PLAN DOCUMENT
SUMMARY PLAN DESCRIPTION

FOR

CLARK ATLANTA UNIVERSITY

EMPLOYEE HEALTH BENEFIT PLAN

G - 5540

PLAN EFFECTIVE DATE:
JANUARY 1, 2004
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FOREWORD

TO ALL EMPLOYEES:

We are all aware of the financial disaster that a family may experience as a result of a serious or prolonged illness or accident. The medical benefits available under the Clark Atlanta University Employee Health Benefit Plan (the Plan) and described in this Plan document and summary plan description (SPD) are designed to provide some protection for you and your family against such a disaster.

In sponsoring this Plan, the Company has attempted to provide the best coverage possible within the financial limits of both the Company and you. In keeping with this goal, we periodically review the Plan to ensure we maintain an adequate and reasonably priced program.

The cost of this Plan is in direct proportion to the Claims paid. Therefore, it is important that all Employees and their families use the Plan wisely so the cost will remain affordable to all of us. In addition, the amount of your contribution to the Plan is subject to change at the discretion of the Company.

The Company has selected INTRACORP, a health benefit management service, to provide pre-hospitalization and continued stay review for all persons covered by the Plan. A Covered Person must contact INTRACORP at (800) 822-4692 at least 72 hours prior to any scheduled admission for a medical condition, Mental and Nervous Disorder, or Chemical Dependency treatment. In case of an emergency Hospital admission or emergency surgery, INTRACORP must be notified within two (2) working days of admission. Except in certain cases concerning childbirth, as described more fully in this Plan, all Covered Persons must use the INTRACORP pre-hospitalization and continued stay review service to obtain full benefits under this Plan.

The administration of the Plan may include pre-admission reviews, length of stay reviews, utilization reviews, retrospective reviews, audits, and managed care; each and all of which to such extent as is appropriate to ensure that neither Covered Persons nor the Company incur avoidable hospitalization or other costs in obtaining quality, appropriate medical care covered by the Plan.

Payment of covered charges will be withheld if pre-certification for treatment is based on a diagnosis for which treatment is covered, but the treatment is actually undertaken for a condition which is not covered by the Plan. In no event will pre-certification guarantee payment of any Claims.

In addition to describing your benefits, this Plan document and SPD explain other important procedures such as how you become eligible and how to file a claim for benefits.
IMPORTANT: If, at any time, you have questions about the Plan, please contact the Plan's Administrative Service Agent, Group Resources® Incorporated, for assistance. Group Resources® Incorporated is always available to assist you with your questions.

We are pleased to offer the benefits under this Plan for you and your covered family members as an expression of our appreciation for your efforts on behalf of our Company.

Clark Atlanta University
We understand that your medical information is private, and we are committed to maintaining the privacy of your medical information. Effective on or after April 14, 2004, the Plan will follow the policies below to help ensure that your medical information remains private.

Each time you submit a claim to the Plan for reimbursement, and each time you see a health care provider who is paid by the Plan, a record is created. The record may contain your medical information. In general, the Plan will only use or disclose your medical information without your authorization for the specific reasons detailed below. Except in limited circumstances, the amount of information used or disclosed will be limited to the minimum necessary to accomplish the intent of the use or disclosure.

PERMITTED USES AND DISCLOSURES. The following categories describe different ways that the Plan may use or disclose your medical information. Not every use or disclosure in a category will be listed. However, all of the ways the Plan is permitted to use and disclose information will fall within one of the categories.

Treatment. The Plan may use or disclose your medical information to facilitate medical treatment or services by providers. The Plan may disclose your medical information to providers, including doctors, nurses, technicians, pharmacists, medical students, or other hospital personnel who are involved in your care. For example, the Plan might disclose information about your prior prescriptions to a pharmacist to determine if a pending prescription is contraindicative with prior prescriptions.

Payment. The Plan may use and disclose your medical information to determine eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. For example, the Plan may tell your health care provider about your medical history to determine whether a particular treatment is Experimental/Investigational, or Medically Necessary or to determine whether the Plan will cover the treatment. The Plan may also share medical information with a utilization review or pre-certification service provider. Likewise, the Plan may share medical information with another entity to assist with the adjudication or subrogation of health claims or to another health plan to coordinate benefit payments.

Health Care Operations. The Plan may use and disclose your medical information for other Plan operations. These uses and disclosures are necessary to run the Plan. For example, the Plan may use medical information in connection with: conducting quality assessment and improvement activities; underwriting, premium rating, and other activities relating to Plan coverage; submitting claims for stop-loss (or excess loss) coverage; conducting or arranging for medical review, legal services, audit services, and fraud and abuse detection programs; business planning and development such as cost management; and business management and general Plan administrative activities.
Requirement by Law. The Plan will disclose your medical information when required to do so by federal, state, or local law. For example, the Plan may disclose medical information when required by a court order in a litigation proceeding such as a malpractice action.

Aversion of a Serious Threat to Health or Safety. The Plan may use or disclose your medical information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat. For example, the Plan may disclose your medical information in a proceeding regarding the licensure of a physician.

Organ and Tissue Donation. If you are an organ donor, the Plan may release your medical information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans. If you are a member of the armed forces, the Plan may release your medical information as required by military command authorities. The Plan may also release medical information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation. The Plan may release your medical information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. The Plan may disclose your medical information for public health activities. These activities generally include the following:
  • to prevent or control disease, injury, or disability;
  • to report births and deaths;
  • to report child abuse or neglect;
  • to report reactions to medications or problems with products;
  • to notify people of recalls of products they may be using;
  • to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
  • to notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities. The Plan may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.
Lawsuits and Disputes. If you are involved in a lawsuit or dispute, the Plan may disclose your medical information in response to a court or administrative order. The Plan may also disclose your medical information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. The Plan may release your medical information if asked to do so by a law enforcement official:
- in response to a court order, subpoena, warrant, summons or similar process;
- to identify or locate a suspect, fugitive, material witness or missing person;
- if you are, or are suspected to be, the victim of a crime, under certain limited circumstances, and the Plan Administrator is unable to obtain your agreement;
- about a death the Plan Administrator believes may be the result of criminal conduct;
- about criminal conduct on the Company’s premises; or
- in emergency circumstances to report a crime, the location of the crime or victims, or the identity, description, or location of the person who committed the crime.

Department of Health and Human Services. The Plan will disclose your medical information to the U.S. Department of Health and Human Services when requested for purposes of determining the Plan’s compliance with applicable regulations.

Coroners, Medical Examiners, and Funeral Directors. The Plan may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. The Plan may also release medical information about patients of the hospital to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities. The Plan may release your medical information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, the Plan may release your medical information to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

DISCLOSURES TO THE COMPANY. The Plan will disclose medical information about you to the Company only upon receipt of a certification from the Company that the Company agrees:
- not to further use or disclose medical information about you other than as permitted or required by the Plan documents or as required by law;
• to ensure that any agents, including a subcontractor, to whom it provides medical information received from the Plan agree to the same restrictions and conditions that apply to the Company with respect to such information;
• not to use or disclose the medical information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Company;
• to report to the Plan any use or disclosure of the medical information that is inconsistent with the permitted uses and disclosures;
• to make its internal practices, books, and records relating to the use and disclosure of medical information received from the Plan available to the Department of Health and Human Services for purposes of determining whether the Plan is complying with applicable regulations;
• if feasible, to return or destroy all medical information received from the Plan about you and retain no copies of the information when it is no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, to limit further uses or disclosures to those purposes that make such return or destruction infeasible; and
• to ensure that there is adequate separation between the Plan and the Company (described below).

ACCESS TO MEDICAL INFORMATION. The Plan will make your medical information available to you for inspection and copying upon your written request to the Plan Administrator. The Plan may charge a fee for the costs of copying, mailing or other supplies associated with your request. The Plan may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed.

AMENDMENT OF MEDICAL INFORMATION. If you feel that medical information the Plan has about you is incorrect or incomplete, you may ask the Plan to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan. Your request must be made in writing and submitted to the Plan Administrator. In addition, you must provide a reason that supports your request.

The Plan Administrator may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, the Plan Administrator may deny your request if you ask the Plan Administrator to amend information that:
• is not part of the medical information kept by or for the Plan;
• was not created by the Plan, unless the person or entity that created the information is no longer available to make the amendment;
• is not part of the information which you would be permitted to inspect and copy; or
• is accurate and complete.
ACCOUNTING OF DISCLOSURES. If you wish to know to whom medical information about you has been disclosed for any purpose other than (1) treatment, payment, or health care operations, (2) pursuant to your written authorization, and (3) for certain other purposes, you may make a written request to the Plan Administrator.

Your request must state a time period which may not be longer than six years and may not include dates before April 14, 2004. Your request should indicate in what form you want the list (for example, paper or electronic). The first list you request within a 12-month period will be free. For additional lists, the Plan Administrator may charge you for the costs of providing the list. The Plan Administrator will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

The accounting will not include disclosure for the purposes of treatment, payment, or health care operations. In addition, the accounting will not include disclosures which you have authorized in writing.

SEPARATION BETWEEN THE PLAN AND THE COMPANY. Only employees of the Company who are involved in the day-to-day operation and administrative functions of the Plan will have access to your medical information. In general, this will only include individuals who work in the Company’s Human Resources or Employee Benefits departments. These individuals will receive appropriate training regarding the Plan’s privacy policies. In the event an individual fails to comply with the Plan’s provisions regarding the protection of your medical information, the Company will take appropriate action in accordance with its established policy for failure to comply with the Plan’s privacy provisions.

OTHER USES OF MEDICAL INFORMATION. Any other uses and disclosures of medical information will be made only with your written authorization. If you provide the Plan authorization to use or disclose medical information about you, you may revoke that authorization, in writing, at any time. If you revoke your authorization, the Plan will no longer use or disclose medical information about you for the reasons covered by your written authorization. Please note that the Plan is unable to take back any disclosures it has already made with your authorization, and that the Plan is required to retain records of the care provided to you.
Benefits for a Covered Person are determined by the Covered Person's eligibility classification and by the terms of this Plan. Benefits under this Plan are paid according to the provisions, exclusions and limitations described in this Plan, subject to the schedule outlined below. Reimbursements of all or part of the Reasonable and Customary Charge apply only after satisfaction of any Deductible.

**CALENDAR YEAR DEDUCTIBLE**

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<th>PPO</th>
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Eligible expenses are applied to both the PPO and NON-PPO Deductible. The maximum Deductible will never exceed the amount of the NON-PPO Deductible.

**CO-INSURANCE (After satisfaction of the Calendar Year Deductible)**

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When radiology, anesthesiology, pathology, or emergency room Physician services are rendered by a NON-PPO provider at a PPO facility, and ordered by a PPO Physician, the services will be paid at the PPO rate, subject to the PPO Deductible, PPO Out-of-Pocket, or PPO Copays.

If the Covered Person lives more than 30 miles away from a participating PPO provider/facility, or in the event a NON-PPO provider/facility is used in an emergency situation, benefits will be paid at the PPO rate, subject to the PPO Deductible, PPO Out-of-Pocket, or PPO Copays.

**MAXIMUM OUT-OF-POCKET EXPENSE (Not including Deductible)**

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Eligible expenses are applied to both the PPO and NON-PPO Out-of-Pocket. The maximum Out-of-Pocket will never exceed the amount of the NON-PPO Out-of-Pocket. After the Out-of-Pocket Maximum has been satisfied, all eligible charges subsequently incurred during that Calendar Year will be paid at 100%. However, charges applied to the Deductible, Copays, penalties, and charges incurred for the treatment of Mental or Nervous Disorders or Chemical Dependency do not apply to the Out-of-Pocket Maximum.
ACUPUNCTURE THERAPY
PPO (Deductible applies)........................................................................................................ 90%
NON-PPO (Deductible applies)............................................................................................. 50%
Maximum Visits Per Calendar Year ...................................................................................... 12 visits
Maximum Per Calendar Year ............................................................................................... $500

AMBULANCE SERVICES
PPO (Deductible applies)........................................................................................................ 90%
NON-PPO (Deductible applies)............................................................................................. 50%

CHEMICAL DEPENDENCY TREATMENT
Outpatient
PPO (Deductible applies)........................................................................................................ 90%
NON-PPO (Deductible applies)............................................................................................. 50%
Inpatient
PPO (Deductible applies)........................................................................................................ 90%
NON-PPO (Deductible applies)............................................................................................. 50%
Maximum Per Calendar Year .............................................................................................. $2,000
Lifetime Maximum .............................................................................................................. $5,000

CHEMOTHERAPY/RADIATION/DIALYSIS
PPO (Deductible applies)........................................................................................................ 90%
NON-PPO (Deductible applies)............................................................................................. 50%

CHIROPRACTIC CARE (See Spinal Manipulation)

DIAGNOSTIC LAB & X-RAY
PPO (Deductible applies)........................................................................................................ 90%
NON-PPO (Deductible applies)............................................................................................. 50%

DURABLE MEDICAL EQUIPMENT
PPO (Deductible applies)........................................................................................................ 90%
NON-PPO (Deductible applies)............................................................................................. 50%

EMERGENCY ROOM SERVICES (No restrictions of Medical Necessity – Copay will be waived if admitted into the Hospital within 48 hours)
PPO (Deductible applies)........................................................................................................ $100 copay per visit, then 100%
NON-PPO (Deductible applies)............................................................................................. $100 copay per visit, then 100%
HEARING EXAM/AIDS BENEFIT
PPO (Deductible waived) ................................................................. 100%
NON-PPO (Deductible waived) ......................................................... 100%
Maximum Every Five Years ......................................................... $300

HOME HEALTH CARE
PPO (Deductible applies) ................................................................. 90%
NON-PPO (Deductible applies) ...................................................... 50%
Maximum Visits Per Calendar Year .................................................. 90 visits

(Each visit by a member of a Home Health Care team shall be considered as one Home Health Care visit and four (4) hours of home health aide services shall be considered as one Home Health Care visit.)

HOSPICE CARE
PPO (Deductible applies) ................................................................. 90%
NON-PPO (Deductible applies) ...................................................... 50%

INPATIENT HOSPITAL SERVICES (Must be pre-certified or a penalty will apply)
PPO (Deductible applies) ................................................................. 90%
NON-PPO (Deductible applies) ...................................................... 50%

The Maximum Eligible Charge for room and board in a Hospital will be:
a) for a semi-private room, the average semi-private room rate of the Hospital;
b) for a private room, the average semi-private room rate of the Hospital or, if the Hospital has private rooms only, the maximum eligible charge will be limited to 90% of the actual private room charge;
c) for intensive care, coronary care, and neonatal intensive care, the actual amount charged.

LIFETIME MAXIMUM BENEFIT ............................................................... $1,000,000

MENTAL AND NERVOUS DISORDERS TREATMENT

Outpatient
PPO (Deductible applies) ................................................................. 90%
NON-PPO (Deductible applies) ...................................................... 50%
Maximum Visits Per Calendar Year .................................................. 45 visits

Inpatient
PPO (Deductible applies) ................................................................. 90%
NON-PPO (Deductible applies) ...................................................... 50%
Maximum Days Per Calendar Year .................................................. 90 days
Two days of partial confinement in a Hospital will be considered as one day of confinement. Partial confinement means for at least 3 hours, but no more than 12 hours, in any 24-hour period.

**OCCUPATIONAL THERAPY**
- **PPO** (Deductible applies)................................. 90%
- **NON-PPO** (Deductible applies).......................... 50%
- **Maximum Per Calendar Year** ................................ $5,000

**OUTPATIENT HOSPITAL SERVICES**
- **PPO** (Deductible applies)................................. 90%
- **NON-PPO** (Deductible applies).......................... 50%
- **Maximum Per Calendar Year** ................................ $5,000

**PENALTY FOR FAILURE TO PRE-CERTIFY HOSPITAL ADMISSIONS**
(If pre-certified, will be waived)................................. $250

**PHYSICAL THERAPY**
- **PPO** (Deductible applies)................................. 90%
- **NON-PPO** (Deductible applies).......................... 50%
- **Maximum Per Calendar Year** ................................ $5,000

**PHYSICIAN’S OFFICE VISIT** (All injections performed in the Physician’s office will be at no cost)
- **PPO** (Deductible waived)................................. $25 copay per visit, then 100%
  (Copay includes visit charge, lab, and x-ray if performed in the Physician’s office)
- **NON-PPO** (Deductible applies).......................... 50%

**PHYSICIAN’S SERVICES** (Services rendered outside of the Physician's office)
- **PPO** (Deductible applies)................................. 90%
- **NON-PPO** (Deductible applies).......................... 50%

**PRIVATE DUTY NURSING**
- **PPO** (Deductible applies)................................. 90%
- **NON-PPO** (Deductible applies).......................... 50%

**SKILLED NURSING FACILITY CARE**
- **PPO** (Deductible applies)................................. 90%
- **NON-PPO** (Deductible applies).......................... 50%
- **Maximum Days Per Calendar Year** ......................... 90 days

**SPEECH THERAPY**
- **PPO** (Deductible applies)................................. 90%
- **NON-PPO** (Deductible applies).......................... 50%
- **Maximum Per Calendar Year** ................................ $5,000
SPINAL MANIPULATION TREATMENT

PPO (Deductible applies) ........................................................................................................ 90%
NON-PPO (Deductible applies) ............................................................................................. 50%

Maximum Visits Per Calendar Year ....................................................................................... 52 visits

WELLNESS EXPENSE (Includes immunizations, flu shots, mammogram, pap smear, prostate exam, colonoscopy with routine diagnosis, routine exam, lab, x-ray, and Well Baby Care)

PPO (Deductible waived) ...................................................................................................... $25 copay per visit, then 100%
NON-PPO (Deductible applies) ............................................................................................. 50%

Special immunizations will be covered if required due to travel to a foreign country.

WOMEN’S HEALTH AND CANCER RIGHTS ACT

Pursuant to the Women’s Health and Cancer Rights Act of 1998, this plan provides benefits for Covered Persons for mastectomy-related services, including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from mastectomy (including lymphedema). For further details, please see Subsection 20 of the "ELIGIBLE CHARGES" section of this Plan.
Benefits for a Covered Person are determined by the Covered Person's eligibility classification and by the terms of this Plan. Benefits under this Plan are paid according to the provisions, exclusions and limitations described in this Plan, subject to the schedule outlined below. Reimbursements of all or part of the Reasonable and Customary Charge apply only after satisfaction of any Deductible.

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**CO-INSURANCE** (After satisfaction of the Calendar Year Deductible)

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When radiology, anesthesiology, pathology, or emergency room Physician services are rendered by a NON-PPO provider at a PPO facility, and ordered by a PPO Physician, benefits will be paid at the PPO rate, subject to the PPO Out-of-Pocket or PPO Copays.

If the Covered Person lives more than 30 miles away from a participating PPO provider/facility, or in the event a NON-PPO provider/facility is used in an emergency situation, benefits will be paid at the PPO rate, subject to the PPO Out-of-Pocket and PPO Copays.

**MAXIMUM OUT-OF-POCKET EXPENSE** (Not including Deductible)

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Eligible expenses are applied to both the PPO and NON-PPO Out-of-Pocket. The maximum Out-of-Pocket will never exceed the amount of the NON-PPO Out-of-Pocket. After the Out-of-Pocket Maximum has been satisfied, all eligible charges subsequently incurred during that Calendar Year will be paid at 100%. However, charges applied to the Deductible, Copays, penalties, and charges incurred for the treatment of Mental or Nervous Disorders or Chemical Dependency do not apply to the Out-of-Pocket Maximum.
ACUPUNCTURE THERAPY
PPO ............................................................................................................................ 90%
NON-PPO (Deductible applies) ................................................................................. 50%
Maximum Visits Per Calendar Year ................................................................. 12 visits
Maximum Per Calendar Year ............................................................................ $500

AMBULANCE SERVICES
PPO ............................................................................................................................ 90%
NON-PPO (Deductible applies) ................................................................................. 50%

CHEMICAL DEPENDENCY TREATMENT
Outpatient
PPO ............................................................................................................................ 90%
NON-PPO (Deductible applies) ................................................................................. 50%
Inpatient
PPO ............................................................................................................................ 90%
NON-PPO (Deductible applies) ................................................................................. 50%
Maximum Per Calendar Year ................................................................................ $2,000
Lifetime Maximum .................................................................................................. $5,000

CHEMOTHERAPY/RADIATION/DIALYSIS
PPO ............................................................................................................................ 90%
NON-PPO (Deductible applies) ................................................................................. 50%

CHIROPRACTIC CARE (See Spinal Manipulation)

DIAGNOSTIC LAB & X-RAY
PPO ............................................................................................................................ 90%
NON-PPO (Deductible applies) ................................................................................. 50%

DURABLE MEDICAL EQUIPMENT
PPO ............................................................................................................................ 90%
NON-PPO (Deductible applies) ................................................................................. 50%

EMERGENCY ROOM SERVICES (No restrictions of Medical Necessity – Copay will be waived if admitted into the Hospital within 48 hours)
PPO ........................................................................................................................... $100 copay per visit, then 100%
NON-PPO (Deductible applies) ............................................................................... $100 copay per visit, then 100%
HEARING EXAM/AIDS BENEFIT
PPO ......................................................................................................................... 100%
NON-PPO (Deductible waived) ........................................................................... 100%
Maximum Every Five Years ............................................................................... $300

HOME HEALTH CARE
PPO .......................................................................................................................... 90%
NON-PPO (Deductible applies) ........................................................................... 50%
Maximum Visits Per Calendar Year ................................................................... 90 visits

(Each visit by a member of a Home Health Care team shall be considered as one Home Health Care visit and four (4) hours of home health aide services shall be considered as one Home Health Care visit.)

HOSPICE CARE
PPO .......................................................................................................................................................................................... 90%
NON-PPO (Deductible applies) ........................................................................... 50%

INPATIENT HOSPITAL SERVICES (Must be pre-certified or a penalty will apply)
PPO .......................................................................................................................................................................................... 90%
NON-PPO (Deductible applies) ........................................................................... 50%

The Maximum Eligible Charge for room and board in a Hospital will be:
a) for a semi-private room, the average semi-private room rate of the Hospital;
b) for a private room, the average semi-private room rate of the Hospital or, if the Hospital has private rooms only, the maximum eligible charge will be limited to 90% of the actual private room charge;
c) for intensive care, coronary care, and neonatal intensive care, the actual amount charged.

LIFETIME MAXIMUM BENEFIT ................................................................................ Unlimited

MENTAL AND NERVOUS DISORDERS TREATMENT
Outpatient
PPO .......................................................................................................................... 90%
NON-PPO (Deductible applies) ........................................................................... 50%
Maximum Visits Per Calendar Year ................................................................... 45 visits

Inpatient
PPO .......................................................................................................................... 90%
NON-PPO (Deductible applies) ........................................................................... 50%
Maximum Days Per Calendar Year ................................................................... 90 days
Two days of partial confinement in a Hospital will be considered as one day of confinement. Partial confinement means for at least 3 hours, but no more than 12 hours, in any 24-hour period.

**OCCUPATIONAL THERAPY**
- **PPO** ........................................................................................................... 90%
- **NON-PPO** (Deductible applies) ............................................................... 50%
- Maximum Per Calendar Year ....................................................................... $5,000

**OUTPATIENT HOSPITAL SERVICES**
- **PPO** ........................................................................................................... 90%
- **NON-PPO** (Deductible applies) ............................................................... 50%

**PENALTY FOR FAILURE TO PRE-CERTIFY HOSPITAL ADMISSIONS**
(If pre-certified, will be waived) ...................................................................... $250

**PHYSICAL THERAPY**
- **PPO** ........................................................................................................... 90%
- **NON-PPO** (Deductible applies) ............................................................... 50%
- Maximum Per Calendar Year ....................................................................... $5,000

**PHYSICIAN’S OFFICE VISIT** (All injections performed in the Physician’s office will be at no cost)
- **PPO** ........................................................................................................... $20 copay per visit, then 100%
  (Copay includes visit charge, lab, and x-rays if performed in the Physician’s office)
- **NON-PPO** (Deductible applies) ............................................................... 50%

**PHYSICIAN’S SERVICES** (Services rendered outside of the Physician's office)
- **PPO** ........................................................................................................... 90%
- **NON-PPO** (Deductible applies) ............................................................... 50%

**PRIVATE DUTY NURSING**
- **PPO** ........................................................................................................... 90%
- **NON-PPO** (Deductible applies) ............................................................... 50%

**SKILLED NURSING FACILITY CARE**
- **PPO** ........................................................................................................... 90%
- **NON-PPO** (Deductible applies) ............................................................... 50%
- Maximum Days Per Calendar Year .............................................................. 90 days

**SPEECH THERAPY**
- **PPO** ........................................................................................................... 90%
- **NON-PPO** (Deductible applies) ............................................................... 50%
- Maximum Per Calendar Year ....................................................................... $5,000
SPINAL MANIPULATION TREATMENT

PPO........................................................................................................................... 90%
NON-PPO (Deductible applies)................................................................................ 50%
Maximum Visits Per Calendar Year........................................................................ 52 visits

WELLNESS EXPENSE (Includes immunizations, flu shots, mammogram, pap smear, prostate exam, colonoscopy with routine diagnosis, routine exam, lab, x-ray, and Well Baby Care)

PPO................................................................................. $20 copay per visit, then 100%
NON-PPO (Deductible applies)................................................................................ 50%
Special immunizations will be covered if required due to travel to a foreign country.

WOMEN'S HEALTH AND CANCER RIGHTS ACT

Pursuant to the Women's Health and Cancer Rights Act of 1998, this plan provides benefits for Covered Persons for mastectomy-related services, including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from mastectomy (including lymphedema). For further details, please see Subsection 20 of the "ELIGIBLE CHARGES" section of this Plan.
MAIL ORDER PRESCRIPTION DRUG PROGRAM

ScriptCare home delivery pharmacy service is a mail order prescription drug service which charges a flat fee for a 90-day supply of prescription maintenance drugs, such as birth control pills, ulcer medication, insulin, thyroid medication, etc. Employees will need to request two prescriptions from their doctor, one for a two or three week supply to be filled by their local pharmacy, and the other for the remainder of their 90 day supply.

Copay For Each Mail Order Prescription or Refill (90-day supply) (No Deductible)
- Non-Preferred: $40
- Preferred: $20
- Generic Drugs: $10

PRESCRIPTION DRUG CARD PROGRAM (Available at ScriptCare Network Pharmacies)

Copay For Each Mail Order Prescription or Refill (30-day supply) (No Deductible)
- Non-Preferred: $40
- Preferred: $20
- Generic Drugs: $10

*The Per Prescription Copay is not eligible for reimbursement under the Plan.*

Non-Preferred means drugs which are not on the prescription vendor's preferred list. Choosing these drugs results in the highest Copay.

Preferred means drugs which are preferred by the prescription vendor. Since these drugs typically have a lower cost, they are not charged the highest Copay.

Generic means drugs that are available from many sources and in generic form. These are typically the lowest cost drugs and result in the lowest Copay.

Some drug expenses which are covered:
1) Legend drugs;
2) Compound prescriptions of which at least one ingredient is a legend drug in a therapeutic amount;
3) Insulin and insulin syringes;
4) Diabetic supplies;
5) Oral contraceptives;
6) Contraceptive devices;
7) Erectile dysfunction/organic impotence drugs, limited to six tablets per month;
8) Prescription smoking cessation products, limited to $350 per prescription
9) Cosmetic agents;
10) Glucose monitors;
11) Prenatal vitamins; and
12) Vitamins with fluoride.

Some drug expenses which are not covered:
1) Over-the-counter medication;
2) Non-insulin syringes;
3) Biological serums (immunological vaccines);
4) Diet control drugs (anorexics);
5) Medical devices/supplies, other than those listed;
6) Fertility drugs;
7) Diagnostic agents (test kits);
8) RU486 (Mifepristone);
9) Hair growth stimulants;
10) Growth hormones;
11) Vitamins, except as stated above;
12) Non-drug items, such as stockings or devices, even if a prescription is required;
13) Refills obtained more than one year after the original prescription date or prior to 75% of
    the completion of the projected usage; and
14) Any drugs or medicines which are Experimental/Investigational (see “EXCLUSIONS AND
    LIMITATIONS” section of this Plan for further details).

This is not a complete list of drugs that are included or excluded. Please contact
ScriptCare at (800) 880-9988 to determine specific drug coverage.
Pre-Authorization Requirement for Organ Transplant
Expenses incurred in connection with any organ or tissue transplant listed in this provision will be covered subject to referral to and pre-authorization by the Plan Administrator's authorized review specialist. (Cornea transplants are not subject to the pre-authorization provision, but will be considered on the same basis as any other medical expense coverage under this Plan.) Transplant coverage is offered under this Plan through a preferred provider network of specialized professionals and facilities. Coverage is also provided for Transplant services obtained outside of the preferred network, at a reduced benefit level.

As soon as reasonably possible, but in no event more than ten (10) days after a Covered Person's attending Physician has indicated that the Covered Person is a potential candidate for a transplant, the Covered Person or his Physician should contact the Plan Administrator for referral to the network's medical review specialist, for evaluation and pre-authorization. A comprehensive treatment plan must be developed for this Plan's medical review, and must include such information as diagnosis, the nature of the transplant, the setting of the procedure, (i.e. name and address of the Hospital), any secondary medical complications, a five year prognosis, two (2) qualified opinions confirming the need for the procedure, as well as a description and the estimated cost of the proposed treatment (One or both confirming second opinions may be waived by the Plan's medical review specialist). Additional attending Physician's statements may also be required. The Covered Person may provide a comprehensive treatment plan independent of the preferred provider network, but this will be subject to medical appropriateness review and may result in non-network benefit coverage. All potential transplant cases will be assessed for their appropriateness for Large Case Management.

Failure to pre-authorize a transplant procedure will result in the application of a $5,000 deductible to all covered expenses incurred as a result of the transplant. This deductible is in addition to any other Plan deductible and co-payment requirements that would normally be applicable to the transplant procedure.

Organ Transplant Network
As a result of the pre-authorization review the Covered Person will be asked to consider obtaining transplant services from a participating Outcome-Based Transplant Network facility arranged by the Plan Administrator. The purpose of designating Outcome-Based Transplant Networks is to perform necessary transplants in the most appropriate setting for the procedure, to improve the quality and probability of a successful outcome, and reduce the average cost of the procedures.

There is no obligation for the patient to use a participating transplant network facility. However, benefits for the transplant and its related expenses may vary depending on whether services are provided in or out of the transplant network.
Organ and/or Tissue Transplant

If a transplant is performed out of network, but the Covered Person has received approval for the Plan’s medical review specialist for out of network services, then network benefits will apply to the transplant and its related expenses. If services are provided out of network without approval from the medical review specialist, then out of network benefits will apply.

Transplant Benefit Period
Covered transplant expenses will accumulate during a Transplant Benefit Period, and will be charged toward the transplant benefit period maximums, if any, shown in the Transplant Schedule of Benefits. The term "Transplant Benefit Period" means the period beginning on the date of the initial evaluation and ending on the date twelve consecutive months following the date of the transplant. (If the transplant is a bone marrow transplant, the date the marrow is re-infused is considered the date of the transplant.)

Covered Transplant Expenses
The term "covered expenses" with respect to transplants includes the Reasonable and Customary expenses for services and supplies which are covered under this Plan (or which are specifically identified as covered only under this provision) and which are Medically Necessary and appropriate to the transplant, including:

1) Charges incurred in the evaluation, screening, and candidacy determination process.

2) Charges incurred for organ transplantation.

3) Charges for organ procurement, including donor expenses not covered under the donor's plan of benefits.

Coverage for organ procurement from a non-living donor will be provided for costs involved in removing, preserving and transporting the organ.

Coverage for organ procurement from a living donor will be provided for the costs involved in screening the potential donor, transporting the donor to and from the site of the transplant, as well as for medical expenses associated with removal of the donated organ and the medical services provided to the donor in the interim and for follow up care.

If the transplant procedure is a bone marrow transplant, coverage will be provided for the cost involved in the removal of the Covered Person’s bone marrow (autologous) or the donor’s marrow (allogenic). Coverage will also be provided for search charges to identify an unrelated match, and treatment and storage cost of the marrow, up to the time of reinfusion. (The harvesting of the marrow need not be performed within the transplant benefit period.)
4) Charges incurred for follow up care, including immuno-suppressant therapy.

5) Charges for transportation to and from the site of the covered organ transplant procedure for the recipient and one other individual, or in the event that the recipient or the donor is a minor, two (2) other individuals. In addition, all reasonable and necessary lodging and meal expenses incurred during the transplant benefit period will be covered up to a maximum of $10,000 per transplant period.

**Re-transplantation**
Re-transplantation will be covered for up to two re-transplants, for a total of three transplants per person, per lifetime. Each transplant will be subject to the Pre-Authorization Requirement for Organ Transplant. Each transplant and re-transplant will have a new benefit period and a new maximum benefit, subject to the Plan's overall per-person maximum lifetime benefit.

**Accumulation of Expenses**
Expenses incurred during any transplant period for the recipient and for the donor will accumulate towards the recipient's benefit and will be included in the Plan's overall per-person maximum lifetime benefit.

**Donor Expenses**
Medical expenses of the donor will be covered under this provision to the extent that they are not covered elsewhere under this Plan or any other benefit plan covering the donor. In addition, medical expense benefits for a donor who is not a participant under this Plan are limited to a maximum of $10,000 per transplant benefit period when the transplant services are provided out of network. This does not include the donor's transportation and lodging expenses.

**Pre-Existing Conditions Limitation**
Transplant charges will be subject to this Plan's pre-existing conditions limitation.

**Extended Benefits in the Event of Termination**
In the event of termination of the Plan, or of the Covered Person's termination of membership in an eligible class, if a transplant treatment program had commenced while coverage was in force and benefits had not been exhausted, then benefits will be paid for expenses related to the same organ transplant which are incurred during the lesser of a) the remainder of that transplant benefit period or b) one month after termination of the Plan or membership, as though coverage had not ended.
### CENTERS OF EXCELLENCE NETWORK BENEFITS

Network for “ORGAN AND/OR TISSUE TRANSPLANT” is Centers of Excellence, call Group Resources® Incorporated at (770) 623-8383.

<table>
<thead>
<tr>
<th>Transplant Procedure</th>
<th>Network Benefits</th>
<th>Non-Network Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart</td>
<td>100% of eligible charges</td>
<td>100% of eligible charges, up to an overall maximum of $110,000 including a Physician’s maximum of $20,000.</td>
</tr>
<tr>
<td>Lung</td>
<td>100% of eligible charges</td>
<td>100% of eligible charges, up to an overall maximum of $155,000 including a Physician’s maximum of $20,000.</td>
</tr>
<tr>
<td>Bone Marrow</td>
<td>100% of eligible charges</td>
<td>100% of eligible charges, up to an overall maximum of $130,000 including a Physician’s maximum of $20,000.</td>
</tr>
<tr>
<td>Liver</td>
<td>100% of eligible charges</td>
<td>100% of eligible charges, up to an overall maximum of $130,000 including a Physician’s maximum of $20,000.</td>
</tr>
<tr>
<td>Heart/Lung</td>
<td>100% of eligible charges</td>
<td>100% of eligible charges, up to an overall maximum of $150,000 including a Physician’s maximum of $20,000.</td>
</tr>
<tr>
<td>Pancreas</td>
<td>100% of eligible charges</td>
<td>100% of eligible charges, up to an overall maximum of $70,000 including a Physician’s maximum of $20,000.</td>
</tr>
<tr>
<td>Kidney</td>
<td>100% of eligible charges</td>
<td>100% of eligible charges, up to an overall maximum of $55,000 including a Physician’s maximum of $20,000.</td>
</tr>
<tr>
<td>Kidney/Pancreas</td>
<td>100% of eligible charges</td>
<td>100% of eligible charges, up to an overall maximum of $95,000 including a Physician’s maximum of $20,000.</td>
</tr>
</tbody>
</table>
VISION BENEFITS

CALENDAR YEAR DEDUCTIBLE ................................................................. None

EYE EXAMINATION ................................................................................ 100%
  Maximum Every 12 Months ................................................................. $60

LENSES/CONTACT LENSES ................................................................. 100%
  Maximum Every 12 Months ................................................................. $100

FRAMES .................................................................................................. 100%
  Maximum Every 12 Months ................................................................. $200

The above schedule applies to routine vision correction treatment and services. Vision treatment resulting from an Injury or disease of the eye will be covered as any other Illness under the provisions of “MEDICAL BENEFITS.”

THE COVERED PERSON MAY RECEIVE SERVICES FROM ANY LICENSED VISION CARE PRACTITIONER.
Benefits are payable only if the covered dental expenses are for treatment that is:
1) Incurred and completed while dental coverage is in effect; and
2) Provided by:
   • A licensed Dentist;
   • A licensed Doctor; or
   • A dental assistant or a Dental Hygienist working under the direct supervision of a Dentist; and
3) Provided according to generally accepted dental practice; and
4) Necessary for the diagnosis, prevention or correction of dental disease, defect or accidental injury.

**CALENDAR YEAR DEDUCTIBLE**
- Single ..................................................................................................................... $50
- Family .................................................................................................................. $150

**CALENDAR YEAR MAXIMUM BENEFIT PER PERSON**
(Excluding orthodontia) ............................................................................... $2,000

**LIFETIME MAXIMUM BENEFIT FOR ORTHODONTIA** ..................................................... $2,000

**Percent of Covered Charges Payable**

**CLASS I-DIAGNOSTIC AND PREVENTIVE PROCEDURES** (Deductible waived) ................................................................. 100%

**CLASS II-BASIC PROCEDURES** (Deductible applies) .............................................. 80%

**CLASS III-MAJOR PROCEDURES** (Deductible applies) ........................................ 50%

**CLASS IV-ORTHODONTIA** (Deductible applies) .................................................. 50%

**CLASS I-DIAGNOSTIC AND PREVENTIVE PROCEDURES**
Oral Examinations
One set of bitewings every six months
Panorex once every three years
Emergency treatment
Prophylaxis twice per Calendar Year
Fluoride treatment – under age 16 only
Sealants – under age 16 only
Space maintainers

**CLASS II – BASIC PROCEDURES**
General anesthesia
Fillings:
  - Amalgam
  - Silicate
  - Acrylic
Endodontics
Periodontics
Prosthodontics:
  - Maintenance
Oral surgery

**CLASS III – MAJOR PROCEDURES**
Installation of:
  - Full dentures
  - Partial dentures
  - Fixed bridgework
  - Crowns

**CLASS IV - ORTHODONTIA**
This is treatment to move teeth by means of appliances, to correct a handicapping malocclusion of the mouth. Services include preliminary study and treatment plan, x-rays, diagnostic casts, active treatment and retention appliance. Payments for comprehensive full-banded orthodontic treatments are made in installments.

**COVERED CHARGES.** Covered Charges will be the actual cost charged for the treatment or service for a dental condition, but not more than the Reasonable and Customary Charge.

If it is determined that more than one procedure could be performed to correct a dental condition, Covered Charges will be limited to the least expensive of the procedures that would provide professionally acceptable results.

Covered Charges will include only those charges for treatment or services that begin and are completed while the Covered Person is covered under this Plan.
BEGINNING DATE FOR TREATMENT OR SERVICE. Treatment or service will be considered to begin:
1) For root canal therapy, on the date pulp chamber is opened and the pulp canal explored to the apex;
2) For crowns, fixed bridgework, inlays or onlays restoration, on the date the tooth or teeth are fully prepared;
3) For full or partial dentures, on the date the master impression is made; or
4) For all other services, on the date the treatment or service is performed.

LIMITATIONS AND EXCLUSIONS. Dental benefits will not be paid for:
1) Any part of a charge for treatment or service that exceeds the Reasonable and Customary Charge;
2) The services of any person who is not a Dentist or a licensed Dental Hygienist under the supervision of a Dentist;
3) The services of any person who is an immediate family member of a Covered Person;
4) Personalization of dentures or crowns or for any other treatment that is primarily cosmetic and any procedure that does not have uniform professional endorsement;
5) Implants;
6) Drugs and medicines, except for antibiotic injections;
7) Instructions for plaque control, oral hygiene, or diet;
8) Treatment or service to alter vertical dimension or restore occlusion or to duplicate a lost or stolen prosthetic device;
9) Treatment or service for which the Covered Person has no financial liability or that would be provided at no charge in the absence of coverage or that is paid for or furnished by the United States government or one of its agencies;
10) Treatment or service that results from war or act of war or from voluntary participation in criminal activities;
11) Treatment or service that is covered by a workers' compensation or occupational disease or similar law; or
12) Teeth lost prior to the original effective date under the Plan until the Covered Person has maintained coverage for 24 consecutive months.

PRE-TREATMENT DETERMINATION. A Dental Treatment Plan should be filed with the Administrative Service Agent before treatment begins when charges for a Period of Dental Treatment (other than emergency treatment) are expected to exceed $200.

THE COVERED PERSON MAY RECEIVE SERVICES FROM ANY LICENSED DENTAL CARE PRACTITIONER.
As used in this Plan, the following words and phrases shall have the meanings indicated:

**ADMINISTRATIVE SERVICE AGENT** means the firm providing administrative services to the Employer in connection with the operation of the Plan, such as maintaining current eligibility data, billing, processing and payment of Claims and providing the Employer with any other information deemed necessary.

**CALENDAR YEAR** means each period of time beginning on January 1 and ending on December 31 of the same year.

**CHEMICAL DEPENDENCY** means a physical, emotional, or physiological dependency on alcohol or drugs (whether legal or illegal) or any type of substance abuse.

**COINSURANCE** means the percentage of an eligible charge that is paid by the Plan on behalf of the Covered Person.

**COMPANY** means Clark Atlanta University or any affiliate which is participating in the Plan with the permission of Clark Atlanta University.

**COPAY** means the amount which is required to be paid to a provider by a Covered Person at the time of service.

**COSMETIC TREATMENT** means treatment performed for the purpose of improving appearance rather than for restoring bodily function.

**COVERED PERSON** means an Employee or a Dependent for whom the coverage provided by this Plan is in effect. A Covered Person may be covered under this Plan as an Employee or as a Dependent, but not both at the same time.

**DEDUCTIBLE** means the amount of eligible charges that a Covered Person must incur before benefits will be payable, as listed in “MEDICAL BENEFITS” and “DENTAL BENEFITS.”

**DENTAL HYGIENIST** means a person who works under the supervision of a Dentist and is licensed to practice dental hygiene.

**DENTAL TREATMENT PLAN** means the Dentist's report of proposed treatment which:
1) lists the procedures required for the Period of Dental Treatment; and
2) shows the charges for each procedure; and
3) is accompanied by any diagnostic materials that might be required.
Definitions

DENTIST means:
1) a person licensed to practice dentistry; and
2) a licensed Physician who provides dental treatment or service.

DEPENDENT means a person who:
1) is the Employee's spouse or meets the definition of a Dependent of an Employee under the provisions of Section 152 or 213(d)(5) of the Internal Revenue Code of 1986; and
2) is an Employee's:
   a) spouse who is a legal resident of the United States (unless the spouse is legally separated or divorced from the Employee);
   b) unmarried child less than 19 years of age;
   c) unmarried child less than 25 years of age and a Full-Time Student; or
   d) unmarried child meeting all of the following conditions:
      i) totally and permanently disabled or physically or mentally handicapped, and
      ii) unable to earn a living, and
      iii) for whom proof of such disability, handicap, or inability to earn a living is submitted to the Plan Administrator within 30 days of the date coverage would have ended as a result of the child's age.

The term "child" includes a natural child, an adopted child at time of placement, a Foster Child living full-time with the Employee on a permanent basis, a child for whom the Employee has been awarded Legal Guardianship by the court, a child of the Covered Person whose coverage is ordered under a qualified medical child support order (QMCSO), and a stepchild, if the stepchild is dependent on the Employee for principal support.

For purposes of continuation coverage pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended, "Dependent" shall also include any child born to or placed for adoption with a Covered Person during the period of continuation coverage.

The term "Dependent" does not include any person serving in the armed forces of any country. If a husband and wife are both Employees, their children may be considered Dependents of either the husband or wife but not of both.

DURABLE MEDICAL EQUIPMENT means equipment which is:
1) able to withstand repeated use;
2) primarily and customarily used to serve a medical purpose; and
3) not generally used by a person in the absence of Illness or Injury.
**Definitions**

**EMPLOYEE** means any person employed on a regular basis by the Company in the conduct of the Company's regular business, who is regularly scheduled to work at least 25 hours per week, and who is classified by the Company, pursuant to its regular administrative practices, as a common law Employee, excluding any person who (a) is a leased Employee under Code Section 414 (n) or (b) is covered under a collective bargaining agreement which is the subject of good faith bargaining, unless the agreement provides for participation in the Plan.

The term "Employee" shall exclude any individual classified by the Company, in its sole discretion, in a designation which would exclude the person from being considered as an Employee under the Company's customary worker classification procedures, regardless of whether such classification is in error.

**FOSTER CHILD** means an unmarried child under the limiting age shown as a Dependent of this plan for whom a covered Employee has assumed a legal obligation. All of the following conditions must be met:
1) the child is being raised as the covered Employee's;
2) the child depends on the covered Employee for primary support;
3) the child lives in the home of the covered Employee; and
4) the covered Employee may legally claim the child as a federal income tax deduction.

A covered Foster Child is not a child temporarily living in the covered Employee's home; one placed in the covered Employee's home by a social service agency which retains control of the child; or one over whom the natural parent(s) may exercise or share parental responsibility and control.

**FULL-TIME STUDENT** means a person who is enrolled in and regularly attending an accredited college or university for the minimum number of credit hours required by that college or university in order to maintain full-time student status.

**HOME HEALTH CARE** means the following services and supplies furnished in the home by a Home Health Care agency in accordance with a Home Health Care plan, provided that the Physician certifies that Hospital confinement would otherwise be required:
1) part-time or intermittent nursing care by a Registered Nurse (R.N.), or Licensed Practical Nurse (L.P.N.) under the supervision of a Registered Nurse (R.N.);
2) part-time or intermittent home health aide services;
3) Occupational Therapy, Speech Therapy and Physical Therapy which are provided by a Home Health Care Agency;
4) medical supplies and medications prescribed by a Physician and laboratory services of a Hospital if such items would have been covered while confined in a Hospital.
Definitions

Home Health Care is provided to a Covered Person in accordance with a Home Health Care plan only if:
1) the Covered Person was confined in a Hospital for at least three consecutive days and the Home Health Care begins within 14 days following this period of Hospital confinement; and
2) the Home Health Care is given for the same or related condition for which the Covered Person was hospitalized.

The term "Home Health Care" does not include:
1) services or supplies not included in the Home Health Care plan;
2) services of a person who ordinarily resides in a Covered Person's home or is a member of the Covered Person's family or the Covered Person's spouse's family;
3) custodial care consisting of services and supplies which are provided to the Covered Person primarily to assist in the activities of daily living;
4) care received in any period during which the Covered Person is not under the continuing care of a Physician; or
5) transportation.

HOSPICE means a public agency or private organization which meets all of the following requirements:
1) is primarily engaged in providing care to terminally ill patients;
2) provides 24-hour care to control the symptoms associated with terminal Illness;
3) has on its staff an interdisciplinary team which includes at least one Physician, one Registered Nurse (R.N.), one social worker and one counselor;
4) is a licensed organization whose standards of care meet those of the National Hospice Organization;
5) maintains central clinical records on all patients;
6) provides appropriate methods of dispensing drugs and medicines; and
7) offers a coordinated program of home care and Inpatient care for the terminally ill patient and the patient's family.

The term "Hospice" does not include an organization or part thereof which is primarily engaged in providing:
1) custodial care;
2) care for drug addicts and alcoholics; or
3) domestic services.

The term "Hospice" does not include an organization or part thereof which is primarily:
1) a place of rest;
2) a place for the aged; or
3) a hotel or similar institution.
Definitions

HOSPITAL means a place which meets all of the following requirements:
1) is accredited as a general Hospital by the Joint Commission on Accreditation of Hospitals;
2) is open at all times;
3) is operated chiefly for the treatment of sick or injured persons as Inpatients;
4) has a staff of one or more Physicians available at all times;
5) provides 24 hour nursing services by Registered Nurses (R.N.s); and
6) includes areas designed for diagnosis and major Surgical Procedures, or, if it is chiefly a
designated place for the treatment of mentally handicapped persons, has an agreement with a
Hospital to perform surgery which may be required.

The term "Hospital" does not include:
1) a convalescent facility, nursing home, rest home or Skilled Nursing Facility; or
2) a facility chiefly operated for treatment of the aged, drug addicts, or alcoholics.

ILLNESS means a disorder of the body or mind, a disease, or pregnancy. All Illnesses which
are due to the same cause or to a related cause or causes will be deemed to be one Illness.

INJURY means bodily Injury caused by an accident and which results directly from the accident
and independently of all other causes.

INPATIENT means an individual confined as a registered bed patient in a Hospital, Skilled
Nursing Facility or Hospice.

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 a minor child.

MAXIMUM BENEFIT means the maximum amount payable for the period indicated for a
Covered Person for all eligible charges incurred while covered under the Plan.

MEDICAL EMERGENCY means a sudden and unexpected onset of a medical condition
requiring medical care which the patient secures immediately after the onset and, as a general
rule, is a condition which would be life threatening or would cause serious impairment if
immediate care were not received.

MEDICALLY NECESSARY means health care services, supplies, or treatment which is:
1) recommended, approved, or ordered by a Physician or Dentist;
2) consistent with the patient's condition or accepted standards of good medical and dental
practice;
3) not performed for the convenience of the patient or the provider of medical and dental
services;
4) not conducted for research purposes; and
5) is the most appropriate level of services which can be safely provided to the patient.
All of these criteria must be met. Merely because a Physician or Dentist recommends, approves, or orders certain care does not mean that it is Medically Necessary. The determination of whether a service, supply, or treatment is or is not Medically Necessary may include findings of the American Medical Association and the Plan Administrator's own medical advisors. The Plan Administrator has the discretionary authority to decide whether care or treatment is Medically Necessary.

**MENTAL OR NERVOUS DISORDER** means an Illness, including, but not limited to, a neurosis, Psychoneurosis, psychopathy, psychosis, personality disorder, or any other Illness, the layman's understanding of which is a mental or nervous disorder. Mental or Nervous Disorder does not include Chemical Dependency or any condition resulting therefrom. In the event of any dispute as to the interpretation of this term, the decision of the Plan Administrator shall prevail.

**OCCUPATIONAL THERAPY** means a program of care which focuses on the physical, cognitive and perceptual disabilities that influence the patient's ability to perform functional tasks. The therapist evaluates the patient's ability to use his fingers and hands, (fine motor skills), perceptual skills, cognitive functioning and eye-hand coordination. Therapy sessions may also involve physical movement exercises. Functional tasks also may be used. The therapist may also perform splinting of the patient’s arms or hands and may provide the patient with special equipment.

**OUT-OF-POCKET EXPENSE** means the maximum amount that a covered Employee or Dependent will have to pay for covered expenses under the Plan. This does not include the Deductible amount on this Plan, Copays, non-covered items, penalties, and remaining Coinsurance for the treatment of Mental and Nervous Disorders or Chemical Dependency.

**OUTPATIENT** means an individual receiving medical services, but not confined as a registered bed patient in a Hospital, Skilled Nursing Facility, or Hospice.

**OUTPATIENT SURGICAL CENTER** means any public or private establishment which:
1) has a staff of Physicians;
2) has permanent facilities that are equipped and operated primarily for the purpose of performing Surgical Procedures; and
3) provides continuous Physician and nursing services while patients are in the facility.

**PERIOD OF DENTAL TREATMENT** means all sessions of dental care that result from the same initial diagnosis and any related complications.

**PHYSICAL THERAPY** means a plan of care provided to return a patient to the highest level of motor functioning possible. The physical therapist extensively evaluates the patient’s muscle tone, movement, balance, endurance, ability to ambulate, ability to plan motor movements, strength and coordination.
If the patient requires special equipment (such as a wheelchair, walker or splint), the therapist evaluates the patient’s ability to use the equipment and determines the correct size and type of equipment for the specific patient. The therapist constructs a program of exercises and movements to maximize the patient’s motor skills.

**PHYSICIAN** 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 Registered Nurse Anesthetist (C.R.N.A.), Licensed Professional Counselor (L.P.C.), Licensed Physical Therapist (L.P.T.), Midwife, Occupational Therapist, Optometrist (O.D.), Physiotherapist, Psychiatrist, Psychologist (Ph.D.), Speech and Language Pathologist, 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 their license.

The term "Physician" does not include a person who:
1) is the Covered Person receiving treatment; or
2) is a relative by blood or marriage of the Covered Person receiving treatment.

**PRE-ADMISSION TESTING** means X-ray and laboratory examinations which:
1) are performed on an Outpatient basis;
2) are performed within seven days of a scheduled surgery which is performed within 48 hours following the Covered Person's admission to the Hospital; and
3) are related to the Illness or Injury that caused Hospital confinement or the need for surgery.

**PREFERRED PROVIDER ORGANIZATION (PPO)** means the Plan has retained the services of a Preferred Provider Organization in order to provide quality medical care to participants who are within the PPO's area of operation, at lower cost to both the Plan and participants. PPOs vary among the type of services to be provided. Utilization of PPO network providers will usually result in an increase in the amount of benefits paid on eligible expenses. A list of the providers included in the PPO will be furnished automatically, without charge, and is also available on the internet at [www.phcs.com](http://www.phcs.com).

**REASONABLE AND CUSTOMARY CHARGE** means the ordinary charge made by a person, group, or other entity which provides the services, treatments, or materials in question. It does not include any charge which the Plan Administrator finds to be more than the general level of charges made:
1) by others who provide such services, treatments, or materials;
2) for an Illness or Injury of comparable severity and nature to the Illness or Injury being treated; or
3) to persons in the area where the Covered Person normally resides. The term "area" means a county or such greater area as is determined to be appropriate by the Plan Administrator to obtain a typical cross section of others who provide such services, treatments, or materials.
SKILLED NURSING CARE means those charges incurred for:
1) visiting nurse care by an R.N. or L.P.N. The term "visiting nursing care" means a visit of not more than two hours for the purposes of performing specific Skilled Nursing tasks; and
2) private duty nursing by an R.N. or L.P.N. if the patient condition requires Skilled Nursing services and visiting nurse care is not adequate.

The term "Skilled Nursing Care" does not include:
1) that part or all of any nursing care that does not require the skills of an R.N.; or
2) any nursing care given while the person is an Inpatient in a health care facility that could safely and adequately be furnished by the facility's general nursing staff if it were fully staffed.

SKILLED NURSING FACILITY means a place, or a distinct part of a place, which meets all of the following criteria:
1) is licensed according to state or local laws;
2) provides as its chief purpose Skilled Nursing treatment to patients who are recovering from an Illness or Injury;
3) includes areas for medical treatment;
4) provides 24-hour-a-day nursing services under the full-time supervision of a Physician or a Registered Nurse (R.N.);
5) maintains daily health records for each patient;
6) has an agreement which provides for the services of a Physician;
7) has a suitable method for providing drugs and medicines to patients;
8) has an arrangement with one or more Hospitals for the transfer of patients;
9) has an effective utilization review plan;
10) develops functions with the advice and review of a skilled group which includes at least one Physician; and
11) is not solely a place for:
   a) rest, rehabilitation or custodial care;
   b) the aged;
   c) drug addicts;
   d) alcoholics; or
   e) those who are mentally handicapped or who have mental disorders.

SPEECH THERAPY means a program of care which evaluates the patient's motor-speech skills, expressive and receptive language skills, writing and reading skills and determines if the patient requires an extensive hearing evaluation by an audiologist. The therapist also evaluates the patient's cognitive functioning, as well as his social interaction skills such as the ability to maintain eye contact and initiate conversation.
**Definitions**

**SURGICAL PROCEDURE** includes, but not limited to, incision and excision, sutures, debridement of tissue, correcting a fracture, reducing a dislocation, manipulating a joint under general anesthesia, electocauterizing, paracentesis, applying plaster casts, endoscopy, injecting sclerosing solution, arthroscopic procedures, lithotripsy, catheterization, and injections into a joint.

**TOTAL DISABILITY or TOTALLY DISABLED** means an Injury or Illness which:
1) with respect to an Employee, prevents the Employee from performing the main duties of the Employee's occupation with the Company; and
2) with respect to a Dependent, prevents the Dependent from performing the normal activities of a healthy person of the same age and sex.

**WELL BABY CARE** means preventative medical care, i.e., periodic checkups and immunizations as recommended by the AMA Board of Pediatrics.
WHEN COVERAGE BEGINS

Benefits for a Covered Person are determined by the Covered Person's eligibility classification and by the terms of this Plan. Any change in benefits as a result of a change in the classification will be effective on the date the change in class occurs.

A Covered Person will not receive benefits:
1) for which such person is not eligible; or
2) in excess of the maximum amount provided under any benefit for which the person is covered.

ELIGIBILITY CLASSIFICATION - DESCRIPTION OF ELIGIBLE CLASSES:

All Employees in an eligible class.

No benefits are provided for retired Employees or their Dependents.

REQUIRED EMPLOYEE CONTRIBUTIONS:

Employees do contribute toward the cost of Employee Coverage.

Employees do contribute toward the cost of Dependent Coverage.

The amount that Employees contribute is calculated by the Plan Administrator and is a portion of the cost of coverage under the Plan.

WAITING PERIOD means the period of 30 days that begins with an Employee's first hour of service during his most recent employment with the Company. For any Late Enrollee, as defined in the "WHEN COVERAGE BEGINS" section of the Plan, any period before the Late Enrollee's enrollment in the Plan is not a Waiting Period.

ELIGIBILITY FOR EMPLOYEE COVERAGE. An Employee becomes eligible for coverage provided by this Plan on the later of:
1) the effective date of the Plan; or
2) the first day following completion of the Waiting Period.

OPEN ENROLLMENT means the period from December 1 through December 31 during which individuals who are currently enrolled or eligible to enroll in this Plan or any other healthcare plan sponsored by the Company may make changes to their coverage. Coverage under any newly elected option will take effect on January 1 provided the individual is in full-time service on that date, and the enrollment requirements of this Plan have been met.
SPECIAL ENROLLMENT RIGHTS. If an Employee declines enrollment for himself or his Dependents (including spouse) because of other health coverage, the Employee may in the future be able to enroll himself or his Dependents in this Plan, provided that the Employee requests enrollment within 30 days after the other coverage ends. In addition, if the Employee has a new Dependent as a result of marriage, birth, adoption, or placement for adoption, the Employee may be able to enroll himself and his Dependents, provided that the Employee requests enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. The subsection entitled "SPECIAL ENROLLMENT PERIOD" below describes the procedures for Special Enrollment.

SPECIAL ENROLLMENT PERIOD. Notwithstanding any other provisions in the Plan to the contrary, Employees and their Dependents shall be eligible to enroll in the Plan within 30 days of the occurrence of one of the following:

1) the Employee or Dependent loses other health coverage and meets the following conditions:
   a) the individual had other health coverage at the time he became eligible for the Plan;
   b) the Employee stated in writing that he was declining to enroll himself and/or his Dependents in the Plan because of the other coverage;
   c) coverage being lost was (i) COBRA coverage that was exhausted, (ii) other coverage for which the individual is no longer eligible (for example, by reason of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment), or (iii) provided by another employer which ceased to pay for it. (However, loss of coverage due to a failure to pay premiums will not trigger a Special Enrollment period; nor will loss of coverage for cause [such as making a fraudulent claim or an intentional misrepresentation] trigger a Special Enrollment period); and
   d) the individual makes a request in writing, in the form prescribed by the Plan Administrator, for enrollment under the Plan within 30 days after losing the other coverage.

2) an Employee marries, has a child, adopts a child, or has a child placed for adoption, and makes a request, in writing, in the form prescribed by the Plan Administrator, for enrollment under the Plan within 30 days of such event.

EFFECTIVE DATE FOR EMPLOYEE COVERAGE. Except as stated in "Delayed Effective Date for Employee Coverage" below, coverage for an Employee becomes effective as follows:

1) for a Special Enrollment:
   a) in the case of a loss of coverage or marriage, the date which is the first day of the first calendar month beginning after the request for enrollment is received by the Plan Administrator; and
   b) in the case of a Dependent's birth, adoption, or placement for adoption, the date of the birth, adoption, or placement for adoption, respectively; and

2) for all other enrollments, the date which is the later of:
   a) the date the Employee becomes eligible for coverage; or
   b) the date the Employee makes written application and written election to pay for coverage provided said application is made within 30 days of the eligibility date.
When Coverage Begins

**DELAYED EFFECTIVE DATE FOR EMPLOYEE COVERAGE.** If an Employee fails to make written application for coverage within 30 days of his initial eligibility under the Plan (or during a Special Enrollment period, if applicable), he shall be deemed a "Late Enrollee" and he may not apply for coverage until the earlier of (1) the next Open Enrollment period, or (2) a Special Enrollment period.

**ELIGIBILITY FOR DEPENDENT COVERAGE.** An Employee becomes eligible for Dependent Coverage on the later of:

1) the date the Employee becomes eligible for coverage; or
2) the date the Employee first acquires a Dependent.

**EFFECTIVE DATE FOR DEPENDENT COVERAGE.** Except as stated in "Delayed Effective Date for Dependent Coverage" below, coverage for a Dependent becomes effective as follows:

1) for a Special Enrollment:
   a) in the case of a loss of coverage or marriage, the date which is the first day of the first calendar month beginning after the request for enrollment is received by the Plan Administrator; and
   b) in the case of a Dependent's birth, adoption, or placement for adoption, the date of the birth, adoption, or placement for adoption, respectively; and

2) for all other enrollments, the date which is the later of:
   a) the date the Employee becomes eligible for Dependent coverage; or
   b) the date the Employee makes written application and written election to pay for Dependent coverage, provided said application is made within 30 days of the eligibility date.

**DELAYED EFFECTIVE DATE FOR DEPENDENT COVERAGE.** If an Employee fails to make written application for coverage of the Dependent when the Dependent first becomes eligible (or during a Special Enrollment period, if applicable), the Dependent shall be deemed a "Late Enrollee" and the Employee may not apply for coverage for the Dependent until the earlier of (1) the next Open Enrollment period or (2) a Special Enrollment period.

**NO MULTIPLE STATUS.** You may not have multiple status under the Plan (i.e., you may not receive benefits under this Plan as both an Employee and as a Dependent).

**PRE-TAX PREMIUM PAYMENT.** Your portion of your health care premium will be paid with pre-tax dollars. With this feature, your deductions are subtracted from your gross pay before taxes are determined. By doing this, your taxable pay is reduced so you pay less in taxes. Once enrolled in the pre-tax Health Care Plan program, your election for coverage for yourself or your Dependents cannot be changed during the Plan year unless you experience a change in family status such as:

1) marriage or divorce;
2) birth or adoption of a child, change in child custody, or the addition of stepchildren;
When Coverage Begins

3) death of a Dependent;
4) a child reaching the disqualifying age for coverage;
5) any significant change in health care coverage for you or your spouse due to your spouse’s employment;
6) commencement of employment by your spouse;
7) you or your spouse switching from part-time to full-time employment or vice versa;
8) the beginning or end of your spouse’s employer-provided insurance coverage because of a change in employment status; or
9) a change in your employment status that affects benefit eligibility.
WHEN COVERAGE ENDS

EMPLOYEE COVERAGE. An Employee’s coverage will terminate on the earliest of:
1) the date this Plan is terminated;
2) the end of the period for which the last required Employee contribution for the Employee’s coverage has been paid; or
3) the date the covered Employee ceases to be in a class eligible for coverage under the Plan.

Ceasing active work is deemed termination of employment unless:
1) the covered Employee is disabled due to illness or injury. In that event, coverage may be continued up to six months during the disability provided required Employee contributions, if any, are made by such covered Employee; or
2) cessation of work is due to an approved leave of absence. In that event, coverage may be continued for up to 12 weeks, in compliance with the Family and Medical Leave Act of 1993. Required contributions, if any, must be made by the covered Employee in accordance with the agreement reached between the Employee and Employer prior to the leave of absence becoming effective.

A covered Employee’s coverage for any specific benefit will terminate on the earlier of:
1) the date coverage under the Plan for such benefit ends; or
2) the date the covered Employee ceases to be eligible for that benefit.

DEPENDENT COVERAGE. Dependent coverage will cease for any Dependent on the earliest of:
1) the date the covered Employee’s coverage terminates;
2) the date this Plan is terminated;
3) the date Dependent coverage is discontinued under this Plan;
4) the date the covered Employee ceases to be in a class eligible for Dependent coverage;
5) the end of the period for which the last required Employee contribution for Dependent coverage has been paid;
6) the date the covered Employee no longer has any Dependents; or
7) the date the individual ceases to qualify as a Dependent under this Plan.

FULL-TIME STUDENT DEPENDENT COVERAGE. The Full-Time Student Dependent is no longer eligible for Medical or Dental coverage on the earliest of:
1) The date of graduation;
2) The date he or she turns 25;
3) The date he or she marries;
4) The date he or she voluntarily stops attending school full-time as defined by the institution; or
5) The last day of attendance in any quarter or semester in any 12 month period during which the Student Dependent did not complete at least three quarters or two semesters of the 12 month period, unless he or she is off for the summer with intent to resume full-time student status as of the next available quarter or semester.
When Coverage Ends

If the covered Full-Time Student Dependent is unable to attend school full-time because of Illness or Accidental Injury, coverage will terminate on the first day of the next regular semester or quarter, unless he or she has resumed attendance before then.

**LIMITED CONTINUATION OF COVERAGE.** As described below, and in accordance with the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA), Covered Persons may be able to continue their coverage under this Plan in certain limited circumstances. A Covered Person may elect to continue coverage under this Plan for up to 18 months if his coverage terminates because:

1) the covered Employee's employment is terminated (for reasons other than gross misconduct); or
2) the covered Employee's number of hours of employment is reduced such that he is no longer eligible for coverage under this Plan.

The 18 months of continuation coverage may be extended to 29 months if the Social Security Administration determines, according to Title II or XVI of the Social Security Act, that a Covered Person was disabled at any time during the first 60 days of the continuation coverage, or for a child born to or placed for adoption with a Covered Person during the continuation coverage period, at any time during the first 60 days of birth or adoption. All Covered Persons with respect to the disabled individual who would otherwise lose coverage are entitled to the extension. It is the Covered Person's responsibility to obtain this disability determination from the Social Security Administration and to provide a copy of the determination letter to the Plan Administrator within 60 days of the date of determination and before the original 18 months of continuation coverage ceases. If there is a final determination that the Covered Person is no longer disabled, the Plan Administrator must be notified by the Covered Person within 30 days of the determination, and any coverage extended beyond the maximum that would otherwise apply will be terminated for all qualified beneficiaries.

A covered Dependent may elect to continue coverage under this Plan for up to 36 months, if such Dependent's coverage terminates because:

1) the covered Employee dies;
2) the covered Employee is divorced or legally separated;
3) the covered Employee becomes entitled to Medicare benefits under Title XVIII of the Social Security Act;
4) a child covered under the Plan ceases to be a Dependent.

**NOTICE.** The Covered Person must notify the Plan Administrator of a divorce or legal separation or when a child ceases to be a Dependent within 60 days of such event. Failure to do so will result in the loss of coverage under this Limited Continuation of Coverage provision. Upon notice that one of these events or another qualifying event has occurred, the Plan Administrator or its designee will notify the Covered Person of his Limited Continuation of Coverage rights.
ELECTION. A Covered Person is entitled to an election period of 60 days in which to elect to continue coverage under the Plan. The 60-day election period begins on the date the Covered Person would lose Plan coverage because of one of the events described above, and ends on the later of 60 days following such date or the date the Covered Person is sent a notice about eligibility to elect to continue coverage.

If a Covered Person elects continuation coverage within the 60-day election period, continuation coverage will generally begin on the date regular Plan coverage ceases. Even if a Covered Person waives continuation coverage, but within the 60-day election period revokes the waiver, continuation coverage will also begin on the date regular Plan coverage ceases. A Covered Person may not revoke a waiver after the end of the 60-day election period.

If a Covered Person does not choose continuation coverage within the 60-day election period, eligibility for continuation coverage under the Plan ends at the end of that period.

COST OF CONTINUATION COVERAGE. To receive continuation coverage, the Covered Person, or any third party, must pay the required monthly premium plus a two percent administrative charge. If a Covered Person is determined to have been disabled under Title II or XVI of the Social Security Act at the time of the qualifying event of termination of employment or reduction of hours of employment, then the cost of continuation coverage will be 150 percent of the normal required monthly premium for all months after the 18th month of continuation coverage.

Each monthly premium for continuation coverage is due on the first day of the month for which coverage is being continued. However, the first such monthly premium is not due until 45 days after the date on which the Covered Person initially elects continuation coverage.

BENEFITS UNDER CONTINUATION COVERAGE. If a Covered Person chooses continuation coverage, the coverage is identical to the coverage then being provided under the Plan to similarly situated Employees, their spouses, and their Dependent children who have not experienced a qualifying event. If their coverage changes, continuation coverage will change in the same way.

PAYMENT OF CLAIMS. No claim will be payable under this Limited Continuation of Coverage provision until the Plan Administrator receives the applicable premium.

TERMINATION. A Covered Person's Coverage under this Limited Continuation of Coverage provision will terminate on the earliest of:

1) the date on which the Company ceases to provide a group health plan to any Employee;
2) the date the Covered Person first becomes covered under any other group health plan after electing continuation coverage, provided that applicable law precludes any pre-existing condition exclusion in the new plan from affecting the Covered Person's coverage under the new plan;
When Coverage Ends

3) the date the Covered Person becomes entitled to Medicare benefits under Title XVIII of the Social Security Act;
4) the date the required monthly premium is due, if the Covered Person fails to make payment within 30 days after the due date; or
5) the end of the applicable continuation coverage period described above.

In no case will coverage extend beyond thirty-six months from the original qualifying event, even if a second qualifying event occurs during the continuation coverage period.
ELIGIBLE CHARGES

DEDUCTIBLE. The Covered Person must meet a new Deductible each Calendar Year. The Deductible will be applied separately to each Covered Person except when the family Deductible (shown in “MEDICAL BENEFITS”) has been met by the family. Once the family Deductible is met, no further Deductible for any Covered Person in that family will be required during that Calendar Year.

BENEFITS. After a Covered Person has satisfied any applicable Deductible, eligible charges will be paid subject to exclusions, limitations and other terms of the Plan. The amount payable for any Eligible Charge will generally be equal to the percentage of the Reasonable and Customary Charge as described in “MEDICAL BENEFITS.”

MAXIMUM BENEFITS. The benefits paid for a Covered Person’s Illnesses and Injuries will not exceed the maximum for a Covered Person shown in “MEDICAL BENEFITS.”

Only charges incurred by a Covered Person while covered under this Plan may be considered "eligible charges." An eligible charge is considered to be incurred on the date a service is provided, and not when the Covered Person is formally billed or pays for the service. Other eligible charges are incurred when the purchase is made. Eligible charges are the Reasonable and Customary Charges incurred for an Illness or Injury for one or more of the following:

1) Room and board and routine nursing services for each day of confinement in a Hospital;
2) Intensive or cardiac care room and board if Medically Necessary;
3) Medical services and supplies furnished by a Hospital;
4) Anesthetics and their administration;
5) Fees of Physicians for medical treatment including, but not limited to, fees for Surgical Procedures;
6) Services of a Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.) for private duty nursing;
7) Services of a licensed physical therapist or occupational therapist;
8) Speech Therapy administered by a speech therapist, that is expected to restore speech to a person who has lost existing speech function as the result of Illness or Injury, or is the result of congenital birth defects up to age 18;
9) Charges for Outpatient skeletal adjustment, adjunctive therapy, vertebral manipulation, and services for the care or treatment of dislocations or subluxations of the vertebrae;
10) X-rays (other than dental), laboratory tests, and other diagnostic services which:
    a) are performed as a result of definite symptoms of an Illness or Injury; or
    b) reveal the need for medical treatment;
11) X-ray and radiation therapy, chemotherapy, and dialysis;
12) Local Medically Necessary professional land ambulance service. A charge for this item will be a covered charge only if the service is to the nearest Hospital or Skilled Nursing Facility where necessary treatment can be provided, but in any event, no more than 50 miles from the place of pickup, unless the Plan Administrator finds a longer trip was Medically Necessary;

13) Medical supplies as follows:
   a) drugs and medicines (including diabetic supplies, oral contraceptives, devices, and injectables):
      i) which are approved by the Food and Drug Administration;
      ii) which require the written prescription of a Physician; and
      iii) which must be dispensed by a licensed pharmacist or Physician;
   b) blood, marrow, or other fluids;
   c) artificial limbs and eyes to replace natural limbs and eyes;
   d) repair and adjustment of prosthetic devices, when Medically Necessary;
   e) contact lenses or lenses for standard glasses only if required promptly after, and because, of, cataract surgery;
   f) casts, splints, trusses, braces, crutches, and surgical dressings; and
   g) rental or purchase, if less expensive, of Hospital-type equipment including, but not limited to, wheelchairs, Hospital beds, iron lungs, and oxygen equipment;

14) Charges for services performed in an Outpatient Surgical Center;

15) Charges for each day of confinement in a Skilled Nursing Facility if the confinement:
   a) follows a Hospital confinement for which at least three straight days of Hospital room and board charges were included as eligible charges under the Plan;
   b) begins within 14 days after the Covered Person is released from such Hospital confinement;
   c) is for treatment of the same Illness or Injury which resulted in such Hospital confinement; and
   d) is one during which a Physician is present and consults with the Covered Person at least once every seven days;

16) Second surgical opinion;

17) Routine Inpatient newborn care for a newborn child who is either a Covered Person at the time of birth or is enrolled in the Plan within 30 days of his birth. Routine newborn care includes:
   a) Hospital charges for room, board, services, and supplies;
   b) charges related to circumcision; and
   c) fees from Physicians for routine Inpatient pediatric care;

18) Hospice care for a Covered Person who is a terminally ill patient and for members of the Covered Person's family who are also Covered Persons under this Plan. A terminally ill patient is someone who has a life expectancy of six months or less as certified in writing by the Physician who is in charge of the Covered Person's care and treatment. Hospice care expenses for a Covered Person will be limited to the following:
Eligible Charges

a) Hospice care in a Hospital-based Hospice, an extended care Hospice facility or nursing home Hospice;
b) care received from an interdisciplinary team of professionals for Hospice and home care;
c) pre-bereavement counseling; and
d) post-bereavement counseling during the 12 months following the death of the terminally ill patient, up to a limit of six sessions;

19) Home Health Care provided by a Home Health Care provider if:
a) on an intermittent basis, the Covered Person requires nursing services, therapy, or other services provided by a Home Health Care provider;
b) the Covered Person is Totally Disabled and is essentially confined to the home;
c) the Covered Person would otherwise have been confined as an Inpatient in a Hospital or Skilled Nursing Facility;
d) the Covered Person is examined by the attending Physician at least once every 60 days; and
e) the plan of treatment including Home Health Care is:
   i) established in writing by the attending Physician prior to the commencement of such treatment; and
   ii) certified by the attending Physician at least once every month;

Eligible Home Health Care services will not include:
a) custodial care;
b) meals or nutritional services;
c) housekeeper services;
d) services or supplies not specified in the Home Health Care plan;
e) services of a relative of the Covered Person;
f) services of any social worker;
g) transportation services;
h) care for tuberculosis;
i) care for Chemical Dependency;
j) care for the deaf or blind; or
k) care for senility, mental deficiency, retardation or mental Illness;

20) For Covered Persons undergoing covered mastectomies, and upon consultation with the Covered Person's Physician:
a) reconstruction of the breast on which the mastectomy has been performed;
b) surgery or reconstruction of the other breast to produce a symmetrical appearance; and

c) prostheses and physical complications of all stages of a mastectomy, including lymphedemas;
21) Services related to organ transplants when the Covered Person is the recipient (including charges for the organ procurement to the extent that they are not covered by the donor's insurance coverage) for the following procedures:
   a) cornea; e) pancreas;
   b) heart; f) liver;
   c) lung; g) kidney; and
   d) heart/lung; h) bone marrow.
   See “ORGAN AND/OR TISSUE TRANSPLANTS” for guidelines;

22) Charges for Injury to or care of mouth, teeth, gums, and alveolar processes, but only if that care is for treatment of an Injury to sound and natural teeth, including the replacement of such teeth or setting of a jaw fractured or dislocated in an accident, if such treatment is necessitated by an accident which occurs while the Covered Person's coverage under the Plan is in effect and is received within 12 months after such accident;

23) Charges for tubal ligation, vasectomy, and abortions; and

24) Routine services as outlined in “MEDICAL BENEFITS.”
EXCLUSIONS AND LIMITATIONS

BREAST SURGERY. No benefits will be paid for that portion of breast surgery which involves the implanting or injecting of any substance into the body for restoring breast shape. Charges will, however be covered as part of the treatment plan for a Medically Necessary mastectomy due to Illness, as set forth in the "ELIGIBLE CHARGES" section of the Plan. Charges related to the removal of a prosthesis due to medical complications will be covered; however no benefits will be allowed for the replacement of a prosthesis which was originally inserted as a part of a voluntary breast augmentation.

COSMETIC TREATMENT. No benefits will be paid for Cosmetic Treatment, except for that which:
1) results from an Illness or Injury which occurs while the Covered Person is covered under the Plan and is performed within 24 months of the date of such Illness or Injury; or
2) is indicated because of congenital birth defects.

COURT MANDATED. No benefits will be paid for services that are provided due to a court order except as required in the ERISA Requirements section under "MISCELLANEOUS PLAN PROVISIONS."

CUSTODIAL CARE. No benefits will be paid for services which are custodial in nature or primarily consist of bathing, feeding, homemaking, moving the patient, giving medication, or acting as a companion or sitter.

DRUGS - POISON. To the extent not prohibited by federal law and regulations issued thereunder, no benefits will be paid for any Illness or Injury to Covered Persons over the age of seven, which is due to:
1) the voluntary and intentional taking of drugs except those taken as prescribed by a Physician;
2) the voluntary and intentional taking of poison; or
3) the voluntary and intentional inhaling of gas.
However, this exclusion shall not apply to Injuries resulting from an act of domestic violence or a medical condition (physical or mental).

EDUCATIONAL/RECREATIONAL/BIOFEEDBACK. No benefits will be paid for any services or supplies deemed to be educational in nature, or for any services or supplies related to self-care or self-help training and any related diagnostic training.

EXPERIMENTAL/INVESTIGATIONAL. Benefits will not be paid for any services or supplies which are experimental/investigational in nature. A drug, device, or medical treatment or procedure is experimental/investigational:
1) if the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished;
2) if reliable evidence shows that the drug, device or medical treatment or procedure is the subject of ongoing Phase I, II, or III clinical trials or under study to determine its:
   a) maximum tolerated dose;
   b) toxicity;
   c) safety;
   d) efficacy; and
   e) efficacy as compared with the standard means of treatment or diagnosis; or

3) if reliable evidence shows that the consensus among experts regarding the drug, device, or medical treatment or procedure is that further studies or clinical trials are necessary to determine its:
   a) maximum tolerated dose;
   b) toxicity;
   c) safety;
   d) efficacy; and
   e) efficacy as compared with the standard means of treatment or diagnosis.

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

FOOT CARE LIMITATION. No benefits are payable for any medical services or supplies furnished for the treatment of (a) weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions, or (b) corns, calluses or toenails, except for surgery performed for a condition listed in (a) or removal of nail roots, and treatment of a condition listed in (b) because of any metabolic or peripheral vascular disease.

GOVERNMENT AGENCIES. No benefits will be paid for Hospital confinement, services, treatments or supplies furnished by the United States or a foreign government or any agency of either, unless federal laws dictate that the Plan is primary.

HAZARDOUS ACTIVITY. To the extent not prohibited by federal law and regulations issued thereunder, no benefits will be paid for any accident or Injury directly or indirectly attributable to hazardous sporting activities including, but not limited to, motorcycle racing, off-road vehicle competitions, hang gliding, parasailing, drag racing, motor cross racing, road racing, and sporting stunts. However, this exclusion shall not apply to Injuries resulting from an act of domestic violence or a medical condition (physical or mental).
Exclusions

HOSPITAL WEEKEND ADMISSIONS. No benefits will be paid for the initial Friday, Saturday, and Sunday room and board charges incurred in connection with a Hospital confinement which begins on Friday, Saturday, or Sunday except for emergency Hospital admissions or scheduled surgery within the 24 hours immediately following Hospital admission.

ILLEGAL ACTIVITY. No benefits will be paid for any Illness or Injury which is incurred while taking part in an illegal activity, including but not limited to felonies, misdemeanors, or an attempt to commit a crime.

INDUCEMENT OF PREGNANCY. No benefits will be paid for expenses related to artificial insemination, in vitro fertilization, infertility drugs, or other attempts to induce pregnancy, including drug therapy.

JAW AND JAW JOINTS. No benefits will be paid for treatment of Temporomandibular Joint (TMJ) Syndrome, osteotomy, orthognathic surgery, or maxillo facial or dental facial orthopedics.

LEARNING/BEHAVIOR DISORDERS. No benefits will be paid for special education, treatment, or training for learning or behavior disorders.

LEGAL DUTY. Coverage is provided only for services and supplies for which the Covered Person has a legal duty to pay.

MATERNITY EXPENSES. No benefits will be paid for pregnancy expenses incurred by a Dependent child.

MEDICALLY NECESSARY. No benefits will be paid for charges which are not Medically Necessary.

NICOTINE ADDICTION. No benefits will be paid for the treatment of nicotine use or addiction.

OBESITY. No benefits will be paid for the treatment of obesity, weight control, or diet.

OTHER. Benefits will not be paid for charges not listed under the section entitled “ELIGIBLE CHARGES.”

PHYSICIAN’S DIRECT CARE. Benefits will be paid only for eligible charges incurred by a Covered Person under the direct care of a Physician.

PRE-EXISTING CONDITIONS. If charges are incurred as a result of an Illness or Injury which the Plan Administrator finds to be Pre-Existing, payment for such charges will be limited in accordance with the section of the Plan entitled “PRE-EXISTING CONDITIONS.”
Exclusions

REASONABLE AND CUSTOMARY. No benefits will be paid for charges which are more than the Reasonable and Customary charge.

RELATIVE PERFORMING SERVICE. Benefits will not be paid for charges for the services of a Physician or any other provider of services:
1) who usually resides in the same household with the Covered Person; or
2) who is related by blood, marriage or legal adoption to the Covered Person or to the Covered Person's spouse.

REVERSAL OF STERILIZATION. No benefits will be paid for the reversal of sterilization.

RIOT – CIVIL DISTURBANCE. No benefits will be paid for any Illness or Injury which is incurred while taking part in a riot or civil disturbance.

SELF-INFLICTED. To the extent not prohibited by federal law and regulations issued thereunder, no benefits will be paid for an Illness or Injury which is intentionally self-induced or self-inflicted. However, this exclusion shall not apply to Injuries resulting from an act of domestic violence or a medical condition (physical or mental).

SEX CHANGE. No benefits will be payable for sex change surgery or any treatment of gender identity disorders, including medications, implants, hormone therapy, surgery, medical or psychiatric treatment.

TELEPHONE CONSULTATIONS. Benefits will not be paid for telephone consultations or for any other charges by a Physician who is not physically present when consulting with the Covered Person.

TREATMENT OF TEETH AND GUMS. Except as described in “ELIGIBLE CHARGES”, no benefits will be paid under “MEDICAL BENEFITS” for teeth, gums, alveolar process, or supplies used in such treatment, or for dental appliances.

VISION CARE. No benefits will be paid for:
1) treatment of refractive errors including, but not limited to, eye exercises, visual therapy, fusion therapy, visual aids or orthoptics, or any related examinations; or
2) Surgical Procedures to eliminate the need for eyeglasses or to correct refractive errors of the eye (such as radial keratotomy, LASIK (laser in-situ Keratomileusis) or any other vision enhancement surgery solely to correct nearsightedness, farsightedness or astigmatism), including any confinement, treatment, services, or supplies given in connection with or related to the surgery.
Exclusions

This exclusion does not apply to surgery for cataracts or replacement of the lens of the eye following cataract surgery. This exclusion also does not apply to soft lenses or scleral shells used as corneal bandages.

WAR. No benefits will be paid for any Illness or Injury which is due to revolt, war or any act of war, whether declared or not.

WORK RELATED ILLNESS OR INJURY. No benefits will be provided for an Illness or Injury:
1) which arises out of or in the course of employment for any employer which is eligible to obtain coverage for its employees under workers' compensation or occupational disease or similar law; or
2) for which the Covered Person is eligible or paid benefits under workers' compensation or occupational disease or similar law.
Except as stated below, this Plan does not pay benefits for "pre-existing conditions." A "pre-existing condition" is any condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the six-month period ending on the individual's enrollment date; provided, however, genetic information shall not be treated as a "pre-existing condition" in the absence of a diagnosis of the condition related to such information.

Notwithstanding any other provision of this "PRE-EXISTING CONDITIONS" section of the Plan to the contrary, in no event shall a pre-existing condition exclusion apply to the following:

1) pregnancy;
2) a newborn, an adoptee under the age of 18, or a child under the age of 18 placed for adoption with the Employee, so long as the child is enrolled in the Plan within 30 days after birth, adoption, or placement for adoption, whichever is applicable, provided the child is enrolled pursuant to the provisions set forth in the "WHEN COVERAGE BEGINS" section of the Plan; and
3) prescription drugs purchased through the “PRESCRIPTION DRUG PROGRAM.”

For purposes of this pre-existing condition section, "enrollment date" means the first day of coverage under the Plan or, if earlier, the first day of the Waiting Period under the Plan.

An individual covered under the Plan will be subject to these pre-existing condition limitations for the duration of the pre-existing condition exclusion period. For purposes of this Plan, the "pre-existing condition exclusion period" is the 12-month period (18 months for late enrollees) following the enrollment date, as reduced by any period of "creditable coverage."

For purposes of this section, "creditable coverage" means coverage under any of the following:

1) a group health plan;
2) health insurance coverage;
3) coverage under Medicare;
4) coverage under Medicaid (other than coverage consisting solely of the program for distribution of pediatric vaccines);
5) medical coverage for members of the uniformed services and their dependents;
6) medical care programs of the Indian Health Service or other tribal organizations;
7) a state health benefits risk pool;
8) the Federal Employees Health Benefits Program;
9) a public health plan (as defined in federal regulations); and
10) health coverage under the Peace Corps Act.
Pre-Existing Conditions

For purposes of this section, the pre-existing condition exclusion period shall be reduced by the days of creditable coverage, excluding any creditable coverage incurred prior to a "break in coverage."

"Break in coverage" means a period of more than 63 days during which an individual has no type of creditable coverage. A break in coverage will not include any Waiting Periods under the Plan or any other plan or insurance coverage.

To demonstrate evidence of creditable coverage, individuals must present to the Plan Administrator a Certificate(s) of Group Health Plan Coverage, issued by the prior plan(s) or insurance carrier(s), or, in the absence of such Certificate(s), such other evidence of health coverage as may be required by the Plan Administrator, including but not limited to, copies of claim forms, explanations of benefits, pay stubs reflecting premium payments, and summary plan descriptions. If necessary, the Plan Administrator will assist an individual in obtaining the Certificate(s) of Group Health Plan Coverage.

Upon enrollment in the Plan, each individual will be required to provide evidence of creditable coverage to the Plan Administrator. Upon receipt of the evidence of creditable coverage, the Plan Administrator shall review the evidence and will provide to each individual a notice regarding to what extent any pre-existing condition limitation exclusion shall apply to the individual. The notice will contain the name of the Plan, the period to which the pre-existing condition exclusion applies, and notice of the right to appeal the Plan Administrator's decision. Each individual who receives a determination regarding the imposition of a pre-existing condition exclusion period shall have the right to appeal the determination directly to the Plan Administrator and to present additional evidence of prior creditable coverage. For information on appeals procedures, refer to the "FILING A CLAIM" section of the Plan.
PRE-CERTIFICATION/CONTINUED STAY REVIEW. A Covered Person must call INTRACORP at least 72 hours prior to Hospital admission for a medical condition, Mental and Nervous Disorder, or Chemical Dependency treatment, and in case of an emergency hospitalization, must call within two (2) working days following admission. The number for INTRACORP is (800) 822-4692.

The Covered Person must provide INTRACORP with the name, address, and birth date of the patient, the names, addresses, and telephone numbers of the Physician and Hospital, and the reason for hospitalization or surgery. The Covered Person is responsible for informing the attending Physician of the requirements of the pre-hospitalization review procedure. Continued stay review is also conducted by INTRACORP.

The INTRACORP medical care counselor will contact the Physician to discuss the proposed admission and treatment plan. If the diagnosis and treatment meet the criteria for Inpatient Hospital care, the counselor and the Physician will discuss the length of time required in the Hospital, as well as any care appropriate for recovery.

If the Covered Person fails to follow the Plan’s procedures for pre-admission or continued stay review, the Pre-certification Penalty described in “MEDICAL BENEFITS” will be applicable.

Payment of covered charges will be withheld if pre-certification for treatment is based on a diagnosis for which treatment is covered, but the treatment is actually undertaken for a condition which is not covered by the Plan.

Pre-certification by INTRACORP does not guarantee coverage or Preferred Provider Organization benefits. It is the Employee's responsibility to verify that the medical facility and Physicians are members of their PPO and that the proposed service is covered by this Plan.

MOTHERS AND NEWBORNS. Notwithstanding any other provision of this "MANAGED CARE " section, the Plan shall not:

1) restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child following (a) a normal vaginal delivery, to less than 48 hours, or (b) a cesarean section, to less than 96 hours, unless discharged earlier by a Physician after consultation with the mother; or

2) require any Covered Person or provider to obtain authorization under the pre-certification features of this section in conjunction with any such stay that does not exceed the number of hours set forth in 1) above.
CASE MANAGEMENT PROGRAM. The case management program is a special program designed for Covered Persons who are suffering from a complex illness requiring continued medical care.

Alternate forms of treatment or alternate treatment facilities may be recommended as part of the case management program.

Subject to the Administrative Service Agent's approval, expenses for such alternative forms will be payable under this Plan on the same basis as the treatment or facilities for which they are substituted.

The Administrative Service Agent will have the authority to implement the alternate forms of care and treatment recommended by the case management program.

ALTERNATIVE CARE. The Plan may elect to offer benefits for services furnished by any provider pursuant to an alternative treatment plan for a Covered Person whose condition would otherwise require Hospital care.

The Plan shall provide such alternative benefits at its sole discretion and only when and for so long as it determines that alternative services are Medically Necessary and cost effective, and that the total benefits paid for such services will not exceed the total benefits to which the Covered Person would otherwise be entitled under this Plan in the absence of such alternative benefits.

If the Plan elects to provide alternative benefits for a Covered Person in one instance, it shall not be obligated to provide the same or similar benefits for other Covered Persons under this Plan in any other instance, nor shall it be construed as a waiver of the right to administer this Plan thereafter in strict accordance with its express terms.
COORDINATION OF BENEFITS

To prevent duplicate benefit payments if a Covered Person is covered under more than one plan, the Coordination of Benefits (COB) provision of this Plan is included to coordinate all the benefits provided by this Plan with benefits payable under any other medical plan or policy.

In this section, the term "plan" means any health care arrangement which provides medical or dental care benefits on an insured or uninsured basis. It includes, but is not limited to:
1) group, blanket, or individual insurance;
2) Hospital or medical service pre-payment plans;
3) labor-management trustee plans, union welfare plans, employer or employee organization plans;
4) government plans or programs;
5) coverage required or provided by law;
6) no fault auto insurance; and
7) third party liability insurance.

COORDINATION PROCEDURES. The procedure hereinafter described will be used to determine the amount of benefits payable under this Plan for a Covered Person when the Covered Person is covered under any other plan. In that event, one plan is the primary plan, and all other plans are secondary, in the order described below.

The primary plan pays its benefits first, without taking other plans into consideration. The secondary plan then pays benefits up to the extent of its liability, after taking into consideration the benefits provided by the other plan. Benefits under any other plan include benefits which the Covered Person could have received if such benefits had been claimed.

If the benefits paid by the secondary plan are less than the Plan would have paid as primary, the unused benefits will be set aside as COB savings. COB savings may be used to pay any benefits which are not covered by the normal payments of the primary and secondary plans, as long as the expense is allowable under one of the plans. COB savings is accrued on a Calendar Year basis and can only be used in the Calendar Year in which it has accrued.

No more than 100% of allowable expenses will be paid by the combination of this Plan, COB savings and any other plan(s). “Allowable expense” means any eligible charges which are Reasonable and Customary, Medically Necessary, and covered under at least one of the Plans. When this Plan is secondary (i.e., when this Plan pays after another Plan), “allowable expense” will include any Deductible, Coinsurance or Copay amounts not paid by the other plan. “Allowable expense” will not include any PPO, HMO, or other provider discounts. An “allowable expense” will not include an expense incurred when coverage is not in effect under this Plan.
Coordinated of Benefits

1) If a plan has no COB provision, it is automatically the primary plan;
2) If all the plans have COB provisions, a plan is primary if it covers the person as an employee, and secondary if it covers the person as a Dependent;
3) If a person is covered as a Dependent child under more than one plan:
   a) the plan of the parent whose birthday falls earlier in the year is the primary plan;
   b) if the father and mother share the same birthday, the plan covering the parent longer is the primary plan;
   c) if the other plan coordinates benefits according to the sex of the parents, then the plan that covers the person as a Dependent of a male is the primary plan;
   d) if parents are separated or divorced, the following applies:
      the plan which covers a child as a Dependent of the parent with legal custody of the child is the primary plan, unless a court decree outlines the obligation for medical expenses for the child in which case the plan which covers the child as a Dependent of the parent with such obligation for medical expenses is primary;
4) If a plan is no fault auto insurance, required by law, or third party liability insurance, it is the primary plan; and
5) If the primary plan is still not established by the rules above, then the plan that has covered such person for the longest continuous period of time will be the primary plan.

COORDINATION WITH HEALTH MAINTENANCE ORGANIZATION (HMO) OR PREFERRED PROVIDER ORGANIZATION (PPO) PLANS. This Plan will not consider any charges in excess of what an HMO or PPO provider has agreed to accept as payment in full. When an HMO is the primary plan and the Covered Person did not use the services of an HMO provider, this Plan will not consider as an allowable charge any charge that would have been covered by the HMO had the Covered Person used the services of an HMO provider.

RIGHT TO EXCHANGE DATA. The Plan Administrator has the right to exchange benefit information with any plan, insurance company, organization or person to determine benefits payable using this COB provision. Any such data may be exchanged without the consent of, or notice to, any person. Any person who Claims benefits under this Plan must provide the Plan Administrator with data it requires to apply this provision. Notwithstanding the preceding, the Plan Administrator will comply with applicable federal regulations regarding the privacy of medical information on and after the effective date of such regulations.

PAYMENT AND OVERPAYMENT. If payments have been made under any other plan which should have been made under this Plan, this Plan will have the right to reimburse such other plan to the extent necessary to satisfy the intent of this COB provision. This Plan also has the right to recover any overpayment made because of coverage under another plan. This Plan may recover this overpayment from any insurance company, organization or person to whom or for whom this Plan paid benefits.
GOVERNMENT BENEFITS. Except as set forth below, no benefits will be paid for any services, treatment, or supplies, to the extent that the services, treatment, or supplies were furnished by the United States, a state, a municipality, or a foreign government or any agency thereof, unless federal law dictates that the Plan is primary.

EFFECT OF MEDICARE ON BENEFITS. A covered Employee who reaches age 65, and his spouse, may remain covered by the Plan unless the Employee or spouse makes an election to waive coverage under this Plan and chooses Medicare as the primary payer of benefits. In the event that an Employee or spouse waives coverage under this Plan and thereby elects Medicare as the primary source of benefits, no benefits will be payable under this Plan. If an Employee or spouse who is entitled to Medicare does not waive coverage under the Plan, Medicare will be the secondary payer of benefits.

Notwithstanding the above, Medicare shall be the primary payer of benefits for an individual after the individual's first 30 months of entitlement to Medicare due to end stage renal disease.
SUBROGATION AND REIMBURSEMENT

WHEN THIS PROVISION APPLIES. You or your Dependent(s) (hereinafter "beneficiary") may incur medical or dental expenses because of Illness or Injuries for which benefits are paid by the Plan but which were caused by another party. The beneficiary may therefore have a claim against the other party for payment of the medical or dental expenses incurred. In these instances, the Plan has both a right of subrogation and a right of reimbursement. Each right is separate and the waiver of one right by the Plan shall not be deemed to waive the other right. Under the Plan's right of subrogation, the Plan is subrogated to all of the rights the beneficiary may have against that other party. This right of subrogation also applies when a beneficiary has a right to recover under an uninsured or underinsured motorist's plan, homeowner's plan, renter's plan, or any other insurance policy under which the beneficiary is insured. The Plan also retains a right of first lien against any monies received by the beneficiary from the other person. Any monies received by a beneficiary or his attorney to which this Plan has a right of subrogation or reimbursement shall be held in trust for the benefit of the Plan. Under this right of reimbursement, the beneficiary will be required to reimburse the Plan out of any monies the beneficiary receives from the other person or on behalf of the other person as a result of judgment, settlement, or otherwise, without regard as to whether the recovery has been apportioned between medical and other damages, and without regard as to whether full or complete recovery of damages has occurred. The Plan specifically rejects the "make-whole doctrine" and the "common-fund doctrine" with respect to its rights of subrogation and reimbursement. The Plan will not be responsible for expenses or attorney's fees incurred by a beneficiary in connection with any recovery. Accordingly, beneficiaries must pay their own legal fees. Furthermore, the Plan is subrogated to attorney's fees and expenses in enforcing its rights.

Failure to execute a subrogation agreement upon request by the Plan Administrator may result in the non-payment of any related Claims.

AMOUNT SUBJECT TO SUBROGATION OR REIMBURSEMENT. In no case will the amount subject to subrogation or reimbursement exceed the amount of medical or dental benefits paid for the Illness or Injuries under the Plan.

The beneficiary is required to provide information and assistance including testimony or the execution of documents to enforce the Plan's rights of subrogation and reimbursement. In addition, the beneficiary will do nothing to prejudice the right of the Plan to subrogation or reimbursement. The Plan also reserves the right to initiate an action in the name of the Plan or in the name of the beneficiary to recover the Plan's subrogation and/or reimbursement interest.

DEFINED TERMS

1) "Recovery" means monies paid to the beneficiary by way of judgment, settlement, claim, or otherwise by the other party to compensate for the Illness or Injuries sustained;
2) **"Subrogation"** means the Plan's right to pursue the beneficiary's Claims for medical or dental charges against the other party and to be compensated in accordance with appropriate laws and regulations; and

3) **"Reimbursement"** means repayment or reimbursement to the Plan of medical or dental benefits that it has paid toward care and treatment of the beneficiary's Illness or Injuries.

**RIGHTS OF RECOVERY.** Whenever payments have been made by the Plan with respect to allowable expenses in excess of the maximum amount of payment necessary to satisfy the intent of this Plan, the Plan shall have the right, exercisable alone and in its sole discretion, to recover such excess payments.
FILING A CLAIM FOR BENEFITS

To receive benefits under the Plan as quickly as possible, complete the claim forms clearly and accurately.

Following is a description of how the Plan processes Claims for benefits. A Claim is defined as any request for a Plan benefit, made by a claimant or by a representative of a claimant, that complies with the Plan’s procedure for making benefit Claims.

HOW TO MAKE A CLAIM:

To assist the Administrative Service Agent in processing your Claim, please follow the steps listed below in the order in which they appear.

Step 1) You must provide the Administrative Service Agent with current information regarding other coverage you may have. This information is requested on your enrollment form and must be furnished each year.

Step 2) Also on the enrollment form is an important authorization request, which requires your signature. Your signature allows the Administrative Service Agent to request the necessary information from your Physician, in order to process your Claims for payment. If you have a spouse covered under the Plan, they must also sign this authorization to release information.

Step 3) If items 1 and or 2 above are not on file with the Administrative Service Agent, a Claim form will be requested, which may result in a delay in the processing of your Claim.

Step 4) In the case of Hospital confinement, a form provided by the Hospital must be completed by the Hospital and submitted directly to the Administrative Service Agent.

Step 5) Other bills or receipts relating to a covered expense may be submitted directly to the Administrative Service Agent. All bills must show the following:
   a) the employer's name, or group number;
   b) the Employee's name;
   c) the Employee's social security number;
   d) the patient's name;
   e) the Physician's name;
   f) the type of service rendered;
   g) an itemization of the charges;
   h) the condition for which the service was incurred;
   i) the date of service; and
   j) accident/Injury detail, if applicable (can be provided by the Plan participant on a separate document).
Filing a Claim

Step 6) A receipt for a prescription drug must show the following:
   a) the employer's name, or group number;
   b) the Employee's name, or social security number;
   c) the name of the drug being prescribed;
   d) the prescribing Physician;
   e) the prescription number;
   f) an itemization for each separate prescription item; and
   g) the date of purchase.

Step 7) Forward all related bills and receipts to the Administrative Service Agent for processing.

Step 8) Provide any additional information that may be requested by the Plan or Administrative Service Agent.

TYPES OF CLAIMS AND TIME PERIOD FOR PROCESSING. There are different kinds of Claims and each one has a specific timetable for either approval, payment, request for further information, or denial of the Claim. If you have any questions regarding this procedure, please contact the Plan Administrator. A period of time begins at the time the Claim is filed. “Days” means calendar days.

URGENT CARE CLAIM. A Claim involving Urgent Care is any Claim for medical care or treatment where using the timetable for a non-urgent care decision 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 the attending or consulting Physician, would subject the claimant to severe pain that could not be adequately managed without the care or treatment that is the subject of the Claim.

In the case of the Claim involving Urgent Care, the following timetable shows the maximum amount of time in which particular events generally must occur:

<table>
<thead>
<tr>
<th>Event</th>
<th>Time Permitted</th>
</tr>
</thead>
<tbody>
<tr>
<td>Notification to claimant of benefit determination (adverse or not)</td>
<td>72 hours</td>
</tr>
<tr>
<td>If there is insufficient information on the Claim, or the claimant has failed to follow the Plan’s procedure for filing a Claim:</td>
<td></td>
</tr>
<tr>
<td>Notification to claimant of deficiency, orally or in writing</td>
<td>24 hours</td>
</tr>
<tr>
<td>Response by claimant, orally or in writing</td>
<td>Not less than 48 hours</td>
</tr>
<tr>
<td>Benefit determination, orally or in writing</td>
<td>48 hours after receipt of additional information or expiration of claimant’s time to respond</td>
</tr>
<tr>
<td>Ongoing courses of treatment, notification of:</td>
<td></td>
</tr>
<tr>
<td>Reduction or termination before the end of treatment</td>
<td>72 hours</td>
</tr>
<tr>
<td>Determination as to extending course of treatment</td>
<td>24 hours</td>
</tr>
</tbody>
</table>
If there is an adverse benefit determination on a Claim involving Urgent Care, a request for an expedited appeal may be submitted orally or in writing by the claimant. All necessary information, including the Plan’s benefit determination on review, may be transmitted between the Plan and the claimant by telephone, facsimile, or other similarly expeditious method.

**PRE-SERVICE CLAIM.** A Pre-Service Claim means any Claim for a benefit under the Plan where the Plan conditions receipt of the benefit, in whole or in part, on approval in advance of obtaining medical care. These are, for example, Claims subject to pre-certification or mandatory second opinions. Please see the “MANAGED CARE” section of this Plan for further information about Pre-Service Claims.

In the case of a Pre-Service Claim, the following timetable shows the maximum amount of time in which particular events generally must occur:

<table>
<thead>
<tr>
<th>Event</th>
<th>Time Permitted</th>
</tr>
</thead>
<tbody>
<tr>
<td>Notification to claimant of benefit determination (adverse or not)</td>
<td>15 days</td>
</tr>
<tr>
<td>Extension due to matters beyond the control of the Plan</td>
<td>15 days</td>
</tr>
<tr>
<td>If there is insufficient information on the Claim:</td>
<td></td>
</tr>
<tr>
<td>Notification to claimant of deficiency</td>
<td>15 days</td>
</tr>
<tr>
<td>Response by claimant</td>
<td>At least 45 days</td>
</tr>
<tr>
<td>Notification, orally or in writing, of failure to following the Plan’s procedures for filing a Claim</td>
<td>5 days</td>
</tr>
<tr>
<td>Ongoing courses of treatment, notification of:</td>
<td></td>
</tr>
<tr>
<td>Reduction or termination before the end of treatment</td>
<td>15 days</td>
</tr>
<tr>
<td>Determination as to extending course of treatment</td>
<td>15 days</td>
</tr>
<tr>
<td>Review of adverse benefit determination</td>
<td>30 days</td>
</tr>
</tbody>
</table>

**POST-SERVICE CLAIM.** A Post-Service Claim means any Claim for a Plan benefit that is not a Claim involving Urgent Care or a Pre-Service Claim. In other words, a claim that is a request for payment under the Plan for covered medical services already received by the claimant for which no prior approval was required. In the case of a Post-Service Claim, the following timetable shows the maximum amount of time in which particular events generally must occur:

<table>
<thead>
<tr>
<th>Event</th>
<th>Time Permitted</th>
</tr>
</thead>
<tbody>
<tr>
<td>Notification to claimant of benefit determination (adverse or not)</td>
<td>30 days</td>
</tr>
<tr>
<td>Extension due to matters beyond the control of the Plan</td>
<td>15 days</td>
</tr>
<tr>
<td>If there is insufficient information on the Claim:</td>
<td></td>
</tr>
<tr>
<td>Notification to claimant of deficiency</td>
<td>15 days</td>
</tr>
<tr>
<td>Response by claimant</td>
<td>At least 45 days</td>
</tr>
<tr>
<td>Review of adverse benefit determination</td>
<td>60 days</td>
</tr>
</tbody>
</table>
NOTICE OF ADVERSE BENEFIT DETERMINATIONS. Except with Urgent Care Claims (in which event the notification may be given orally followed by written or electronic notification within three days of the oral notification), the Plan Administrator will provide written or electronic notification of any adverse benefit determination. The notice will set forth:

1) the specific reason(s) for the adverse determination;
2) reference to the specific Plan provision(s) on which the determination was based;
3) a description of any additional material or information necessary for the claimant to perfect the Claim and an explanation of why such material or information is necessary;
4) a description of the Plan’s review procedures and the time limits applicable to such procedures, including any expedited review procedures for urgent care Claims, as well as any other statements required under the law; and
5) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.

In addition, if the adverse benefit determination was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such rule, guideline, protocol, or criterion was relied upon in making the adverse benefit determination and a copy will be provided free of charge to the claimant upon request.

Further, if the adverse benefit determination is based on the fact that the treatment was not Medically Necessary or the Experimental/Investigational exclusion or similar exclusion or limit was applied, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant’s medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided free of charge, upon request.

APPEAL OF ADVERSE BENEFIT DETERMINATION. When a claimant receives an adverse benefit determination, the claimant has 180 days following receipt of the notification in which to appeal the decision. A claimant may submit written comments, documents, records and other information relating to the Claim. If the claimant so requests, he or she will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.

The review will take into account all comments, documents, records, and other information submitted by the claimant relating to the Claim, without regard to whether such information was submitted or considered in the initial benefit determination.

The review will not afford deference to the initial adverse benefit determination and will be conducted by a fiduciary of the Plan who is neither the individual who made the adverse determination nor a subordinate of that individual.
If the determination was based 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 fiduciary will consult with a health care professional who was not involved in the original benefit determination. This health care professional will have appropriate training and experience in the field of medicine involved in the medical judgment. Additionally medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the initial determination will be identified upon request.

NOTICE OF ADVERSE DETERMINATION ON APPEAL. The Plan Administrator will provide written or electronic notification of an adverse benefit determination on appeal. The notice will set forth:
1) the specific reason(s) for the adverse determination;
2) reference to the specific Plan provision(s) upon which the determination was based;
3) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of all document, records, and other information relevant to the claimant’s Claim for benefits; and
4) any other information required by law.

In addition, if the determination was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included in the notice of adverse determination that such rule, guideline, or protocol was relied on in making the adverse benefit determination and a copy will be provided free of charge upon request.

Further, if the adverse benefit determination was based on Medical Necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant’s medical circumstances, or a statement that such explanation will be provided free of charge upon request will be included in the notice of adverse determination.

QUESTIONS ON CLAIMS CALL:

GROUP RESOURCES® INCORPORATED AT: (770) 623-8383
MONDAY THROUGH FRIDAY, BETWEEN 8:30 AM AND 5:00 PM EST.

PRE-ADMISSION CERTIFICATION CONTACT:

INTRACORP AT: (800) 822-4692
MONDAY THROUGH FRIDAY, BETWEEN 8:30 AM AND 8:00 PM EST.
PROOF OF LOSS. A Claim must be made no later than one year from the date of service unless the claimant was legally incapacitated. The Plan Administrator may require, as part of the proof, authorization to obtain medical and non-medical information.

PHYSICAL EXAMINATIONS. The Plan Administrator, at its expense, may have a Covered Person examined as often as reasonably necessary while any Claim is pending.

TIME BAR TO LEGAL ACTION. No legal action may be commenced or maintained against the Plan prior to the Covered Person’s exhaustion of the claims procedures. In addition, no legal action may be commenced or maintained against the Plan more than 90 days after the Plan Administrator’s decision on review.
AMENDMENT OR TERMINATION. The continued maintenance of the Plan is completely voluntary on the part of the Company and neither its existence nor its continuation shall be construed as creating any contractual right to or obligation for its future continuation. While the Company intends to continue the Plan indefinitely, it reserves the right at any time and for any reason, in its sole and absolute discretion, through the procedure of an execution of a document by any officer who is authorized, to curtail benefits under, or otherwise amend or terminate the Plan or any portion thereof, including, without limitation, those portions of the Plan outlining the benefits provided or the classes of Employees or Dependents eligible for benefits under the Plan.

PLAN ADMINISTRATOR DISCRETION. The Plan Administrator shall have the sole discretionary authority to construe the terms of the Plan and all facts surrounding Claims for benefits under the Plan and shall determine all questions arising in the administration, interpretation and application of the Plan, including, but not limited to, those concerning eligibility for benefits. Accordingly, benefits under this Plan shall be paid only if the Plan Administrator decides at its discretion that an applicant is entitled to them. All determinations of the Plan Administrator shall be conclusive and binding on all parties.

ERISA REQUIREMENTS. Notwithstanding anything in the Plan to the contrary, the Plan will comply with the following requirements of ERISA Section 609:

1) Medical Child Support Orders. The Plan will comply with the requirements of any "qualified medical child support order" as defined in ERISA Section 609(a)(2)(a). The Plan Administrator will develop procedures to determine whether a medical child support order is qualified and for complying therewith. A Covered Person may obtain, without charge, a copy of these procedures upon request to the Plan Administrator;

2) Rights of States Where Covered Persons are Eligible for Medical Benefits. The Plan Administrator will comply with the requirements set forth in ERISA Section 609(b) regarding:
   a) assignments of rights;
   b) enrollment and provision of benefits without regard to Medicaid eligibility; and
   c) acquisition by states of rights of third parties;

3) Coverage of Dependent Children in Cases of Adoption. The Plan Administrator will comply with the requirements set forth in ERISA Section 609(c) regarding:
   a) the effective date of insurance for adopted Dependent children; and
   b) the prohibition of restrictions based on pre-existing conditions at the time of placement for adoption.

COMPLIANCE WITH FEDERAL LAWS. The terms of the Plan shall be construed and administered in a manner calculated to meet the requirements of the following laws, as the laws are applicable to this Plan:

1) Americans With Disabilities Act of 1990;
2) Family and Medical Leave Act of 1993;
3) Uniformed Services Employment and Reemployment Rights Act of 1994, as amended;
4) Health Insurance Portability and Accountability Act of 1996, as amended;
5) Personal Responsibility and Work Opportunity Reconciliation Act of 1996;
6) The Newborns’ and Mothers’ Health Protection Act of 1996;
7) The Mental Health Parity Act of 1996, as amended; and

To the extent a Plan provision is contrary to or fails to address the minimum requirements of these laws, the Plan shall provide the coverage or benefit necessary to comply with the minimum requirements thereof.

NON-DISCRIMINATION. Notwithstanding anything in the Plan to the contrary, the Plan may not discriminate against any individual or a Dependent of that individual with respect to health coverage on the basis of a health factor.

GOVERNING LAW. The Plan shall be governed by ERISA and the regulations promulgated thereunder. Any assignee of a Covered Person under this Plan shall be treated as the Covered Person with respect to any claim or request for payment of expenses for medical services submitted to the Plan, the Plan Administrator, the Plan Sponsor, the Third Party Administrator, or any agent or Employee thereof. Any Claims or causes of action asserted by any Covered Person or assignee shall be subject to ERISA, and no state law Claims or causes of action shall be applicable with respect to any expenses related to the provision of health care services.
Name of the Plan: Clark Atlanta University
Employee Health Benefit Plan

Name, address, and telephone number of the Plan Sponsor and Plan Administrator:

Clark Atlanta University
223 James P. Brawley Drive, SW
Atlanta, GA 30314-4391
(404) 880-6237

The Plan Administrator is responsible for the administration of the Plan and is the "Named Fiduciary" under the Employee Retirement Income Security Act of 1974, as amended.

Employer Identification Number (EIN): 36-2739571

Plan Number: 501

Type of Plan: Self-Funded welfare benefit plan providing health and hospitalization benefits. Claims under the Plan are paid solely from the general assets of the Company. While the Company may obtain insurance to limit its losses under the Plan, no insurance protects any of the benefits or Claims under this Plan.

Name, address, and telephone number of the Administrative Service Agent:

Group Resources® Incorporated
3080 Premiere Parkway
Suite 100
Duluth, GA 30097-4904
(770) 623-8383
The designated agent for service of legal process is:

Office of the President
Clark Atlanta University
223 James P. Brawley Drive, SW
Atlanta, GA  30314-4391

Service of legal process may also be served upon the Plan Trustee or the Plan Administrator.

Names and addresses of the Plan's Trustees:

Clark Atlanta University
223 James P. Brawley Drive, SW
Atlanta, GA  30314-4391

Claims Administration: The plan is administered by the Plan Administrator, with Group Resources Incorporated, an Administrative Service Agent, acting as Claims paying agent.

Plan Funding: Company and Employee contributions cover the cost of the Plan. Company contributions and any Employee pre-tax contributions withheld by way of payroll deduction are held by the Company and used to pay Plan benefits. All Employee contributions to the Plan shall be withheld from the Employee's paycheck on a pre-tax basis unless the Employee requests, in writing to the Plan Administrator, that the required contributions be withheld on an after-tax basis. Any after-tax Employee contributions may be held in trust by the trustee. The amount of all such contributions is actuarially determined where necessary.

The Plan fiscal year ends on: December 31
STATEMENT OF ERISA RIGHTS

As a participant in the Clark Atlanta University Employee Health Benefit Plan you are entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974, as amended (ERISA). ERISA provides that all Plan participants shall be entitled to the following:

RECEIVE INFORMATION ABOUT YOUR PLAN AND BENEFITS.

- Examine, without charge, at the Plan Administrator’s office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including collective bargaining agreements, 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.

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

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

CONTINUE GROUP HEALTH PLAN COVERAGE.

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

- Reduction or elimination of exclusionary periods of coverage for pre-existing conditions under the Plan, if you have creditable coverage from another health plan. You should be provided a certificate of creditable coverage, free of charge, from the Plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.
PRUDENT ACTIONS BY PLAN FIDUCIARIES. In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

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

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

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

ASSISTANCE WITH YOUR QUESTIONS. If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Miscellaneous Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of Employee Benefits Security Administration at (866) 444-3272.