connection with the initial denial of the claim, or his or her subordinates, will not be consulted on review.

The Claims Administrator will notify you of the decision on review within the following time periods:

- For urgent care claims, as soon as possible, but no later than 72 hours after receipt of the request for review.
- For pre-service claims, within a reasonable period of time, but no later than 30 days after receipt of the request for review.
- For post-service claims, within a reasonable period of time, but no later than 60 days after receipt of the request for review.
- For concurrent care claims, within the period of time for urgent care claims, pre-service claims or post-service claims, as applicable.

The notice of the decision on review will be given in writing, electronically or, in the case of an urgent care claim, by telephone, facsimile or similar means. If the appeal is denied in whole or in part, the notice will give specific plan provisions on which the denial is based, state you will be provided upon request, without charge, access to and copies of all documents, records and other information relevant to the claim and include a statement of your right to bring a civil action under Section 502(a) of ERISA. If the Claims Administrator relied on a rule, guideline, protocol or similar criterion in denying the appeal, the notice will either include a copy or state that it was relied on and will be provided upon request, without charge. Notice of a denial based on medical necessity, experimental treatment or a similar exclusion or limit will either explain the scientific or clinical judgment for the decision as applied to the medical circumstances or state that an explanation will be provided upon request, without charge. The decision on review will be final and nonreviewable, unless a court determines that it is arbitrary and capricious, and will be binding on you and the University.

C. External Review Process

Until such time as a state external review process is adopted, the federal external review process will be followed. For any claim for which external review has not been initiated prior to September 20, 2011, only adverse benefit determinations involving medical judgments or rescission of coverage will be subject to the federal external review process. Upon request, a copy of the federal external review procedures will be provided to you at no charge.

D. Legal Actions

You may not sue the University, the Plan or any Claims Administrator for Benefits under this Plan:

- Before sixty (60) days following the date you send us your claim for benefits; or
- After three (3) years following the end of the period required for submitting your claim for benefits.

XIII. Definitions

When used in this Summary Plan Description, unless otherwise defined, the following terms, whether or not capitalized, have the meanings given such terms in this Definitions section.

1. Admission means an Inpatient stay at a Hospital or other Inpatient facility, at the direction and under the supervision of a Physician. Admissions within 72 hours for the same or similar conditions are considered as one Admission.

2. Alcoholism means the excessive or prolonged use of alcohol containing beverages to the extent of dependence, addiction, or damage.

3. Benefits shall mean those health care, services, supplies, equipment and facility charges rendered under the following conditions: (a) prescribed by a Physician for the therapeutic treatment of a non-occupational Injury, Illness or pregnancy; (b) deemed Medically Necessary and appropriate in type, level, setting, and length of service by the Plan; (c) rendered in accordance with generally accepted medical practice and professionally recognized standards; (d) not considered to be Experimental or Investigational, or which are performed for research purposes; (e) provided on or after the Effective Date and before a Covered Individual's coverage terminates in accordance with Section VIII, X or XI and at a time the Covered Individual met all applicable requirements for eligibility set forth in Sections II and III; and (f) services which are specifically included and not excluded or limited, or not specifically excluded by the Plan.

4. Benefit Period means a time period of one year or less during which enrollment under the Plan remains in effect, as designated for your Program. You will be separately notified of the Benefit Period for your Program.

5. Board Certified Specialist means a Physician certified by a member Board of the Council of Medical Specialties.

6. Chemical Dependency means the psychological or physiological dependence upon and abuse of drugs, including alcohol, characterized by drug tolerance or withdrawal and impairment of social or occupational role functioning in both.

7. Chief Medical Officer or CMO means a licensed Physician designated by the Plan and/or such other licensed Physician or Practitioner as the Chief Medical Officer may designate who monitors the quality of medical care rendered to Covered Individuals.

8. Child has the meaning given to such term in Section II.C.

9. Child Health Supervision means the Periodic Review of a child's physical and emotional status by a Physician. "Periodic Review" means with respect to a child, a history, complete physical examination, developmental assessment, anticipatory guidance, appropriate immunizations, and laboratory tests in keeping with prevailing medical standards as determined by the Plan.

10. Claims Administrator means the administrative vendors retained by the Plan to process the claims for the Plan. As of the effective date of this Summary Plan Description, the Plan has retained two Claims Administrators: one Claims Administrator to process and adjudicate the prescription drug Benefits and the other Claims Administrator to process and adjudicate all other Benefits under the Plan.

11. Coinsurance means the Covered Individual's share of the cost of Eligible Charges stated as a percentage up to the Out-of-Pocket Maximum, if any, as indicated in Section IV.F of this Summary Plan Description.

12. Copayment means the portion of the cost of covered Benefits that are payable by the Participant, either for himself or his Dependents.

13. Covered Employee means a Participant who has coverage under the Plan by virtue of the performance of services for the University or, when expressly required in order to be in compliance with applicable law, a Participant who is an employee of the University and is not otherwise excludable under such law.

14. Covered Individual has the meaning given to such term in Section II.C.

15. Deductible means a specified dollar amount of services as detailed in Section IV, Benefits, that must be incurred by a Covered Individual or Family during a Benefit Period before any other services will be considered for payment under the Plan. The term Deductible includes the Deductible for a Covered Individual ("Individual Deductible") and the Deductible for a family ("Family Deductible"). No Benefit is payable for any part of an Individual Deductible or Family Deductible.

16. Dependent has the meaning given to such term in Section II.C.

17. Developmental Service means a service of, relating to, or being designed to assist growth or bring about improvement in a Covered Individual who has not met biological or non-biological maturation expectations. Developmental Services include those services designed to assist Covered Individuals who have never had the ability to perform a task in learning and/or achieving that task performance.

18. Educational Service means a service provided as a means of training Covered Individual through formal instruction and supervised practice. Educational Services include those services designed to assist Covered Individuals who do not currently meet maturation expectations in making progress toward those goals.

19. Eligible Charges means the charges up to the Usual and Customary Charge for a covered Benefit rendered by a Provider reduced by any Non-Compliance Reduction. The Plan will recognize Eligible Charges for covered Benefits up to the Usual and

Customary Charge. Charges in excess of the Usual and Customary Charge are the Covered Individual's responsibility and are not considered a covered Benefit or covered expense.

20. Eligible Dependent has the meaning given to such term in Section II.C.

21. Eligible Participant has the meaning given to such term in Section II.C.

22. Emergency Care means those services and supplies furnished or required to screen and stabilize an Emergency Medical Condition.

23. Emergency Medical Condition means a medical condition that manifests itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, possessing an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (a) the Covered Individual's health (or, with respect to a pregnant woman, the health of the women or her unborn child) being placed in serious jeopardy; (b) serious impairment to a bodily function; (c) serious dysfunction of any bodily organ or part; (d) inadequately controlled pain; or (e) with respect to a pregnant woman who is having contractions, when (i) there is inadequate time to effect a safe transfer to another hospital before delivery; or (ii) transfer to another hospital may pose a threat to the health or safety of the woman or unborn child.

24. ERISA refers to the Employee Retirement Income Security Act of 1974, as amended.

25. Experimental or Investigational means procedures, drugs, devices, services and/or supplies that are: (i) provided or performed in special settings for research purposes under a controlled environment and which are being studied for safety, efficiency, and effectiveness; (ii) awaiting endorsement by the appropriate national medical specialty college or federal governmental agency for general use by the medical community at the time they are rendered; (iii) not approved by Medicare; (iv) with regard to drugs and devices, not yet approved by the Federal Drug Administration at the time used or administered; or (v) do not meet the Plan's criteria. The Plan's criteria for determining whether or not a procedure or treatment will be considered Experimental or Investigational will include, but not be limited to, the following:

    (1) Whether the patient meets the criteria for treatment or other procedure with regard to age, general health, etc., and has been determined to be a good candidate by an accredited facility.
    (2) Whether the procedure or treatment is commonly performed on a widespread geographic basis.
    (3) Whether the procedure or treatment is generally accepted by the medical profession (based on the opinions of organizations such as the American Medical Association).
    (4) The failure rate and side effects of the treatment or procedure.
    (5) Whether other, more conventional methods of treatment have been exhausted.
    (6) Whether the procedure or treatment is Medically Necessary and is expected to meaningfully extend the patient's life.

(7) Whether the procedure or treatment is recognized for reimbursement by Medicare, Medicaid, and other insurers and self-funded plans.

26. Family means the Participant and his or her Dependents under the Plan.

27. Homebound means an individual who is confirmed to the home as a result of their physical condition.

28. Home Health Provider means a public or private agency or organization or a subdivision of an agency or organization, that: (a) is primarily engaged in providing skilled nursing and other therapeutic services; (b) has policies established by associated professional personnel, including one or more Physicians and one or more registered nurses to govern the services provided under the supervision of Physicians or registered nurses; (c) maintains medical records on all patients; (d) is licensed or approved by the state or local law as meeting the standards established for such licensing, and (e) has a full-time administrator. A Home Health Provider does not include an organization which is engaged primarily in the care and treatment of Mental Illness.

29. Hospice means an organization which provides a coordinated set of services rendered at home or in an out-patient or institutional setting for individuals suffering from a disease or condition with a terminal (within six months) prognosis. A Hospice must have an inter-disciplinary group of personnel which includes at least one Physician and one registered nurse, and it must maintain central clinical records on all patients. A Hospice must meet the standards of the National Hospice Organization and applicable state licensing requirements.

30. Hospice Care means a program of care which offers 24-hour services to terminally ill patients in the home, on an outpatient and/or a short-term Inpatient basis, and includes such services and items as nursing care, Physical Therapy, medical social services, home health aid, medical supplies, Physician services, short-term Inpatient care and counseling for the family.

31. Hospital means a duly licensed institution for the care of persons having an acute non-occupational Illness or Injury and for which services provided under the care of a Physician; that is open at all times; that has a staff or one or more Physicians on call at all times; and that has 24-hour nursing services provided by registered nurses. This does not mean a health resort, rest home, nursing home, Skilled Nursing Facility, convalescent home, custodial home of the aged or similar institutions. Confinement in a special unit of a Hospital used primarily for rehabilitation therapy services, a rest or convalescent home or Skilled Nursing Facility will not be deemed to be confinement in a Hospital. A Hospital does not include a licensed ambulatory surgical center.

32. Incur or Incurred means the date upon which a particular covered Benefit is provided to a Covered Individual, not the date on which charges are billed or payments (e.g., Deductibles, Copayments and/or Coinsurance) are made.

33. Illness means only a non-occupational bodily or mental disorder, disease or infirmity of a Covered Individual where the life or health of the Covered Individual is in jeopardy.

34. Injury means only a non-occupational condition occurring suddenly and caused by accidental means which results in damage to the Covered Individual's body from an external force independent of disease or bodily infirmity or any other cause.

35. Inpatient means an individual who, while confined in a Hospital is assigned to a bed in any department of the Hospital other than its outpatient department, observation unit, room or bed, or emergency room and for whom a charge for Room and Board is made by the Hospital.

36. Maintenance Service means drills, techniques, and exercises that preserve the Covered Individual's present level of function and prevent further regression. Maintenance begins when the therapeutic goals have been met and when no further functional progress is apparent or expected to occur.

37. Medically Necessary means, in the sole discretion of the applicable Claims Administrator, health care services and supplies which are ordered by a Provider to be: (a) medically appropriate and necessary to meet the health care needs of the Covered Individual; (b) rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the covered Benefit; (c) consistent in type, frequency and duration of treatment with scientifically based guidelines of national medical, research, or health care coverage organizations or governmental agencies that are accepted by the Plan; (d) consistent with the diagnosis of the conditions; and (e) of demonstrated medical value. Medically Necessary does not include care, which is provided primarily for the convenience of the Covered Individual or a Provider, or care, which is rendered more frequently than that accepted as medically appropriate by the medical profession. With respect to Inpatient care, the symptoms or conditions must require, in the sole discretion of the Claims Administrator, that treatment be provided to the Covered Individual as an Inpatient since the treatment cannot be safely provided to the Covered Individual as an outpatient. In order to meet the definition of Medically Necessary, the service, treatment or supply must be prescribed, ordered or recommended by a qualified Physician. However, the fact that a Physician may prescribe, order, recommend or approve a service, treatment or supply does not, in and of itself, make the service, treatment or supply Medically Necessary. The Claims Administrator, in its sole discretion, may use peer review organizations, utilization review organizations, medical evaluation organizations or other professional opinions to determine if a specific service, treatment or supply is Medically Necessary, consistent with professionally recognized standards of care with respect to quality, frequency and duration and is provided in the most efficient and economical manner. In order to be covered by the Plan, Medically Necessary services, treatment or supplies must also be Benefits.

38. Medicare means the two programs established by Title XVIII of the Social Security Act and regulations thereunder, as it may be amended, and includes, without limitation, Part A - Hospital Insurance Benefits for the Aged and Part B - Supplementary Medical Insurance Benefits for the Aged.

39. Mental Health Professional means a licensed Physician specializing in the treatment of Mental Illness, a licensed Psychologist, a licensed Clinical Social Worker or a licensed Professional Counselor acting within the scope of their license.

40. Mental Illness refers to any diagnosed condition listed in the Diagnostic and Statistical Manual of Mental Disorders (DSM, most recent edition, revised), for which treatment is commonly sought from a psychiatrist or Mental Health Professional. The DSM is a clinical diagnostic tool developed by the American Psychiatric Association and used by Mental Health Professionals. Mental Illness includes eating disorder, but excludes mental retardation, pervasive developmental disorders or learning disorders.

41. Named Fiduciary means the University and, with respect to claims only, the applicable Claims Administrator.

42. Non-Compliance Reduction means the amount by which charges considered for payment under the Plan are reduced as a result of a Covered Individual's failure to comply with the pre-certification and second opinion requirements of the Utilization Management Program when so required. Any reduction in Eligible Charges will not be used to meet a Deductible or Out-of-Pocket Maximum, if any.

43. Occupational Therapy means the constructive therapeutic activity designed and adopted to promote the restoration of useful, physical function, other than educational training or services designed and adopted to develop a physical function.

44. Open Enrollment Period means any period the Plan Administrator may designate from time to time in its sole discretion. The Open Enrollment Period will vary based on the type of academic Program under which the Eligible Participant is admitted.

45. Outpatient Facility means a health care facility, other than a Hospital, or a separate facility operated by or in conjunction with a Hospital, which provides outpatient services including, but not limited to, prescheduled surgical service, Emergency Care, Urgent Care, laboratory or diagnostic services.

46. Participant has the meaning given to such term in Section II.C.

47. Participating Pharmacy means a Pharmacy that has agreed to provide prescription drug Benefits to Covered Individuals under an arrangement with the Plan's Claims Administrator for prescription drug Benefits.

48. Participating Provider means any Provider (other than a "Participating Pharmacy") who or which is employed by, or is under contract (directly or indirectly) with, the Plan, the University, SLUCare, and/or Coventry Health Care of Missouri and has agreed to provide Medically Necessary Benefits to Covered Individuals.

49. Pharmacy means an establishment duly licensed under applicable law to dispense prescription medications to individuals.

50. Physical Therapy means the treatment of an Illness, Injury or condition by physical means, which is designed and adopted to promote the restoration of a useful physical function. It does not include educational training or services designed and adopted to develop a physical function.

51. Physician means a legally qualified medical or dental physician who holds a Degree of Doctor of Medicine or Doctor of Osteopathy and is entitled to practice medicine in all branches under the laws of the state or jurisdiction where the services are rendered within the scope of his license. Physician shall also include, without limitation, a doctor of chiropractic medicine, doctor of optometry, doctor of podiatry, oral surgeon or dentist legally licensed under applicable state law to provide services within the scope of their particular license. A Physician shall not include a Covered Individual or any member of a Covered Individual's family.

52. Plan means the University Health Plan.

53. Plan Administrator means Saint Louis University.

54. Practitioner means a Physician or individual acting within the scope of his or her applicable state licensure/certification requirements and holding the applicable degree, including, without limitation, a Certified Registered Nurse Anesthetist (C.R.N.A.), Registered Physical Therapist (R.P.T.), Psychologist (Ph.D., Ed.D., Psy.D.), Licensed Clinical Social Worker (L.C.S.W.), Master of Social Work (M.S.W.), Marriage, Family, Child Counselor (M.F.C.C.) or Occupational Therapist.

55. Primary Care Physician or PCP means a general internal medicine, pediatrics, or family medicine Physician.

56. Provider means any Physician, Practitioner, Hospital, Outpatient Facility or other health care facility or provider other than a Pharmacy.

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

58. Room and Board refers to all charges, by whatever name called, made by a Hospital, Skilled Nursing Facility, Mental Nervous Treatment Facility, Substance Abuse/Alcoholism Treatment Facility, Rehabilitation Facility or other health care facility as a condition of occupancy, except that Room and Board does not include professional services of Practitioners by whatever name called.

59. Semi-Private means a room in a Hospital or Skilled Nursing Facility containing two (2) or more beds and/or classified as semi-private by such Hospital or Skilled Nursing Facility.

60. Skilled Nursing Facility means an institution, or distinct part thereof, operated pursuant to state and federal law, and one which meets all of the following conditions: (a) it is licensed to provide, and is engaged in providing, on an Inpatient basis, for persons recovering from non-occupational Injury or Illness, professional nursing services rendered by a registered nurse or a licensed practical nurse under the direction of a registered nurse and physical restoration services to assist patients to reach a degree of body functioning to permit self-care and essential daily living activities; (b) services are provided for the treatment of its patients and under the full-time supervision of a Physician or registered nurse; (c) it maintains a complete medical record on each patient; (d) it has an effective utilization review plan; (e) it is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, mental retardates, custodial or educational care or care of mental disorders; and (f) it is approved and licensed by Medicare.

61. Sound Natural Teeth means teeth and tissue that are viable, functional, and free of disease. A sound natural tooth has no decay, no filling on more than two surfaces, no gum disease associated with bone loss, no root canal therapy, is not a dental implant, and functions normally in chewing and speech.

62. Specialist means a Physician that is not a general internal medicine, pediatrics, or family medicine Physician.

63. Speech Therapy means the treatment for the correction of a speech impairment resulting from disease, trauma, congenital abnormalities, or previous therapeutic processes, designed and adopted to promote the restoration of a useful physical function. It does not include educational training or services designed and adopted to develop a physical function.

64. Spouse has the meaning given to such term in Section II.C.

65. Substance Abuse means the uncontrollable or excessive use of addictive substances including, but not limited to, alcohol, morphine, cocaine, heroin, opium, cannabis, barbiturates, amphetamines, tranquilizers, and/or hallucinogens, and the resultant physiological and/or psychological dependency which develops with continued used of such addictive substances requiring Medically Necessary care as determined by a Physician.

66. Totally Disabled means: (i) in the case of a Covered Individual employed by the University, that he is unable to perform any of the duties of his occupation, solely due to Injury, Illness, Mental Illness, Substance Abuse or Alcoholism; or (ii) in the case of a dependent, the Injury, Illness, Mental Illness, Substance Abuse or Alcoholism substantially limits or impairs a major life activity of such individual.

67. University means Saint Louis University.

68. Urgent Care means those services necessary for treatment of a health condition, which are required in order to prevent rapid and/or serious deterioration in a Covered Individual's health as a result of an Injury or Illness. Urgent Care is not the same as Emergency Care.

69. Usual and Customary Charge means the designation of a charge as being the usual and customary charge made by a health care physician, practitioner, provider or facility for care, services, supplies, medications, or equipment that does exceed the general level of charges made by other providers in rendering or furnishing similar care or treatment with the same or similar area. The term area in this definition means the geographical area for which statistical information has been obtained to provide a representative cross section of such charges. Due consideration will be given to the nature and severity of the condition being treated and any medical complication or unusual circumstances which will require additional time, skill or expertise. The determination of usual, reasonable, and customary will be made solely by the Claims Administrator.

70. Utilization Management Program means the Program that includes a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures, or settings, and includes components of pre-certification review, concurrent review during a confinement, retrospective review, discharge planning, second opinion review, and case management, when required or requested by the Plan.

XIV. HIPAA Privacy

In addition to this Summary Plan Description, there are also other formal documents that govern the Plan's operation. One of these documents is a document adopted by the Plan that describes how the University, as administrator of the Plan, will use and disclose certain information that may be considered "protected health information" under the federal law known as the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). This law provides comprehensive requirements concerning your protected health information.

Most of the comprehensive requirements are outlined in the "Notice of Privacy Practices" you have received from the Plan.

The Plan is permitted to use and disclose your protected health information without your consent or authorization, as necessary, to carry out Plan functions and duties. For example, the Plan may obtain health claims information and provide it to the Claims Administrator to perform claims adjudication and appeals. The University and the Plan will comply with any law that requires a disclosure of your protected health information, such as a court order.

Please review the Notice of Privacy Practices for a more complete discussion about how the Plan and the University may use your protected health information and disclose it to third parties.

XV. Rights of Participants

This Section XV only applies to Covered Employees and their Dependents. As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all Plan participants shall be entitled to:

A. Receive Information about Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, all documents governing the Plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report.

B. Continue Group Health Plan Coverage

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

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

C. Prudent Actions by Plan Fiduciaries

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

D. Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30

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

E. Assistance With Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration (formerly the Pension and Welfare Benefit Administration), U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C., 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

XVI. Additional Information about the Plan

A. Amendment and Termination of the Plan

Although the University intends to continue this Plan, the University has the right to amend, modify or terminate the Plan (including this Summary Plan Description and its attachments) at any time. If the Plan is terminated, the rights of Covered Individuals are limited to expenses Incurred before termination.

B. Limitations on Rights of Participants

Participation in the Plan does not give you the right to be retained in any academic or training Program of the University, nor does it entitle you to any interest, pension, or benefits other than the benefits specifically provided for in the Plan.

C. Plan Name

The Plan is known as the University Health Plan, which is part of the Saint Louis University Welfare Benefit Plan.

D. Type of Plan

Self-funded "Welfare Benefit Plan" under ERISA, which qualifies as a group health plan, providing comprehensive health benefits.

E. Plan Year

The Plan Year is January 1st through December 31st. The first plan year was from July 1st through December 31st.

F. Plan Sponsor and Identification Number of Employer Which Maintains the Plan

Saint Louis University
3545 Lindell Blvd, First Floor
St. Louis, Missouri 63103

and the Identification Number of the University is 43-0654872.

G. Plan Number

518

H. Type of Administration and Funding

The Plan is self-funded. The Claims Administrators have been hired to process claims for Benefits under the Plan. The Claims Administrators do not serve as insurers, but merely as claims processors. The University is ultimately responsible for providing Plan Benefits. The Claims Administrators and the University share responsibility for administering the Plan, as described in this Summary Plan Description.

Contributions to the Plan are made in part by the University out of its general assets and in part by Covered Individuals.

I. Plan Administrator

The University is the Plan Administrator.

University Health Plan
1402 S. Grand Blvd., Room C119
St. Louis, Missouri 63104-1004
Telephone No.: (314) 977-5666

J. Claims Administrators

For prescription drug Benefits:

Catamaran
1600 McConnor Parkway
Schaumburg, Illinois 60173-6801

Telephone No.: 1-800-282-3232

For all other Benefits:

Coventry Health Care of Missouri, Inc.
550 Maryville Centre Drive, Suite 300
Saint Louis, MO 63141
Telephone No.: 1-800-775-3540

K. Agent for Service of Legal Process

Office of General Counsel
Health Sciences Center
3556 Caroline Mall – Room 307
St. Louis, Missouri 63104
Telephone No.: (314) 977-5767

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

L. Employer Whose Covered Employees are Covered by the Plan.

Saint Louis University
3545 Lindell Blvd, First Floor
St. Louis, Missouri 63103
Telephone No.: (314) 977-2304

EXHIBIT 1 – SUMMARY OF PRESCRIPTION DRUG BENEFITS

University Health Plan Prescription Drug Benefit Summary
Effective: January 1, 2014
Administered by: Catamaran

The University Health Plan Prescription Drug Benefit Program is administered by Catamaran. The information below is not a guarantee of benefits and may be subject to change. If there is any discrepancy between this information and any other legal documents governing the plan, the legal documents govern.

For questions concerning your pharmacy benefits (for example, copay, eligibility, or location of a nearby participating pharmacy), call **Catamaran Member Services** toll-free, 24 hours a day, 7 days a week at:

1-800-207-2568

TTY: 1-888-411-0767

Your Cost

When your covered prescriptions are filled under this program, you share a portion of the cost. The plan pays for the rest. Your costs for the program are as follows:

Retail Pharmacy (short-term medications):		**Retail Pharmacy (long-term medications)*:**	
Prescriptions written for up to 30-day supply		Prescriptions written for a 90-day supply (Advantage90™)	
Generic:	$ 5.00**	Generic:	$10.00**
Brand:	$25.00**	Brand:	$50.00**
Accutane, Acne (topical), Atopic Dermatitis, COX-2 Inhibitors, Effexor XR, Lamisil/Sporanox, Lexapro, Non-Sedating Antihistamines, Prevacid & Proton Pump Inhibitors:	$40.00**	Accutane, Acne (topical), Atopic Dermatitis, COX-2 Inhibitors, Effexor XR, Lamisil/Sporanox, Lexapro, Non-Sedating Antihistamines, Prevacid & Proton Pump Inhibitors:	$80.00**

* Only available at select retail pharmacies. See list of pharmacies participating in Advantage90™ 90-day retail program.
** A covered prescription for a "preventive health service" will have a $0.00 copayment and will not subject to any deductible. **Exception:** Copayments for a "preventive health service" may apply to Brand products for which a Generic product is available.

It is standard pharmacy practice (and in some states required by law) to substitute generic equivalents for brand-name drugs whenever possible. Under the Plan, whenever a brand-name drug is dispensed when a generic substitute is available and allowable, **you will be responsible for the brand copayment plus the difference between the brand and generic price of each drug.**

Covered Drugs

- Federal legend drugs (that is, drugs that federal law prohibits dispensing without a prescription)
- Disposable insulin syringes/needles
- Insulin

Drugs Not Covered

- Hair loss treatments (for example minoxidil, Propecia ®)
- Infertility drugs
- Obesity (weight reduction) drugs
- Over-the-counter (OTC) items

This is a *partial* listing of drugs which are covered and drugs not covered. **Certain prescriptions may require pre-authorization.** For specific drug inquiries, contact Catamaran Member Services at 1-800-207-2568.

Participating Pharmacies

Covered Individuals can choose from more than 60,000 participating pharmacies. Below are just *some* of the many pharmacies participating in the Catamaran retail network. For additional participating pharmacies, call Catamaran Member Services at 1-800-207-2568.

The University Health Plan prescription drug program does not include a mail order option. All prescriptions must be filled through a retail pharmacy.

The plan's specialty pharmacy provider **BriovaRx™ Specialty Pharmacy** can be contacted at 855-427-4682.

Albertsons *	Fred's Pharmacy	Medicine Shoppe *	Sav-on Drugs *
Aurora Pharmacy *	Giant Eagle	Meijer *	ShopKo *
Bi-Lo	Giant Pharmacy	Osco Drug *	ShopRite
Brooks Pharmacy *	HEB Pharmacy *	Pamida Pharmacy	Stop & Shop
Costco	Hy-Vee *	Pathmark Pharmacy	Target *
CVS Pharmacy *	Kmart *	Publix *	Von's *
Duane Reade *	Kroger *	Rite Aid *	Walgreens *
Eckerd *	Longs Drugs *	Safeway *	Wal-Mart *
Fred Meyer *	Medicap Pharmacy *	Sam's Club *	Winn-Dixie *

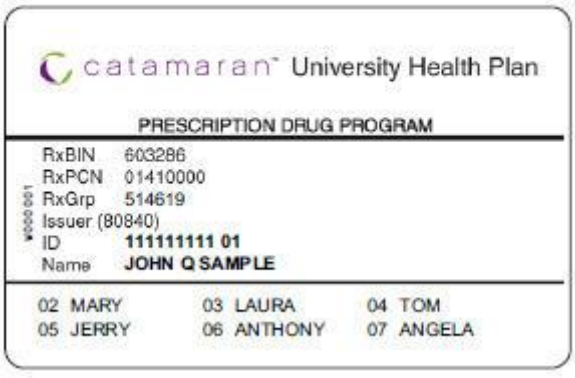
* Pharmacies participating in Advantage90™ 90-day retail program.

Catamaran Cards

Within 10–14 days of enrollment, Covered Individuals will receive Catamaran cards via mail. **Covered Individuals must present their Catamaran card when covered prescriptions are filled under this program (see sample cards below).**

The RxBin# for the retail prescription plan is 603286. The RxGroup# is 514619. The PCN# is 01410000.

FRONT



BACK

PLEASE PRESENT THIS CARD EACH TIME
YOU VISIT A PARTICIPATING RETAIL PHARMACY

TERMS AND CONDITIONS

This card is non-transferable and is for identification purposes only. It is not a guarantee of coverage. The terms of the agreement between Catamaran and the insuring organization govern all prescription benefits obtained through use of this card, which is the sole property of Catamaran. Any fraudulent or unauthorized use of this card is strictly prohibited by law. When your eligibility terminates, this card is void.

Submit UCF Claims to:
Catamaran
P.O. Box 545 · Deerfield, IL 60015

Catamaran Member Services:
1-800-207-2568 or visit WalgreensHealth.com

General Information About Prescription Drug Coverage Under Medicare Part D

Medicare Part D provides a prescription drug benefit that is available to individuals who are enrolled in Medicare Part A or Medicare Part B, or both. Coverage under Medicare Part D is voluntary and requires enrollment and payment of a premium. Eligible individuals must decide whether to enroll in Medicare Part D before the end of their initial enrollment periods, or be subject to an increased premium on a permanent basis if they do not enroll when first eligible. Eligible individuals who have creditable prescription drug coverage under a group health plan (coverage that is equal to or better than prescription drug coverage under Medicare Part D) are permitted to waive coverage without being subject to the increased premium or the enrollment limitation as long as the group health plan coverage remains creditable. Once coverage is waived and an eligible individual loses creditable prescription drug coverage under a group health plan, enrollment in Medicare Part D must take place during the applicable enrollment period.

If required and of you are eligible for Medicare Part D, you will be provided a disclosure notice (Certificate of Creditable Coverage) that indicates whether or not this Plan provides prescription drug coverage that is creditable. It is important that you read the disclosure notice carefully so that you can make an informed and timely decision about whether to enroll in Medicare Part D. The disclosure notice is distributed annually and at other times as required by the Centers for Medicare & Medicaid Services. Contact the Plan Administrator if you need a copy of the Plan's disclosure notice.

To learn more about prescription drug coverage under Medicare Part D, go to www.Medicare.gov. To learn more about this Plan's prescription drug coverage for Covered Individuals who are eligible for Medicare Part D and how the Plan's benefits will impact their decision regarding Medicare Part D, please contact the Plan Administrator.

EXHIBIT 2 – SUMMARY OF MEDICAL COVERAGE AND BENEFITS

University Health Plan Medical Coverage Benefit Summary

Effective: January 1, 2014

Administered by: Coventry Health Care of Missouri

Note: This is not a contract. This Summary of Benefits is intended to give an overview of the Plan benefits. In the event that this summary and the Plan Document differ or associated benefit riders differ, the Plan Document or the associated benefit riders will govern.

Benefit Requirements	Tier 1 (SLU*Care* Network)	Tier 2 (Coventry Network)	Tier 3 (Out-of-Network)
Medical Benefit Maximum Per Member (While Covered)	Unlimited	Unlimited	Unlimited
Calendar Year Deductibles - Per Member	None	$100	$500
- Family	None	$200	$1,000
Calendar Year Out-of-Pocket Maximums (Maximums accumulate separately for each tier) - Per Member	$1,100 (Deductibles, co-ins, co-pymts)	$1,500 (Deductibles, co-ins, co-pymts)	Unlimited
- Family	$3,300 (Deductibles, co-ins, co-pymts)	$4,000 (Deductibles, co-ins, co-pymts)	Unlimited
New Dependents – Must be enrolled within **31** days of qualifying event (i.e. marriage, adoption). **Newborns –** Children born to a mother with UHP coverage in effect will be provided 30 days of coverage starting from the date of birth. To extend a newborn's coverage past their first 30 days, an enrollment form must be submitted within **31** days of birth and arrangements made to pay applicable premium. **Loss of Coverage** – Participants and dependents that become eligible due to loss of coverage under another plan must enroll within **31** days of coverage loss.	**Medical Services** – Must be provided by SLU*Care* affiliated network provider at a SLU*Care* affiliated office. **Facility Services** – Must be provided by a SLU*Care* affiliated facility including: Saint Louis University Hospital Saint Elizabeth's – Belleville, IL Cardinal Glennon Children's Hospital (Pediatrics only) SSM St. Mary's – Clayton (OB/GYN only) **Precertification** – Required for certain procedures.	**Medical Services** – Must be provided by a Coventry network provider. **Facility Services** – Must be provided by a Coventry network facility. **Precertification** – Required for certain procedures.	Benefits subject to usual customary and reasonable limits. **Balance billing may apply**. **Precertification** - Required for certain procedures.
MEDICAL SERVICES			
Physician Office Services and Supplies	$0 Copayment per Primary Care visit $10 Copayment per Specialist visit	$25 Copayment per Primary Care visit $40 Copayment per Specialist visit	35% Coinsurance After Deductible
Professional Fees for Surgical Services and Other Medical Care	$0 Copayment	20% Coinsurance After Deductible	35% Coinsurance After Deductible
Immunizations: Routine administrations present on CDC recommended schedules	$0 Copayment	$0 Copayment	35% Coinsurance After Deductible

Benefit Requirements	Tier 1 (SLU *Care* Network)	Tier 2 (Coventry Network)	Tier 3 (Out-of-Network)
Preventive Health Screenings - Routine Only	$0 Copayment	$0 Copayment	35% Coinsurance After Deductible
Allergy Services: - Office Visits - Injections/Treatment	 $0 Copayment per Primary Care visit $10 Copayment per Specialist visit $0 Copayment	 $25 Copayment per Primary Care visit $40 Copayment per Specialist visit $0 Copayment	 35% Coinsurance After Deductible 35% Coinsurance After Deductible 35% Coinsurance After Deductible
Outpatient Diagnostics: Covered health services received on an outpatient basis, at a Hospital or Alternate Facility including: - Laboratory services - X-Ray/Imaging - Other diagnostic/therapeutic services When some lab and x-ray services are performed in a Physician's office, physician charges may apply.	 Laboratory services: $0 Copayment X-Ray/Imaging: $0 Copayment Other diagnostic/therapeutic services: $0 Copayment	 Laboratory services: $0 Copayment X-Ray/Imaging: 20% Coinsurance After Deductible Other diagnostic/therapeutic services: 20% Coinsurance After Deductible	 Laboratory services: 35% Coinsurance After Deductible X-Ray/Imaging: 35% Coinsurance After Deductible Other diagnostic/therapeutic services: 35% Coinsurance After Deductible
Maternity: - Office Visits - Lab and Diagnostic	 One time $10 Copayment for all office visits associated with prenatal care during a single pregnancy $0 Copayment	 One time $40 Copayment for all office visits associated with prenatal care during a single pregnancy $0 Copayment	 35% Coinsurance After Deductible 35% Coinsurance After Deductible
INPATIENT HOSPITAL SERVICES **OBSERVATION CARE** Coverage up to 48 hours. Services that exceed one day must be pre approved.	$0 Copayment per admission $0 Copayment per admission	$565 Copayment per admission $565 Copayment per admission	35% Coinsurance After Deductible 35% Coinsurance After Deductible
OUTPATIENT SERVICES Emergency Care Service and Supplies	 $75 Copayment per visit. Copayment charge will be waived when inpatient admission for the same condition occurs within 24 hours	 $75 Copayment per visit. Copayment charge will be waived when inpatient admission for the same condition occurs within 24 hours	 $75 Copayment per visit. Copayment charge will be waived when inpatient admission for the same condition occurs within 24 hours.
Non-Emergency Services: - Outpatient Surgery - Outpatient Hospital Procedures	 $50 Copayment $0 Copayment	 $200 Copayment $75 Copayment per visit	 35% Coinsurance After Deductible 35% Coinsurance After Deductible
Urgent Care	N/A	$25 Copayment per visit	$75 Copayment per visit
Rehabilitation Services: Outpatient Rehabilitative Therapy limited to 60 combined visits per Calendar Year for Physical, Occupational, and Speech Therapy.	10% Coinsurance	20% Coinsurance After Deductible	35% Coinsurance After Deductible

Benefit Requirements	Tier 1 (SLU *Care* Network)	Tier 2 (Coventry Network)	Tier 3 (Out-of-Network)
Nutritional Counseling: Limited to 3 visits per Calendar Year	$0 Copayment per Primary Care visit $10 Copayment per Specialist visit	$25 Copayment per Primary Care visit $40 Copayment per Specialist visit	35% Coinsurance After Deductible
MENTAL HEALTH/ALCOHOLISM/ CHEMICAL DEPENDENCY Outpatient Therapeutic Services for Mental Illness	Members may contact Saint Louis Behavioral Medicine Institute (SLBMI) at 314-977-1066. Members may also contact the Saint Louis University Student Health and Counseling Center at 314-977-2323. $0 Copayment per session	Must obtain authorization prior to service by calling Mercy Managed Behavioral Health at 314-729-4600 or 1-800-413-8008. $0 Copayment per session	 35% Coinsurance After Deductible
Inpatient Services for Mental Illness	$0 Copayment per admission	$565 Copayment per admission	35% Coinsurance After Deductible
Outpatient Therapeutic Alcoholism and Chemical Dependency	$0 Copayment per session	$0 Copayment per session	35% Coinsurance After Deductible
Inpatient Alcoholism and Chemical Dependency Services	$0 Copayment per admission	$565 Copayment per admission	35% Coinsurance After Deductible
MISCELLANEOUS COVERED SERVICES Home Health Agency Services: Limited to 60 visits per Calendar Year	$0 Copayment	$0 Copayment	35% Coinsurance After Deductible
Skilled Nursing Facility Services: Limited to 60 days per Calendar Year	$0 Copayment	$0 Copayment	35% Coinsurance After Deductible
Hospice Services: Limited to 180 days during the entire period member is covered.	$0 Copayment	$0 Copayment	35% Coinsurance After Deductible
Ambulance	$0 Copayment	$0 Copayment	$0 Copayment
Prosthetic Devices	20% Coinsurance	20% Coinsurance After Deductible	35% Coinsurance After Deductible
Orthotic Equipment (i.e. support braces, splints, collars ordered by physician) and Foot Orthotics (for vascular insufficiency, correction of anatomic, structural congenital or developmental defect only)	20% Coinsurance	20% Coinsurance After Deductible	35% Coinsurance After Deductible
Durable Medical Equipment and Supply	20% Coinsurance	20% Coinsurance After Deductible	35% Coinsurance After Deductible
Surgical Implants (i.e. pacemakers, stints, stents)	20% Coinsurance	20% Coinsurance After Deductible	35% Coinsurance After Deductible
Diabetes Services	Copayment consistent with type of service received	Copayment consistent with type of service received	35% Coinsurance After Deductible
Transplant Services	$0 Copayment	$0 Copayment	Covered In Network Only

Benefit Requirements	Tier 1 (SLU *Care* Network)	Tier 2 (Coventry Network)	Tier 3 (Out-of-Network)
Dialysis	$0 Copayment	$0 Copayment	Covered In Network Only
Mammography	$0 Copayment	$0 Copayment	35% Coinsurance After Deductible
Eye Care Services One eye exam performed during a Calendar Year.	$10 Copayment per Specialist visit	$40 Copayment per Specialist visit	35% Coinsurance After Deductible
Nutritional Supplements	20% Coinsurance for a thirty (30) day supply	20% Coinsurance After Deductible for a thirty (30) day supply	35% Coinsurance After Deductible
Accidental Dental	20% Coinsurance	20% Coinsurance After Deductible	35% Coinsurance After Deductible
Injectables: Out-of-Pocket Max - $100 per injection	20% Coinsurance	20% Coinsurance After Deductible	35% Coinsurance After Deductible
Human Leukocyte Antigen Testing: One Per Lifetime	$0 Copayment	$0 Copayment	35% Coinsurance After Deductible
Natural Family Planning Services	$0 Copayment	$100 Copayment	Covered In Network Only
Smoking Cessation Services	$0 Copayment	$0 Copayment	Covered In Network Only
Hearing Screenings for Newborns	$0 Copayment	$0 Copayment	35% Coinsurance After Deductible
Neuropsych Testing (i.e. for brain injury including Alzheimers)	$0 Copayment	20% Coinsurance After Deductible	35% Coinsurance After Deductible
PKU Formula	20% Coinsurance	20% Coinsurance After Deductible	35% Coinsurance After Deductible
Clinical Trials – Cancer	Copayment consistent with services received	Copayment consistent with services received	35% Coinsurance After Deductible
Autism Spectrum Disorders	Copayment consistent with services received	Copayment consistent with services received	35% Coinsurance After Deductible
Chiropractic Services	Not covered	Not covered	Not covered
Travel Immunizations not available through Primary Care Physician	Pre-authorization by UHP Office (314-977-5666) required. Member must pay at time of service and request reimbursement from UHP Office.		

Summary of Limitations and Exclusions

This is not a contract. This is only a summary of benefits, exclusions and limitations and is intended to give an overview of the Plan. In the event that this summary and the Plan Document differ or associated benefit riders differ, the Plan Document or the associated benefits riders will govern.

For further information pertaining to benefits, exclusions and limitations, please contact Coventry Health Care of Missouri Customer Services department 1-800-775-3540.

Revised: **01/01/14**

EXHIBIT 3 - CHILDREN'S HEALTH INSURANCE PROGRAM

Medicaid and the Children's Health Insurance Program (CHIP) Offer Free Or Low-Cost Health Coverage To Children And Families

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, you can contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer's health plan is required to permit you and your dependents to enroll in the plan – as long as you and your dependents are eligible, but not already enrolled in the employer's plan. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**.

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of States is current as of November 3, 2010. You should contact your State for further information on eligibility –

ALABAMA – Medicaid	**CALIFORNIA** – Medicaid
Website: http://www.medicaid.alabama.gov Phone: 1-800-362-1504	Website: http://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx Phone: 1-866-298-8443
ALASKA – Medicaid	**COLORADO** – Medicaid and CHIP
Website: http://health.hss.state.ak.us/dpa/programs/medicaid/ Phone (Outside of Anchorage): 1-888-318-8890 Phone (Anchorage): 907-269-6529	Medicaid Website: http://www.colorado.gov/ Medicaid Phone (In state): 1-800-866-3513 Medicaid Phone (Out of state): 1-800-221-3943 CHIP Website: http:// www.CHPplus.org CHIP Phone: 303-866-3243
ARIZONA – CHIP	

Website: http://www.azahcccs.gov/applicants/default.aspx Phone (In state): 1-877-764-5437	
ARKANSAS – CHIP	**FLORIDA** – Medicaid
Website: http://www.arkidsfirst.com/ Phone: 1-888-474-8275	Website: http://www.fdhc.state.fl.us/Medicaid/index.shtml Phone: 1-866-762-2237
GEORGIA – Medicaid	**MONTANA** – Medicaid
Website: http://dch.georgia.gov/ Click on Programs, then Medicaid Phone: 1-800-869-1150	Website: http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml Telephone: 1-800-694-3084
IDAHO – Medicaid and CHIP	**NEBRASKA** – Medicaid
Medicaid Website: www.accesstohealthinsurance.idaho.gov Medicaid Phone: 1-800-926-2588 CHIP Website: www.medicaid.idaho.gov CHIP Phone: 1-800-926-2588	Website: http://www.dhhs.ne.gov/med/medindex.htm Phone: 1-877-255-3092
INDIANA – Medicaid	**NEVADA** – Medicaid and CHIP
Website: http://www.in.gov/fssa/2408.htm Phone: 1-877-438-4479	Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900 CHIP Website: http://www.nevadacheckup.nv.org/ CHIP Phone: 1-877-543-7669
IOWA – Medicaid	
Website: www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562	
KANSAS – Medicaid	**NEW HAMPSHIRE** – Medicaid
Website: https://www.khpa.ks.gov Phone: 800-766-9012	Website: www.dhhs.nh.gov/ombp/index.htm Phone: 603-271-4238
KENTUCKY – Medicaid	**NEW JERSEY** – Medicaid and CHIP
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 1-800-356-1561 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
LOUISIANA – Medicaid	
Website: http://www.lahipp.dhh.louisiana.gov Phone: 1-888-342-6207	
MAINE – Medicaid	**NEW MEXICO –** Medicaid and CHIP
Website: http://www.maine.gov/dhhs/oms/ Phone: 1-800-321-5557	Medicaid Website: http://www.hsd.state.nm.us/mad/index.html Medicaid Phone: 1-888-997-2583 CHIP Website: http://www.hsd.state.nm.us/mad/index.html
MASSACHUSETTS – Medicaid and CHIP	

Medicaid & CHIP Website: http://www.mass.gov/MassHealth Medicaid & CHIP Phone: 1-800-462-1120	Click on Insure New Mexico CHIP Phone: 1-888-997-2583
MINNESOTA – Medicaid	**NEW YORK –** Medicaid
Website: http://www.dhs.state.mn.us/ Click on Health Care, then Medical Assistance Phone (Outside of Twin City area): 800-657-3739 Phone (Twin City area): 651-431-2670	Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
MISSOURI – Medicaid	**NORTH CAROLINA** – Medicaid
Website: http://www.dss.mo.gov/mhd/index.htm Phone: 573-751-6944	Website: http://www.nc.gov Phone: 919-855-4100
NORTH DAKOTA – Medicaid	**UTAH** – Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-800-755-2604	Website: http://health.utah.gov/medicaid/ Phone: 1-866-435-7414
OKLAHOMA – Medicaid	**VERMONT**– Medicaid
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://ovha.vermont.gov/ Telephone: 1-800-250-8427
OREGON – Medicaid and CHIP	**VIRGINIA** – Medicaid and CHIP
Medicaid & CHIP Website: http://www.oregonhealthykids.gov Medicaid & CHIP Phone: 1-877-314-5678	Medicaid Website: http://www.dmas.virginia.gov/rcp-HIPP.htm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.famis.org/ CHIP Phone: 1-866-873-2647
PENNSYLVANIA – Medicaid	**WASHINGTON** – Medicaid
Website: http://www.dpw.state.pa.us/partnersproviders/medicalassistance/doingbusiness/003670053.htm Phone: 1-800-644-7730	Website: http://hrsa.dshs.wa.gov/premiumpymt/Apply.shtm Phone: 1-800-562-3022 ext. 15473
RHODE ISLAND – Medicaid	**WEST VIRGINIA** – Medicaid
Website: www.dhs.ri.gov Phone: 401-462-5300	Website: http://www.wvrecovery.com/hipp.htm Phone: 304-342-1604
SOUTH CAROLINA – Medicaid	**WISCONSIN** – Medicaid
Website: http://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dhs.wisconsin.gov/medicaid/publications/p-10095.htm Phone: 1-800-362-3002

TEXAS – Medicaid	**WYOMING** – Medicaid
Website: https://www.gethipptexas.com/ Phone: 1-800-440-0493	Website: http://www.health.wyo.gov/healthcarefin/index.html Telephone: 307-777-7531

To see if any more States have added a premium assistance program since November 3, 2010, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Ext. 61565

OMB Control Number 1210-0137 (expires 09/30/2013)