SUMMARY PLAN DESCRIPTION
FOR
UNIVERSITY OF NOTRE DAME
MERITAIN CHA HMO
(MEDICAL)
AMENDED AND RESTATTED AS OF:
   January 1, 2011
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INTRODUCTION

In the event of any conflict between this document and any other document or oral communication, this document will control.

This is the University of Notre Dame Meritain CHA HMO (“the Plan”) for Medical, amended and restated as of January 1, 2011.

The Plan Sponsor reserves the right to terminate or amend the Plan at any time and for any reason.

The Plan will pay benefits only for the eligible expenses incurred while this coverage is in force. Benefits are not payable for eligible expenses incurred before coverage began or after coverage terminated. An expense for a service or supply is incurred on the date the service or supply is furnished.

As used in this document, the word year refers to a calendar year. All annual benefit maximums and deductibles accumulate during the calendar year. The word Lifetime as used in this document refers to the period of time that a Plan Participant under the University of Notre Dame Meritain CHA HMO is covered.

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

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Administrator at 574-631-9718. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

Defined terms are capitalized and defined in the Defined Terms section. This document is divided into the following sections:

Schedule of Medical Benefits. Provides a description of the Plan’s benefits.

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

Eligibility and Commencement of Coverage Provisions. Explains eligibility and when coverage begins under the Plan.

Termination of Coverage and Extension of Coverage Provisions. Explains when a Plan Participant’s coverage would end and when a Plan Participant may extend coverage under the Plan.

Medical Management. Explains the Medical Management Program, which protects a Covered Person from significant health care expenses and helps to provide quality care.

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

Medical Benefits. Provides a description of medical benefits provided under the Plan.

Plan Exclusions. Lists services, treatment and charges incurred that are not covered by the Plan.

Filing a Claim. Explains how to submit a claim for consideration of benefits under the Plan.
Claims Procedure. Explains the procedures for filing a claim and the claim appeal process.

Coordination of Benefits. Explains the Plan benefit payment order when a Covered Person is covered under more than one plan providing benefits.

Other Important Plan Provisions. Explains other important Plan provisions.

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

COBRA Continuation Options. Explains continuation options available under the Plan.

Responsibilities for Plan Administration. Explains the responsibilities of the Plan Administrator.


General Plan Information. Provides general Plan information.
SCHEDULE OF BENEFITS

MEDICAL BENEFITS

The following Schedule of Benefits describes the benefits of the Plan. Additional Plan provisions, which may affect benefit payment, can be found in the Benefit Description sections.

All benefits described in the Schedule of Medical Benefits are subject to the exclusions and limitations described in the Plan Exclusion Section.

Required Precertification: The following services must be precertified or reimbursement from the Plan may be reduced or not available:

- Inpatient Hospitalizations
- Developmental Delays

The Plan does not require precertification for a maternity length of stay that is 48 hours or less for a vaginal delivery or 96 hours or less for a cesarean delivery.

For precertification call: Meritain Health
888-668-6855

Detailed information regarding precertification requirements and penalties for failure to comply can be found in the Medical Management section.

Participating Providers

This Plan has entered into an agreement with certain Hospitals, Physicians and other health care providers, which are called Participating Providers. Because these Participating Providers have agreed to charge reduced fees to persons covered under the Plan, the Plan can afford to reimburse a higher percentage of their fees.

Therefore, when a Covered Person uses a Participating Provider, that Covered Person will receive the plan benefit as outlined in the Schedule of Benefits. When a Non-Participating Provider is used, there are no benefits available under this Plan.

Medical Emergency Services

CHA Service Area – Includes the following Counties in Indiana (St. Joseph, Elkhart, Fulton, LaGrange, Marshall, LaPorte, Stark and Porter) and the following Counties in Michigan (Cass, Berrien and St. Joseph).

If a Covered Person is provided Medical Emergency services by a Non-Participating Provider located outside the CHA Service Network, the Covered Person will be reimbursed at the Participating Provider benefit level.

If a Covered Person is provided Medical Emergency services by a Non-Participating Provider located in the CHA Service Network when the emergency is deemed to be life-threatening (see the Medical Emergency definition), the Covered Person will be reimbursed at the Participating Provider benefit level.

If a Covered Person is provided Medical Emergency services by a Non-Participating Provider located in the CHA Service Network when the accident or Injury is deemed not to be life-threatening but is determined to be a Medical Emergency by a prudent layperson (see the Medical Emergency definition), the Covered Person will not be reimbursed for services rendered.
Copays payable by Plan Participants

Copays are dollar amounts that the Covered Person or all Covered Person's in a Family must pay before the Plan will consider expenses for reimbursement.

A copay is an amount that a Covered Person pays to his or her provider at the time of service.
# SCHEDULE OF MEDICAL BENEFITS

## MAXIMUM LIFETIME BENEFIT

(Per Covered Person)  
Unlimited  

Details regarding Medical Benefits are in the Medical Benefits section.

<table>
<thead>
<tr>
<th>BENEFIT DESCRIPTION</th>
<th>PLAN BENEFIT</th>
<th>BENEFIT COPAY AND MAXIMUM(S)</th>
<th>ADDITIONAL LIMITATIONS AND EXPLANATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventive Care</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Routine Well Adult Care</td>
<td>100%</td>
<td>1 exam per calendar year maximum</td>
<td>Includes: office visits, pap smear, mammogram, gynecological exam, routine physical examination, immunizations/flu shots, Colonoscopy, Sigmoidoscopy, prostate specific antigen and laboratory blood tests. School/athletic physical examinations are covered as long as they are not billed by a school. Routine hearing tests and vision tests are covered when performed during the routine physical examination benefit.</td>
</tr>
</tbody>
</table>

**Frequency limitations:**

- **Colonoscopy:** 1 per calendar year at age 50 and over  
  1 per calendar year prior to age 50, if the Covered Person or a close relative (parent, sibling or grandparent) have had colorectal polyps or colorectal cancer

- **Sigmoidoscopy:** 1 per calendar year at age 50 and over  
  1 per calendar year prior to age 50, if the Covered Person or a close relative (parent, sibling or grandparent) have had colorectal polyps or colorectal cancer

- **Prostate Specific Antigen:** 1 per calendar year at age 50 and over  
  1 per calendar year prior to age 50, if the Covered Person or a close relative (parent, sibling or grandparent) have had colorectal polyps or colorectal cancer

- **Routine mammograms:** 1 baseline for women ages 35 to 39  
  1 per calendar year for women ages 40 and over

**Note:** For covered women under age 40 who have a family history of breast cancer or other risk factors, coverage will include a mammogram at the intervals considered **Medically Necessary** by the woman’s health care provider.
<table>
<thead>
<tr>
<th>BENEFIT DESCRIPTION</th>
<th>PLAN BENEFIT</th>
<th>BENEFIT COPAY AND MAXIMUM(S)</th>
<th>ADDITIONAL LIMITATIONS AND EXPLANATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine Well Child Care</td>
<td>100% 1 exam per calendar year maximum</td>
<td></td>
<td>Includes: office visits, routine physical examination, laboratory blood tests, x-rays and immunizations until age 26. School/athletic physical examinations are covered as long as they are not billed by a school. Routine hearing tests and vision tests are covered when performed during the routine physical examination benefit.</td>
</tr>
<tr>
<td>Note: Immunizations will be covered in accordance with the following schedules issued by the Health and Human Services Centers for Disease Control and Prevention.</td>
<td></td>
<td></td>
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<tr>
<td>Recommended Adult Immunization Schedule – United States</td>
<td></td>
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<tr>
<td>Recommended Child and Adolescent Immunization Schedules – United States</td>
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<tr>
<td><strong>X-Ray &amp; Laboratory Services</strong></td>
<td></td>
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</tr>
<tr>
<td>Pre-Admission and Pre-Surgical Testing, within seven (7) days of a scheduled Inpatient Hospital admission.</td>
<td>100%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnostic Charges (X-ray and Laboratory)</td>
<td>100%</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Hospital Services, Specialized Treatment Facilities and Services</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient Hospital Services, including Room and Board</td>
<td>85%  room and board limited to the semiprivate room rate</td>
<td>$350 deductible and 15% coinsurance, up to $800 maximum per Covered Person, per calendar year, $700 deductible and 15% coinsurance up to $1,600 maximum per Family per calendar year</td>
<td>The Plan’s payment will be reduced by 50% if the requirements of the Plan are not followed. Any charge not deemed Medically Necessary will be denied if the requirements of the Plan are not followed.</td>
</tr>
<tr>
<td>Intensive Care Unit</td>
<td>85% room and board limited to the ICU/CCU room rate</td>
<td>$350 deductible and 15% coinsurance, up to $800 maximum per Covered Person, per calendar year, $700 deductible and 15% coinsurance up to $1,600 maximum per Family per calendar year</td>
<td>The Plan’s payment will be reduced by 50% if the requirements of the Plan are not followed. Any charge not deemed Medically Necessary will be denied if the requirements of the Plan are not followed.</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>100%</td>
<td>$40 copay per visit at Urgent Care Facility at Medpoint, $25 copay at Medpoint Express</td>
<td>$40 copay for Urgent Care Centers outside of the Network for Medical Emergencies</td>
</tr>
<tr>
<td>BENEFIT DESCRIPTION</td>
<td>PLAN BENEFIT</td>
<td>BENEFIT COPAY AND MAXIMUM(S)</td>
<td>ADDITIONAL LIMITATIONS AND EXPLANATIONS</td>
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</tr>
<tr>
<td>Maternity (Pre-Natal and Post-Natal Office Visits)</td>
<td>100% Services outside the global maternity program fee will be paid at the applicable benefit level</td>
<td>$20 copay for initial visit only</td>
<td></td>
</tr>
<tr>
<td>Maternity (Inpatient Delivery Charges)</td>
<td>85%</td>
<td>$350 deductible and 15% coinsurance, up to $800 maximum per Covered Person, per calendar year, $700 deductible and 15% coinsurance up to $1,600 maximum per Family per calendar year</td>
<td></td>
</tr>
<tr>
<td>Baby Steps Maternity Management Program</td>
<td>N/A</td>
<td>The $350 Inpatient Hospital deductible will be waived for expectant mothers who enroll in the Baby Steps Maternity Management program. If the Inpatient deductible has already been met in the calendar year, the Plan will issue a credit up to $350 for inpatient hospital delivery coinsurance expenses. Covered Persons must enroll in the Baby Steps Maternity Management program within the first trimester of pregnancy.</td>
<td></td>
</tr>
<tr>
<td>Routine Well Newborn Care</td>
<td>85%</td>
<td>$350 deductible and 15% coinsurance, up to $800 maximum per Covered Person, per calendar year, $700 deductible and 15% coinsurance up to $1,600 maximum per Family per calendar year</td>
<td></td>
</tr>
<tr>
<td>Outpatient Hospital</td>
<td>100%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Birthing Center</td>
<td>85%</td>
<td>$350 deductible and 15% coinsurance, up to $800 maximum per Covered Person, per calendar year, $700 deductible and 15% coinsurance up to $1,600 maximum per Family per calendar year</td>
<td></td>
</tr>
<tr>
<td>Home Health Care</td>
<td>100%</td>
<td>$20 copay per visit 60 visit per calendar year maximum</td>
<td></td>
</tr>
<tr>
<td>Hospice Care</td>
<td>100%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>BENEFIT DESCRIPTION</td>
<td>PLAN BENEFIT</td>
<td>BENEFIT COPAY AND MAXIMUM(S)</td>
<td>ADDITIONAL LIMITATIONS AND EXPLANATIONS</td>
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<td>----------------------------------------</td>
</tr>
<tr>
<td>Skilled Nursing Facility, Extended Care Facility and Rehabilitation Facility</td>
<td>100%</td>
<td>60 day limit per calendar year</td>
<td></td>
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<tr>
<td>Ambulance Service</td>
<td>100%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency Room and Non-Emergency Room, including all related services performed during the same visit. Follow-up treatment will not be considered under the Emergency Room benefit.</td>
<td>100%</td>
<td>$120 copay per visit (waived if admitted)</td>
<td>Visits to a Non-Participating Emergency room facility for emergency care shall be covered, including all related services performed during the same visit. Use of the Emergency room for a condition not considered a Medical Emergency will not be covered. Meritain Health must be notified at 888-668-6855 within 48 hours of the admission, even if the Covered Person is discharged within 48 hours of the admission.</td>
</tr>
<tr>
<td>Medical and Surgical Physician Services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spinal Manipulation/Chiropractic</td>
<td>100%</td>
<td>$20 copay per visit 20 visits per calendar year maximum</td>
<td></td>
</tr>
<tr>
<td>Inpatient Surgery (Includes anesthesiologists)</td>
<td>85%</td>
<td>$350 deductible and 15% coinsurance, up to $800 maximum per single per calendar year, $700 deductible and 15% coinsurance up to $1,600 maximum per family per calendar year</td>
<td></td>
</tr>
<tr>
<td>Outpatient Surgery (Includes anesthesiologists)</td>
<td>100%</td>
<td>$100 copay per procedure</td>
<td></td>
</tr>
<tr>
<td>Surgery performed in a Physician's office</td>
<td>100%</td>
<td></td>
<td>Pre-certification is not required.</td>
</tr>
<tr>
<td>Inpatient Physician visits</td>
<td>100%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Occupational Therapy</td>
<td>100%</td>
<td>$20 copay per visit 50 visits per calendar Year</td>
<td></td>
</tr>
<tr>
<td>Physical Therapy</td>
<td>100%</td>
<td>$20 copay per visit 50 visits per calendar year</td>
<td></td>
</tr>
<tr>
<td>Speech Therapy</td>
<td>100%</td>
<td>$20 copay per visit 50 visits per calendar Year</td>
<td></td>
</tr>
<tr>
<td>BENEFIT DESCRIPTION</td>
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</tr>
<tr>
<td>Primary Care Office Visit</td>
<td>100%</td>
<td>$20 copay per visit</td>
<td>Includes diagnostic services performed in the Physician's Office.</td>
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<tr>
<td>Pediatrician</td>
<td></td>
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<tr>
<td>Internist</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family Practitioner</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>General Practitioner</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OB/GYN</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specialist Office visits</td>
<td>100%</td>
<td>$30 copay per visit</td>
<td>Includes diagnostic services performed in the Physician's Office.</td>
</tr>
<tr>
<td>Includes any provider specialty other than those listed as Primary Care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hearing Aids</td>
<td>100%</td>
<td>Maximum benefit $1,500 every 36 months</td>
<td></td>
</tr>
<tr>
<td>Diabetic Management and Education</td>
<td>Covered the same as any other Illness</td>
<td>Limited to three (3) visits after diagnosis per calendar year.</td>
<td></td>
</tr>
<tr>
<td>Developmental Delays</td>
<td>Covered the same as any other Illness</td>
<td>Covered only when deemed to be Medically Necessary.</td>
<td></td>
</tr>
<tr>
<td>All Other Covered Medical and Surgical Expenses</td>
<td>100%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Durable Medical Equipment, Supplies, Prosthetics and Orthotics**

| Durable Medical Equipment                       | 100%        |                              |                                        |
| Medical Supplies                                 | 100%        |                              |                                        |
| Prosthetics                                      | 100%        |                              |                                        |
| Orthotics                                       | 100%        |                              |                                        |
| Wig After Chemotherapy                           | 100%        |                              |                                        |

**Mental Disorders and Substance Use Disorders**

<p>| Inpatient                                       | 85%         | $350 deductible and 15% coinsurance, up to $800 maximum per Covered Person, per calendar year, $700 deductible and 15% coinsurance up to $1,600 maximum per Family per calendar year |                                        |
| Outpatient                                       |             |                              |                                        |
| Office visits                                    | 100%        | $20 copay per visit          |                                        |
| All other related services                       | 100%        |                              |                                        |</p>
<table>
<thead>
<tr>
<th>BENEFIT DESCRIPTION</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Emergency Care (ambulance and emergency room)</td>
<td>100%</td>
<td>$120 copay per visit</td>
<td>Visits to a Non-Participating Emergency room facility for emergency care shall be covered, including all related services performed during the same visit. Use of the Emergency room for a condition not considered a Medical Emergency will not be covered. Meritain Health must be notified at 888-668-6855 within 48 hours of the admission, even if the Covered Person is discharged within 48 hours of the admission.</td>
</tr>
</tbody>
</table>
DEFINED TERMS

The following terms, when capitalized in the Plan, have the special meanings indicated.

**Active Employee** is an Employee who has an appointment with the University of Notre Dame.

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

**Assistant Surgeon** is a Physician who actively assists the Physician in charge of a case in performing a surgical procedure. Depending on the type of surgery to be performed, an operating surgeon may have one or two Assistant Surgeons. The need for an Assistant Surgeon is dictated by the technical aspects of the surgery involved.

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

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

**Brand Name** means a trade name medication.

**Complications of Pregnancy** means condition(s) (when the Pregnancy is not terminated) whose diagnosis is distinct from Pregnancy but which is adversely affected by Pregnancy or caused by Pregnancy; such as, acute nephritis, nephrosis, cardiac decompensation, missed abortion and similar medical and surgical conditions of comparable severity. Complications of Pregnancy also include an ectopic Pregnancy which is terminated, or spontaneous termination of Pregnancy which occurs during a period of gestation when a viable birth is not possible; and, pernicious vomiting (hyperemesis gravidarum) and toxemia with convulsions (eclampsia of Pregnancy).

Complications of Pregnancy do not include false labor, occasional spotting, Physician prescribed rest during the period of Pregnancy, morning sickness and similar conditions, which, although associated with the management of a difficult Pregnancy, are not medically classified as distinct Complications Of Pregnancy.

**Cosmetic** means care and treatment performed primarily to improve one's appearance, and does not promote the proper function of the body or prevent or treat an Illness, Injury or disease.

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

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

Creditable Coverage does not include coverage consisting solely of dental or vision benefits; long-term care benefits if provided under a separate policy; coverage that is limited to a specified disease or Illness; Hospital indemnity or other fixed dollar indemnity insurance if provided under a separate policy, certificate or contract of insurance; coverage only for accidents; disability income insurance; liability insurance; workers' compensation or similar insurance; automobile medical payment insurance; credit-only insurance; or, coverage for on-site medical clinics. Days in a waiting period from a prior plan during which an Employee has no other coverage are not considered Creditable Coverage under the Plan, nor are these days taken into account when determining a Significant Break In Coverage.
Custodial Care is care (including room and board needed to provide that care) that is given principally for personal hygiene or for assistance in daily activities and can, according to generally accepted medical standards, be performed by persons who have no medical training. Examples of Custodial Care are help in walking and getting out of bed; assistance in bathing, dressing, feeding; or supervision over medication which could normally be self-administered.

Diagnostic Charges means charges for x-ray or laboratory examinations made or ordered by a Physician in order to detect a medical condition.

Disability means the inability to perform all the duties of the Covered Person's occupation as the result of a non-occupational Illness or Injury. For an unemployed Covered Person, Disability means the inability to perform the normal duties of a person of the same age.

Disability (Disabled) for an Active Employee means the complete inability to perform any and every duty of his or her occupation or of a similar occupation for which the person is reasonably capable due to education and training, as a result of Illness or Injury. Disability will be determined by the attending Physician.

Disability (Disabled) for a Dependent child means incapable of self-sustaining employment by reason of mental or physical handicap, primarily dependent upon the covered Employee for support and the complete inability as a result of Illness or Injury to perform the normal activities of a person of like age and sex in good health.

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

Employer is the Plan Sponsor and any other entity, with the consent of the Plan Sponsor that adopts the Plan.

Enrollment Date is the first day of coverage or, if there is a waiting period, the first day after the waiting period.

Experimental and/or Investigational means services, supplies, care and treatment which do not constitute accepted and appropriate medical practice considering the facts and circumstances of the case and by the generally accepted standards of a reasonably substantial, qualified, responsible, relevant segment of the appropriate medical community or government oversight agencies at the time services were rendered, as determined by the Plan Administrator in accordance with the principles set forth below.

The Plan Administrator must make an independent evaluation of the experimental/nonexperimental standings of specific technologies. The Plan Administrator shall be guided by a reasonable interpretation of Plan provisions. The decisions shall be made in good faith and rendered following a detailed factual background investigation of the claim and the proposed treatment. The decision of the Plan Administrator will be final and binding on the Plan. In addition to the above, the Plan Administrator will be guided by the following principles to determine whether a proposed treatment is deemed to be Experimental and/or Investigational:

1. if the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA) and approval for marketing has not been given at the time the drug or device is furnished, then it is deemed to be Experimental and/or Investigational; or

2. if the drug, device, medical treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval, then it is deemed to be Experimental and/or Investigational; or

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

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

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

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

Expenses related to Off-Label Drug Use (the use of a drug or a purpose other than that for which it was approved by the FDA) will be eligible for coverage when all of the following criteria have been satisfied:

(1) the named drug is not specifically excluded under the General Limitations of the Plan; and

(2) the named drug has been approved by the FDA; and

(3) the Off-Label Drug Use is appropriate and generally accepted by the medical community for the condition being treated; and

(4) if the drug is used for the treatment of cancer, the American Medical Association Drug Evaluations, The American Hospital Formulary Service Drug Information or the Compendia-Based Drug Bulletin recognize it as an appropriate treatment for that form of cancer.

Expenses for drugs, devices, services, medical treatments or procedures related to an Experimental and/or Investigational treatment (“Related Services”) and complications from an Experimental and/or Investigational treatment and their Related Services are excluded from coverage, even if such complications and Related Services would be covered in the absence of the Experimental and/or Investigational treatment.

Final determination of Experimental and/or Investigational, Medical Necessity and/or whether a proposed drug, device, medical treatment or procedure is covered under the Plan will be made by and in the sole discretion of the Plan Administrator.

Family is an Employee who is a Covered Person and his or her Dependents who are Covered Persons.

Home Health Care Agency is an organization that provides Home Health Care Services and Supplies; is federally certified as a Home Health Care Agency; and is licensed by the state in which it is located, if licensing is required.

Home Health Care Plan is a formal written plan made by the patient's attending Physician. It must state the diagnosis and must specify the type and extent of Home Health Care required for the treatment of the patient.

Home Health Care Services and Supplies include: part-time or intermittent nursing care by or under the supervision of a registered nurse (R.N.); part-time or intermittent home health aide services provided through a Home Health Care Agency (this does not include general housekeeping services); physical, occupational and speech therapy; medical supplies; and laboratory services by or on behalf of the Hospital.
Hospice Agency is a public or private organization, licensed and operated according to the law, primarily engaged in providing Hospice Care Services and Supplies for palliative, supportive, and other related care for a Covered Person diagnosed as terminally ill with a medical prognosis that life expectancy is 6 months or less.

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

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

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

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

"Hospital" also includes:

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

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

Illness means a non-occupational bodily disorder, disease, physical sickness, Substance Use Disorder or Mental Disorder. Illness includes Pregnancy, childbirth, miscarriage, as defined by the Employer.

Infertility means incapable of producing offspring.

Injury means a non-occupational accidental physical injury caused by an unexpected external means.

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

Lifetime is used in the Plan in reference to benefit maximums and limitations and is understood to mean while covered under the Plan.

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

(1) a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in (1) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (2) serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ or part; or

(2) an Illness or Injury which occurs suddenly and unexpectedly and is deemed to be life-threatening, requiring immediate medical care and use of the most accessible Hospital equipped to furnish care to prevent the death or serious impairment of the Covered Person.

Such conditions include but are not limited to suspected heart attack, loss of consciousness, actual or suspected poisoning, acute appendicitis, heat exhaustion, convulsions, emergency medical care rendered in accident cases and other acute conditions.

Medically Necessary means the treatment is generally accepted by medical professionals in the United States as proven, effective and appropriate for the condition based on recognized standards of the health care specialty involved.

"Proven" means the care is not considered Experimental/Investigational, meets a particular standard of care accepted by the medical community and is approved by the Food and Drug Administration (FDA), for general use.

"Effective" means the treatments beneficial effects can be expected to outweigh any harmful effects. Effective care is treatment proven to have a positive effect on your health, while addressing particular problems caused by disease, injury, illness or a clinical condition.

"Appropriate" means the treatment's timing and setting are proper and cost effective.

Medical treatments which are not proven, effective and appropriate are not covered by the University of Notre Dame Meritain CHA HMO.

All criteria must be satisfied. When a Physician recommends or approves certain care, it does not mean that care is Medically Necessary.

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

Morbid obesity is defined as (1) a body mass index (BMI) of 40 or greater or (2) a BMI of 35 or greater in conjunction with a severe co-morbidity, such as obesity hypoventilation, sleep apnea, diabetes, hypertension, cardiomyopathy, or musculoskeletal dysfunction.

Non-Participating (Out-of-Network) Provider means a Hospital, Physician or other health care provider that has not entered into a contractual agreement with the Plan's Provider Network.

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

Participating (In-Network) Provider means a Hospital, Physician or other health care provider that has a contractual agreement with the Plan's Provider Network.
**Pharmacy** means a licensed establishment where covered Prescription Drugs are filled and dispensed by a pharmacist licensed under the laws of the state where he or she practices.

**Physician (Health care Provider)** means a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Dental Surgery (D.D.S.), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), Audiologist, Certified Nurse Anesthetist, Licensed Professional Counselor, Licensed Professional Physical Therapist, Licensed Mental Health Counselors (MHC), Licensed Marriage and Family Therapists (MFT), Master of Social Work (M.S.W.), Midwife, Occupational Therapist, Optometrist (O.D.), Physiotherapist, Psychiatrist, Psychologist (Ph.D.), Speech Language Pathologist, Nutritionist/Dietician and any other practitioner of the healing arts who is licensed and regulated by a state or federal agency and is acting within the scope of his or her license.

**Plan Administrator** is the Plan Sponsor.

**Plan Participant** is any Employee or Dependent who is covered under the Plan.

**Plan Sponsor** is University of Notre Dame du Lac, as further identified under General Plan Information.

**Plan Year** is defined on the General Plan Information page.

**Pregnancy** is childbirth and conditions associated with Pregnancy, including Complications of Pregnancy.

**Prescription Drug** means any of the following: a Food and Drug Administration-approved drug or medicine which, under federal law, is required to bear the legend: "Caution: federal law prohibits dispensing without prescription"; injectable insulin; hypodermic needles or syringes.

**Qualified Clinical Trial.** A Qualified Clinical Trial is defined as a clinical trial that meets all the following conditions:

1. The clinical trial is intended to treat cancer in a Covered Person who has been so diagnosed; and
2. The clinical trial has been peer reviewed and is approved by at least one of the following:
   1. One of the United States National Institutes of Health;
   2. A cooperative group or center of the National Institutes of Health;
   3. A qualified non-governmental research entity identified in guidelines issued by the National Institutes of Health for center support grants;
   4. The United States Food and Drug Administration pursuant to an investigational new drug exemption;
   5. The United States Departments of Defense or Veterans Affairs;
   6. Or, with respect to Phase II, III and IV clinical trials only, a “qualified institutional review board”. A “qualified institutional review board” shall mean a committee of physicians, statisticians, researchers, community advocates and others that ensures a clinical trial is ethical and that the rights of the trial participants are protected; and
3. The facility and personnel conducting the clinical trial are capable of doing so by virtue of their experience and training and treat a sufficient volume of patients to maintain that expertise as determined by the Plan Administrator; and
4. The Covered Person meets the patient selection criteria enunciated in the study protocol for participation in the clinical trial; and
(5) The Covered Person has provided informed consent for participation in the clinical trial in a manner that is consistent with current, generally accepted, legal and ethical standards; and

(6) The available clinical or pre-clinical data provides a reasonable expectation that the Covered Person's participation in the clinical trial will provide a medical benefit that is commensurate with the risks of participation in the clinical trial; and

(7) The clinical trial does not unjustifiably duplicate existing studies; and

(8) The clinical trial must have a therapeutic intent and must, to some extent, assess the effect of the intervention on the Covered Person.

Qualified Medical Child Support Order (QMCSO) is a judgment or decree by a court of competent jurisdiction or order issued through an administrative process established under state law that requires the Plan to provide coverage to the children of an Employee pursuant to a state domestic relations law.

A medical child support order must meet certain requirements specified in the law in order to be considered "qualified."

Routine Well Adult Care. Routine well adult care is care by a Physician that is not for an Illness or Injury.

Routine Well Child Care. Routine well child care is routine care by a Physician that is not for an Illness or Injury.

Significant Break in Coverage is a period of 63 consecutive days during all of which the individual does not have any Creditable Coverage, except that a waiting period is not taken into account in determining a Significant Break in Coverage.

Skilled Nursing Facility, including an extended care facility and a rehabilitation facility, is a facility that fully meet all of the following:

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

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

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

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

(5) It has an effective utilization review plan.

(6) It is not, other than incidentally, a place for rest, the aged, Custodial or educational care.

(7) It is approved and licensed by Medicare.

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

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

**Spouse** is defined in the "Eligibility" section of this document.

**Substance Use Disorder** means any disease or condition that is classified as a Substance Use Disorder in the current edition of the International Classification of Diseases, published by the World Health Organization.

**Temporomandibular Joint (TMJ) syndrome** is the treatment of jaw joint disorders including conditions of structures linking the jawbone and skull and the complex of muscles, nerves and other tissues related to the temporomandibular joint. Care and treatment shall include, but are not limited to orthodontics, crowns, inlays, physical therapy and any appliance that is attached to or rests on the teeth.

**Urgent Care Facility** is a public or private facility, licensed and operated according to the law, which provides immediate care in the case of a Medical Emergency or accidental Injury. Treatment must be administered under the supervision of a recognized Physician or nurse as defined in the Plan and the facility must maintain relationship with an available pool of specialists for consultation and treatment when necessary. The facility cannot provide any inpatient treatment and cannot be accessed for routine care, non-emergencies or as a private practice.

**Usual and Customary Charge** is a charge which is not more than the usual charge made by the provider of the care or supply and does not exceed the usual charge made by most providers of that care or supply in the same area, as determined by the Plan Administrator. The nature and severity of the condition being treated will be considered. It will also consider medical complications or unusual circumstances that require more time, skill or experience.

If the actual charge billed is less than the Usual and Customary Charge as defined above, the lesser charge billed will be deemed to be the Usual and Customary Charge.
ELIGIBILITY AND COMMENCEMENT OF COVERAGE PROVISIONS

ELIGIBILITY

Eligible Classes of Employees. An Employee of the Employer who is:

(1) a full-time or part-time Employee regularly scheduled to work at least 20 hours per week for the Employer (as determined by the Employer) and is on the regular payroll of the Employer.

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

(1) is a regular full time faculty or staff, research associate, visiting faculty, intern or part time faculty and staff who work at least twenty hours per week.

(2) is a visiting scholar on a (J1) visa.

(3) completes the waiting period as an Active Employee. If the date of hire is the first day of the month then there is no waiting period, but if the date of hire is after the first of the month then the waiting period is until the first day of the following month. Please see section titled Effective Date of Coverage to determine when coverage begins after the waiting period. For the purpose of this provision, an Employee shall not be treated as absent from work if the absence is because of a health condition.

Individuals with a J1 visa will not have a waiting period even if they initiate employment during a month.

Should an Employee of the Employer change to full-time status, any waiting period required to be eligible for coverage under the University of Notre Dame Meritain CHA HMO will be calculated from the Employee’s date of hire. If the Employee has been employed with the Employer longer than the required waiting period, coverage would begin on the first day of the month following the date the Employee changed to full-time status.

Notwithstanding the foregoing, the term Employee shall not include:

(1) any leased employee of the Employer, or

(2) any person who is not classified by the Employer as a common law employee of the Employer, regardless of whether or not such person is later reclassified by a court or any regulatory agency as a common law employee of the Employer, or

(3) any person classified by the Employer as a temporary employee of the Employer (as determined by the Employer).
Effective Date of Employee Coverage

When the enrollment requirements are met, an eligible Employee's coverage is effective for:

1. Faculty - coverage will be effective July 1st (including teaching and research, special professional faculty and research) with an August 22nd contract and a July 1st pay and benefit schedule.

2. Visiting Faculty - coverage will be effective August 1st with an August 22nd contract and an August 1st pay and benefit schedule.

3. Employees - the first day of the calendar month following the waiting period.

In the case of a Special Enrollment Situation or Status Change, coverage will be effective on the date of the event, provided the enrollment application is received within the time period established in the Special Enrollment Situation/Status Change section.

An Employee must be an Active Employee (as defined by the Plan) for coverage to begin.

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

1. A covered Employee's Spouse, unless legally separated.

2. A covered Employee's Dependent Child or Qualifying Child until the end of the month in which the child attains age 26; provided such child does not have coverage available through another employer-sponsored group health plan, other than one available through his or her parent's employer.

3. A covered Employee's Dependent Child or Qualifying Child age 26 or older, who is unable to be self supporting by reason of mental or physical handicap and is incapacitated, provided the child suffered such incapacity prior to the end of the month in which the child attained age 26. The child must be unmarried, primarily dependent upon the covered Employee for support, and not eligible for any other type of health coverage (other than Medicaid or Medicare). The Plan Sponsor may require subsequent proof of the child's disability and dependency, including a Physician's statement certifying the child's physical or mental incapacity.

4. A child for whom the covered Employee is required to provide health coverage due to a Qualified Medical Child Support Order (QMCOSO). Procedures for determining a QMCOSO may be obtained from the Plan Sponsor at no cost.

The term "Spouse" shall mean the person of the opposite sex recognized as the covered Employee's husband or wife under the laws of Indiana. The Plan Sponsor may require documentation proving a legal marital relationship.

The term “Dependent Child” shall mean a covered Employee's natural born son, daughter, stepson, stepdaughter, legally adopted child (or a child placed with the covered Employee in anticipation of adoption), or a child for whom the covered Employee is legal guardian (a child for whom the covered Employee is legal guardian will remain in effect until such child no longer meets the age requirements of an eligible Dependent under the terms of the Plan, regardless of whether or not such child has attained age 18 (or any other applicable age of emancipation of minors).

For purposes of this section, the term “legal guardian” means a person recognized by a court of law as having the duty of taking care of the person and managing the property and rights of an individual that is placed with such person by judgment, decree, or other order of any court of competent jurisdiction.

The Plan Sponsor may require documentation proving dependency, including birth certificates, tax records or initiation of legal proceedings severing parental rights.
The following are excluded as Dependents: any Spouse or Qualifying Child who is on active duty in any military service of any country; or any person who is covered under the Plan as an Employee.

If a person covered under the Plan changes status from Employee to Dependent or Dependent to Employee, and the person is covered continuously under the Plan, during and after the change in status, credit will be given toward deductibles and all amounts applied to Plan maximums.

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

Effective Date of Dependent Coverage. Dependent coverage is effective on the day that the Eligibility Requirements are met; the Employee is covered under the Plan; and all enrollment requirements are met. In the case of a Special Enrollment Situation or Status Change, coverage will be effective on the date of the event, provided the enrollment application is received within the time period established in the Special Enrollment Situation/Status Change section.

ENROLLMENT

Enrollment Requirements. An Employee must enroll for coverage by filling out and signing an enrollment application along with the appropriate payroll deduction authorization. As part of the enrollment requirements an Employee will be required to provide his or her social security number, as well as the social security numbers of his or her Spouse and any Dependent children. The Plan Administrator may request this information at any time for continued eligibility under the Plan. Failure to provide the required social security numbers will result in loss of eligibility or loss of continued eligibility under the Plan.

Enrollment Requirements for Newborn Children

A newborn child of a covered Employee who has Dependent coverage is automatically enrolled in this Plan for 31 days. Charges for covered routine nursery care will be applied toward the Plan of the covered parent. If the newborn child is not enrolled in this Plan on a timely basis, as defined in the section "Timely Enrollment" following this section, there will be no payment from the Plan and the parents will be responsible for all costs.

Charges for covered routine Physician care will be applied toward the Plan of the newborn child.

TIMELY INITIAL ENROLLMENT

Initial enrollment is considered "timely" if the completed enrollment form is received by the Plan Administrator no later than 60 days after the person becomes eligible for coverage under the Plan, initially or under a Special Enrollment Situation.

When two Employees (husband and wife) are covered under the Plan and the Employee covering the Dependent children is no longer eligible for coverage under the Plan, Dependent coverage may continue under the other Covered Employee with no waiting period. However, coverage must be continuous from one Employee to the other.

SPECIAL ENROLLMENT SITUATION/STATUS CHANGE

The Plan provides an Employee and his or her eligible Dependents the opportunity to enroll in the Plan during a special enrollment period, provided certain special enrollment/status change events occur. The special enrollment/status change events that occur resulting in a special enrollment period under the Plan are more fully described below. With respect to the special enrollment events below, any Employee who has a special enrollment right may elect coverage (for such Employee and his or her Dependents) under any Plan option that is available to an Employee during an initial or annual enrollment opportunity, as long as the Employee (or Dependent) is otherwise eligible for that Plan option.
Special Enrollment Events

(1) Special Enrollment Rights because of loss of other coverage. An Employee or Dependent is eligible for coverage under the Plan, but chose not to enroll in the Plan, because he or she was covered at the time coverage under the Plan was previously offered may enroll later if one of the following conditions is met:

(a) The other coverage was not COBRA coverage and that coverage terminates because of a Loss of Eligibility, (as described below);

(b) The other coverage was not COBRA coverage and an employer’s contributions towards the coverage cease; or

(c) The coverage of the Employee or Dependent was under COBRA and the COBRA coverage is exhausted.

It is important to note that when an Employee or Dependent loses coverage due to one of the above events, both the Employee and Dependent may special enroll.

A “Loss of Eligibility” includes a loss of eligibility because of legal separation, divorce, cessation of dependent status, death of an employee, termination of employment or a reduction in the number of hours of employment. A Loss of Eligibility also occurs if the other coverage is provided through an HMO or another arrangement that does not provide benefits to individuals who no longer reside or work in a service area, if the Employee or Dependent no longer lives or works in the applicable services area (unless the HMO or other arrangement is part of a group plan that makes another benefit option available to the affected Employee or Dependent). In addition, a “Loss of Eligibility” occurs if an individual incurs a claim that would meet or exceed a lifetime limit on all benefits “Exhaustion of COBRA coverage” occurs when COBRA coverage ceases for any reason other than a failure of the Employee or Dependent to pay premiums on a timely basis or for cause. Exhaustion of COBRA coverage occurs when COBRA coverage ceases because an employer or other responsible party fails to remit premiums on a timely basis. For COBRA coverage provided through an HMO or another arrangement that does not provide benefits to individuals who no longer reside or work in a service area, exhaustion of COBRA coverage also occurs if coverage ceases because the Employee or Dependent no longer lives or works in the applicable service area (unless other COBRA coverage is available). In addition, exhaustion of COBRA coverage occurs if an individual incurs a claim that would meet or exceed a lifetime limit on all benefits and no other COBRA coverage is available to the individual.

The Plan Administrator may require the Employee to state in writing at the time coverage is offered that other health coverage was the reason for declining enrollment in the Plan (for the Employee or a Dependent). If the Plan Administrator imposes such a requirement and informs the Employee of the requirement, the Employee or Dependent will not be eligible for special enrollment based on the loss of coverage unless the Employee provided the required statement at the time coverage was declined.

The Employee or Dependent must request enrollment in the Plan during the special enrollment period, which ends 31 days after (1) the other coverage terminates, (2) employer contribution’s cease, or (3) COBRA coverage is exhausted, whichever applies. However, if the loss of coverage results from an individual reaching a lifetime limit on all benefits, the Special Enrollment Period ends 31 days after a claim is denied for exceeding the lifetime limit. Coverage will be effective no later than the first day of the first month that begins after the Plan Administrator receives a completed request for enrollment.
An individual does not have a special enrollment right if the Employee or Dependent loses other coverage because of a failure to pay premiums or required contributions or if the other coverage is terminated for cause (such as for making a fraudulent claim).

(2) Special Enrollment Rights because of marriage, birth or adoption.

(a) An otherwise eligible Employee (i.e., an Employee who is not a current participant but who has completed any waiting period and any other eligibility requirements under the Plan) may enroll himself or herself in the Plan during the special enrollment period described below if an individual becomes a Dependent of the Employee through marriage, birth, adoption or placement for adoption.

(b) An active Participant may enroll an individual who becomes or is his or her spouse (determined under federal law) during the special enrollment period described below if either (1) the individual becomes the Participant’s spouse or (2) the individual is the Participant’s spouse and a child becomes a Dependent of the Participant through birth, adoption or placement for adoption.

(c) An otherwise eligible Employee may elect to enroll in the Plan the Employee and an individual who becomes or is his or her spouse (determined under federal law) during the special enrollment period described below if (1) the Employee and the individual become married or (2) the Employee and the individual already are married and a child becomes a Dependent of the Employee through birth, adoption or placement for adoption.

(d) An active Participant may enroll an individual in the Plan during the special enrollment period described below if the individual becomes a Dependent of the Participant through marriage, birth, adoption or placement for adoption.

(e) An otherwise eligible Employee may elect to enroll the Employee and an individual who becomes a Dependent of the Employee (including the Employee’s spouse) in the Plan, if the individual becomes a Dependent of the Employee through marriage, birth, adoption or placement for adoption.

For purposes of paragraphs (a) through (e) above, “marriage” is limited to marriages that are recognized for purposes of Indiana state law.

The special enrollment period is a period of 31 days that begins on the date of the marriage, birth, adoption or placement for adoption.

Coverage for an Employee or Dependent who enrolls in the Plan because of a marriage, birth or adoption special enrollment right will be effective:

(f) in the case of marriage, no later than the first day of the first month beginning after the date the Plan Administrator receives a completed request for enrollment electing coverage for the Employee or Dependent, if the completed request for enrollment is submitted within 31 days after the marriage;

(g) in the case of a Dependent’s birth, on the date of birth if the completed request for enrollment is submitted within 31 days of the birth; or

(h) in the case of a Dependent’s adoption or placement for adoption, on the date of the adoption or placement for adoption if the completed request for enrollment is submitted within 31 days of the date of the adoption or placement for adoption.

(3) Special Enrollment due to coverage under Medicaid or under a State Children’s Health Insurance Program (CHIP). If an Employee or eligible Dependent did not enroll in the Plan when initially eligible, but was otherwise eligible to enroll, he or she will be permitted to later enroll in the
Plan under one of the following circumstances:

(a) The Employee or eligible Dependent was covered under Medicaid or CHIP at the time of initial enrollment and such coverage subsequently terminates; or

(b) The Employee or eligible Dependent becomes eligible for a premium assistance subsidy under Medicaid or CHIP subsequent to the time they were initially eligible.

The Employee or eligible Dependent must request enrollment in the Plan within 60 days after coverage under Medicaid or CHIP terminates or within 60 days after his or her eligibility for a premium assistance subsidy under Medicaid or CHIP is determined, whichever is applicable.

(4) Special Enrollment for Children Up To Age 26

A Dependent Child described in this paragraph (and the Employee, if the Employee is not enrolled) is eligible to enroll in the Plan during a one-time Special Enrollment Period. This Special Enrollment Period is available for any Dependent Child under age 26 whose coverage ended or who was denied coverage or who was not eligible for coverage under the Plan before January 1, 2011. The Special Enrollment Period will begin no later than the date described in the previous sentence and no earlier than the date written notice of this Special Enrollment Period is provided to such dependent or the Employee and will last for a period of thirty days. Enrollment that is properly requested during that Special Enrollment Period will become effective on January 1, 2011.

(5) Special Enrollment for Individuals Who Previously Reached a Lifetime Maximum

An individual described in this Paragraph (and the Employee, if the Employee is not enrolled) is eligible to enroll in the Plan during a one-time Special Enrollment Period. This Special Enrollment Period is available for any person who is as an eligible Employee or Dependent during the Special Enrollment Period whose coverage under the Plan previously ended because he or she reached a lifetime limit on benefits that applied under the Plan. The Special Enrollment Period for purposes of this paragraph begins no later than January 1, 2011 and no earlier than the date written notice of this Special Enrollment Period is provided to the Dependent or the Employee and will last for a period of thirty days. Enrollment that is properly requested during that Special Enrollment Period will become effective on January 1, 2011.

Status Change Events

An employee or dependent may also enroll in the Plan based on a status change election that is permitted under Section 125 of the Internal Revenue Code and the terms of an applicable Section 125 Plan or the Plan Sponsor. Such coverage will become effective as provided under the terms of the applicable Section 125 Plan.
TERMINATION OF COVERAGE AND EXTENSION OF COVERAGE PROVISIONS

When Employee Coverage Terminates. Employee coverage terminates on the earliest of the following dates:

1. The date all benefits, or the applicable benefit(s), are terminated by amendment of the Plan, by whole or partial termination of the Plan or by discontinuation of contributions by the Employer.

2. The last day of the calendar month in which the covered Employee ceases to be in one of the Eligible Classes. This includes death or termination of Active Employment of the covered Employee.

3. The date the Employee reports to active military service.

4. The beginning of the period for which a required contribution has not been paid.

5. The date the Employee (or any person seeking coverage on behalf of the Employee) performs an act, practice, or omission that constitutes fraud.

6. The date the Employee (or any person seeking coverage on behalf of the Employee) makes an intentional misrepresentation of a material fact.

Continuation of coverage will be coverage which was in force on the last day the covered Employee worked as an Active Employee. However, if benefits reduce for Active Employees in the same Eligible Class, benefits will also reduce for the continued person.

Employees on Leave. Employees on approved, extended leave, personal leave or special agreement (if the agreement includes extended health insurance coverage) will continue to be eligible to participate in the Plan.

Continuation During Family and Medical Leave (FMLA)

The Plan shall at all times comply with the Family and Medical Leave Act of 1993 (FMLA) as promulgated in regulations issued by the Department of Labor. During any leave taken under FMLA, the Employer may maintain coverage under the Plan on the same conditions as coverage would have been provided if the covered Employee had been continuously employed during the leave period.

If a covered Employee qualifies for an approved Family or Medical leave (as defined in the Family and Medical Leave Act of 1993), eligibility may continue for the duration of the leave if the covered Employee pays any required contributions toward the cost of coverage. Failure to make payment within 31 days of the due date established by the Employer will result in the termination of coverage. If the covered Employee fails to return to work after the approved Family or Medical leave, the Employer has the right to recover from the Employee any contributions toward the cost of coverage it made on the Employee's behalf during the approved Family or Medical leave.

Rehiring a Terminated Employee. Except as otherwise specifically specified in the Plan, a terminated Employee who is rehired will be treated as a new hire and will be required to satisfy all Eligibility, enrollment requirements and Pre-Existing Condition exclusions of the Plan.

The re-hire provision of the Plan applies only to Employees that terminate employment and are later re-hired by the Employer. This provision does not apply when benefits under the Plan terminate due to reasons not related to termination of employment.
Employees on Military Leave. Employees going into or returning from military service may elect to continue Plan coverage as mandated by the Uniformed Services Employment and Reemployment Rights Act. These rights apply only to Employees and their Dependents that were covered under the Plan at the time of leaving for military service.

1. The maximum period of coverage of an Employee and the Employee's Dependents under such an election shall be the lesser of:
   a. The 24 month period beginning the date on which the Employee's absence begins; or
   b. The period beginning on the day the Employee's military service absence begins and ending on the day after the date on which the Employee returns to employment with the employer or fails to apply for or return to a position of employment with the Employer within the time limit that applies under USERRA.

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

3. Continuation coverage provided under USERRA counts as COBRA continuation coverage as long as the notice requirements of COBRA are satisfied in connection with the USERRA leave.

4. An Employee returning from USERRA-covered military leave who participated in the Plan immediately before going on USERRA leave has the right to resume coverage under the Plan upon return from USERRA leave, as long as the Employee resumes employment within the time limit that applies under USERRA. No waiting period or pre-existing condition exclusionary period will apply to an Employee returning from USERRA leave (within the applicable time period) unless the waiting period or exclusionary period would have applied to the Employee if the Employee had remained continuously employed during the period of military leave.

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

1. The date all benefits, or the applicable benefit(s), are terminated by amendment of the Plan, by whole or partial termination of the Plan or by discontinuation of contributions by the Employer.

2. The date that the Employee's coverage under the Plan terminates for any reason including death.

3. The date the Dependent (other than a Dependent Child) reports to active military service.

4. On the last day of the calendar month that a covered Spouse ceases to be a Dependent.

5. On the last day of the calendar month that a dependent child ceases to be a Dependent as defined by the Plan.

6. The first day of the period for which the required contribution has not been paid.

7. The date the dependent (or any person seeking coverage on behalf of the dependent) performs an act, practice, or omission that constitutes fraud.

8. The date the dependent (or any person seeking coverage on behalf of the dependent) makes an intentional misrepresentation of a material fact.

Retroactive Termination of Coverage
Except in cases where an Employee or other Covered Person fails to pay any required contribution to the cost of coverage, the Plan will not retroactively terminate coverage under the Plan for any Covered Person unless the Covered Person (or a person seeking coverage on behalf of that person) performs an act, practice, or omission that constitutes fraud with respect to the Plan, or unless the individual makes an intentional misrepresentation of material fact. In such cases, the Plan will provide at least thirty days advance written notice to each Participant or Dependent who would be affected before coverage will be retroactively terminated. As provided above, coverage may be retroactively terminated in cases where required employee contributions have not been paid by the applicable deadline. In those cases, no advance written notice is required.
MEDICAL MANAGEMENT

Medical Management Phone Number

Meritain Health
888-668-6855

The Covered Person or a family member must call this number to receive certification of certain health care services. This call must be made at least 24 hours in advance of services being rendered or within 48 hours after an admission due to a Medical Emergency.

MEDICAL MANAGEMENT

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

The program consists of:

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

- Inpatient Hospitalizations
- Developmental Delays

(b) Retrospective review of Medical Necessity of the listed services;

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

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

This program is not intended to diagnose or treat medical conditions, guarantee benefits, validate eligibility or to be a substitute for the medical judgment of the attending Physician or other health care provider.

The Covered Person will not be required to obtain precertification from the Plan for a maternity length of stay that is 48 hours or less for a vaginal delivery or 96 hours or less for a cesarean delivery.

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

PRECERTIFICATION

Before a Covered Person enters a Medical Care Facility, other than a Skilled Nursing Facility, on a non-emergency basis, Medical Management will, in conjunction with the attending Physician, be required to certify the care as Medically Necessary. A non-emergency stay in a Medical Care Facility, other than a Skilled Nursing Facility, is one that can be scheduled in advance.

Medical Management is set in motion by a telephone call from the Covered Person or a family member. Medical Management must be called, at least 24 hours before the listed medical services are scheduled to be rendered, with the following information:

- The name of the Covered Person and relationship to the covered Employee
- The name, Social Security number and address of the covered Employee
- The name of the Employer
- The name and telephone number of the attending Physician
- The name of the Medical Care Facility, other than a Skilled Nursing Facility, proposed date of admission, and proposed length of stay
- The diagnosis and/or type of surgery

If there is a Medical Emergency admission to the Medical Care Facility, other than a Skilled Nursing Facility, the Covered Person, a family member, Medical Care Facility, other than a Skilled Nursing Facility, or attending Physician must contact Medical Management within 48 hours of the first business day after the admission.

Medical Management will determine the number of days of Medical Care Facility, other than a Skilled Nursing Facility, confinement that is Medically Necessary. When the required review procedures outlined above are followed, benefits will be unaffected, and the Plan Participant and the Plan avoid expenses related to unnecessary health care.

FAILURE TO FOLLOW REQUIRED REVIEW PROCEDURES

If a Covered Person does not obtain precertification, as required for certain benefits under the Plan, eligible expenses will be reduced by 50%. However, any charges not deemed Medically Necessary will be denied.

The amount the Covered Person pays when Medical Management review procedures are not followed does not apply to the Plan's out-of-pocket maximum.

CONCURRENT REVIEW, DISCHARGE PLANNING

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

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

PREADMISSION TESTING SERVICE

The Medical Benefits percentage payable will be for diagnostic lab tests and x-ray exams when:

(1) performed on an outpatient basis within seven days of a Hospital confinement;
(2) related to the condition which causes the confinement; and
(3) tests performed in an outpatient setting instead of diagnostic tests performed while Hospital confined.

CASE MANAGEMENT

Case Management is a program whereby a case manager monitors patients and explores, discusses and recommends coordinated and/or alternate types of appropriate Medically Necessary care. The case manager consults with the patient, the family and the attending Physician in order to develop a plan of care for approval by the patient's attending Physician and the patient. The plan of care may include some or all of the following:

-- personal support to the patient;
-- contacting the family to offer assistance and support;
-- monitoring Hospital, Skilled Nursing Facility, extended care facility or rehabilitation facility;
-- determining alternative care options; and

-- assisting in obtaining any necessary equipment and services.

Once agreement has been reached, the Plan will reimburse for Medically Necessary expenses as stated in the treatment plan, even if these expenses normally would not be paid by the Plan.

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

Examples of Illnesses or Injuries that would be appropriate for Case Management include, but are not limited to:

- **Terminal Illnesses**
  - Cancer
  - AIDS
- **Chronic Illnesses**
  - Multiple Sclerosis
  - Renal Failure
  - Obstructive Pulmonary Disease
  - Cardiac Conditions
- **Accident Victims Requiring Long-Term Rehabilitative Therapy**
- **Newborns with High Risk Complications or Multiple Birth Defects**
- **Diagnosis Involving Long-Term IV Therapy**
- **Illnesses Not Responding to Medical Care**
- **Child and Adolescent Mental Disorders**

**BABY STEPS MATERNITY MANAGEMENT**

The Maternity Management Program, in addition to the prenatal care provided by a Physician, can assist expectant mothers in achieving a healthy pregnancy and a healthy newborn.

The Maternity Management Program is designed especially to provide expectant mothers with guidance and information during pregnancy. When an expectant mother enrolls in the Maternity Management Program they will receive a series of brochures, pamphlets, coupons and other materials.

It is highly recommended, but not a requirement of the Plan that an expectant mother calls the Meritain Health Care Manager during the first trimester of Pregnancy or upon confirmation of Pregnancy. At this time, an R.N. will ask questions about the expectant mother's general health and medical history. This information may be discussed with the patient's Physician to help determine the risk factor of the Pregnancy.

As part of the program, a nurse will be available as an advisor and maternal/newborn specialist. The nurse can:

- Discuss health history;
- Discuss diet and exercise routines;
- Identify potential pregnancy risk factors;
- Discuss ways to minimize these risks for mother and baby;
- Answer questions and provide written material on pregnancy and child care issues that are a concern;
- Provide community resources where to find additional information;
- Contact the expectant mother's physician to assist in the coordination of her care, and;
- Provide education and support related to labor and delivery.
MEDICAL BENEFITS

The following is a description of the medical benefits provided under the Plan. The Plan provides benefits only with respect to covered services and supplies which are Medically Necessary in the specific treatment of a covered Illness or Injury, unless specifically mentioned otherwise in Covered Medical Expenses.

BENEFIT PAYMENT

Each calendar year, except as otherwise provided in the Plan, benefits will be paid for covered charges of a Covered Person that are in excess of the deductible and any copays. Payment will be made at the percentages shown as the reimbursement percentage in the Schedule of Benefits.

MAXIMUM BENEFIT AMOUNT

The maximum benefit amount is shown in the Schedule of Medical Benefits. The maximum benefit amount is the total amount of benefits that will be paid under the Plan for all covered charges incurred by a Covered Person.

COVERED MEDICAL EXPENSES

Covered charges are the Usual and Customary Charges, where applicable, incurred for the following services and supplies:

A charge is considered incurred on the date that the service or supply is performed or furnished.

(1) **Hospital Care.** Covered medical services and covered supplies furnished by a Hospital or Ambulatory Surgical Center. Covered Hospital charges will be payable as shown in the Schedule of Medical Benefits. This benefit includes Hospital expenses for covered dental services if the attending Physician certifies that care in a Hospital is Medically Necessary to safeguard the health of the patient.

Room and board, including non-routine nursery care, not to exceed the cost of a semiprivate room or other accommodations if the attending Physician certifies Medical Necessity. If a private room is the only accommodation available, the Plan will cover an amount equal to the prevailing semiprivate room rate in that facility.

Charges for an Intensive Care Unit (ICU) and Coronary Care Unit (CCU) stay are payable as described in the Schedule of Medical Benefits and based on the Hospital's ICU or CCU charge.

(2) **Pregnancy Care.** The care and treatment of a Pregnancy is covered the same as any other Illness. This benefit includes services and supplies furnished by a Birthing Center, as shown in the Schedule of Medical Benefits.

The Plan generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending Physician, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, the Plan may not, under Federal law, require that a provider obtain authorization from the Plan for prescribing a length of stay not in excess of 48 hours (or 96 hours as applicable).
(3) **Skilled Nursing Facility, Extended Care Facility and Rehabilitation Facility admissions.** The room and board and nursing care furnished by a Skilled Nursing Facility, extended care facility and rehabilitation facility will be payable as outlined in the Schedule of Medical Benefits. In order to be eligible, the following must occur:

(a) the Covered Person is confined as a bed patient in the facility;

(b) the confinement starts immediately following a Hospital confinement or a period of Home Health Care; and

(c) the attending Physician certifies that confinement is needed for further care of the condition that caused the Hospital confinement; and

(d) the attending Physician completes a treatment plan which includes a diagnosis, the proposed course of treatment and the projected date of discharge from the Skilled Nursing Facility, extended care facility or rehabilitation facility.

Covered charges for a Covered Person’s care in these facilities are limited to the facility’s semiprivate room rate.

(4) **Physician Care.** Inpatient, outpatient, office or home professional services of a Physician for surgical or medical services to treat an Illness or Injury. Inpatient care includes services by an attending Physician or non-attending Physician. This benefit also includes the following:

(a) Second surgical opinion (and/or second medical opinion) and necessary third surgical/medical opinions.

(b) Multiple surgical procedures, subject to the following provisions:

Two (2) or more surgical procedures performed during the same session through the same incision, natural body orifice or operative field. The amount eligible for consideration is the Usual and Customary charge for the largest amount billed for one (1) procedure plus 50% of the sum of Usual and Customary charges for all other procedures performed; or

Two (2) or more surgical procedures performed during the same session through different incisions, natural body orifices or operative fields. The amount eligible for consideration is the Usual and Customary charge for the largest amount billed for one (1) procedure plus 50% of the sum of Usual and Customary charges billed for all other procedures performed.

(c) Assistant Surgeon, if required. The Assistant Surgeon’s covered charge will not exceed 20% of the surgeon’s Usual and Customary allowance, if applicable.

(5) **Home Health Care Services and Supplies.** Charges for home health care services and supplies are covered only for care and treatment of an Illness or Injury when Hospital or Skilled Nursing Facility confinement would otherwise be required. The diagnosis, care and treatment must be pre-certified by Medical Management and supported by a certification and a treatment plan from the attending Physician.

Benefit payment for nursing, home health aide and therapy services is subject to the Home Health Care maximum as outlined in the Schedule of Medical Benefits.

Benefit payment for Home Health Care services is subject to the Home Health Care limit, (up to four (4) hours equal one (1) visit), as outlined on the Schedule of Medical Benefits.
(6) **Hospice Care Services and Supplies.** Covered charges for hospice care services and supplies are covered only when the attending Physician has diagnosed the Covered Person's condition as being terminal, determined that the Covered Person is not expected to live more than six months and has placed the Covered Person under a Hospice Care Plan and only as outlined in the Schedule of Medical Benefits. A Hospice Care Plan primarily provides palliative, supportive, and other related care.

Covered bereavement counseling services by a licensed social worker or a licensed pastoral counselor for the patient's covered Spouse and/or covered Dependent Children. Bereavement services must be furnished within six months after the patient's death.

(7) **Other Medical Services and Supplies.** Services and supplies not otherwise included in the items listed above are covered as follows:

(a) **Allergy Services** includes allergy testing, preparation of serum and allergy injections.

(b) **Ambulance transportation** provided by a professional ambulance service for local land or air transportation for a Medical Emergency. A charge for this service will be considered a covered charge only if the service is to the nearest Hospital or emergency care facility where necessary treatment can be provided. Benefits are also provided for transportation from one Medical Care Facility to another, when Medically Necessary.

(c) **Amniocentesis** only when the attending Physician certifies that the procedure is Medically Necessary.

(d) **Anesthetic services** when performed by a licensed anesthesiologist or certified registered nurse anesthetist in connection with a covered surgical procedure.

(e) **Blood** and blood derivatives that are not donated or replaced. Administration of these services is also considered an eligible expense.

(f) **Cardiac rehabilitation** as deemed Medically Necessary provided services are rendered (a) under the supervision of a Physician; (b) in connection with a myocardial infarction, coronary occlusion or coronary bypass surgery; (c) initiated within 12 weeks after other treatment for the medical condition ends; and (d) in a Medical Care Facility as defined by this Plan.

(g) **Chemotherapy and radiation treatment** with radioactive substances. The materials and services of technicians are included.

(h) **Contact lenses,** eyeglasses, eye examinations, professional fees for fitting of the lenses, vision therapy and orthoptics are covered only for diagnosis and treatment of an Illness or Injury. Contact lenses or eyeglasses are also covered when needed to replace the human lens lost due to cataract surgery and other intraocular surgeries. Benefits for contact lenses or eyeglasses are limited to the initial prescription only.

(i) **Developmental Delay.** A significant variation in normal development in one or more of the following areas measured by appropriate diagnostic instruments and procedures and identified by the American Academy of Pediatrics as an appropriate developmental milestone based upon the Medical Necessity of the Covered Person: treatment of autism; cognitive development; physical development; communication development; social-emotional development or adaptive development. Outpatient therapy benefits for developmental delays will be subject to the maximum benefits allowed for physical, speech and occupational therapies. Precertification will be required. Benefits are limited as outlined under the Schedule of Medical Benefits.
(j) **Diabetic Management and Education.** The following diabetic education and self-management programs: (a) all Physician prescribed medically appropriate and necessary equipment and supplies used in the management and treatment of diabetes; and (b) diabetes outpatient self-management training and education, including medical nutrition therapy that is provided by a certified, registered, or licensed health care professional working in a program consistent with the national standards of diabetes self-management education as established by the American Diabetes Association. Coverage is provided for individuals with gestational, Type I or Type II diabetes.

(k) **Durable Medical Equipment,** including oxygen and oxygen equipment, if deemed Medically Necessary. A statement is required from the prescribing Physician describing how long the equipment is expected to be Medically Necessary. This statement will determine whether the equipment will be rented or purchased. Benefits are limited to the fair market value of the equipment at the time of purchase. If the equipment is purchased, benefits include expenses related to necessary repairs and maintenance. Initial replacement equipment will be covered if the replacement equipment is required due to a change in the Covered Person's physical condition; or, purchase of new equipment will be less expensive than repair of existing equipment.

(l) **Expatriation,** including

(i) Repatriation of remains up to $7,500 per Lifetime.

(ii) Medical evacuation to the Covered Person’s home country once per calendar year, up to $10,000, per Covered Person.

(m) **Foot treatment** if deemed Medically Necessary for conditions, including removal of nail roots, surgical procedures or treatment of a metabolic or peripheral vascular disease. Routine foot care such as non-surgical treatment of weak, strained, flat, unstable, or unbalanced feet; metatarsalgia or bunions; corns; callouses; and toe nails is excluded.

(n) **Hearing examinations,** hearing aids, or related services and supplies, including usual and reasonable for fittings, approved hearing correction devices and the first set of batteries for hearing aids, limited as outlined in the Schedule of Medical Benefits. All services must be provided by an Audiologist or Certified Hearing Aid Specialist and recommended or prescribed by a Physician. Over the counter hearing aids, repair of broken hearing aids, lost aids, or replacement batteries will not be considered eligible.

(o) **Impotence** treatment for or related to sexual dysfunction or inadequacies caused by an organic disease or accidental Injury only with an approved treatment plan and is deemed Medically Necessary, for Covered Persons age 18 and over.

(p) For Medically Necessary treatment to diagnose infertility, test for physical abnormalities of the reproductive system that might cause infertility, and correct existing pathologies of the reproductive system.

For care in conjunction with IUI or GIFT when the treatment assists normal reproductive processes to achieve pregnancy if the sperm is collected during normal sexual relations through the use of a perforated condom and if approved by the Plan after a review of the facts and circumstances.

(q) **Diagnostic laboratory studies.**

(r) **Marital counseling.** Charges are covered only if provided by a Licensed Mental Health Counselor (MHC) or a Licensed Marriage and Family Therapist (MFT). Claims by a Licensed Mental Health Counselor (MHC) or a Licensed Marriage and Family
Therapist (MFT) will only be covered for services in connection with marital counseling.

Covered charges for care, supplies and treatment of **Mental Disorders and Substance Use Disorder**, limited as outlined in the Schedule of Medical Benefits.

Psychiatrists (M.D.), psychologists (Ph.D., Ed-D or Psy.D.), counselors (Ph.D.), Licensed Certified Social Workers (L.C.S.W.) or Masters of Social Work (M.S.W.) may bill the Plan directly. Other licensed mental health practitioners must be under the direction of and must bill the Plan through these professionals.

Injury to or care of **mouth, teeth and gums**. Charges for Injury to or care of the mouth, teeth, gums and alveolar processes will be Covered Charges under Medical Benefits only if that care is for the following oral surgical procedures:

- Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth.
- Emergency repair due to Injury to sound natural teeth.
- Surgery needed to correct accidental injuries to the jaws, cheeks, lips, tongue, floor and roof of the mouth.
- Excision of benign bony growths of the jaw and hard palate.
- External incision and drainage of cellulitis.
- Incision of sensory sinuses, salivary glands or ducts.

Charges will not be covered under Medical Benefits for dental and oral surgical procedures involving orthodontic care of the teeth, unless otherwise specified, periodontal disease and preparing the mouth for the fitting of or continued use of dentures.

**Occupational therapy** by a licensed occupational therapist. Therapy must be ordered by a Physician to restore body function lost due to an Injury, Illness or surgery. Covered expenses do not include recreational programs, maintenance therapy or supplies used in occupational therapy.

The Plan will cover services provided for Pervasive Developmental Disorder (PDD), including but not limited to, Asperger’s syndrome and autism, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association. Covered services will include Physical Therapy, Speech Therapy and Occupational Therapy.

**Organ transplant** expenses. Services and supplies in connection with Medically Necessary non-Experimental transplant procedures,

**Organ Donor** expenses. Charges for obtaining donor organs or tissues are covered charges under the Plan for the following:

**If a recipient is covered by the Plan** – If the organ recipient is covered by the Plan and the organ donor does not have health care coverage for charges to obtain the organ or tissues, the Plan will include these charges under the Lifetime Maximum Benefits under the Plan.

**If a recipient is not covered by this Plan** – If the recipient is not covered by the Plan, but the donor (our Plan Participant) is a member of the recipients immediate family, the Plan will include these charges under the Lifetime Maximum Benefits under the Plan for donor expenses.
for obtaining the organ or tissues, but only if the recipient does not have coverage for donor expenses. For the purpose of this plan immediate family member shall include: spouse, child, parent, and sibling.

Donor charges include:

- evaluating the organ or tissue;
- removing the organ or tissue from the donor; and
- transportation of the organ or tissue from within the United States of America and Canada to the place where the transplant is to take place.

(x) The initial purchase, fitting and repair of **orthotic appliances** such as braces, splints or other appliances which are required for support for an injured or deformed part of the body as a result of a disabling congenital condition or an Injury or Sickness. Coverage includes custom molded orthopedic shoes, custom fitted orthotics, repair and replacement when due to normal childhood growth, or normal wear and tear as determined by the manufacturer and Plan Administrator.

(y) **Physical therapy** provided by a licensed physical therapist. Therapy must be in accord with a Physician's exact orders as to the type, frequency and duration of therapy and for conditions which are subject to significant improvement through short-term therapy. Eligible expenses do not include maintenance therapy.

The Plan will cover services provided for Pervasive Developmental Disorder (PDD), including but not limited to, Asperger's syndrome and autism, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association. Covered services will include Physical Therapy, Speech Therapy and Occupational Therapy.

(z) **Pre-admission and pre-surgical testing** within seven (7) days of a scheduled inpatient Hospital admission, as outlined in the Schedule of Medical Benefits.

(aa) **Prescription Drugs**, medicines or supplies dispensed through the Physician's office, and take-home prescription drugs from a Hospital, for which the patient is charged, are covered under the Medical Benefits section of the Plan.

(bb) **Routine Preventive Care.** Covered charges under Medical Benefits are payable for routine Preventive Care as outlined in the Schedule of Medical Benefits. Routine hearing and vision tests associated with the routine physical examination and performed at the time of the routine physical examination will be considered under the Routine Preventive Care benefit.

(cc) The initial purchase, fitting and repair of fitted **prosthetic devices**, artificial limbs and artificial eyes, which replace body parts. Replacement of such devices is only covered if the replacement is necessary due to a change in the physical condition of the Covered Person, or, replacement is less expensive than repair of the existing device. Benefits are limited as outlined in the Schedule of Medical Benefits.

(dd) **Qualified Clinical Trial Expenses.** Healthcare items or services that are furnished to a Covered Person enrolled in a Qualified Clinical Trial, which are consistent with the Usual and Customary standard of care for someone with the Covered Person's diagnosis, are consistent with the study protocol for the clinical trial, and would be covered if the Covered Person did not participate in the Qualified Clinical Trial.
Notwithstanding the above, Qualified Clinical Trial Expenses do not include any of the following:

(i) An FDA approved drug or device shall be considered a Qualified Clinical Trial Expense only to the extent that the drug or device is not paid for by the manufacturer, the distributor or the provider of the drug or device; or

(ii) Non-healthcare services that a Covered Person may be required to receive as a result of being enrolled in the Qualified Clinical Trial; or

(iii) Costs associated with managing the research associated with the Qualified Clinical Trial; or

(iv) Costs that would not be covered for non-investigational/experimental treatments; or

(v) Any item, service or cost that is reimbursed or otherwise furnished by the sponsor of the Qualified Clinical Trial; or

(vi) The costs of services, which are not provided as part of the Qualified Clinical Trial’s stated protocol or other similarly intended guidelines.

(ee) **Reconstructive Surgery.** Correction of abnormal congenital conditions, birth abnormalities resulting in the malformation or absence of a body part or conditions caused by an accidental Injury or covered Illness. Reconstructive Mammoplasties will also be considered covered charges.

Mammoplasty benefits will include reimbursement for:

(i) reconstruction of the breast on which a mastectomy has been performed,

(ii) surgery and reconstruction of the other breast to produce a symmetrical appearance, and

(iii) coverage of prostheses and physical complications during all stages of mastectomy, including lymphedemas,

in a manner determined in consultation with the attending Physician and the patient.

(ff) **Speech therapy** provided by a licensed speech therapist. Therapy must be ordered by a Physician and follow either: (i) surgery for correction of a congenital condition of the oral cavity, throat or nasal complex (other than a frenectomy) of a Covered Person; (ii) an Injury; or (iii) an Illness that is other than a learning or Mental Disorder.

The Plan will cover services provided for Pervasive Developmental Disorder (PDD), including but not limited to, Asperger’s syndrome and autism, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association. Covered services will include Physical Therapy, Speech Therapy and Occupational Therapy.

(gg) **Spinal Manipulation/Chiropractic services** by a licensed M.D., D.O. or a D.C. Eligible expenses do not include maintenance treatment. Maintenance care is not covered.
(hh) **Supplies** such as surgical dressings and other medical supplies, but limited as follows:

(i) Insulin infusion pumps, limited to one (1) in every five (5) years, and related supplies; and

(ii) Jobst/compression garments, limited to four (4) per calendar year.

(ii) **Well Newborn Nursery/Physician Care Charges.**

**Routine Nursery Care.** Routine well newborn nursery care is care while the newborn is Hospital-confined after birth and includes room and board charges and other normal routine care.

This coverage is only provided if the newborn is properly enrolled.

The benefit is limited to charges for nursery care for the newborn child while Hospital confined as a result of the child’s birth.

Charges for covered routine nursery care will be applied toward the Plan of the covered parent.

**Physician Care.** Benefits are limited to charges incurred by a newborn child while the newborn child is Hospital confined as a result of the child’s birth, including circumcision.

Charges for covered routine Physician care will be applied toward the Plan of the newborn child.

(jj) **Wig** or artificial hairpiece expenses and charges associated with the initial purchase of the wig or hairpiece following chemotherapy. Benefit is limited as outlined in the Schedule of Medical Benefits.

(kk) **Diagnostic X-rays.** including ultrasounds only if the attending Physician certifies that the procedure is Medically Necessary.
PLAN EXCLUSIONS

For all Medical Benefits shown in the Schedule of Medical Benefits, a charge for the following is not covered:

(1) **Abortion.** Services, supplies, care or treatment in connection with an elective abortion. This exclusion does not apply to terminated pregnancies, including those for covered Dependent daughters, when the life of the mother is endangered by the continued Pregnancy. If complications arise after the performance of any abortion, any expenses incurred to treat those complications will be eligible, whether the abortion was eligible or not.

(2) **Acupuncture.**

(3) **Administrative costs.** Administrative costs of completing claim forms, itemized bills, medical reports or for providing records, mailing and/or shipping expenses, expenses for broken appointments or expenses for telephone calls.

(4) **Adoption expenses.**

(5) **Artificial Heart or Other Organ.** Artificial heart or other organ and any expenses related to its insertion or maintenance.

(6) **Complications of non-covered surgery or treatment.** Care, services or treatment required as a result of complications from any non-covered surgery or treatment.

(7) **Custodial care.** Services or supplies provided mainly as a rest cure, maintenance, Custodial Care or care in a sanitarium.

(8) **Dental and Oral Surgical Procedures.** No charge will be covered under Medical Benefits for dental and oral surgical procedures involving orthodontic care of the teeth, periodontal disease, preparing the mouth for the fitting or the continued use of dentures, non-emergency repair due to Injury of sound, natural teeth, removal of impacted wisdom teeth, or services related to TMJ.

(9) **Educational or vocational testing.** Services for educational or vocational testing, training.

(10) **Exercise programs.** Exercise programs for treatment of any condition, except for Physician-supervised cardiac rehabilitation and occupational or physical therapy covered by the Plan.

(11) **Experimental and/or Investigational.** Expenses for treatment, procedures, devices, drugs or medicines which are determined to be Experimental and/or Investigational, except when such expenses are considered Qualified Clinical Trial Expenses.

(12) **Eye care.** Radial keratotomy or other eye surgery to correct refractive disorders. This exclusion does not apply to aphakic patients and soft lenses or sclera shells intended for use as corneal bandages.

(13) **Foot care.** Treatment of weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions (except open cutting operations), and treatment of corns, calluses or toenails (unless needed in treatment of a metabolic or peripheral-vascular disease).

(14) **Genetic Testing,** includes diagnostic testing of genetic information and counseling, unless the treatment Plan would be altered due to the results of a genetic test.

(15) **Government coverage.** Expenses for services furnished by or for the United States government or any other government, unless payment is legally required.
(16) **Hair loss.** Care and treatment for hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a Physician, except for wigs after chemotherapy up to the limit shown in the Schedule of Medical Benefits.

(17) **Hearing Exams and Hearing Aids.** Charges for services or supplies in connection with over-the-counter hearing aids, repair of broken hearing aids, lost aids, or replacement batteries.

(18) **Hospital employees.** Professional services billed by a Physician or nurse who is an employee of a Hospital or Skilled Nursing Facility and who is paid by the Hospital or facility for the service.

(19) **Illegal acts.** Charges for services received as a result of Injury or Sickness occurring directly or indirectly, as a result of a Serious Illegal Act, or a riot or public disturbance. For purposes of this exclusion, the term "Serious Illegal Act" shall mean any act or series of acts that, if prosecuted as a criminal offense, a sentence to a term of imprisonment in excess of one year could be imposed. It is not necessary that criminal charges be filed, or, if filed, that a conviction result, or that a sentence of imprisonment for a term in excess of one year be imposed for this exclusion to apply. Proof beyond a reasonable doubt is not required. This exclusion does not apply if the Injury or Illness resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

(20) **Infertility.** No payment will be made for expenses incurred by the Employee or any eligible Dependents:

For or in connection with in-vitro fertilization (IVF), PROST/ZIFT, ICSI, artificial insemination or any other treatment (other than IUI or GIFT) designed to replace normal reproductive processes to achieve pregnancy.

For or in connection with IUI or GIFT when the treatment replaces normal reproductive processes to achieve pregnancy if the sperm is not collected during normal sexual relations or if not approved by the University of Notre Dame.

Treatment for voluntary sterilization.

Treatment required as a result of prior voluntary sterilization.

Services received if you are donating sperm or oocytes to help another person have children.

Surrogate pregnancies by the Plan Participant to help another person have children.

Non-medical expenses of donors or surrogates helping the Plan Participant to have children.

(21) **Medically Necessary.** Expenses for goods or services, not Medically Necessary or primarily Cosmetic in nature.

(22) **Morbid Obesity.** Surgical treatment includes non-surgical treatment, including reversal of any surgical treatment of Morbid Obesity, unless deemed Medically Necessary.

(23) **No charge.** Care, treatment and services for which there would not have been a charge if no coverage had been in force.

(24) **Non-compliance.** All charges in connection with treatments or medications where the patient either is in non-compliance with or is discharged from a Hospital or Skilled Nursing Facility against medical advice.

(25) **Non-emergency Hospital admissions on Friday/Saturday.** Care, treatment and services billed by a Hospital for non-Medical Emergency admissions on a Friday or a Saturday. This does not apply if surgery is performed within 24 hours of admission.
(26) **No obligation to pay.** Charges incurred for which the Plan has no legal obligation to pay.

(27) **No Physician recommendation.** Care, treatment, services or supplies not recommended and approved by a Physician; and care, treatment, services or supplies when the Covered Person is not under the regular care of a Physician. Regular care means ongoing medical supervision or treatment which is appropriate care for the Injury or Illness.

(28) **Norplant.**

(29) **Not specified as covered.** Non-traditional services, treatments and supplies which are not specified as covered under the Plan, such as, but not limited to holistic, massage therapy, rolfing, hypnosis, homeopathic, biofeedback and naturopathic services.

(30) **Nuclear accidents.** Services related to any actual or alleged nuclear reaction, nuclear radiation, radioactive contamination or radioactive substance.

(31) **Obesity.** Care and treatment of obesity, weight loss or dietary control whether or not it is, in any case, a part of the treatment plan for another Illness.

(32) **Occupational.** Services, supplies, care or treatment that are covered under the Indiana Workers’ Compensation Act.

(33) **Personal comfort items.** Personal comfort items or other equipment, such as, but not limited to, television, telephone, guest meals, air conditioners, air-purification units, humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, elastic bandages or stockings (except as specified), nonprescription drugs and medicines, first-aid supplies, non-hospital adjustable beds, heating pads, hot water bottles, waterbeds, hot tubs, swimming pools, or any other equipment that could be used in the absence of an Illness or Injury.

(34) **Plan exclusions.** Charges excluded by the Plan as noted in this document.

(35) **Private duty nursing.** Charges in connection with care, treatment or services provided by a private duty nurse.

(36) **Relative giving services.** Professional services performed by a person who ordinarily resides in the Covered Person's home or is related to the Covered Person as a Spouse, parent, child, brother or sister, whether the relationship is by blood or exists in law.

(37) **Removal of breast implants or other prosthetic implants.** Removal of implants are not covered if the implants were: (1) inserted in connection with Cosmetic surgery, regardless of the reason for removal; or (2) not inserted in connection with Cosmetic surgery, but the removal is not Medically Necessary. Includes all expenses for or related to such removal.

(38) **Replacement braces.** Replacement of braces of the leg, arm, back, neck, or artificial arms or legs, unless there is sufficient change in the Covered Person's physical condition to make the original device no longer functional, or, replacement is less expensive than repair of the existing device.

(39) **Self-Inflicted.** Any loss due to an intentionally self-inflicted Injury. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition or to overdose treatment if such overdose is accidental.

(40) **Services before or after coverage.** Care, treatment or supplies for which a charge was incurred before a person was covered under the Plan or after coverage ceased under the Plan.
(41) **Services outside of the United States of America.** Care, treatment or supplies rendered outside the United States of America or its territories, except for covered charges related to an Injury or a Medical Emergency.

(42) **Sex changes.** Care, services or treatment for non-congenital transsexualism, gender dysphoria or sexual reassignment or change. This exclusion includes medications, implants, hormone therapy, surgery, medical or psychiatric treatment.

(43) **Sleep disorders.** Care, treatment, services and supplies for sleep disorders, unless deemed Medically Necessary.

(44) **Smoking cessation.** Care and treatment for smoking cessation, including office visits for smoking cessation consultations, unless primary diagnosis is due to smoking.

(45) **Specialty medications.** Specialty medications that are included on the list of prescription drugs from the Prescription Benefit Manager when administered in the Physician’s office, Home Infusion or by another Specialty Vendor. One courtesy fill will be allowed under the medical plan and all future claims will be denied. Specialty medications administered at an inpatient facility or outpatient facility will be covered under the Medical Plan.

(46) **Surgical sterilization.** Expenses related to surgical sterilizations or their reversal.

(47) **Travel or accommodations.** Charges for travel or accommodations, whether or not recommended by a Physician, except for ambulance charges as defined as a covered expense.

(48) **War, etc.** Any loss that is due to a declared or undeclared act of war. This exclusion does not apply to Injuries resulting from an act of terrorism on United States soil.
FILING A CLAIM

HOW TO SUBMIT A CLAIM

The following general steps should be followed in order to submit a claim for Medical:

1. Obtain a claim form from the Human Resource Department, the Plan Administrator or on-line at mymeritain.com.

2. Complete the Employee section of the form. Answer all questions, even if the answer is "none" or "N/A" (not applicable), including the section referring to other insurance ("COB"). A separate claim form must be completed for each Covered Person for whom benefits are being requested.

3. The Physician or other provider must complete the provider's portion of the form.

4. Attach bills for services rendered. Documentation must include:

   - Name of Plan
   - Employee's name
   - Name of patient
   - Name, address, telephone number and federal tax identification number of the provider of care
   - Diagnosis
   - Type of services rendered, with diagnosis and/or procedure codes
   - Date of service
   - Charges
   - If another plan is the primary payor, a copy of the other plan's Explanation of Benefits (EOB) must accompany the claim form sent to the Plan.

5. Mail the completed claim form and attached documentation to the Claims Processing Office or at the address listed below:

   Meritain Health
   P.O. Box 853921
   Richardson, Texas  75085-3921

   Questions regarding the claim can be addressed by calling the toll-free number on the member's ID card.

WHEN CLAIMS MUST BE SUBMITTED

Claims must be filed with the Claims Processor within one year of the date the service was incurred. Benefits are based on the Plan's provisions at the time the charges were incurred. Claims filed after one year of the date the service was incurred will be declined.

The Claims Processor will determine if sufficient information has been submitted for appropriate consideration of the claim. If not, additional information may be requested.
CLAIMS PROCEDURE

The Plan's claims procedures are intended to reflect the Department of Labor's claims procedures regulations, and should be interpreted accordingly. In the event of any conflict between the summary and those Regulations, those Regulations will control. In addition, any changes in those Regulations shall be deemed to amend this summary automatically, effective as of the date of those changes.

To receive benefits under the Plan, the claimant must follow the procedures established by the Plan Administrator and/or the insurance company which has the responsibility for making the particular benefit payments to the claimant.

Initial claims for Plan benefits are made to the Plan Administrator or, if applicable, the Insurer providing that benefit. The Plan Administrator, (or Insurer, if applicable) will review the claim itself or appoint an individual or an entity to review the claim, following these procedures:

(1) **Urgent Care Claims.** A health benefits claim is considered an urgent care claim if the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function or, in the opinion of a Physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that could not be adequately managed without the care or treatment which is the subject of the claim. If the claimant's claim is for urgent care health benefits, the reviewer will notify the claimant of the Plan's benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim by the Plan, unless the claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. In the case of such a failure, the reviewer will notify the claimant as soon as possible, but not later than 24 hours after receipt of the claim by the Plan, of the specific information necessary to complete the claim. The notification may be oral unless written notification is requested by the claimant. The claimant will be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. The reviewer will notify the claimant of the Plan's determination as soon as possible, but in no case later than 48 hours after the earlier of (1) the Plan's receipt of the specified additional information or (2) the end of the period afforded the claimant to provide the specified additional information.

(2) **Concurrent Care Claims.** If the Plan has approved an ongoing course of health care treatment to be provided over a period of time or number of treatments, any reduction or termination by the Plan of the previously approved course of treatment (other than by Plan amendment or termination) before the approved time period or number of treatments constitutes an adverse benefit determination. In such a case, the reviewer will notify the claimant of the adverse benefit determination at a time sufficiently in advance of the reduction or termination to allow the claimant to appeal and obtain a determination on review of that adverse benefit determination before reduction or termination of the benefit.

Any request by a claimant to extend a previously approved course of treatment beyond the approved period of time or number of treatments shall be decided as soon as possible, taking into account the medical exigencies, and the reviewer will notify the claimant of the benefit determination, whether adverse or not, within twenty-four (24) hours after receipt of the claim by the Plan, provided that any such claim is made to the Plan at least twenty-four (24) hours prior to the expiration of the prescribed period of time or number of treatments.

(3) **Other Health Benefit Claims.** In the case of a health benefit claim not described above:

(a) For a pre-service health benefit claim, the reviewer will notify the claimant of the Plan's benefit determination (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim by the Plan. If, due to matters beyond the control of the Plan, the reviewer needs additional time to process a claim, the reviewer may extend the time for notifying the claimant of the Plan's benefit determination for up to 15 days, provided that the reviewer notifies the claimant within 15 days after the Plan
receives the claim, of those special circumstances and of when the reviewer expects to make its decision. However, if such an extension is necessary due to a failure of the claimant to submit the information necessary to decide the claim, the notice of extension must specifically describe the required information, and the claimant will be afforded at least 45 days from receipt of the notice within which to provide the specified information.

A health benefit claim is considered a pre-service claim if the claim requires approval, in part or in whole, in advance of obtaining the health care in question.

(b) For a post-service health benefit claim, the reviewer will notify the claimant of the Plan's adverse benefit determination within a reasonable period of time, but not later than 30 days after receipt of the claim. If, due to special circumstances, the reviewer needs additional time to process a claim, the reviewer may extend the time for notifying the claimant of the Plan's benefit determination on a one-time basis for up to 15 days, provided that the reviewer notifies the claimant within 30 days after the Plan receives the claim, of those special circumstances and of the date by which the reviewer expects to make a decision. However, if such a decision is necessary due to the failure of the claimant to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information, and the claimant will be afforded at least 45 days from receipt of the notice within which to provide the specified information.

A health benefit claim is considered a post-service claim if it is a request for payment of services which the claimant has already received.

(4) Calculation of Time Periods. For purposes of the time periods relating to the Plan's initial benefit determination, the period of time during which an initial benefit determination is required to be made begins at the time a claim is filed in accordance with the Plan procedures without regard to whether all the information necessary to make a decision accompanies the request. If a period of time is extended due to a claimant's failure to submit all information necessary, the period for making the determination is "frozen" from the date the notification is sent to the claimant until the date the claimant responds to the request for additional information.

(5) Manner and Content of Denial of Initial Claims. If the reviewer denies a claim, it must provide to the claimant, in writing or by electronic communication:

(a) The specific reasons for the denial;

(b) A reference to the Plan provision or insurance contract provision upon which the denial is based;

(c) A description of any additional information or material that the claimant must provide in order to perfect the claim, if applicable;

(d) An explanation of why the additional material or information is necessary, if applicable;

(e) Notice that the claimant has a right to request a review of the claim denial and information on the steps to be taken if the claimant wishes to request a review of the claim denial along with the time limits applicable to a request for review;

(f) A statement of the participant's right to request an external review or, if applicable, to bring a civil action under a Federal law called "ERISA" following any denial on review of the initial denial;

(g) A copy of any rule, guideline, protocol, or other similar criterion relied upon in making the adverse determination (or a statement that the same will be provided upon request by the claimant and without charge); and
(h) If the adverse benefit determination is based on the Plan's Medical Necessity, experimental treatment or similar exclusion or limit, either: (a) an explanation of the scientific or clinical judgment applying the exclusion or limit to the claimant's medical circumstances, or (b) a statement that the same will be provided upon request by the claimant and without charge.

NOTE: For an adverse benefit determination concerning a health claim involving urgent care, the information described in this Section may be provided to the claimant orally within the permitted time frame, provided that a written or electronic notification in accordance with this Section is furnished to the claimant no later than 3 days after the oral notification.

Internal Review of Initially Denied Claims

If a claimant submits a claim for Plan benefits and it is initially denied under the procedures described above, the claimant may request a review of that denial under the following procedures.

(1) **Health Benefit Claims**. A claimant for health benefits has one hundred eighty (180) days following receipt of a notification of an adverse initial benefit determination within which to request a review of the adverse initial benefit determination. For a request for a second level appeal, the claimant has sixty (60) days following receipt of a notification of an adverse benefit determination at the first level of appeal to request a second level appeal of the adverse benefit determination. In such cases, the review will meet the following requirements:

(a) The Plan will provide a review that does not afford deference to the adverse initial benefit determination and that is conducted by an appropriate named fiduciary of the Plan who did not make the adverse initial benefit determination that is the subject of the appeal, nor is a subordinate of the individual who made the adverse initial determination.

(b) The appropriate named fiduciary of the Plan will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment before making a decision on review of any adverse initial benefit determination based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug or other item is Experimental, Investigational or not Medically Necessary or appropriate. The professional engaged for purposes of a consultation in the preceding sentence shall be an individual who was neither an individual who was consulted in connection with the adverse initial benefit determination that is the subject of the appeal, nor the subordinate of any such individual.

(c) The Plan will identify to the claimant the medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the adverse initial benefit determination, without regard to whether the advice was relied upon in making the adverse initial benefit determination.

(d) In the case of a requested review of a denied adverse initial benefit determination involving urgent health care, the review process shall meet the expedited deadlines described below. The claimant's request for such an expedited review may be submitted orally or in writing by the claimant and all necessary information, including the Plan's determination on review, shall be transmitted between the Plan and the claimant by telephone, facsimile or other available similarly expeditious method.

(e) The reviewer will afford the claimant an opportunity to review and receive, without charge, all relevant documents, information and records relating to the claim for benefits and to submit issues and comments relating to the claim for benefits in writing to the Plan Administrator (or Insurer, if applicable). The reviewer will take into account all comments, documents, records and other information submitted by the claimant relating to the claim regardless of whether the information was submitted or considered in the initial benefit determination.
All requests for review of initially denied claims (including all relevant information) must be submitted to the following address:

Meritain Health, Inc.
Appeals Department
P. O. Box 1380
Amherst, NY 14226-1380

(2) Deadline for Internal Review of Initially Denied Claims.

(a) Urgent Health Benefit Claims. The Plan provides for two levels of appeal for urgent care claims. For each level of appeal, the reviewer will notify the claimant of the Plan's determination on review as soon as possible, taking into account the medical exigencies, but not later than 36 hours after receipt of the claimant's request for review of the adverse initial benefit determination (or of the adverse first-level appeal benefit determination) by the Plan.

(b) Other Health Benefit Claims.

(i) The Plan provides for two levels of appeal for a pre-service health claim. At each level of appeal, the reviewer will notify the claimant of the Plan's determination on review within a reasonable period of time appropriate to the medical circumstances, but in no event later than 15 days after the Plan receives the claimant's request for review of the adverse initial benefit determination (or of the adverse first-level appeal benefit determination).

(ii) The Plan provides for two levels of appeal for a post-service health claim. At each level of appeal, the reviewer will notify the claimant of the Plan's determination on review within a reasonable period of time appropriate to the medical circumstances, but in no event later than 30 days after the Plan receives the claimant's request for review of the adverse initial benefit determination (or of the adverse first-level appeal benefit determination).

(c) Calculation of Time Periods. For purposes of the time periods specified in this Section, the period of time during which a benefit determination on review is required to be made begins at the time relating to the Plan's review of adverse initial benefit determination is filed in accordance with the Plan procedures without regard to whether all the information necessary to make a benefit determination or review accompanies the request for review.

(3) Manner and Content of Notice of Decision on Internal Review of Initially Denied Claims. Upon completion of its review of an adverse initial benefit determination (or an adverse first-level appeal benefit determination), the reviewer will give the claimant, in writing or by electronic notification, a notice containing:

(a) Its decision;

(b) The specific reasons for the decision;

(c) The relevant Plan provisions or insurance contract provisions on which its decision is based;

(d) A statement that the claimant is entitled to receive, upon request and without charge, reasonable access to, and copies of, all documents, records and other information in the Plan's files which is relevant to the claimant's claim for benefits;

(e) A statement describing the claimant's right to request a second level appeal;
(f) If an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination on review, a statement that a copy of the rule, guideline, protocol or other similar criterion will be provided without charge to the claimant upon request, if applicable;

(g) If the adverse determination on review is based on a Medical Necessity, experimental treatment or similar exclusion or limit, either: (a) an explanation of the scientific or clinical judgment on which the determination was based, applying the terms of the Plan to the claimant's medical circumstances, or (b) a statement that such an explanation will be provided without charge upon request, if applicable; and

(h) The following statement: “You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and, if your benefit is an insured benefit, your State insurance regulatory agency.”

Plan's Failure to Follow Procedures

If the Plan fails to follow the claims procedures described above, a claimant will be deemed to have exhausted the administrative remedies available under the Plan and will be entitled to pursue any available remedy under State or Federal law on the basis that the Plan has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim.

Insured Benefits and State Insurance Laws

For any insured benefit under the Plan, nothing in the Plan's claims procedures will be construed to supersede any provision of any applicable State law that regulates insurance, except to the extent that such law prevents application of the Plan's claims procedures.

Statute of Limitations for Plan Claims

Please note that no legal action may be commenced or maintained to recover benefits under the Plan more than 12 months after the final review/appeal decision by the Plan Administrator has been rendered (or deemed rendered).
COORDINATION OF BENEFITS

Coordination of the benefit plans. Coordination of benefits is the order of payment when charges are eligible under two or more benefit plans. Coordination of benefits also occurs when the Covered Person is covered by the Plan and Medicare.

When a Covered Person is covered under more than one benefit plan, the "primary" plan will determine and pay benefits first without regard to benefits provided under any other group health plan.

When the Plan is the "secondary" payor, the Plan will coordinate payment with the primary plan in such a way that when the secondary Plan's payment is combined with the primary plan's payment, the total does not exceed the amount the secondary Plan would have paid if it were primary.

For example, if another group health plan is "primary" and the Plan is "secondary," and the "primary" plan pays 70% for a covered benefit while the Plan would pay 80% for the same benefit, the Plan would pay the difference between 70% and 80%, or 10% of the remaining covered expenses. This is called non-duplication of benefits. The balance due, if any, is the responsibility of the Covered Person.

Benefit plan. The Plan will coordinate the medical benefits with the following plans:

1. Group or group-type plans, including franchise or blanket benefit plans.
2. Blue Cross and Blue Shield group plans.
3. Group practice and other group prepayment plans.
4. Federal government plans or programs, including Medicare.
5. Other plans required or provided by law. This provision does not include any benefit plan or Medicaid that, by its terms, does not allow coordination.
6. No Fault Auto Insurance.

Allowable charge. The Plan will consider only covered charges under the Plan as Allowable Charges.

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

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

No-Fault limitations. When medical payments are available under vehicle insurance, the Plan will pay excess benefits only, without reimbursement for vehicle plan deductibles. The Plan will always be considered secondary and coordinate with benefits provided or required by any no-fault insurance statute whether or not a no-fault policy is in effect.
Benefit plan payment order. When two or more benefit plans provide benefits for the same Allowable Charge, benefit payment will follow these rules.

(1) Benefit plans that do not have a coordination of benefits provision will pay first.

(2) Benefit plans with a coordination of benefits provision will pay benefits up to the Allowable Charge as follows:

(a) The benefit plan which covers the person directly (that is, as an employee, member or subscriber) will determine benefits thereunder before benefits are considered under a benefit plan which covers the person as a dependent.

(b) The benefit plan which covers a person as an employee who is neither laid-off nor retired will determine benefits before a benefit plan which covers that person as a laid-off or retired employee. The benefit plan which covers a person as a dependent of an employee who is neither laid-off nor retired will determine benefits thereunder before benefits are considered under a benefit plan which covers a person as a dependent of a laid-off or retired employee.

(c) The benefit plan which covers a person as an employee who is neither laid-off nor retired will determine benefits before benefits are considered under a benefit plan which covers that person as a laid-off or retired employee. If the other benefit plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.

(d) The benefit plan which covers a person as an employee who is neither laid-off nor retired or a dependent of an employee who is neither laid-off nor retired will determine benefits before benefits are considered under a benefit plan which covers the person as a COBRA beneficiary.

(e) When a child is covered as a dependent and the parents are not separated or divorced, the following rules will apply:

(i) The benefit plan of the parent whose birthday falls earlier in a year will determine benefits before benefits are considered under a benefit plan of the parent whose birthday falls later in that year;

(ii) If both parents have the same birthday, the benefit plan which has covered the patient for the longer period of time will determine benefits before benefits are considered under the benefit plan which covers the other parent.

(f) When a child's parents are divorced or legally separated, the following rules will apply:

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

(ii) This rule applies when the parent with custody of the child has remarried. First, the benefit plan of the parent with custody determine benefits. Next, the benefit plan of the stepparent that covers the child as a dependent will determine benefits. Finally, the benefit plan of the parent without custody will determine benefits.

(iii) This rule will be in place of items (i) and (ii) above when it applies. A court decree may state which parent is financially responsible for medical and dental benefits of the child. In this case, the benefit plan of that parent will determine benefits before benefits are considered under other plans that cover the child as a Dependent.
(iv) If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the benefit plans covering the child shall follow the order of benefit determination rules outlined above when a child is covered as a Dependent and the parents are not separated or divorced.

(g) When a child's parents were never married to each other, the rules as set out above in letter (e), will apply as long as paternity has been established.

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

(3) Medicare will pay primary, secondary or last, as specified in applicable law.

When Medicare is the primary payor, the Plan will base its payment upon benefits allowable by Medicare. If the Covered Person did not elect coverage under Medicare Parts A and/or B when eligible, the Plan will be secondary and coordinate with benefits that would have been provided by Medicare.

(4) If a Covered Person is under a disability extension from a previous benefit plan, that benefit plan will pay first and the Plan will pay second.
OTHER IMPORTANT PLAN PROVISIONS

Assignment Of Benefits. No benefit under the Plan shall be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge, and any attempt to do so shall be void. No benefit under the Plan shall in any manner be liable for or subject to the debts, contracts, liabilities, engagements or torts of any person.

Notwithstanding the foregoing, the Plan will honor any Qualified Medical Child Support Order (“QMCSO”) which provides for coverage under the Plan for an Alternate Recipient, in the manner described in ERISA Section 609(a) and in the Plan's QMCSO Procedures.

Inability to Locate Recipient. If the Plan Administrator is unable to make payment to any Covered Person or other person to whom a payment is due under the Plan because it cannot ascertain the identity or whereabouts of such Covered Person or other person after reasonable efforts have been made to identify or locate such person (including a notice of the payment so due mailed to the last known address of such Covered Person or other person as shown on the records of the Employer), such payment and all subsequent payments otherwise due to such Covered Person or other person shall be forfeited eighteen (18) months after the date such payment first became due.
THIRD PARTY RECOVERY PROVISION

RIGHT OF SUBROGATION AND REFUND

When this provision applies. As a condition to accepting and receiving benefits under the Plan, Covered Person(s), including all Dependents, agree that their rights to make a claim, sue and recover damages when the injury or illness giving rise to the benefits occurs through the negligent or intentional act or omission of another person is automatically transferred to the Plan at the time the benefits have been paid by the Plan.

Alternatively, and in the sole discretion of the Plan, if a Covered Person receives any full or partial recovery, by way of award, judgment, settlement or otherwise, from another person or business entity, including any underinsured or uninsured motorists coverage that applies to the Covered Person, the Covered Person agrees to reimburse the Plan, in first priority, for any benefits paid by the Plan from a fund created by the money received from the award, judgment, settlement or other payments up to the amount of any benefits paid by the Plan (i.e., the Plan shall be first reimbursed fully, to the extent of any and all benefits paid by the Plan, from any monies received, with the balance, if any, retained by the Covered Person).

The obligation to reimburse the Plan, in full, in first priority, exists regardless of whether the award, judgment, settlement or other payment specifically designates the recovery, or a portion thereof, as including Plan expenses or specifically excludes Plan benefits. Furthermore, the obligation to reimburse the Plan, in full, in first priority, exists regardless of whether the award, judgment, settlement or other recovery together with all other previous or anticipated recoveries fully compensates the Covered Person for any damages the Covered Person may have experienced. The Plan is not subject to the Made Whole Doctrine or any other similar legal doctrine or theory.

This provision is effective regardless of whether an agreement to this effect is actually signed. The Plan’s rights of full recovery, either by way of subrogation or right of reimbursement, may be from funds the Covered Person receives or is entitled to receive from the third party, any liability or other insurance covering the third party, the Covered Person’s own uninsured motorist insurance or underinsured motorist coverage, any medical, disability or other benefit payments, no-fault or school insurance coverage, or other amounts which are paid or payable to or on behalf of the Covered Person as a result of the damages caused by the other person.

The Plan may enforce its reimbursement or subrogation rights by requiring the Covered Person to assert a claim to any of the foregoing coverage to which he or she may be entitled. The Plan will not pay attorney fees or costs associated with the Covered Person’s claim without prior express written authorization by the Plan. The Plan will not be subject to the Common Fund Doctrine or any “make whole” or other subrogation rules.
A federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), requires that most employers sponsoring a group health plan offer covered Employees and their covered spouses and dependent children the opportunity for a temporary extension of health coverage (called "COBRA continuation coverage") in certain instances where coverage under the Plan would otherwise end. This section is intended to inform you, in summary fashion, of the rights and obligations under the continuation coverage provisions of COBRA, as amended and reflected in regulations issued by the Department of the Treasury and the Department of Labor. This section is intended to reflect the law and does not grant or take away any rights that apply under applicable law. Instructions on COBRA rights and procedures, as well as election forms and other information, will be provided by the Plan Administrator to Covered Persons who become Qualified Beneficiaries under COBRA.

What is COBRA continuation coverage? COBRA continuation coverage is group health plan coverage that an employer must offer to certain Plan Participants and their eligible family members (called "Qualified Beneficiaries") at specific rates for up to a statutory-mandated maximum period of time or until they become ineligible for COBRA continuation coverage, whichever occurs first. The right to COBRA continuation coverage is triggered by the occurrence of one of certain enumerated events that result in the loss of coverage under the terms of the Plan (the "Qualifying Event"). The continuation coverage is identical to the coverage under the Plan that the Qualified Beneficiary had immediately before the Qualifying Event, or, if the coverage has been changed, the coverage is identical to the coverage provided to similarly situated Active Employees who have not experienced a Qualifying Event.

Who is a Qualified Beneficiary? In general, a Qualified Beneficiary is:

(i) Any individual who, on the day before a Qualifying Event, is covered under the Plan as either a covered Employee, the Spouse of a covered Employee, or a Dependent child of a covered Employee, and who loses coverage under the Plan because of the Qualifying Event.

(ii) Any child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage.

In addition, if the Qualifying Event is a bankruptcy proceeding under Title 11 of the U.S. Code with respect to an Employer, a covered retired Employee (who retired from employment with that Employer) and any individual who is covered under the Plan as the Spouse, surviving Spouse or Dependent child of such a retired Employee may also be Qualified Beneficiaries. Those individuals are qualified beneficiaries only if (1) for the Employee, he or she retired on or before the date of substantial elimination of coverage and (2) for any other individuals, they were beneficiaries under the Plan on the day before the bankruptcy proceeding commenced.

An individual is not a Qualified Beneficiary if the individual's status as a covered Employee is attributable to a period in which the individual was a nonresident alien who received from the individual's Employer no earned income that constituted income from sources within the United States. If, for the reason described in the preceding sentence, an individual is not a Qualified Beneficiary, then a Spouse or Dependent child of the individual is not a Qualified Beneficiary by virtue of the relationship to the individual.

Each Qualified Beneficiary (including a child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage) is offered the opportunity to make an independent election to receive COBRA continuation coverage.

What is a Qualifying Event? A Qualifying Event is any of the following if an Employee, a Spouse or a Dependent child would lose coverage (i.e., would cease to be covered under the same terms and conditions as in effect immediately before the Qualifying Event) in the absence of COBRA continuation coverage.

For a covered Employee, the following may be a Qualifying Event:

(i) The termination (other than because of the Employee's gross misconduct), or reduction of hours, of a covered Employee's employment.
For a covered Spouse, in addition to (i), the following may be Qualifying Events:

(ii) The death of a covered Employee.

(iii) The divorce or legal separation of a covered Employee from the Employee's Spouse.

(iv) A covered Employee's entitlement to Medicare.

For a covered Dependent child, in addition to events (i)-(iv) above, the following may be a Qualifying Event:

(v) A Dependent child's ceasing to satisfy the Plan's requirements for coverage as a Dependent child (e.g., attainment of the maximum age for dependency under the Plan).

Finally, for a covered retired Employee (or a Spouse, surviving Spouse, or Dependent who has coverage as the Spouse, surviving Spouse or Dependent of a retired Employee), the following may also be a Qualifying Event:

(vi) A proceeding in bankruptcy under Title 11 of the U.S. Code with respect to an Employer from whose employment a covered retired Employee retired at any time.

If the Qualifying Event causes the Employee, or the Spouse or a Dependent child of the covered Employee, to cease to be covered under the Plan under the same terms and conditions as in effect immediately before the Qualifying Event (the persons losing such coverage become Qualified Beneficiaries under COBRA. In addition, if a bankruptcy Qualifying Event causes a former Employee (who retired on or before the date of a substantial elimination of coverage), or such a former Employee's Spouse, surviving Spouse or Dependent child to experience a substantial elimination of coverage under the Plan occurring within 12 months before or after the date the bankruptcy proceeding commences), that former Employee, Spouse, surviving Spouse or Dependent child becomes a Qualified Beneficiary under COBRA. Any increase in contribution that must be paid by a covered Employee, former Employee or the Spouse, surviving Spouse or a Dependent child of the covered Employee, for coverage under the Plan that results from the occurrence of one of the events listed above is a loss of coverage.

The taking of leave under the Family and Medical Leave Act of 1993 ("FMLA") does not constitute a Qualifying Event. A Qualifying Event occurs, however, if a covered Employee does not return to employment at the end of the FMLA leave. If a Qualifying Event occurs, it occurs on the last day of FMLA leave and the applicable maximum coverage period is measured from this date. Note that the covered Employee and covered Family members will be entitled to COBRA continuation coverage even if they failed to pay the employee portion of premiums for coverage under the Plan during the FMLA leave.

**What is the election period and how long must it last?** An election period is the time period within which the Qualified Beneficiary can elect COBRA continuation coverage under the Plan. Availability of COBRA continuation coverage is conditioned upon the timely election of such coverage. The election period begins on the date of the Qualifying Event and ends 60 days after the later of (1) the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event or (2) the date notice is provided to the Qualified Beneficiary of her or his right to elect COBRA continuation coverage.

**Is a covered Employee or Qualified Beneficiary responsible for informing the Plan Administrator of the occurrence of a Qualifying Event?** Yes, in some cases. Each covered Employee or Qualified Beneficiary is responsible for notifying the Plan Administrator of the occurrence of a Qualifying Event that is:

(i) A Dependent child's ceasing to be a Dependent child under the Plan.

(ii) The divorce or legal separation of the covered Employee.
A Qualified Beneficiary (or the covered Employee or Spouse) must notify the Plan Administrator within 60 days after the later of the date one of these Qualifying Events occurs.

This notice must be provided, along with any required documentation to:

Plan Administrator
COBRA Qualifying Event
University of Notre Dame du Lac
Office of Human Resources
100 Grace Hall
Notre Dame, Indiana  46556-5612
ATTN:  Accountant

The notice must be provided in writing in a letter addressed to the Plan Administrator. The notice must include:

(i) The covered Employee's name, address, phone number and health plan ID number.

(ii) The name, address, phone number and health plan ID number for any Dependent child or Spouse whose eligibility is affected by the qualifying event.

(iii) A description of the Qualifying Event (or a notice of a disability determination or termination of disability status, as described below) and the date on which it occurred.

(iv) The following statement: "By signing this letter, I certify that the Qualifying Event described in this letter occurred on the date described in this letter." If the notice concerns a disability determination or a change in disability status, as described below, this statement is not required.

(v) The signature of the person sending the letter.

The Qualified Beneficiary (or the covered Employee or Spouse) must also provide, along with the letter, documentation of the event that occurred, such as a photocopy of a divorce order or legal separation order showing the date of the divorce or the date the legal separation began. If a Qualified Beneficiary or anyone else has a question about what type of documentation is required, he or she should contact the Plan Administrator.

In addition to accepting a letter with the information described above, the Plan Administrator, in its discretion, may develop and make available a form, which may then be completed to provide the required notice. If such a form is available, a covered Employee or a covered Spouse or Dependent child may obtain a copy by requesting it from the Plan Administrator at the address provided in this notice.

The Plan is not required to offer the Qualified Beneficiary an opportunity to elect COBRA continuation coverage if the notice is not provided to the Plan Administrator within 60 days after the later of (1) the date of the Qualifying Event or (2) the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event.

Is a waiver before the end of the election period effective to end a Qualified Beneficiary's election rights? If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of COBRA continuation coverage. However, if a waiver is later revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent to the Employer or Plan Administrator, as applicable.
When may a Qualified Beneficiary’s COBRA continuation coverage be terminated? COBRA continuation coverage ends on the earliest of the following dates:

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

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

(iii) The date upon which the Employer ceases to provide any group health plan (including successor plans) to any Employee.

(iv) The date, after the date of the election, that the Qualified Beneficiary first becomes covered under any other group health plan that does not include an exclusion or limitation with respect to any pre-existing condition that would affect the Qualified Beneficiary.

(v) The date, after the date of the election, that the Qualified Beneficiary is first entitled to Medicare. This date does not apply for anyone who became a Qualified Beneficiary because of a bankruptcy proceeding.

(vi) For a Qualified Beneficiary who is entitled to a disability extension, the later of:

(a) the first day of the first month that is later than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary’s entitlement to the disability extension is no longer disabled, whichever is earlier; or

(b) the last day of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension.

The Plan can terminate for cause the coverage of a Qualified Beneficiary on the same basis that the Plan terminates for cause the coverage of similarly situated non-COBRA participants, (for example, for fraud.)

In the case of an individual who is not a Qualified Beneficiary and who is receiving coverage under the Plan solely because of the individual's relationship to a Qualified Beneficiary, if the Plan’s obligation to make COBRA continuation coverage available to the Qualified Beneficiary ceases, the Plan is not obligated to make coverage available to the individual who is not a Qualified Beneficiary.

What are the maximum coverage periods for COBRA continuation coverage? The maximum coverage periods are based on the type of the Qualifying Event and the status of the Qualified Beneficiary, as shown below.

(i) If the Qualifying Event is a termination of employment or reduction of hours of employment, except as provided in paragraphs (ii) and (iii) below, the maximum coverage period ends 18 months after the Qualifying Event.

(ii) If the Qualifying Event is a termination of employment or reduction of hours of employment and the Qualified Beneficiary is entitled to a disability extension, the maximum coverage period ends 29 months after the Qualifying Event if there is a disability extension (unless the disability ends before the end of that 29- month period).
(iii) If a covered Employee becomes entitled to Medicare before experiencing a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period for Qualified Beneficiaries other than the covered Employee ends on the later of:

(a) 36 months after the date the covered Employee becomes entitled to Medicare; or

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

(iv) For a bankruptcy Qualifying Event, the maximum coverage period for a Qualified Beneficiary who is a retired covered Employee (or a surviving Spouse on the day before the bankruptcy Qualifying Event) ends on the date of the covered retired Employee's (or surviving Spouse's) death. The maximum coverage period for a Qualified Beneficiary who is the Spouse or Dependent child of the covered retired Employee ends 36 months after the death of the covered retired Employee.

(v) For a Qualified Beneficiary who is a child born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, the maximum coverage period is the maximum coverage period applicable to the Qualifying Event giving rise to the period of COBRA continuation coverage during which the child was born or placed for adoption.

(vi) For any Qualifying Event other than those described above, the maximum coverage period ends 36 months after the Qualifying Event.

Under what circumstances can the maximum coverage period be expanded? If a Qualifying Event that gives rise to an 18-month or 29-month maximum coverage period is followed, within that 18- or 29-month period, by a second Qualifying Event that gives rise to a 36-month maximum coverage period, the maximum coverage period may be expanded to 36 months, but only for individuals who are Qualified Beneficiaries at the time of both Qualifying Events. In no circumstance can the COBRA maximum coverage period be expanded to last longer than 36 months after the date of the first Qualifying Event.

However, no event is a second Qualifying Event unless that event would have been an initial Qualifying Event if it had occurred for an active covered Employee. For example, an Employee's entitlement to Medicare cannot be a second Qualifying Event for a Spouse or a Dependent child unless an active Employee's entitlement to Medicare would have been an initial Qualifying Event, i.e., unless an Employee's entitlement to Medicare would have resulted in a loss of coverage for the Spouse or Dependent child.

A Qualified Beneficiary (or a covered Employee or Spouse) must notify the Plan Administrator of a second Qualifying Event within 60 days after the later of the date of the Qualifying Event or the date the Qualified Beneficiary would lose coverage because of the Qualifying Event. To submit this notice, the Qualified Beneficiary must follow the procedures described above under "Is a covered Employee or Qualified Beneficiary responsible for informing the Plan Administrator of the occurrence of a Qualifying Event?"

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

If a Qualified Beneficiary becomes entitled to a disability extension and then there is a final determination by the Social Security Administration, under title II or XVI of the Social Security Act, that the Qualified Beneficiary is no longer disabled, the Qualified Beneficiary (or the covered Employee or someone else must notify the Plan Administrator of the occurrence of a disability extension. To submit this notice, the Qualified Beneficiary must follow the procedures described above under "Is a covered Employee or Qualified Beneficiary responsible for informing the Plan Administrator of the occurrence of a disability extension?"
Administrator of that determination within 30 days after the date of the final determination. The notice should take the form of a letter as described above under "Is a covered Employee or Qualified Beneficiary responsible for informing the Plan Administrator of the occurrence of a Qualifying Event?"

**Can a Plan require payment for COBRA continuation coverage?** Yes. For any period of COBRA continuation coverage, the Plan will require the payment of an amount equal to 102% of the actual cost of coverage except the Plan will require the payment of an amount equal to 150% of the actual cost of coverage for any period of COBRA continuation coverage covering a disabled qualified beneficiary that would not be required to be made available in the absence of a disability extension.

**Must the Plan allow payment for COBRA continuation coverage to be made in monthly installments?** Yes.

**What is Timely Payment for payment for COBRA continuation coverage?** For regular monthly payments, Timely Payment means a payment made by the first day of the month in question (the "due date") or within a 30 day grace period beginning on that due date.

Notwithstanding the above paragraph, the Plan will not require payment for any period of COBRA continuation coverage for a Qualified Beneficiary earlier than 45 days after the date on which the election of COBRA continuation coverage is made for that Qualified Beneficiary. Payment is considered made on the date on which it is sent to the Plan.

**Special Additional Continuation Coverage Election Period for "TAA-Eligible Individuals".** In addition to the other COBRA rules described in the Plan, there are some special rules that apply if an individual is classified as a "TAA-eligible individual" by the U.S. Department of Labor. (This applies only if the individual qualifies for assistance under the Trade Adjustment Assistance Reform Act 2002 because he or she became unemployed as a result of increased imports or the shifting of production to other countries.)

If an individual who is classified by the Department of Labor as a TAA-eligible individual does not elect continuation coverage when he or she first loses coverage, he or she may qualify for an election period that begins on the first day of the month in which the individual becomes a TAA-eligible individual and lasts up to 60 days. However, in no event does this election period last later than 6 months after the date of the individual's TAA-related loss of coverage. If a TAA eligible individual elects continuation coverage during this special election period, continuation coverage would begin at the beginning of that election period, but, for purposes of determining the maximum required COBRA coverage period, the coverage period will be measured from the date of the original Qualifying Event, i.e., the TAA-related loss of coverage.

The Trade Adjustment Assistance Act also provides for a tax credit that may apply to some expenses for continuation coverage. An affected individual should consult with a financial advisor if he or she has questions about the tax credit.
RESPONSIBILITIES FOR PLAN ADMINISTRATION

PLAN ADMINISTRATOR. The Plan Sponsor shall be the Plan Administrator. The Plan Administrator shall be the named fiduciary for purposes of ERISA. Except as to those functions reserved to the Plan Sponsor, the Plan Administrator shall control and manage the operation and administration of the Plan.

The Plan Administrator shall administer the Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of the Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits, to decide disputes which may arise relative to a Plan Participant's rights, and to decide questions of interpretation of the Plan and those of fact relating to the Plan. The decisions of the Plan Administrator will be final and binding on all interested parties and may not be reversed by a court of competent jurisdiction unless held to be arbitrary and capricious.

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

SELF-FUNDED NATURE OF PLAN

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

All Plan benefits are paid from the Employer's general assets. No trust or other separate fund is maintained in connection with the Plan.

The level of any Employee contributions will be set by the Plan Sponsor.

PLAN IS NOT AN EMPLOYMENT CONTRACT

The Plan is not to be construed as a contract of employment. Nothing contained in the Plan shall be deemed:

(1) to give any Employee the right to be retained in the employ of the Employer; or

(2) to affect the right of the Employer to discipline or discharge any Employee at any time.

ADMINISTRATIVE ERROR

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

AMENDING, MODIFYING AND TERMINATING THE PLAN

If the Plan is terminated, the rights of the Plan Participants are limited to covered expenses incurred before termination. If the Plan is amended or modified, expenses incurred prior to the modification or amendment of the Plan will be considered as provided under the terms of the Plan prior to its amendment or modification.

The Employer by action evidenced in writing reserves the right, at any time, without prior notice, to amend, suspend or terminate the Plan in whole or in part, with respect to any class of eligible Employees (including retired eligible Employees) or Dependents. In the event of the dissolution, merger, consolidation or reorganization of the Plan Sponsor, the Plan automatically will terminate unless it is continued by a successor to the Plan Sponsor.
PARTICIPANT'S RIGHTS UNDER ERISA

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

1. Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, and union halls, if applicable, all Plan documents and copies of all documents governing the Plan, including benefit contracts and collective bargaining agreements, if any, 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 Employee Benefits Security Administration.

2. Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including benefit contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 series) and an updated summary plan description. The Employee may have to pay a reasonable charge to the Plan Administrator to cover the cost of photocopying.

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

Continue Group Health Plan Coverage. Continue health care coverage for the Employee or eligible Dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event. The Employee and his or her Dependents may have to pay for such coverage. Review the documents governing the Plan (including this Plan document and Summary Plan Description) on the rules governing each Covered Person's rights to COBRA continuation coverage.

Reduction or elimination of exclusionary periods of coverage for Pre-Existing conditions under the Plan, if the Covered Person has Creditable Coverage from another plan. The Covered Person should be provided a certificate of Creditable Coverage, free of charge, from the Plan or health insurance issuer when the Covered Person loses coverage under the Plan, when the Covered Person becomes entitled to elect COBRA continuation coverage, when the Covered Person’s COBRA continuation coverage ceases, if the Covered Person requests it before losing coverage, or if the Covered Person requests it up to 24 months after losing coverage. Without evidence of Creditable Coverage, the Covered Person may be subject to a Pre-Existing Condition exclusion for up to 12 months (18 months for late enrollees) after the Covered Person's Enrollment Date.

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

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

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

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

If the Plan Participant has a claim for benefits which is denied or ignored, in whole or in part, the participant may file suit in state or federal court.

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

**Assistance With Questions.** If the Plan Participant has any questions about the Plan, he or she should contact the Plan Administrator. If the Plan Participant has any questions about this statement or his or her rights under ERISA, or if the Plan Participant needs assistance in obtaining documents from the Plan Administrator, that Plan Participant should contact either the nearest area office of the Employee Benefits Security Administration, U.S. Department of Labor listed in the 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, DC 20210. The Plan Participant may also obtain certain publications about his or her rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.
HEALTH INFORMATION PRIVACY AND SECURITY

SCOPE OF SECTION

This Section is intended to provide for the Plan's compliance with all applicable requirements of final Regulations issued by the Department of Health and Human Services pursuant to the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 and published as the "Standards for Privacy of Individually Identifiable Health Information" (the "Privacy Regulations") and the "Health Insurance Reform: Security Standards" (the "Security Regulations") and other applicable guidance, as well as all applicable requirements of Subtitle D of the "Health Information Technology for Economic and Clinical Health Act" (the "HITECH Act") and any authoritative guidance issued pursuant to that Act, if and as they become applicable to the Plan.

This Section applies only to benefits offered under the Plan that are subject to the Privacy and Security Regulations (as determined by the Plan Administrator). For purposes of those benefits, the Plan will comply with all applicable requirements of the Privacy Regulations, the Security Regulations and Subtitle D of the HITECH Act, as interpreted pursuant to any authoritative guidance issued by the Department of Health and Human Services. If there is any conflict between the requirements of the Privacy and Security Regulations or Subpart D of the HITECH Act and any provision of this Plan, applicable law will control. Also, any amendment or revision or authoritative guidance relating to the Privacy and Security Regulations or of Subpart D of the HITECH Act is hereby incorporated into the Plan as of the date that the Plan is required to comply with that guidance.

PROTECTED HEALTH INFORMATION

For purposes of this Section, "Protected Health Information" has the same meaning as provided for that term in the Privacy Regulations and is limited to information that is Protected Health Information with respect to the Plan.

DISCLOSURE OF PROTECTED HEALTH INFORMATION TO PLAN SPONSOR

The Plan will disclose Protected Health Information to the Plan Sponsor only as follows:

(a) **Summary Health Information.** The Plan, or a health insurance issuer or HMO with respect to the Plan, may disclose Protected Health Information that is summary health information to the Plan Sponsor if the Plan Sponsor requests the summary health information for the purpose of:

   (i) Obtaining premium bids from insurance issuers for providing health insurance coverage under the Plan; or

   (ii) Modifying, amending or terminating the Plan.

For purposes of this subsection, "summary health information" means information that summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom the Plan Sponsor has provided health benefits under the Plan, from which certain identifying details have been removed, as provided in section 164.504(a) of the Privacy Regulations.

(b) **Enrollment Information.** The Plan, or a health insurance issuer or HMO with respect to the Plan, may disclose to the Plan Sponsor information on whether an individual is participating in the Plan, or is enrolled in or has disenrolled from a health option or HMO offered by the Plan.

(c) **Other Disclosures to Plan Sponsor.** Except as provided in subsections (a) or (b) above, or under the terms of an applicable individual authorization, the Plan may disclose Protected Health Information to the Plan Sponsor and may permit the disclosure of Protected Health Information by a health insurance issuer or HMO with respect to the Plan to the Plan Sponsor only if the Plan Sponsor requires the Protected Health Information to administer the Plan.
The Plan Sponsor, by signing this document, certifies that it:

(i) will not use or further disclose Protected Health Information other than as permitted or required by the Plan or as required by law;

(ii) will ensure that any agents to whom it provides Protected Health Information received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information;

(iii) will not use or disclose the information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor;

(iv) will report to the Plan any use or disclosure, of which it becomes aware, of the information that is inconsistent with the uses or disclosures permitted under the Plan;

(v) will make Protected Health Information available to the individual who is the subject of that information in accordance with Section 164.524 of the Privacy Regulations;

(vi) will consider requested amendments to an individual's Protected Health Information in accordance with Section 164.526 of the Privacy Regulations;

(vii) will make available the information required to provide an accounting of disclosures of Protected Health Information in accordance with Section 164.528 of the Privacy Regulations;

(viii) will make its internal practices, books, and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Regulations;

(ix) if feasible, will return or destroy all Protected Health Information received from the Plan that the Plan Sponsor still maintains in any form and will retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if return or destruction is not feasible, the Plan Sponsor will limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and

(x) will ensure that the adequate separation of the Plan and the Plan Sponsor as required in this Section is established.

(d) Prohibited Disclosures. The Plan will not disclose Protected Health Information to the Plan Sponsor for the purpose of employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

SEPARATION OF HEALTH PLANS AND PLAN SPONSOR

The Plan is a legal entity separate from the Plan Sponsor. The Plan Sponsor has designated and trained certain employees of the Plan Sponsor as the only employees of the Plan Sponsor who will have access to Protected Health Information.

The Plan Sponsor will work with the Plan's designated Privacy Official to establish effective policies and procedures for identifying, investigating, remedying and disciplining any alleged instances of noncompliance with the requirement that employees of the Plan Sponsor who have access to Protected Health Information use that Protected Health Information only for the purposes specified in this Section.
PRIVACY NOTICE

The Plan will comply with the applicable requirements of the Privacy Notice issued by the Plan pursuant to the requirements of the Privacy Regulations and the Plan’s Privacy Notice is incorporated into the Plan by this reference. If the Privacy Notice is revised, the Plan will comply with the revised Privacy Notice as of the effective date of the revision. A revised Privacy Notice is incorporated into the Plan as of the effective date of each revision without the need for further amendment of the Plan.

HIPAA SECURITY REGULATIONS

The Plan Sponsor, by adopting this document, certifies that it will:

- Reasonably and appropriately safeguard electronic Protected Health Information created, received, maintained, or transmitted to or by the Plan Sponsor or the Employer on behalf of the Plan;

- Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information that it creates, receives, maintains, or transmits on behalf of the Plan;

- Ensure that the adequate separation required by §164.504(f)(2)(iii) of the Privacy Regulations is supported by reasonable and appropriate security measures;

- Ensure that any agent, including a subcontractor, to whom it provides electronic Protected Health Information agrees to implement reasonable and appropriate security measures to protect that information; and

- Report to the Plan any security incident of which it becomes aware.

OTHER ADMINISTRATIVE SIMPLIFICATION REGULATIONS

Notwithstanding any other provision of the Plan, the Plan will comply with all applicable requirements of the Administrative Simplification regulations issued by the Department of Health and Human Services pursuant to the Health Insurance Portability and Accountability Act of 1996, as they become applicable to the Plan and the Plan shall be construed to be consistent with such requirements.
GENERAL PLAN INFORMATION

TYPE OF ADMINISTRATION
The Plan is a self-funded group health plan administered by the Employer.

PLAN NAME
University of Notre Dame Meritain CHA HMO

PLAN NUMBER: 510

TAX ID NUMBER: 35-0868188

INITIAL PLAN EFFECTIVE DATE: January 1, 2003

RESTATATED PLAN EFFECTIVE DATE: January 1, 2011

PLAN YEAR: The 12-month period for the Plan Sponsor preceding December 31, unless otherwise stated.

EMPLOYER INFORMATION

University of Notre Dame du Lac
100 Grace Hall
Notre Dame, Indiana 46556-5612
574-631-9718

AGENT FOR SERVICE OF LEGAL PROCESS

University of Notre Dame du Lac
100 Grace Hall
Notre Dame, Indiana 46556-5612

CLAIMS PROCESSOR

Meritain Health
P.O. Box 853921
Richardson, Texas 75085-3921
BY THIS AGREEMENT, University of Notre Dame Meritain CHA HMO, amended and restated as of January 1, 2011 is hereby adopted as shown.

IN WITNESS WHEREOF, this instrument is executed for University of Notre Dame du Lac on or as of the day and year first below written.

By ____________________________________
   University of Notre Dame du Lac
Date ____________________________________

Witness __________________________________________
Date __________________________________________