PLAN DOCUMENT AND
SUMMARY PLAN DESCRIPTION

FOR

UNIVERSITY OF THE CUMBERLANDS
EMPLOYEE MEDICAL BENEFIT PLAN

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INTRODUCTION

This document is a description of University of the Cumberlands Employee Medical Benefit Plan (the Plan). No oral interpretations can change this Plan. The Plan described is designed to protect Plan Participants against certain catastrophic health expenses.

Coverage under the Plan will take effect for an eligible Employee and designated Dependents when the Employee and such Dependents satisfy all the eligibility requirements of the Plan.

The Employer fully intends to maintain this Plan indefinitely. However, it reserves the right to terminate, suspend, discontinue or amend the Plan at any time and for any reason.

Changes in the Plan may occur in any or all parts of the Plan including benefit coverage, deductibles, maximums, copayments, exclusions, limitations, definitions, eligibility and the like.

For Plan Years that begin on or after January 1, 2014, to the extent that an item or service is a covered benefit under the Plan, the terms of the Plan shall be applied in a manner that does not discriminate against a health care provider who is acting within the scope of the provider's license or other required credentials under applicable State law. This provision does not preclude the Plan from setting limits on benefits, including cost sharing provisions, frequency limits, or restrictions on the methods or settings in which treatments are provided and does not require the Plan to accept all types of providers as a Network Provider.

Failure to follow the eligibility or enrollment requirements of this Plan may result in delay of coverage or no coverage at all. Reimbursement from the Plan can be reduced or denied because of certain provisions in the Plan, such as coordination of benefits, subrogation, exclusions, timeliness of COBRA elections, utilization review or other cost management requirements, lack of Medical Necessity, lack of timely filing of claims or lack of coverage. These provisions are explained in summary fashion in this document; additional information is available from the Plan Sponsor at no extra cost.

The Plan will pay benefits only for the expenses incurred while this coverage is in force. No benefits are payable for expenses incurred before coverage began or after coverage terminated. An expense for a service or supply is incurred on the date the service or supply is furnished.

If the Plan is terminated, amended, or benefits are eliminated, the rights of Covered Persons are limited to Covered Charges incurred before termination, amendment or elimination.

This document summarizes the Plan rights and benefits for covered Employees and their Dependents and is divided into the following parts:

Schedule of Benefits. Provides an outline of the Plan reimbursement formulas as well as payment limits on certain services.

Eligibility, Funding, Effective Date and Termination. Explains eligibility for coverage under the Plan, funding of the Plan and when the coverage takes effect and terminates.

Benefit Descriptions. Explains when the benefit applies and the types of charges covered.

Cost Management Services. Explains the methods used to curb unnecessary and excessive charges.

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

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

Plan Exclusions. Shows what charges are **not** covered.

Claim Provisions. Explains the rules for filing claims and the claim appeal process.

Coordination of Benefits. Shows the Plan payment order when a person is covered under more than one plan.

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

Continuation Coverage Rights Under COBRA. Explains when a person's coverage under the Plan ceases and the continuation options which are available.

SCHEDULE OF BENEFITS

Verification of Eligibility (877) 309-2955

Call this number to verify eligibility for Plan benefits **before** the charge is incurred.

MEDICAL BENEFITS

All benefits described in this Schedule are subject to the exclusions and limitations described more fully herein including, but not limited to, the Plan Sponsor's determination that: care and treatment is Medically Necessary; that charges are Usual and Reasonable; that services, supplies and care are not Experimental and/or Investigational. The meanings of these capitalized terms are in the Defined Terms section of this document.

This document is intended to describe the benefits provided under the Plan but, due to the number and wide variety of different medical procedures and rapid changes in treatment standards, it is impossible to describe all covered benefits and/or exclusions with specificity. Please contact the Plan Sponsor if you have questions about specific supplies, treatments or procedures.

Note: The following services must be precertified or reimbursement from the Plan may be reduced.

The attending Physician does not have to obtain precertification from the Plan for prescribing a maternity length of stay that is 48 hours or less for a vaginal delivery or 96 hours or less for a cesarean delivery.

Hospitalizations
Imaging Services (MRI/CAT scans, etc.)
Inpatient Substance Abuse/Mental Disorder treatments
Skilled Nursing Facility stays
Home Health Care
Hospice Care
Durable Medical Equipment
Physical, Speech and/or Occupational Therapy
Cardiac Rehabilitation Therapy
Outpatient Surgical Procedures
Prosthetics and Orthotics
Maternity Delivery (outside the legislated time period for delivery)
Transplant Services
Non Emergent Ambulance

Please see the Cost Management section in this booklet for details.

The Plan is a plan which contains a Participating Provider Organization.

PPO name: Anthem Blue Cross & Blue Shield
Address: 13550 Triton Park Boulevard
Louisville, Kentucky 40223
Telephone: (800) 810-2583
Fax: (502) 889-2414

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

Therefore, when a Covered Person uses a Network Provider, that Covered Person will receive better benefits from the Plan than when a Non-Network Provider is used. It is the Covered Person's choice as to which Provider to use.

Under the following circumstances, the higher Network payment will be made for certain Non-Network services:

If a Covered Person has no choice of Network Providers in the specialty that the Covered Person is seeking within the PPO service area.

If a Covered Person is out of the PPO service area and has a Medical Emergency requiring immediate care.

If a Covered Person receives Physician or anesthesia services by a Non-Network Provider at a Network facility.

Additional information about this option, as well as a list of Network Providers, will be given to Plan Participants, at no cost, and updated as needed. This list will include providers who specialize in obstetrics or gynecology.

Deductibles/Copayments payable by Plan Participants

Deductibles/Copayments are dollar amounts that the Covered Person must pay before the Plan pays.

A deductible is an amount of money that is paid once a Calendar Year per Covered Person. Typically, there is one deductible amount per Plan and it must be paid before any money is paid by the Plan for any Covered Charges. Each January 1st, a new deductible amount is required.

A copayment is the amount of money that is paid each time a particular service is used. Typically, there may be copayments on some services and other services will not have any copayments.

Maximum out-of-pocket payments, per Calendar Year

The Plan will pay the percentage of Covered Charges designated until the following amounts of out-of-pocket payments are reached, at which time the Plan will pay 100% of the remainder of Covered Charges for the rest of the Calendar Year unless stated otherwise. The maximums shown in the Schedule of Benefits are separate. The out-of-pocket maximum for Network Providers applies only to those charges. The out-of-pocket maximum for non-Network Providers applies only to those charges. Through December 31, 2014, there is no out-of-pocket maximum for Prescription Drug costs, other than for Tier IV drugs. Beginning January 1, 2015, Pharmacy Charges will apply towards the Pharmacy Maximum Out-of-Pocket amount, other than amounts for the increased costs of brand named drugs where a generic drug is available.

BlueCard Program
Like all Blue Cross & Blue Shield plans throughout the country, Anthem participates in a program called "BlueCard." This program lets the Member get Covered Charges at the Network cost-share when he/she is traveling out of state and needs health care, as long as the Member uses a BlueCard Provider. All the Member has to do is show their Identification Card to a participating Blue Cross & Blue Shield Provider, and they will send the claims to the Claims Administrator.

If a Member is out of state and an Emergency or urgent situation arises, the Member should get care right away. In a non-Emergency situation, the Member can find the nearest contracted Provider by visiting the BlueCard Doctor and Hospital Finder website (www.BCBS.com) or call the number on the back of their Identification Card. Members can also access Doctors and Hospitals outside of the U.S. The BlueCard program is recognized in more than 200 countries throughout the world.

Care outside the United States – BlueCard Worldwide
Prior to travel outside the United States, Members should check with the Plan Sponsor or call Customer Service at the number on their Identification Card to find out if their Plan has BlueCard Worldwide benefits. Coverage outside the United States may be different and it is recommended:

- Before leaving home, Members should call the Customer Service number on their Identification Card for coverage details.
- Members should always carry the current Identification Card.
- In an emergency, a Member should go directly to the nearest Hospital.
- The BlueCard Worldwide Service Center is available 24 hours a day, seven days a week toll-free at (800) 810-BLUE (2583) or by calling collect at (804) 673-1177. An assistance coordinator, along with a medical professional, will arrange a Physician appointment or hospitalization, if needed.

Call the Service Center in these non-emergent situations:

- A Member needs to find a Physician or Hospital or need medical assistance services. An assistance coordinator, along with a medical professional, will arrange a Physician appointment or hospitalization, if needed.
- A Member needs to be hospitalized or need Inpatient care. After calling the Service Center, the Member must also call the Claims Administrator to obtain approval for benefits at the phone number on their Identification Card. Note: this number is different than the phone numbers listed above for BlueCard Worldwide.

Payment Information

- Participating BlueCard Worldwide Hospitals. In most cases, when a Member makes arrangements for hospitalization through BlueCard Worldwide, he/she should not need to pay upfront for Inpatient care at participating BlueCard Worldwide hospitals except for the Out-of-Pocket costs (non-Covered Charges, Deductible, Copayments and Coinsurance) you normally pay. The Hospital should submit the claim on the Member's behalf.
- Doctors and/or non-participating Hospitals. Members will need to pay upfront for outpatient services, care received from a Doctor, and Inpatient care not arranged through the BlueCard Worldwide Service Center. Then the Member can complete a BlueCard Worldwide claim form and send it with the original bill(s) to the BlueCard Worldwide Service Center (the address is on the form).

Claim Filing

- The Hospital will file a Member's claim if the BlueCard Worldwide Service Center arranged the Member's hospitalization. The Member will need to pay the Hospital for the Out-of-Pocket costs he/she would normally pay.
- The Member must file the claim for outpatient and Physician care, or Inpatient care not arranged through the BlueCard Worldwide Service Center. The Member will need to pay the Provider and subsequently send an international claim form with the original bills to the Claims Administrator.

Claim Forms
International claim forms are available from the Claims Administrator, the BlueCard Worldwide Service Center, or online at www.bcbs.com/bluecardworldwide. The address for submitting claims is on the form.

MEDICAL BENEFITS SCHEDULE

	NETWORK	NON-NETWORK
Lifetime Maximum Benefit	Unlimited	Unlimited
Annual Deductible (Single/Family)	$500/$1,000	$1,000/$2,000
Maximum Out-Of-Pocket (Single/Family) Maximum Excludes: • Cost Containment Penalties • Non-Network Transplant Charges	Medical: $2,000/$4,000 Pharmacy: $2,500/$5,000	$4,000/$8,000
COVERED BENEFITS	**MEMBER COST SHARE RESPONSIBILITY**	
Physician Office Services		
Office Visit Copayment (PCP/SCP)	$20/$35	40%
Allergy Injection Copayment	$5	40%
Allergy Testing and Serum	20%	40%
Imaging Services (MRI, MRA, PETS,C-SCAN)	20%	40%
Diagnostic Testing in Office Visit (Lab and X-Ray)[1]	$20/$35	40%
Optometrist (1 eye exam annually and then as Medically Necessary for illness or injury)	$20	40%
Ophthalmologist	$35	40%
Preventive Care Services Office Visit Copayment Services Include But Not Limited To: • Routine Exams • Pelvic Exams • Mammogram[2] • PAP Testing • PSA Testing • Immunizations • Annual Diabetic Eye Exam • Vision & Hearing Screening • Physician Home and Office Visits • Breast Pumps – 1 per pregnancy[3] • Other Outpatient Services at Hospital or Alternative Care Facility	$0	40%
Emergency Room & Urgent Treatment Center Emergency Room Services Copayment Copayment Waived If Admitted Non-Emergency Care Not Covered	$200	$200
Urgent Treatment Center Services Copayment[4]	$35	40%
• MRAs, MRIs, PETS, C-Scans, Nuclear Cardiology Imaging Studies, Non-Maternity Related Ultrasounds, Pharmaceutical Products	20%	40%
• Allergy Injections[5]	$5	40%
• Allergy Testing	20%	40%

Inpatient & Outpatient Professional Services Services Include But Not Limited To: • Medical Care Visit (1 Per Day) • Intensive Medical Care • Concurrent Care • Consultations • Surgery • Anesthesia Administration • Newborn Exams	20%	40%
Inpatient Facility Services Unlimited Days Except For: • Sixty Days Network/Non-Network Combined For Physical Medicine & Rehabilitation (Limit Includes Day Rehabilitation Therapy Services On An Outpatient Basis) • Ninety Days Network/Non-Network Combined For Skilled Nursing Facility	20%	40%
Outpatient Surgery/Alternate Care Facility Surgery & Administration Of General Anesthesia	20%	40%
Other Outpatient Services Services Include But Not Limited To: • Non-Surgical Outpatient Services For Example: MRI, C-Scan, Chemotherapy, Ultrasounds, Other Diagnostic Services • 100 Visits Network/Non-Network Combined For Home Care Services (Excludes IV Therapy) • Durable Medical Equipment (excluding Prosthetic Devices, Limbs and Medical Supplies) • Orthotics • Prosthetic Devices & Limbs • Physical Medicine Therapy Day Rehabilitation Programs	20%	40%
Private Duty Nursing 82 visit maximum per calendar year and 164 visits per lifetime per member. Does not count toward the Home Health Care visit maximum.	20%	40%
Ambulance Services Ground & Air Ambulance	20%	20%
Hospice Care	Plan Covers 100% Of Charges To Medicare Allowable Amount	
Wig After Chemotherapy	20%	40%
Bereavement Counseling	Based On Place Of Service	40%
Autism Spectrum Disorders	20%	40%
Outpatient Therapy Services ***(Combined Network/Non-Network Limits Apply As Indicated)*** • Physician Home & Office Visit Copayment • Other Outpatient Services	 $20/$35 20%	 40% 40%

Limits Apply To: • Physical Therapy: 20 Visits* • Occupational Therapy: 20 Visits* • Manipulation Therapy: 12 Visits • Speech Therapy: 20 Visits* • Cardiac Rehabilitation: 36 Visits • Pulmonary Rehabilitation: 20 Visits * With prior authorization of the Claims Administrator, additional visits may be allowed for Physical Therapy, Occupational Therapy or Speech Therapy, however in no event may the combined total for these therapies exceed 60 visits.	 $20 $20 $20 $20 Based on Place of Service Based on Place of Service	
Durable Medical Equipment	20%	40%
Hearing Aids & Related Services Members Under Age 18	One Hearing Aid Per Hearing Impaired Ear Every Thirty-Six (36) Months NOTE: If durable medical equipment or appliances are obtained through your Primary Care Physician or another Network Physician's office, Urgent Care Center Services, Outpatient Services, Home Care Services the Copayment/Coinsurance listed above will apply in addition to the Copayment/Coinsurance in the setting where covered Services are received.	
Behavioral Health & Substance Abuse • Inpatient Facility Services • Inpatient Professional Services • Physician Office Visit Copayment (PCP/SCP) • Other Outpatient Services, Outpatient Facility at Hospital/Alternative Care Facility, Outpatient Professional	 20% 20% $20/$35 20%	40%
Temporomandibular Joint Disorder Craniomandibular Jaw Disorder	Based On Place Of Service	Based On Place Of Service
Pregnancy (Dependent Daughters are Not Covered)	Based On Place Of Service	Based On Place Of Service
Dental Services Only When Related To Accidental Injury Or For Certain Members Requiring General Anesthesia	Based On Place Of Service	Based On Place Of Service
Diabetic Equipment, Education & Supplies Information	Copayments/Coinsurance Based On Place Of Service For information on equipment and supplies, please refer to the "Medical Supplies, Durable Medical Equipment and Appliances" provision in this Schedule. For information on Prescription Drug coverage, please refer to the "Prescription Drugs" provision in this Schedule. Screenings for gestational diabetes are covered under "Preventive Care."	

Diagnostic Services Information	When rendered as Physician Home Visits and Office Services or Outpatient Services the Co-payment/Coinsurance is based on the setting where Covered Services are received excpet as listed below. Other Diagnostic Services and or test, including services received at an independent Network lab, may not require a Copayment/Coinsurance. Laboratory services provided by a facility participating in the Administrator's Laboratory Network (as shown in the Provider directory) may not require a Coinsurance/Copayment. If laboratory services are provided by an Outpatient hospital laboratory which is not part of the Administrator's Laboratory network, even if it is a Network Provider for other services they will be covered as an Outpatient Services benefit. Note: MRA, MRI, PET scan, nuclear cardiology imaging studies, and on maternity related ultrasound services are subject to the Other Outpatient Services Copayment/Coinsurance regardless of setting where Covered Services are received.	
Human Organ & Tissue Transplants[6] Acquisition & Transplant Procedures • Transportation and Lodging: Maximum $10,000 per benefit. • Unrelated donor searches for bone marrow/stem cell transplants: Maximum $30,000 per benefit.	Plan Covers 100% Of Charges	50%

PRESCRIPTION DRUG SCHEDULE OF BENEFITS

COVERED BENEFITS	MEMBER COST SHARE RESPONSIBILITY	
Retail Pharmacy (30 Day Supply)		
Tier I Copayment	$10	
Tier II Coinsurance	20% ($20 min/$50 max)	50%, minimum $60
Tier III Coinsurance	25% ($30 min/$100 max)	
Tier IV Coinsurance	25%, $150 per Rx max	
Direct Mail Service (90 Day Supply)		Not Covered
Tier I Copayment	$30	
Tier II Coinsurance	20% ($60 min/$150 max)	
Tier III Coinsurance	25% ($90 min/$300 max)	
Tier IV Coinsurance	25%, $150 per Rx max	
Maximum Out-Of-Pocket; All Prescription Drugs (Single/Family) (effective beginning January 1, 2015)	$2,500 /$5,000	
Member may be responsible for additional cost when not selecting the available generic drug. Medicare Rx - Wrap Specialty medications must be obtained via our Specialty Pharmacy network in order to receive network level benefits. Specialty medications are limited to a 30 day supply regardless of whether they are retail or mail order.		

Schedule of Benefits Notes:

Non-Network Transplant Charges Are Excluded From Medical Out-Of-Pocket Limits. Beginning January 1, 2015, Pharmacy Charges will be subject to a Pharmacy Maximum Out-of-Pocket amount. Pharmacy Charges for the additional cost of brand name drugs where a generic is available will not count toward the Pharmacy Maximum Out-of-Pocket amount.

Deductibles apply only to Covered Medical Services listed with a Coinsurance Percentage and do not apply where a fixed dollar copayment is required unless otherwise noted.

Network and Non-Network Deductibles, Copayments, Coinsurance and Out-of-Pocket Maximums are separate and accumulate separately.

Dependent Coverage to the end of the Calendar Month which Child attains age 26.

No Deductible/Copayment/Coinsurance means No Cost Share up to the Maximum Allowable Amount.

PCP Is a Network Provider who is a Practitioner that specializes in Family Practice, General Practice, Internal Medicine, Pediatrics, Obstetrics/Gynecology, Geriatrics or Any Other Network Provider as allowed by The Plan.

SCP Is a Network Provider, other than a Primary Care Physician (PCP), who provides services within a designated Specialty Area of Practice.

Certain Diabetic and Asthmatic Supplies have no Deductible/Copayment/Coinsurance up to the Maximum Allowable Amount at Network pharmacies except Diabetic Test Strips.

Physician Office Visit Copayment is also applicable if the Office Visit is billed with Allergy Injections. Benefit Period Is on a Calendar Year Basis beginning January 1st and ending December 31st.

“Based on Place of Service” means that the Member cost share responsibility is determined by the type of facility that the service is performed in and how the service is billed by the provider.

[1] All Diagnostic Lab and X-Ray billed as part of the Office Visit with the exception of MRI, MRA, PETS, and C-SCAN will not require additional cost share beyond the Office Visit Copayment.

[2] Diagnostic Mammograms and Preventive Mammograms are covered at 100%

[3] Must be provided by an in network DME (Durable Medical Equipment) Provider. Member will not be reimbursed for a breast pump purchased from a retail store.

[4] Allergy testing, MRA, MRI, PET scan, CAT scan, nuclear cardiology imaging studies, non-maternity related ultrasound services, pharmaceutical injections and drugs received in an Urgent Care Center are subject to the Other Outpatient Services Copayment / Coinsurance.

[5] The Allergy Injection Copayment/Coinsurance will be applied when the injection is billed by itself. The Urgent Care visit Copayment/Coinsurance will apply if an Urgent Care visit is billed with an Allergy Injection.

[6] Transplants are covered at 100%, except Kidney and cornea transplants are treated the same as any other illness and subject to medical benefits, during the Transplant Benefit Period. The Transplant Benefit Period starts one day prior to a Covered Transplant Procedure and continues for the applicable case rate/global time period (The number of days will vary depending on the type of transplant received and the Network Transplant Provider agreement. For specific Transplant questions, contact ARC Administrators and ask to speak with someone regarding Transplants. Prior to and after the Transplant Benefit Period, Covered Services will be paid as Inpatient Services, Outpatient Services or Physician Visits/Office Services depending on where the service is performed.

ELIGIBILITY, FUNDING, EFFECTIVE DATE AND TERMINATION PROVISIONS

A Plan Participant should contact the Plan Sponsor to obtain additional information, free of charge, about Plan coverage of a specific benefit, particular drug, treatment, test or any other aspect of Plan benefits or requirements.

ELIGIBILITY

Eligible Classes of Employees. All Active Employees of the Employer.

Eligibility Requirements for Employee Coverage. A person is eligible for Employee coverage immediately, without a waiting period, from the first day that he or she:

(1) Is an Eligible, Active Employee of the Employer. An Employee is considered to be Eligible if he or she works at least 30 hours per week and is on the regular payroll of the Employer for that work.

For Plan Years beginning on or after January 1, 2015, an Employee's status as a Full-Time Employee will be determined on the basis of the average number of hours worked during an initial or standard look back measurement period, as applicable, as established by the Plan in accordance with applicable law. The Employee's eligibility (or lack of eligibility) for Plan coverage on the basis of his or her Full-Time or Part-Time status will extend through the stability period established by the Plan in accordance with applicable law. In calculating the average hours worked, the Plan will count hours paid and hours for which the Employee is entitled to payment (such as paid holidays, vacation, pay, etc.). For Plan Years beginning before January 1, 2015, an Employee's status as a Full-Time or Part-Time Employee will be determined on the basis of the Employer's standard employment practices.

(2) Is in a class eligible for coverage. For Plan Years beginning on or after January 1, 2015, all Full-Time Employees as determined under the look back measurement period described above, will be eligible for coverage. For Plan Years beginning before January 1, 2015, part-time employees, temporary employees and student related employees, as these classifications are defined in the Employer’s policies and procedures, are not eligible for coverage.

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

(1) A covered Employee's Spouse.

The term "Spouse" shall mean the person recognized as the covered Employee's husband or wife under the laws of the state where the covered Employee lives or was married, and shall not include common law marriages. The term "Spouse" shall not include partners of the same sex who were legally married under the laws of the State in which they were married. The Plan Sponsor may require documentation proving a legal marital relationship.

(2) A covered Employee's Child(ren).

An Employee's "Child" includes his natural child, stepchild, adopted child, or a child placed with the Employee for adoption. An Employee's Child will be an eligible Dependent until reaching the limiting age of 26, without regard to student status, marital status, financial dependency or residency status with the Employee or any other person. When the child reaches the applicable limiting age, coverage will end on the last day of the child's birthday month.

The phrase "placed for adoption" refers to a child whom a person intends to adopt, whether or not the adoption has become final, who has not attained the age of 18 as of the date of such placement for adoption. The term "placed" means the assumption and retention by such person of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child must be available for adoption and the legal process must have commenced.

The term “Child” will also include children for whom the Employee is a Legal Guardian and any child of a Plan Participant who is an alternate recipient under a qualified medical child support order

(QMCSO) shall be considered as having a right to Dependent coverage under this Plan. These children are also subject to the age limit described above. A participant of this Plan may obtain, without charge, a copy of the procedures governing QMCSO determinations from the Plan Administrator.

The Plan Sponsor may require documentation proving eligibility for Dependent coverage, including birth certificates, tax records or initiation of legal proceedings severing parental rights

(3) A covered Dependent Child who reaches the limiting age and is Totally Disabled, incapable of self-sustaining employment by reason of mental or physical handicap, primarily dependent upon the covered Employee for support and maintenance and unmarried. The Plan Sponsor may require, at reasonable intervals, continuing proof of the Total Disability and dependency.

The Plan Sponsor reserves the right to have such Dependent examined by a Physician of the Plan Sponsor's choice, at the Plan's expense, to determine the existence of such incapacity.

These persons are excluded as Dependents: other individuals living in the covered Employee's home, but who are not eligible as defined; the legally separated or divorced former Spouse of the Employee (although such legally separated or divorced former Spouse may have a right to continued coverage as a Qualified Beneficiary as described in the COBRA continuation coverage discussion later in this document) ; any person who is on active duty in any military service of any country; or any person who is covered under the Plan as an Employee.

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

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

Eligibility Requirements for Dependent Coverage. A family member of an Employee will become eligible for Dependent coverage on the first day that the Employee is eligible for Employee coverage and the family member satisfies the requirements for Dependent coverage.

At any time, the Plan may require proof that a Spouse or a Child qualifies or continues to qualify as a Dependent as defined by this Plan.

FUNDING

Cost of the Plan. The University of the Cumberlands shares the cost of Employee and Dependent coverage under this Plan with the covered Employees.

The level of any Employee contributions is set by the Plan Sponsor. The Plan Sponsor reserves the right to change the level of Employee contributions.

ENROLLMENT

Enrollment Requirements. An Employee must enroll for coverage by contacting their HR Department. A newborn child will be automatically enrolled for 31 days from birth; otherwise, separate enrollment for a newborn child is required.

Enrollment Requirements for Newborn Children.

A newborn child of a covered Employee or Employee’s Spouse is automatically enrolled in this Plan for 31 days from date of birth. Charges for covered nursery care will be applied toward the Plan of the newborn child. If the newborn child is not enrolled in this Plan on a timely basis, as defined in the section "Timely Enrollment" following this section, there will be no payment from the Plan and the parents will be responsible for all costs.

Charges for covered routine Physician care will be applied toward the Plan of the newborn child. If the newborn child is not enrolled in this Plan on a timely basis, there will be no coverage beyond the first 31 days, except as permitted for a Late Enrollee.

If the child is not enrolled within 31 days of birth, the enrollment will be considered a Late Enrollment.

TIMELY OR LATE ENROLLMENT

(1) **Timely Enrollment** - The enrollment will be "timely" if the completed form is received by the Plan Sponsor no later than 31 days after the person becomes eligible for the coverage, either initially or under a Special Enrollment Period.

If two Employees (husband and wife) are covered under the Plan and the Employee who is covering the Dependent children terminates coverage, the Dependent coverage may be continued by the other covered Employee with no waiting period as long as coverage has been continuous.

(2) **Late Enrollment** - An enrollment is "late" if it is not made on a "timely basis" or during a Special Enrollment Period. Late Enrollees and their Dependents who are not eligible to join the Plan during a Special Enrollment Period may join only during open enrollment.

If an individual loses eligibility for coverage as a result of terminating employment or a general suspension of coverage under the Plan, then upon becoming eligible again due to resumption of employment or due to resumption of Plan coverage, only the most recent period of eligibility will be considered for purposes of determining whether the individual is a Late Enrollee.

The time between the date a Late Enrollee first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a waiting period. Coverage begins on November 1.

SPECIAL ENROLLMENT RIGHTS

Federal law provides Special Enrollment provisions under some circumstances. If an Employee is declining enrollment for himself or herself or his or her Dependents (including his or her Spouse) because of other health insurance or group health plan coverage, there may be a right to enroll in this Plan if there is a loss of eligibility for that other coverage (or if the other employer stops contributing towards the other coverage). However, a request for enrollment must be made within 31 days after the coverage ends (or after the other employer stops contributing towards the other coverage).

In addition, in the case of a marriage, birth, adoption or placement for adoption, there may be a right to enroll in this Plan. However, a request for enrollment must be made within 31 days of the marriage, birth, adoption or placement for adoption.

The Special Enrollment rules are described in more detail below. To request Special Enrollment or obtain more detailed information of these portability provisions, contact the Plan Sponsor, University of the Cumberlands, 6184 College Station Drive, Williamsburg, Kentucky, 40769, (606) 539-4211.

SPECIAL ENROLLMENT PERIODS

The Enrollment Date for anyone who enrolls under a Special Enrollment Period is the first date of coverage. Thus, the time between the date a special enrollee first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a waiting period.

(1) **Loss of Other Coverage.** An Employee or Dependent who is eligible, but not enrolled in this Plan, may enroll if loss of eligibility for coverage meets all of the following conditions:

(a) The Employee or Dependent was covered under a group health plan or had health insurance coverage at the time coverage under this Plan was previously offered to the individual.

(b) The coverage of the Employee or Dependent who had lost the coverage was under COBRA and the COBRA coverage was exhausted, or was not under COBRA and either the coverage was terminated as a result of loss of eligibility for the coverage or because employer contributions towards the coverage were terminated. Coverage will begin no later than the first day of the first calendar month following the date the completed enrollment form is received.

(c) The Employee or Dependent requests enrollment in this Plan not later than 31 days after the date of exhaustion of COBRA coverage or the termination of non-COBRA coverage due to loss of eligibility or termination of employer contributions, described above. Coverage will begin no later than the first day of the first calendar month following the date the completed enrollment form is received.

For purposes of these rules, a loss of eligibility occurs if one of the following occurs:

(a) The Employee or Dependent has a loss of eligibility due to the plan no longer offering any benefits to a class of similarly situated individuals (i.e.: part-time employees).

(b) The Employee or Dependent has a loss of eligibility as a result of legal separation, divorce, cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan), death, termination of employment, or reduction in the number of hours of employment or contributions towards the coverage were terminated.

(c) The Employee or Dependent has a loss of eligibility when coverage is offered through an HMO, or other arrangement, in the individual market that does not provide benefits to individuals who no longer reside, live or work in a service area, (whether or not within the choice of the individual).

(d) The Employee or Dependent has a loss of eligibility when coverage is offered through an HMO, or other arrangement, in the group market that does not provide benefits to individuals who no longer reside, live or work in a service area, (whether or not within the choice of the individual), and no other benefit package is available to the individual.

If the Employee or Dependent lost the other coverage as a result of the individual's failure to pay premiums or required contributions or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan), that individual does not have a Special Enrollment right.

(2) **New Dependent.** If:

(a) The Employee is a participant under this Plan (or has met the waiting period applicable to becoming a participant under this Plan, if any, and is eligible to be enrolled under this Plan but for a failure to enroll during a previous enrollment period), and

(b) A person becomes a Dependent of the Employee through marriage, birth, adoption or placement for adoption.

Then the Dependent (and if not otherwise enrolled, the Employee) may be enrolled under this Plan. In the case of the birth or adoption of a child, the Spouse of the covered Employee may be enrolled as a Dependent of the covered Employee if the Spouse is otherwise eligible for coverage. If the Employee is not enrolled at the time of the event, the Employee must enroll under this Special Enrollment Period in order for his eligible Dependents to enroll.

The Dependent Special Enrollment Period is a period of 31 days and begins on the date of the marriage, birth, adoption or placement for adoption. To be eligible for this Special Enrollment, the Dependent and/or Employee must request enrollment during this 31-day period.

The coverage of the Dependent and/or Employee enrolled in the Special Enrollment Period will be effective:

(a) In the case of marriage, on the first day of the first month after request for enrollment is received;

(b) In the case of a Dependent's birth, as of the date of birth; or

(c) In the case of a Dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.

(4) **Medicaid and State Child Health Insurance Programs.** An Employee or Dependent who is eligible, but not enrolled in this Plan, may enroll if:

(a) The Employee or Dependent is covered under a Medicaid plan under Title XIX of the Social Security Act or a State child health plan (CHIP) under Title XXI of such Act, and coverage of the Employee or Dependent is terminated due to loss of eligibility for such coverage, and the Employee or Dependent requests enrollment in this Plan within 60 days after such Medicaid or CHIP coverage is terminated.

(b) The Employee or Dependent becomes eligible for assistance with payment of Employee contributions to this Plan through a Medicaid or CHIP plan (including any waiver or demonstration project conducted with respect to such plan), and the Employee or Dependent requests enrollment in this Plan within 60 days after the date the Employee or Dependent is determined to be eligible for such assistance.

If a Dependent becomes eligible to enroll under this provision and the Employee is not then enrolled, the Employee must enroll in order for the Dependent to enroll.

Coverage will become effective as of the first day of the first calendar month following the date the completed enrollment form is received unless an earlier date is established by the Employer or by regulation.

EFFECTIVE DATE

Effective Date of Employee Coverage. An Employee will be covered under this Plan as of the first day that the Employee satisfies all of the following:

(1) The Eligibility Requirement.

(2) The Active Employee Requirement.

(3) The Enrollment Requirements of the Plan.

Active Employee Requirement.

An Employee must be an Active Employee (as defined by this Plan) for this coverage to take effect.

Effective Date of Dependent Coverage. A Dependent's coverage will take effect on the day that the Eligibility Requirements are met; the Employee is covered under the Plan; and all Enrollment Requirements are met.

TERMINATION OF COVERAGE

When Employee Coverage Terminates. Employee coverage will terminate on the earliest of these dates (except in certain circumstances, a covered Employee may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, see the section entitled Continuation Coverage Rights under COBRA):

(1) The date the Plan is terminated.

(2) The last day of the calendar month in which the covered Employee ceases to be in one of the Eligible Classes. This includes death or termination of Active Employment of the covered Employee. (See the section entitled Continuation Coverage Rights under COBRA.) It also includes an Employee on disability, leave of absence or other leave of absence, unless the Plan specifically provides for continuation during these periods.

(3) The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due.

(4) The Employer or Plan has the right to rescind any coverage of the Employee and/or Dependents for cause, making a fraudulent claim or an intentional material misrepresentation in applying for or obtaining coverage, or obtaining benefits under the Plan or fails to notify the Plan Sponsor that he or she has become ineligible for coverage. The Employer or Plan may either void coverage for the Employee and/or covered Dependents for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage. If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the Plan will provide at least 30 days' advance written notice of such action. The Employer will refund all contributions paid for any coverage rescinded; however, claims paid will be offset from this amount. The Employer reserves the right to collect additional monies if claims are paid in excess of the Employee's and/or Dependent's paid contributions.

Continuation During Family and Medical Leave. This Plan shall at all times comply with the Family and Medical Leave Act of 1993 (“FMLA”) as promulgated in regulations issued by the Department of Labor.

During any leave taken under the FMLA, the Employer will maintain coverage under this Plan on the same conditions as coverage would have been provided if the covered Employee had been continuously employed during the entire leave period. If you are going on a paid FMLA leave, your contributions for premiums will continue to be paid through salary deductions. If you are going on unpaid FMLA leave and you opt to continue your coverage, then you may pay your share of the contributions in one of three ways: (a) with after-tax dollars while on leave;, to be paid by check or cash to Human Resources by the payroll date your contribution would have been deducted prior to the FMLA leave, (b) with pre-tax dollars to the extent that you receive compensation during the leave, or by pre-paying all or a portion of your share of the contributions for the expected duration of the leave on a pre-tax salary reduction basis out of your pre-leave compensation, including unused sick days and vacation days (to pre-pay in advance, you must make a special election before such compensation normally would be available to you,but note that pre-payments with pre-tax dollars may not be used to pay for coverage during the next Plan Year); or (c) by other arrangements agreed upon by you and the Employer (for example, the Employer may pay for coverage during the leave and withhold amounts from your compensation upon your return from leave).

If Plan coverage terminates during the FMLA leave, coverage will be reinstated for the Employee and his or her covered Dependents if the Employee returns to work in accordance with the terms of the FMLA leave. Coverage will be reinstated only if the person(s) had coverage under this Plan when the FMLA leave started, and will be reinstated to the same extent that it was in force when that coverage terminated. For example, any waiting periods and for Plan Years beginning before January 1, 2014, Pre-Existing Conditions limitations will not be imposed unless they were in effect for the Employee and/or his or her Dependents when Plan coverage terminated.

Continuation During Periods of Non-FMLA Leave. A person may remain eligible for coverage for a limited time if work ceases due to a non-FMLA leave. This continuance will end as of the date the Employer determines in it discretion. All such continuations shall be determined on a consistent and non-discriminatory basis.

While continued, coverage will be that which was in force on the last day worked as an Active Employee. However, if benefits reduce for others in the class, they will also reduce for the continued person.

Rehiring a Terminated Employee. A terminated Employee who is rehired will be treated as a new hire and be required to satisfy all Eligibility and Enrollment requirements. However, if the Employee is returning to work directly from COBRA coverage, this Employee does not have to satisfy any employment waiting period.

Employees on Military Leave. Employees going into or returning from military service may elect to continue Plan coverage as mandated by the Uniformed Services Employment and Reemployment Rights Act (USERRA)

under the following circumstances. These rights apply only to Employees and their Dependents covered under the Plan immediately before leaving for military service.

(1) The maximum period of coverage of a person and the person's Dependents under such an election shall be the lesser of:

(a) The 24 month period beginning on the date on which the person's absence begins; or

(b) The day after the date on which the person was required to apply for or return to a position of employment and fails to do so.

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

(3) An exclusion or waiting period may not be imposed in connection with the reinstatement of coverage upon reemployment if one would not have been imposed had coverage not been terminated because of service. However, an exclusion or waiting period may be imposed for coverage of any Illness or Injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of uniformed service.

If the Employee wishes to elect this coverage or obtain more detailed information, contact the Plan Sponsor University of the Cumberlands, 6184 College Station Drive, Williamsburg, Kentucky, 40769, (606) 539-4211. The Employee may also have continuation rights under USERRA. In general, the Employee must meet the same requirements for electing USERRA coverage as are required under COBRA continuation coverage requirements. Coverage elected under these circumstances is concurrent not cumulative. The Employee may elect USERRA continuation coverage for the Employee and their Dependents. Only the Employee has election rights. Dependents do not have any independent right to elect USERRA health plan continuation.

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

(1) The date the Plan or Dependent coverage under the Plan is terminated.

(2) The date that the Employee's coverage under the Plan terminates for any reason including death. (See the section entitled Continuation Coverage Rights under COBRA.)

(3) The date a covered Spouse loses coverage due to loss of eligibility status. (See the section entitled Continuation Coverage Rights under COBRA.)

(4) Coverage on the last day of the month in which the Dependent ceases to meet the applicable eligibility requirements. (See the section entitled Continuation Coverage Rights under COBRA.)

(5) Coverage will end on the last day of the month in which the Child ceases to meet the applicable eligibility requirements. (See the section entitled Continuation Coverage Rights under COBRA.)

(6) The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due.

(7) If a Dependent commits fraud or makes an intentional misrepresentation of material fact in applying for or obtaining coverage, or obtaining benefits under the Plan, or fails to notify the Plan Sponsor that he or she has become ineligible for coverage, then the Employer or Plan may either void coverage for the Dependent for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage. If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the Plan will provide at least 30 days' advance written notice of such action.

Certificates of Creditable Coverage. For Plan Years that begin before January 1, 2014, Plan Participants who lose coverage under the Plan will receive a certificate that will show the period of Creditable Coverage under

this Plan. The Plan maintains written procedures that explain how to request this certificate. Please contact the Plan Sponsor for a copy of these procedures and further details.

OPEN ENROLLMENT

Annually all participants will be notified by the Plan Sponsor no less than thirty (30) days in advance of the Open Enrollment period. During the annual open enrollment period, covered Employees and their covered Dependents will be able to change some of their benefit decisions based on which benefits and coverage are right for them.

During the Open Enrollment period Employees and their Dependents who are Late Enrollees will be able to enroll in the Plan.

Benefit choices made during the Open Enrollment period will become effective November 1 and remain in effect until the next November 1 unless there is a Special Enrollment event or a change in family status during the year (marriage, birth, adoption or placement for adoption) or loss of coverage due to loss of a Spouse's employment. To the extent previously satisfied, coverage waiting periods, if any, will be considered satisfied when changing from one benefit option under the Plan to another benefit option under the Plan.

Benefit choices for Late Enrollees made during the Open Enrollment period will become effective November 1.

A Plan Participant who fails to make an election during Open Enrollment will automatically retain his or her present coverage.

Plan Participants will receive detailed information regarding Open Enrollment from their Employer.

MEDICAL BENEFITS

Medical Benefits apply when Covered Charges are incurred by a Covered Person for care of an Injury or Sickness and while the person is covered for these benefits under the Plan.

DEDUCTIBLE

Deductible Amount. This is an amount of Covered Charges for which no benefits will be paid. Before benefits can be paid in a Calendar Year a Covered Person must meet the deductible shown in the Schedule of Benefits.

Family Unit Limit. When the maximum amount shown in the Schedule of Benefits has been incurred by members of a Family Unit toward their Calendar Year deductibles, the deductibles of all members of that Family Unit will be considered satisfied for that year.

OUT-OF-POCKET LIMIT

Covered Charges are payable at the percentages shown each Calendar Year until the out-of-pocket limit shown in the Schedule of Benefits is reached. Then, Covered Charges incurred by a Covered Person will be payable at 100% (except for any charges excluded as shown in the Schedule of Benefits) for the rest of the Calendar Year.

When a Family Unit reaches the out-of-pocket limit, Covered Charges for that Family Unit will be payable at 100% (except for any charges excluded, as shown on the Schedule of Benefits) for the rest of the Calendar Year.

Deductibles, copayments, and co-insurance are included in the out-of-pocket maximum. Costs for premiums, non-covered services, cost-containment penalties (charges not covered due to a failure to obtain required pre-certification), prescription drug costs, and non-network transplant charges will not be applied towards the medical out-of-pocket maximum. Through December 31, 2014, prescription drug costs do not have an out-of-pocket maximum, other than for Tier IV drugs. Effective January 1, 2015, all prescription drug costs will be subject to the Prescription Drug Out-of-Pocket maximum. The excess amount paid for brand name drugs where a generic is available will not count towards the Prescription Drug Out-of-Pocket maximum.

BENEFIT PAYMENT

Each Calendar Year, benefits will be paid for the Covered Charges of a Covered Person that are in excess of the deductible and any copayments. Payment will be made at the rate shown under reimbursement rate in the Schedule of Benefits.

COVERED CHARGES

Covered Charges are the Usual and Reasonable Charges that are incurred for the following items of service and supply. These charges are subject to the benefit limits, exclusions and other provisions of this Plan. A charge is incurred on the date that the service or supply is performed or furnished.

(1) **Hospital Care.** The medical services and supplies furnished by a Hospital or Outpatient Surgical Center or a Birthing Center. Covered Charges for room and board will be payable as shown in the Schedule of Benefits. After 23 observation hours, a confinement will be considered an inpatient confinement.

Room charges made by a Hospital having only private rooms will be paid at 80% of the average private room rate.

Charges for an Intensive Care Unit stay are payable as described in the Schedule of Benefits.

(2) **Coverage of Pregnancy.** The Usual and Reasonable Charges for the care and treatment of Pregnancy are covered the same as any other Sickness for a covered Employee or covered Spouse.

Group health plans generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a

vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

There is no coverage of Pregnancy for a Dependent other than a Covered Spouse.

(3) **Skilled Nursing Facility Care.** The room and board and nursing care furnished by a Skilled Nursing Facility will be payable if and when:

(a) The patient is confined as a bed patient in the facility; and

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

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

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

Covered Charges for a Covered Person's care in these facilities are payable as described in the Schedule of Benefits.

(4) **Physician Care.** The professional services of a Physician for surgical or medical services.

Charges for **multiple surgical procedures** will be a Covered Charge subject to the following provisions:

(a) If bilateral or multiple surgical procedures are performed by one (1) surgeon, benefits will be determined based on the Usual and Reasonable Charge that is allowed for the primary procedures; 50% of the Usual and Reasonable Charge will be allowed for each additional procedure performed through the same incision. Any procedure that would not be an integral part of the primary procedure or is unrelated to the diagnosis will be considered "incidental" and no benefits will be provided for such procedures;

(b) If multiple unrelated surgical procedures are performed by two (2) or more surgeons on separate operative fields, benefits will be based on the Usual and Reasonable Charge for each surgeon's primary procedure. If two (2) or more surgeons perform a procedure that is normally performed by one (1) surgeon, benefits for all surgeons will not exceed the Usual and Reasonable percentage allowed for that procedure; and

(c) If an assistant surgeon is required, the assistant surgeon's Covered Charge will not exceed 20% of the surgeon's Usual and Reasonable allowance.

(5) **Private Duty Nursing Care.** The private duty nursing care by a licensed nurse (R.N., L.P.N. or L.V.N.). Covered Charges for this service will be included to this extent:

(a) **Inpatient Nursing Care.** Charges are covered only when care is Medically Necessary or not Custodial in nature and the Hospital's Intensive Care Unit is filled or the Hospital has no Intensive Care Unit.

(b) **Outpatient Nursing Care.** Charges are covered only when care is Medically Necessary and not Custodial in nature. The only charges covered for Outpatient nursing care are those shown below, under Home Health Care Services and Supplies. Outpatient private duty nursing care on a 24-hour-shift basis is not covered.

(6) **Home Health Care Services and Supplies.** Charges for home health care services and supplies are covered only for care and treatment of an Injury or Sickness when Hospital or Skilled Nursing Facility confinement would otherwise be required. The diagnosis, care and treatment must be certified by the attending Physician and be contained in a Home Health Care Plan.

Benefit payment for nursing, home health aide and therapy services is subject to the Home Health Care limit shown in the Schedule of Benefits.

A home health care visit will be considered a periodic visit by either a nurse or therapist, as the case may be, or four hours of home health aide services.

Chiropractic Services are not covered under the Home Health Care benefit.

(7) **Hospice Care Services and Supplies.** Charges for hospice care services and supplies are covered only when the attending Physician has diagnosed the Covered Person's condition as being terminal, determined that the person is not expected to live more than six months and placed the person under a Hospice Care Plan.

Covered Charges for Hospice Care Services and Supplies are payable as described in the Schedule of Benefits.

Bereavement counseling services by a licensed social worker or a licensed pastoral counselor for the patient's immediate family (covered Spouse and/or other covered Dependents). Bereavement services must be furnished within six months after the patient's death.

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

(a) Local Medically Necessary professional land or air **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 unless the Plan Administrator finds a longer trip was Medically Necessary.

(b) **Anesthetic**; oxygen; blood and blood derivatives that are not donated or replaced; intravenous injections and solutions. Administration of these items is included.

(c) **Accidental Dental**; related to accidental injury. Outpatient Services, Physician Home Visits and Office Services, Emergency Care and Urgent Care services for dental work and oral surgery are covered if they are for the initial repair of an injury to the jaw, sound natural teeth, mouth or face which are required as a result of an accident and are not excessive in scope, duration, or intensity to provide safe, adequate, and appropriate treatment without adversely affecting the patient’s condition. Injury as a result of chewing or biting is not considered an accidental injury. "Initial" dental work to repair injuries due to an accident means performed within 12 months from the injury, or as reasonably soon thereafter as possible and includes all examinations and treatment to complete the repair. For a child requiring facial reconstruction due to dental related injury, there may be several years between the accident and the final repair.

Benefits based on where services are rendered.

Covered charges for accidental dental include, but are not limited to:

- Oral Examinations
- X-Rays
- Tests and Laboratory Examinations
- Restorations

- Prosthetic Services
- Oral Surgery
- Mandibular/Maxillary Reconstruction
- Anesthesia

(d) **Allergy**; Office visits may include allergy testing, injections and serum. When allergy serum is the only charge from a Physician's office, Deductible and Coinsurance apply. When Allergy Serum is billed with an Office Visit, the Office Visit Copayment will apply. When an Allergy Injection is billed alone, the Allergy Injection Copayment will apply.

(e) **Autism**; The diagnosis and treatment of Autism Spectrum Disorders. Autism Spectrum Disorders means a physical, mental, or cognitive illness or disorder which includes any of the pervasive developmental disorders as defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders ("DSM") published by the American Psychiatric Association, including Autistic Disorder, Asperger's Disorder, and Pervasive Developmental Disorder Not Otherwise Specified.

Treatment for autism spectrum disorders includes the following care for an individual diagnosed with any of the autism spectrum disorders:

- Medical care - services provided by a licensed physician, an advanced registered nurse practitioner, or other licensed health care provider;
- Habilitative or rehabilitative care - professional counseling and guidance services, therapy, and treatment programs, including applied behavior analysis, that are necessary to develop, maintain, and restore, to the maximum extent practicable, the functioning of an individual;
- Pharmacy care, if covered by the Plan - Medically Necessary medications prescribed by a licensed physician or other health-care practitioner with prescribing authority, if covered by the plan, and any Medically Necessary health-related services to determine the need or effectiveness of the medications;
- Psychiatric care - direct or consultative services provided by a psychiatrist licensed in the state in which the psychiatrist practices;
- Psychological care - direct or consultative services provided by an individual licensed by the Kentucky Board of Examiners of Psychology or by the appropriate licensing agency in the state in which the individual practices;
- Therapeutic care - services provided by licensed speech therapists, occupational therapists, or physical therapists; and
- Applied behavior analysis prescribed or ordered by a licensed health or allied health professional. Applied behavior analysis means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

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

this Plan.

(g) Radiation or **chemotherapy** and treatment with radioactive substances. The materials and services of technicians are included.

(h) Initial **contact lenses** or glasses required following cataract surgery.

(i) **Diabetic Equipment, Education and Supplies**. Benefits provided based on where Services are rendered. Diabetic Education for an individual with insulin dependent diabetes, non-insulin dependent diabetics, or elevated blood glucose levels induced by pregnancy or another medical condition when:

- Medically necessary
- Ordered by a Physician
- Provided by a certified, registered or licensed Provider

Covered charges also include all Physician prescribed Medically Necessary equipment, supplies, and all medications necessary for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes, and noninsulin-using diabetes if prescribed by a health care provider legally authorized to prescribe the items.

(j) Rental of **durable medical or surgical equipment** if deemed Medically Necessary. These items may be bought rather than rented, with the cost not to exceed the fair market value of the equipment at the time of purchase, but only if agreed to in advance by the Plan Administrator.

Durable Medical Equipment includes Hearing Aids and related services for Members under 18 years of age. One hearing aid per hearing impaired ear every 36 months.

Durable Medical Equipment can also include, but is not limited to: Hemodialysis equipment, crutches and replacement of pads and tips, Pressure machines, Infusion pump for IV fluids and medicine, Glucometer, Tracheotomy tube, Cardiac, neonatal and sleep apnea monitors, Augmentive communication devices are covered when approved by the Plan as Medically Necessary.

(k) Medically Necessary services for care and treatment of **jaw joint conditions, including Temporomandibular Joint syndrome (TMJ)**.

(l) **Laboratory studies.** Covered Charges for diagnostic and preventive lab testing and services.

(m) Treatment of **Mental Disorders and Substance Abuse**. For Plan Years beginning on or after October 3, 2009, regardless of any limitations on benefits for Mental Disorders and Substance Abuse Treatment otherwise specified in the Plan, any aggregate annual limit, financial requirement, out-of-network exclusion or treatment limitation on Mental Disorders and Substance Abuse benefits imposed by the Plan shall comply with federal parity requirements, if applicable.

Covered Charges for care, supplies and treatment of Mental Disorders and Substance Abuse will be limited as follows:

All treatment is subject to the benefit payment limits shown in the Schedule of Benefits.

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

(n) Injury to or care of **mouth, teeth and gums**. Charges for Injury to or care of the mouth, teeth, gums and alveolar processes will be Covered Charges under Medical Benefits only if

that care is for the following oral surgical procedures:

Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth.

Emergency repair due to Injury to sound natural teeth.

Surgery needed to correct accidental injuries to the jaws, cheeks, lips, tongue, floor and roof of the mouth.

Excision of benign bony growths of the jaw and hard palate.

External incision and drainage of cellulitis.

Incision of sensory sinuses, salivary glands or ducts.

Removal of impacted teeth.

Reduction of dislocations and excision of temporomandibular joints (TMJs).

No charge will be covered under Medical Benefits for dental and oral surgical procedures involving orthodontic care of the teeth, periodontal disease and preparing the mouth for the fitting of or continued use of dentures.

(o) **Occupational therapy** by a licensed occupational therapist. Therapy must be ordered by a Physician, result from an Injury or Sickness and improve a body function. Covered Charges do not include recreational programs, maintenance therapy or supplies used in occupational therapy.

(p) **Organ transplant** limits. Charges otherwise covered under the Plan that are incurred for the care and treatment due to an organ or tissue transplant are subject to these limits:

The transplant must be performed to replace an organ or tissue.

Charges for obtaining donor organs or tissues are Covered Charges under the Plan when the recipient is a Covered Person. When the donor has medical coverage, his or her plan will pay first. The benefits under this Plan will be reduced by those payable under the donor's plan. Donor charges include those for:

evaluating the organ or tissue;

removing the organ or tissue from the donor; and

transportation of the organ or tissue from within the United States and Canada to the place where the transplant is to take place.

Prior Approval and Precertification

In order to maximize the Member’s benefits, the Claims Administrator strongly

encourages the Member to call its transplant department to discuss benefit coverage when it is determined a transplant may be needed. The Member must do this before an evaluation and/or work-up for a transplant. The Claims Administrator will assist the Member in maximizing their benefits by providing coverage information, including details regarding what is covered and whether any clinical coverage guidelines, medical policies, Network Transplant Provider requirements, or exclusions are applicable. Contact the Customer Service telephone number on the back of your Identification Card **and ask to speak to someone regarding transplants**. Even if the Claims Administrator issues a prior approval for the Covered Transplant Procedure, the Member or Provider must call the Administrator's Transplant Department for precertification prior to the transplant whether this is performed in an Inpatient or Outpatient setting.

Please note that there are instances where the Provider requests approval for HLA testing, donor searches and/or a harvest and storage of stem cells prior to the final determination as to what transplant procedure will be requested. Under these circumstances, the HLA testing and donor search charges are covered as routine diagnostic testing. The harvest and storage request will be reviewed for Medical Necessity and may be approved. However, such an approval for HLA testing, donor search and/or a harvest and storage is NOT an approval for the subsequent requested transplant. A separate Medical Necessity determination will be made for the transplant procedure.

Transplant Schedule of Benefits	NETWORK	NON-NETWORK
Transplant Services – Human Organ & Tissue Transplant The human organ and tissue transplant (bone marrow/stem cell) services benefits or requirements described below do not apply to the following: Cornea Transplant Kidney Transplant Any Covered Services related to a Covered Transplant Procedure, received prior to or after the Transplant Benefit Period		
Transplant Benefit Period	Starts one day prior to a Covered Transplant Procedure and continues for the applicable case rate/global time period (the number of days will vary depending on the type of transplant received and the Network Transplant Case Manager for specific Network Transplant Provider information) for services received at or coordinated by a Network Transplant Provider facility.	Starts one day prior to a Covered Transplant Procedure and continues to the date of discharge.
Plan Deductible – Transplant Services	Not Applicable	During the Transplant Benefit Period, Covered Transplant Procedure charges that count toward the Deductible will NOT apply to your Out-of-Pocket Limit.

Transplant Schedule of Benefits	NETWORK	NON-NETWORK
Covered Transplant Procedure During The Transplant Benefit Period	During the Transplant Benefit Period, no Copayment or Coinsurance up to the Maximum Allowable Amount. Prior to and after the Transplant Benefit Period, Covered Services will be paid as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending where the service is performed.	During the Transplant Benefit Period, you will pay 50% of the Maximum Allowable Amount and these will NOT apply to your Out-Of-Pocket Limit. If the provider is also a Network Provider for the Plan (for services other than Transplant services and Procedures), then you will not be responsible for Covered Services which exceed the Plan's Maximum Allowable Amount. If the Provider is a Non-Network Provider for the Plan, you **will** be responsible for Covered Services which exceed the Plan's Maximum Allowable Amount. Prior to and after the Transplant Benefit Period, Covered Services will be paid as Inpatient Services, Outpatient Services or Physician Home visits and Office services depending where the service is performed.
Transportation & Lodging – Maximum of $10,000 per benefit	During the Transplant Benefit Period, no Copayment or Coinsurance up to the Maximum Allowable Amount.	During the Transplant Benefit Period, you will pay 50% of the Maximum Allowable Amount and these will NOT apply to your Out-Of-Pocket Limit.
Unrelated Donor Searches For Bone Marrow & Stem Cell Transplants For A Covered Transplant Procedure – Maximum of $30,000 per benefit	During the Transplant Benefit Period, no Copayment or Coinsurance up to the Maximum Allowable Amount.	During the Transplant Benefit Period, you will pay 50% of the Maximum Allowable Amount and these will NOT apply to your Out-Of-Pocket Limit.
Live Donor Health Services	Medically Necessary charges for the procurement of an organ from a live donor are covered up to the Maximum Allowable Amount, including complications from the donor procedure for up to six weeks from the date of procurement.	Member will pay 50% of the Maximum Allowable Amount for Medically Necessary live organ donor expenses. These charges will NOT apply to your Out-of Pocket Limit. Covered expenses include complications from the donor procedure for up to six weeks from the date of procurement.

(q) The initial purchase, fitting and repair of **orthotic appliances** such as braces, splints or other appliances which are required for support for an injured or deformed part of the body as a result of a disabling congenital condition or an Injury or Sickness.

(r) **Physical therapy** by a licensed physical therapist. The therapy must be in accord with a Physician's exact orders as to type, frequency and duration and for conditions which are subject to significant improvement through short-term therapy.

(s) **Prescription** Drugs (as defined).

(t) Routine **Preventive Care.** Covered Charges under Medical Benefits are payable for routine Preventive Care as described in the Schedule of Benefits. Standard Preventive Care shall be provided as required by applicable law if provided by a Panel/Network/Participating Provider. Standard Preventive Care for adults includes services with an "A" or "B" rating from the United States Preventive Services Task Force. Examples of Standard Preventive Care include:

- Screenings for: breast cancer, cervical cancer, colorectal cancer, high blood pressure, Type 2 Diabetes Mellitus, cholesterol, and obesity.
- Immunizations for adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; and
- Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration, including the following:
  - -Women's contraceptives, sterilization procedures, and counseling.
  - -Breastfeeding support, supplies, and counseling.
  - -Gestational diabetes screening.

The list of services included as Standard Preventive Care may change from time to time depending upon government guidelines. A current listing of required preventive care can be accessed at:

- www.HealthCare.gov/center/regulations/prevention.html. and
- www.cdc.gov/vaccines/recs/acip/

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

Charges for Routine Well Child Care. Routine well child care is routine care by a Physician that is not for an Injury or Sickness. Standard Preventive Care shall be provided as required by applicable law if provided by a Panel/Network/Participating Provider. Standard Preventive Care for children includes services with an "A" or "B" rating from the United States Preventive Services Task Force. Examples of Standard Preventive Care include:

- Immunizations for children and adolescents recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. These may include:
  - -Diphtheria,
  - -Pertussis,
  - -Tetanus,
  - -Polio,
  - -Measles,
  - -Mumps,
  - -Rubella,
  - -Hemophilus influenza b (Hib),
  - -Hepatitis B,
  - -Varicella.
- Preventive care and screenings for infants, children and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration

The list of services included as Standard Preventive Care may change from time to time depending upon government guidelines. A current listing of required preventive care can be accessed at:

- www.HealthCare.gov/center/regulations/prevention.html. and
- www.cdc.gov/vaccines/recs/acip/

(u) The initial purchase, fitting and repair of fitted **prosthetic devices** which replace body parts.

(v) **Reconstructive Surgery.** The following are Covered Charges Correction of abnormal congenital conditions and reconstructive mammoplasties will be considered Covered Charges.

- Otoplasty when performed to improve hearing by directing sound in the ear canal, when ear or ears are absent or deformed from trauma, surgery, disease or congenital defect
- Correction of abnormal congenital conditions
- Tongue release for diagnosis of tongue-tied
- Limb deformities
- Cleft Lip and palate
- Reconstructive mammoplasties

This mammoplasty coverage will include reimbursement for:

- Reconstruction of the breast on which a mastectomy has been performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Coverage of prostheses and physical complications during all stages of mastectomy, including lymphedemas

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

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

(x) **Spinal Manipulation/Chiropractic services** by a licensed M.D., D.O. or D.C.

(y) **Sterilization** procedures.

(z) **Surgical dressings**, splints, casts and other devices used in the reduction of fractures and dislocations.

(aa) **Telehealth Consultation Services.** Covered services include a medical or health consultation, for purposes of patient diagnosis or treatment, that requires the use of advanced telecommunications technology including by not limited to:

- Compressed digital interactive video, audio, or data transmission
- Clinical data transmission via computer imaging for teleradiology or telepathology
- Other technology that facilitates access to other covered health care services or medical specialty expertise.

(ab) Coverage of **Well Newborn Nursery/Physician Care**.

Charges for Routine Nursery Care. Routine well newborn nursery care is care while the newborn is Hospital-confined after birth and includes room, board and other normal care for which a Hospital makes a charge.

This coverage is only provided if the newborn child is an eligible Dependent and a parent (1) is a Covered Person who was covered under the Plan at the time of the birth, or (2) enrolls himself or herself (as well as the newborn child if required) in accordance with the Special Enrollment provisions with coverage effective as of the date of birth.

The benefit is limited to Usual and Reasonable Charges for nursery care for the newborn child while Hospital confined as a result of the child's birth.

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

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

The Plan, including but not limited to, any restrictions on hospital length of stay in connection with childbirth, shall be interpreted to comply with the Newborns' and Mothers' Health Protection Act.

Charges for Routine Physician Care. The benefit is limited to the Usual and Reasonable Charges made by a Physician for the newborn child while Hospital confined as a result of the child's birth.

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

(ac) Charges associated with the initial purchase of a **wig after chemotherapy**.

(ad) Diagnostic **x-rays**.

COST MANAGEMENT SERVICES

Cost Management Services Phone Number

ARC Administrators
(877) 309-2955

Please refer to the Employee ID card for the Cost Management Services phone number.

The provider must call this number to receive certification of certain Cost Management Services. This call must be made at least 24 hours in advance of services being rendered or within 48 hours after a Medical Emergency.

UTILIZATION REVIEW

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

The program consists of:

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

Hospitalizations
Imaging Services (MRI/CAT scans, etc.)
Inpatient Substance Abuse/Mental Disorder treatments
Skilled Nursing Facility stays
Home Health Care
Hospice Care
Durable Medical Equipment
Physical, Speech and Occupational Therapy
Cardiac Rehabilitation Therapy
Outpatient Surgical Procedures
Prosthetics and Orthotics
Non Emergent Ambulance

(b) Retrospective review of the Medical Necessity of the listed services provided on an emergency basis;

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

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

The purpose of the program is to determine what charges may be eligible for payment by the Plan. This program is not designed to be the practice of medicine or to be a substitute for the medical judgment of the attending Physician or other health care provider.

If a particular course of treatment or medical service is not certified, it means that either the Plan will not pay for the charges or the Plan will not consider that course of treatment as appropriate for the maximum reimbursement under the Plan. The patient is urged to find out why there is a discrepancy between what was requested and what was certified before incurring charges.

The attending Physician does not have to obtain precertification from the Plan for prescribing a maternity length of stay that is 48 hours or less for a vaginal delivery or 96 hours or less for a cesarean delivery.

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

Here's how the program works.

Precertification. Before a Covered Person enters a Medical Care Facility on a non-emergency basis or receives other listed medical services, the utilization review administrator will, in conjunction with the attending Physician, certify the care as appropriate for Plan reimbursement. A non-emergency stay in a Medical Care Facility is one that can be scheduled in advance.

The utilization review program is set in motion by a telephone call from the provider on behalf of the Covered Person. Contact the utilization review administrator at the telephone number on your ID card **at least 24 hours before** services are scheduled to be rendered with the following information:

- The name of the patient and relationship to the covered Employee
- The name, employee identification number and address of the covered Employee
- The name of the Employer
- The name and telephone number of the attending Physician
- The name of the Medical Care Facility, proposed date of admission, and proposed length of stay
- The proposed medical services
- The proposed rendering of listed medical services

If there is an **emergency** admission to the Medical Care Facility, the patient, patient's family member, Medical Care Facility or attending Physician must contact the utilization review administrator **within 48 hours** of the first business day after the admission.

The utilization review administrator will determine the number of days of Medical Care Facility confinement or use of other listed medical services authorized for payment. **Failure to follow this procedure may reduce reimbursement received from the Plan.**

If the Covered Person does not receive authorization as explained in this section, Allowable Charges may be reduced.

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

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

OUTPATIENT SURGERY

Certain surgical procedures can be performed safely and efficiently outside of a Hospital. Outpatient surgical facilities are equipped for many uncomplicated surgical operations, such as some biopsies, cataract surgeries, tonsillectomies and adenoidectomies, dilation and curettages, and similar procedures.

Charges for covered surgical procedures, when such procedures are performed on an outpatient rather than an inpatient basis, will be paid as outlined in the benefit schedule.

CASE MANAGEMENT

Case Management. The Plan may elect, in its sole discretion, when acting on a basis that precludes individual selection, to provide alternative benefits that are otherwise excluded under the Plan. The alternative benefits, called "Case Management," shall be determined on a case-by-case basis, and the Plan's determination to provide the benefits in one instance shall not obligate the Plan to provide the same or similar alternative benefits for the same or any other Covered Person, nor shall it be deemed to waive the right of the Plan to strictly enforce the provisions of the Plan.

A case manager consults with the patient, the family and the attending Physician in order to develop a plan of care for approval by the patient's attending Physician and the patient. This plan of care may include some or all of the following:

-- personal support to the patient;

-- contacting the family to offer assistance and support;

-- monitoring Hospital or Skilled Nursing Facility;

-- determining alternative care options; and

-- assisting in obtaining any necessary equipment and services.

Case Management occurs when this alternate benefit will be beneficial to both the patient and the Plan.

The case manager will coordinate and implement the Case Management program by providing guidance and information on available resources and suggesting the most appropriate treatment plan. The Plan Sponsor, attending Physician, patient and patient's family must all agree to the alternate treatment plan.

Once agreement has been reached, the Plan Sponsor will direct the Plan to cover Medically Necessary expenses as stated in the treatment plan, even if these expenses normally would not be paid by the Plan. Unless specifically provided to the contrary in the Plan Sponsor's instructions, reimbursement for expenses incurred in connection with the treatment plan shall be subject to all Plan limits and cost sharing provisions.

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

Each treatment plan is individually tailored to a specific patient and should not be seen as appropriate or recommended for any other patient, even one with the same diagnosis.

DEFINED TERMS

The following terms have special meanings and when used in this Plan will be capitalized.

Active Employee is an Employee who has begun to perform the duties of his or her job with the Employer on a regular basis.

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

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

Brand Name means a trade name medication.

Calendar Year means January 1st through December 31st of the same year.

COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Covered Charge(s) means those Medically Necessary services or supplies that are covered under this Plan.

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

Covered Transplant Procedure is any Medically Necessary human organ and tissue transplants or transfusions as determined by the Administrator, on behalf of the Employer including necessary acquisition procedures, harvest and storage, and including Medically Necessary preparatory myeloablative therapy.

Covered Transplant Services are all Covered Transplant Procedures and all Covered Services directly related to the disease that has necessitated the Covered Transplant Procedure or that arises as a result of the Covered Transplant Procedure within a Covered Transplant Benefit Period, including any Diagnostic evaluation for the purpose of determining a Member's appropriateness for a Covered Transplant Procedure.

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

Creditable Coverage does not include coverage consisting solely of dental or vision benefits.

Creditable Coverage does not include coverage that was in place before a significant break of coverage of 63 days or more. With respect to the Trade Act of 2002, when determining whether a significant break in coverage has occurred, the period between the trade related coverage loss and the start of the special second COBRA election period under the Trade Act, does not count.

Custodial Care is care (including Room and Board needed to provide that care) that is given principally for personal hygiene or for assistance in daily activities and can, according to generally accepted medical standards, be performed by persons who have no medical training. Examples of Custodial Care are help in walking and getting out of bed; assistance in bathing, dressing, feeding; or supervision over medication which could normally be self-administered.

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

Emergency Services means a medical screening examination (as required under Section 1867 of the Social Security Act (EMTALA)) within the capability of the Hospital emergency department, including routine ancillary

services, to evaluate a Medical Emergency and such further medical examination and treatment as are within the capabilities of the staff and facilities of the Hospital and required under EMTALA to stabilize the patient.

Employee means a person who is a common law employee of the Employer who is on the Employer's W-2 payroll, and works for the Employer in an Employee/Employer relationship.

Employer is University of the Cumberlands.

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

Experimental and/or Investigational means services, supplies, care and treatment which do not constitute accepted medical practice properly within the range of appropriate medical practice under the standards of the case and by the standards of a reasonably substantial, qualified, responsible, relevant segment of the medical community or government oversight agencies at the time services were rendered.

The Plan Sponsor must make an independent evaluation of the experimental/non-experimental standings of specific technologies. The Plan Sponsor shall be guided by a reasonable interpretation of Plan provisions. The decisions shall be made in good faith and rendered following a detailed factual background investigation of the claim and the proposed treatment. The decision of the Plan Sponsor will be final and binding on the Plan. The Plan Sponsor will be guided by the following principles:

(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; or

(2) if the drug, device, medical treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval; or

(3) if Reliable Evidence shows that the drug, device, medical treatment or procedure is the subject of ongoing phase I or phase II clinical trials, is the research, experimental, study or Investigational arm of ongoing phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or

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

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

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

Family Unit is the covered Employee and the family members who are covered as Dependents under the Plan.

Formulary means a list of prescription medications compiled by the third party payor of safe, effective therapeutic drugs specifically covered by this Plan.

Generic drug means a Prescription Drug which has the equivalency of the brand name drug with the same use and metabolic disintegration. This Plan will consider as a Generic drug any Food and Drug Administration approved generic pharmaceutical dispensed according to the professional standards of a licensed pharmacist and clearly designated by the pharmacist as being generic.

Genetic Information means information about the genetic tests of an individual or his family members, and information about the manifestations of disease or disorder in family members of the individual. A "genetic test" means an analysis of human DNA, RNA, chromosomes, proteins or metabolites, which detects genotypes, mutations or chromosomal changes. It does not mean an analysis of proteins or metabolites that is directly related to a manifested disease, disorder or pathological condition that could reasonably be detected by a health care professional with appropriate training and expertise in the field of medicine involved. Genetic information does not include information about the age or gender of an individual.

Home Health Care Agency is an organization that meets all of these tests: its main function is to provide Home Health Care Services and Supplies; it is federally certified as a Home Health Care Agency; and it is licensed by the state in which it is located, if licensing is required.

Home Health Care Plan must meet these tests: it must be a formal written plan made by the patient's attending Physician which is reviewed at least every 30 days; it must state the diagnosis; it must certify that the Home Health Care is in place of Hospital confinement; and it must specify the type and extent of Home Health Care required for the treatment of the patient.

Home Health Care Services and Supplies include: part-time or intermittent nursing care by or under the supervision of a registered nurse (R.N.); part-time or intermittent home health aide services provided through a Home Health Care Agency (this does not include general housekeeping services); physical, occupational and speech therapy; medical supplies; and laboratory services by or on behalf of the Hospital.

Hospice Agency is an organization where its main function is to provide Hospice Care Services and Supplies and it is licensed by the state in which it is located, if licensing is required.

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

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

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

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

The definition of "Hospital" shall be expanded to include the following:

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

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

Illness means a bodily disorder, disease, physical sickness or Mental Disorder. Illness includes Pregnancy, childbirth, miscarriage or complications of Pregnancy.

Injury means an accidental physical Injury to the body caused by unexpected external means.

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

Late Enrollee means a Plan Participant who enrolls under the Plan other than during the first 31-day period in which the individual is eligible to enroll under the Plan or during a Special Enrollment Period.

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.

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

Medical Emergency means a medical condition manifesting itself by acute symptoms of sufficient severity including severe pain such that a prudent layperson with average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in (1) serious jeopardy to the health of an individual (or, in the case of a pregnant woman, the health of the woman or her unborn child), (2) serious impairment to body functions, or (3) serious dysfunction of any body organ or part. A Medical Emergency includes such conditions as heart attacks, cardiovascular accidents, poisonings, loss of consciousness or respiration, convulsions or other such acute medical conditions.

Medical Non-Emergency Care means care which can safely and adequately be provided other than in a Hospital.

Medically Necessary care and treatment is recommended or approved by a Physician; is consistent with the patient's condition or accepted standards of good medical practice; is medically proven to be effective treatment of the condition; is not performed mainly for the convenience of the patient or provider of medical services; is not conducted for research purposes; and 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 recommends or approves certain care does not mean that it is Medically Necessary.

The Plan Sponsor has the discretionary authority to decide whether care or treatment is Medically Necessary.

Medicare is the Health Insurance For The Aged and Disabled program under Title XVIII of the Social Security Act, as amended.

Mental Disorder means any disease or condition, regardless of whether the cause is organic, that is classified as a Mental Disorder in the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services or is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association.

Morbid Obesity is a diagnosed condition in which the body weight exceeds the medically recommended weight by either 100 pounds or is twice the medically recommended weight for a person of the same height, age and mobility as the Covered Person.

No-Fault Auto Insurance is the basic reparations provision of a law providing for payments without determining fault in connection with automobile accidents.

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

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

Pharmacy means a licensed establishment where covered Prescription Drugs are filled and dispensed by a pharmacist licensed under the laws of the state where he or she practices.

Physician means a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), Audiologist, Certified Nurse Anesthetist, Licensed Professional Counselor, Licensed Professional Physical Therapist, Master of Social Work (M.S.W.), Midwife, Occupational Therapist, Physiotherapist, Psychiatrist, Psychologist (Ph.D.), Speech 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 his or her license.

Plan means University of the Cumberlands Employee Medical Benefit Plan, which is a benefits plan for certain Employees of University of the Cumberlands and is described in this document.

Plan Participant is any Employee or Dependent who is covered under this Plan.

Plan Year is the 12-month period beginning on November 1 and ending on the following October 31.

Pregnancy is childbirth and conditions associated with Pregnancy, including complications.

Prescription Drug means any of the following: a Food and Drug Administration-approved drug or medicine which, under federal law, is required to bear the legend: "Caution: federal law prohibits dispensing without prescription"; injectable insulin; hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed Physician. Such drug must be Medically Necessary in the treatment of a Sickness or Injury.

Sickness is:

For a covered Employee and covered Spouse: Illness, disease or Pregnancy.

For a covered Dependent other than Spouse: Illness or disease, not including Pregnancy or its complications.

Skilled Nursing Facility is a facility that fully meets all of these tests:

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

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

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

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

(5) It has an effective utilization review plan.

(6) It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, mentally disabled, Custodial or educational care or care of Mental Disorders.

(7) It is approved and licensed by Medicare.

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

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

Substance Abuse is regular excessive compulsive drinking of alcohol and/or physical habitual dependence on drugs. This does not include dependence on tobacco and ordinary caffeine-containing drinks.

Temporomandibular Joint (TMJ) syndrome is the treatment of jaw joint disorders including conditions of structures linking the jaw bone and skull and the complex of muscles, nerves and other tissues related to the temporomandibular joint.

Total Disability (Totally Disabled) means: In the case of a Dependent, a determination of total disability by the Social Security Administration.

Urgent Care Services means care and treatment for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room services.

Usual and Reasonable Charge is a charge which is not higher than the usual charge made by the provider of the care or supply and does not exceed the usual charge made by most providers of like service in the same area. This test will consider the nature and severity of the condition being treated. It will also consider medical complications or unusual circumstances that require more time, skill or experience. For Network Provider charges, the Usual and Reasonable Charge will be the contracted rate.

The Plan will pay benefits on the basis of the actual charge billed if it is less than the Usual and Reasonable Charge.

The Plan Sponsor has the discretionary authority to decide whether a charge is Usual and Reasonable.

PLAN EXCLUSIONS

Note: All exclusions related to Prescription Drugs are shown in the Prescription Drug Plan.

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

(1) **Abortion.** Services, supplies, care or treatment in connection with an abortion unless the life of the mother is endangered by the continued Pregnancy or the Pregnancy is the result of rape or incest.

(2) **Acupuncture or any other Holistic Medicine.** Including but not limited to: acupuncture, holistic medicine, homeopathy, hypnosis, aroma therapy, massage, naturopathy, thermograph, orthomolecular therapy, contact reflex therapy, bioenergial synchromization technique (BEST) and iridology-study of the iris**.**

(3) **Alcohol.** Services, supplies, care or treatment to a Covered Person for an Injury or Sickness which occurred as a result of that Covered Person's illegal use of alcohol. The arresting officer's determination of inebriation will be sufficient for this exclusion. Expenses will be covered for Injured Covered Persons other than the person illegally using alcohol and expenses will be covered for Substance Abuse treatment as specified in this Plan. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

(4) **Biofeedback.**

(5) **Complications of non-covered treatments.** Care, services or treatment required as a result of complications from a treatment not covered under the Plan are not covered. Complications from a non-covered abortion are covered.

(6) **Completion of claim forms or charges for medical records unless required by law.**

(7) **Cosmetic Services.** For any procedures, services, equipment or supplies provided in connection with cosmetic services. Cosmetic services are primarily intended to preserve, change or improve your appearance or are furnished for psychiatric or psychological reasons. No benefits are available for surgery or treatments to change the texture or appearance of skin or to change the size, shape or appearance of facial or body features (such as nose, eyes, ears, cheeks, chin, chest or breasts). Complications directly related to cosmetic services treatment or surgery, as determined by the Claims Administrator, on behalf of the Employer, are not covered. This exclusion applies even if the original cosmetic services treatment or surgery was performed while the Member was covered by another carrier/self-funded plan prior to coverage under this Plan. Directly related means that the treatment or surgery occurred as a direct result of the cosmetic services treatment or surgery and would not have taken place in the absence of the cosmetic services treatment or surgery. This exclusion does not apply to conditions including but not limited to: myocardial infarction; pulmonary embolism; thrombophlebitis; and exacerbation of co-morbid conditions

(8) **Court Ordered Testing.** Unless Medically Necessary.

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

(10) **Dental.** Dental Services are excluded under the Medical Plan except as specified as Covered in the Covered Charges section. For dental treatment, regardless of origin or cause, except as specified elsewhere in this Plan Document. Dental Services includes but is not limited to: Preventive care, diagnosis, treatment of or related to the teeth, jawbones (except that TMJ is a Covered Service) or gums, including but not limited to:

- extraction, restoration and replacement of teeth.
- medical or surgical treatments of dental conditions.
- services to improve dental clinical outcomes.

(11) Dental Implants, Dental Braces

(12) For Dental x rays, supplies & appliances and all associated expense. This includes hospitalization and anesthesia, except as required by law. The only exceptions to this are for any of the following:

- transplant preparation
- initiation of immunosuppresives.
- direct treatment of acute traumatic injury, cancer or cleft palate.

(13) Dietary Supplements. Except as Medically Necessary. This exclusion includes, but is not limited to, those supplements that by law do not require either the written prescription of a Physician or dispensing by a licensed pharmacist. It also includes vitamins and food replacements, such as infant formulas and enteral formulas.

(14) Domiciliary care. Services or supplies provided in a residential institution, treatment center, supervised living or halfway house, or school because a Member's own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even when therapy is included.

(15) Educational or vocational testing. Services for educational or vocational testing or training.

(16) Excess charges. The part of an expense for care and treatment of an Injury or Sickness that is in excess of the Usual and Reasonable Charge.

(17) Exercise programs. Exercise programs for treatment of any condition, except for Physician-supervised cardiac rehabilitation, occupational or physical therapy if covered by this Plan.

(18) Experimental or not Medically Necessary. Care and treatment that is either Experimental/Investigational or not Medically Necessary. Notwithstanding the exclusion of charges for Experimental / Investigational services, supplies and treatment, the Plan shall be interpreted and applied in compliance with PHSA Section 2709.

(19) Eye care. For prescription, fitting, or purchase of eyeglasses or contact lenses except as otherwise specifically stated as a Covered Charge. This Exclusion does not apply for initial prosthetic lenses or sclera shells following intra-ocular surgery, or for soft contact lenses due to a medical condition.

Radial keratotomy or other eye surgery to correct refractive disorders are excluded. This exclusion does not apply to aphakic patients and soft lenses or sclera shells intended for use as corneal bandages or as may be covered under the well adult or well child sections of this Plan.

This exclusion also includes orthoptic training.

(20) Foot care. Any services performed when there is not a localized illness, injury or symptom involving the foot are excluded.

Surgical treatment of weak, strained, flat, unstable or unbalanced feet (except under the Orthotic benefit and provided by an MD).

Treatment of metatarsalgia or bunions (except open cutting operations), and treatment of corns, calluses or toenails (unless needed in treatment of a metabolic or peripheral-vascular disease).

(21) Foreign travel. Care, treatment or supplies out of the U.S. if travel is for the sole purpose of obtaining medical services.

(22) Government coverage. Care, treatment or supplies furnished by a program or agency funded by any government. This exclusion does not apply to Medicaid or when otherwise prohibited by applicable law.

(23) **Gynecomastia (surgical treatment).** Unless Medically Necessary.

(24) **Hair loss.** Care and treatment for hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a Physician, except for wigs after chemotherapy up to the limit shown in the Schedule of Benefits.

(25) **Hazardous Hobby or Activity.** Care and treatment of an Injury or Sickness that results from engaging in a Hazardous Hobby or Activity. A hobby or activity is hazardous if it is an activity which is characterized by a constant threat of danger or risk of bodily harm. Examples of hazardous hobbies or activities are skydiving, auto racing, hang gliding or bungee jumping.

(26) **Health Spa.** Excluded for health spa or similar facility.

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

(28) **Human Growth Hormone.** For children born small for gestational age. It is only a Covered Charge in other situations when allowed by the Administrator, on behalf of the Employer, through Prior Authorization.

(29) **Hyperhidrosis (excessive sweating).**

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

(31) **Illegal drugs or medications.** Services, supplies, care or treatment to a Covered Person for Injury or Sickness resulting from that Covered Person's voluntary taking of or being under the influence of any controlled substance, drug, hallucinogen or narcotic not administered on the advice of a Physician. Expenses will be covered for Injured Covered Persons other than the person using controlled substances and expenses will be covered for Substance Abuse treatment as specified in this Plan. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

(32) **Impotence.** Care, treatment, services, supplies or medication in connection with treatment for impotence, regardless of origin. Only the initial diagnosis of Impotence is covered.

(33) **Incarcerated.** Care, supplies, services while incarcerated.

(34) **Infertility.** Care, supplies, services and treatment for infertility, artificial insemination, or in vitro fertilization. Only the initial diagnosis of Infertility is covered.

(35) **Marital or pre-marital counseling.** Care and treatment for marital or pre-marital counseling.

(36) **Manipulation Therapy rendered in the home.** As part of home care services.

(37) **Member Responsibility.** For any service for which the member is responsible under the terms of this document to pay as a Copayment, Coinsurance or Deductible, and the Copayment, Coinsurance or Deductible is waived by a Non-Network Provider.

(38) **Membership Fees.** For any membership fees charged by providers.

(39) **Missed or cancelled appointments.**

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

(41) **No obligation to pay.** Charges incurred for which the Plan has no legal obligation to pay.

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

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

(44) **Non-emergency Hospital admissions.** Care and treatment billed by a Hospital for non-Medical Emergency admissions on a Friday or a Saturday. This does not apply if surgery is performed within 24 hours of admission.

(45) **Not a Provider.** Charges received from an entity that is not a Provider recognized by the Plan.

(46) **Not specified as covered.** Non-traditional medical services, treatments and supplies which are not specified as covered under this Plan.

(47) **Obesity.** Care and treatment of obesity, weight loss or dietary control whether or not it is, in any case, a part of the treatment plan for another sickness; regardless of determination as Medically Necessary. Specifically excluded are charges for bariatric surgery, including but not limited to, gastric bypass, stapling and intestinal bypass, and lapband surgery, including reversals. This exclusion does not apply to the extent that such care or treatment is mandated as preventive care under PHSA Section 2713.

(48) **Occupational.** Care and treatment of an Injury or Sickness that is occupational -- that is, arises from work for wage or profit including self-employment. For any condition, disease, defect, ailment or injury arising out of or in the course of employment if any benefits are available under any Worker's Compensation Act or similar law. This exclusion applies whether or not you claim the benefits or the compensation. It also applies whether or not you recover from any third party.

Physical exams, immunizations or other procedures required for enrollment in any insurance program as a condition of employment, for licensing or similar purposes are also excluded.

(49) **Over the Counter Equivalents.** For drugs, devices or products with over the counter equivalents.

(50) **Personal comfort items.** Personal comfort items or other equipment, such as, but not limited to, air conditioners, air-purification units, humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, elastic bandages or stockings, nonprescription drugs and medicines, and first-aid supplies and nonhospital adjustable beds.

(51) **Plan design excludes.** Charges excluded by the Plan design as mentioned in this document.

(52) **Pregnancy for Dependent Daughters.**

(53) **Private Duty Nursing in a Hospital or Skilled Nursing Facility.** Private Duty Nursing Services are

Covered Charges only when provided through the Home Care Services benefit as specifically stated in the "Covered Charges" section.

(54) **Reconstructive Services.** Except as specifically stated in the Covered charges section.

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

(56) **Replacement braces.** Replacement of braces of the leg, arm, back, neck, or artificial arms or legs, unless there is reasonable justification for the repair, adjustment or replacement.

(57) **Room and Board.** For room and board charges unless the treatment provided meets the Claims Administrator's Medical Necessity criteria for Inpatient admission for your condition.

(58) **Sclerotherapy.** For the treatment of varicose veins of the lower extremities including ultrasonic guidance for needle and/or catheter placement and subsequent sequential ultrasound studies to assess the results of ongoing treatment of varicose veins of the lower extremities with sclerotherapy unless Medically Necessary.

(59) **Second surgical opinions.** Charges for second and third opinions for elective surgery.

(60) **Self Help Training.** Self Help Training and other forms of non-medical self care.

(61) **Services before or after coverage.** Care, treatment or supplies for which a charge was incurred before a person was covered under this Plan or after coverage ceased under this Plan.

(62) **Services performed to preserve** the present level of function or prevent regression of functions for an illness, injury or condition which is resolved or stable.

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

(64) **Surgical sterilization.** Care and treatment for surgical sterilizations or their reversal.

(65) **Surrogate Mother.** Charges for hiring surrogate mother.

(66) **Telangiectatic Dermal Veins (spider veins).** Treatment of spider veins by any method is excluded.

(67) **Telephone Consultations or Electronic Consultations**. Telephone consultations or consultations via electronic mail or internet/website, except as authorized by the Plan Administrator or allowed under the Telehealth services benefit in the Covered Charges section.

(68) **Travel or accommodations.** Charges for travel or accommodations, whether or not recommended by a Physician, except as otherwise defined as a Covered Charge.

(69) **Treatment of congenitally missing, malpositioned, or super numerary teeth.** This exclusion applies even if part of a congenital anomaly.

(70) **War.** Any loss that is due to a declared or undeclared act of war.

(71) **Weight Loss Programs.** Weight loss programs whether or not they are under medical or Physician supervision except as specifically listed as covered in the "Covered Charges" section. Weight loss

programs for medical reasons are also excluded. Weight loss programs include but are not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) or fasting programs. This exclusion does not apply to the extent that such care or treatment is mandated as preventive care under PHSA Section 2713.

(72) **When it is otherwise provided to a participant.** Requests for payment received from a dental or medical department maintained by or on behalf of an employer other than the University of the Cumberlands, mutual benefit association, labor union, trust or similar person or group.

PRESCRIPTION DRUG BENEFITS

Pharmacy Drug Charge

Network pharmacies have contracted with the Plan to charge Covered Persons reduced fees for covered Prescription Drugs. Express Scripts is the administrator of the pharmacy drug plan.

Copayments

The copayment is applied to each covered pharmacy drug or mail order drug charge and is shown in the schedule of benefits. The copayment amount is not a Covered Charge under the medical Plan. Any one pharmacy prescription is limited to a 30-day supply. Any one mail order prescription is limited to a 90-day supply. For Plan Years beginning on or after January 1, 2015, copayments will apply toward satisfaction of the Plan's Prescription Drug Maximum Out-of-Pocket amount. Copayments for the additional cost of brand name drugs where a generic is available will not be included in the Prescription Drug Maximum Out-of-Pocket amount.

If a drug is purchased from a non-Network pharmacy, or a Network pharmacy when the Covered Person's ID card is not used, the amount payable in excess of the amounts shown in the schedule of benefits will be the ingredient cost and dispensing fee.

Percentages Payable

The percentage payable amount is applied to each covered pharmacy drug or mail order drug charge and is shown in the schedule of benefits.

Per-Prescription Maximum

The per-prescription maximum is the maximum amount this Plan will pay toward any one covered prescription.

Mail Order Drug Benefit Option

The mail order drug benefit option is available for maintenance medications (those that are taken for long periods of time, such as drugs sometimes prescribed for heart disease, high blood pressure, asthma, etc.). Because of volume buying, Express Scripts, the mail order pharmacy, is able to offer Covered Persons significant savings on their prescriptions.

Covered Prescription Drugs

(1) All drugs prescribed by a Physician that require a prescription either by federal or state law. This includes oral contraceptives, but excludes any drugs stated as not covered under this Plan.

(2) All compounded prescriptions containing at least one prescription ingredient in a therapeutic quantity.

(3) Insulin and other diabetic supplies when prescribed by a Physician.

(4) Injectable drugs or any prescription directing administration by injection.

Limits To This Benefit

This benefit applies only when a Covered Person incurs a covered Prescription Drug charge. The covered drug charge for any one prescription will be limited to:

(1) Refills only up to the number of times specified by a Physician.

(2) Refills up to one year from the date of order by a Physician.

Expenses Not Covered

This benefit will not cover a charge for any of the following:

(1) **Administration.** Any charge for the administration of a covered Prescription Drug.

(2) **Appetite suppressants.** A charge for appetite suppressants, dietary supplements or vitamin supplements, except for prenatal vitamins requiring a prescription or prescription vitamin supplements containing fluoride.

(3) **Consumed on premises.** Any drug or medicine that is consumed or administered at the place where it is dispensed.

(4) **Devices.** Devices of any type, even though such devices may require a prescription. These include (but are not limited to) therapeutic devices, artificial appliances, braces, support garments, or any similar device.

(5) **Drugs used for cosmetic purposes.** Charges for drugs used for cosmetic purposes, such as anabolic steroids, Retin A or medications for hair growth or removal.

(6) **Experimental.** Experimental drugs and medicines, even though a charge is made to the Covered Person.

(7) **FDA.** Any drug not approved by the Food and Drug Administration.

(8) **Growth hormones.** Charges for drugs to enhance physical growth or athletic performance or appearance unless otherwise approved by the Plan.

(9) **Immunization.** Immunization agents or biological sera unless otherwise approved by the Plan.

(10) **Impotence.** A charge for impotence medication.

(11) **Infertility.** A charge for infertility medication.

(12) **Inpatient medication.** A drug or medicine that is to be taken by the Covered Person, in whole or in part, while Hospital confined. This includes being confined in any institution that has a facility for the dispensing of drugs and medicines on its premises.

(13) **Investigational.** A drug or medicine labeled: "Caution - limited by federal law to investigational use".

(14) **Medical exclusions.** A charge excluded under Medical Plan Exclusions.

(15) **No charge.** A charge for Prescription Drugs which may be properly received without charge under local, state or federal programs.

(16) **Non-legend drugs.** A charge for FDA-approved drugs that are prescribed for non-FDA-approved uses.

(17) **No prescription.** A drug or medicine that can legally be bought without a written prescription. This does not apply to injectable insulin.

(18) **Refills.** Any refill that is requested more than one year after the prescription was written or any refill that is more than the number of refills ordered by the Physician.

HOW TO SUBMIT A CLAIM

Benefits under this Plan shall be paid only if the Plan Sponsor decides in its discretion that a Covered Person is entitled to them.

When a Covered Person has a Claim to submit for payment that person must:

(1) Obtain a Claim form from the Personnel Office, Human Resources Office or the Plan Sponsor.

(2) Complete the Employee portion of the form. ALL QUESTIONS MUST BE ANSWERED.

(3) Have the Physician complete the provider's portion of the form.

(4) For Plan reimbursements, attach bills for services rendered. ALL BILLS MUST SHOW:

- Name of Plan
- Employee's name
- Name of patient
- Name, address, telephone number of the provider of care
- Diagnosis
- Type of services rendered, with diagnosis and/or procedure codes
- Date of services
- Charges

(5) Send the above to the Claims Administrator at this address:

ARC Administrators
P.O. Box 12990
Lexington, Kentucky 40582
(877) 309-2955

WHEN CLAIMS SHOULD BE FILED

Claims should be filed with the Claims Administrator within 180 days of the date charges for the service were incurred. Benefits are based on the Plan's provisions at the time the charges were incurred. Claims filed later than that date may be declined or reduced unless:

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

(b) The claim is submitted within one year from the date incurred. This one-year period will not apply when the person is not legally capable of submitting the claim.

The Claims Administrator will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested from the claimant. The Plan reserves the right to have a Plan Participant seek a second medical opinion.

CLAIMS PROCEDURE

Following is a description of how the Plan processes claims for benefits and reviews the appeal of any claim that is denied. The terms used in this section are defined below.

A "Claim" is defined as any request for a Plan benefit, made by a claimant or by a representative of a claimant, which complies with the Plan's reasonable procedure for filing claims and making benefit claims determinations.

Claims for a request for a determination of an individual's eligibility to participate in the Plan are determined under these claims procedures, however, the initial claims for eligibility will be determined by Human Resources, and appeals will be directed to, and determined by, the Vice President of Business Services.

If a Claim is denied, in whole or in part, or if Plan coverage is rescinded retroactively for fraud or misrepresentation, the denial is known as an "Adverse Benefit Determination."

A claimant has the right to request a review of an Adverse Benefit Determination. This request is an "Appeal." If the Claim is denied at the end of the Appeal process, as described below, the Plan's final decision is known as a "Final Adverse Benefit Determination." If the claimant receives notice of a Final Adverse Benefit Determination, or if the Plan does not follow the Appeal procedures properly, the claimant then has the right to request an independent external review. The External Review procedures are described below.

Both the Claims and the Appeal procedures are intended to provide a full and fair review. This means, among other things, that Claims and Appeals will be decided in a manner designed to ensure the independence and impartiality of the persons involved in making these decisions.

A claimant must follow all Claims and Appeal procedures both internal and external, before he or she can file a lawsuit. However, this rule may not apply if the Plan Sponsor has not complied with the procedures described in this Section. If a lawsuit is brought, it must be filed within two years after the final determination of an Appeal.

Any of the authority and responsibilities of the Plan Sponsor under the Claims and Appeal Procedures or the External Review Process, including the discretionary authority to interpret the terms of the Plan, may be delegated to a third party. If you have any questions regarding these procedures, please contact the Plan Sponsor.

There are different kinds of Claims and each one has a specific timetable for each step in the review process. Upon receipt of the Claim, the Plan Sponsor must decide whether to approve or deny the Claim. The Plan Sponsor's notification to the claimant of its decision must be made as soon as practical and not later than the time shown in the timetable. However, if the Claim has not been filed properly, or if it is incomplete, or if there are other matters beyond the control of the Plan Sponsor, the claimant may be notified, prior to the end of the determination deadline, that the period for providing the notification will need to be extended (other than for Urgent Care Claims). If the period is extended because the Plan Sponsor needs more information from the claimant, the claimant must provide the requested information within the time shown on the timetable. Once the Claim is complete, the Plan Sponsor must make its decision as shown in the timetable. If the Claim is denied, in whole or in part, the claimant has the right to file an Appeal. Then the Plan Sponsor must decide the Appeal and, if the Appeal is denied, provide notice to the claimant within the time periods shown on the timetable. The time periods shown in the timetable begin at the time the Claim or Appeal is filed in accordance with the Plan's procedures. Decisions will be made within a reasonable period of time appropriate to the circumstances, but within the maximum time periods listed in the timetables below. Unless otherwise noted, "days" means calendar days.

The definitions of the types of Claims are:

Urgent Care Claim

A Claim involving Urgent Care is any Claim for medical care or treatment where the Plan conditions receipt of benefits, in whole or in part, on approval in advance of obtaining the care or treatment, and using the timetable for a non-urgent care determination 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. The Urgent Care Claim rules do not apply to claims involving urgent care where Plan benefits are not conditioned on prior approval. These claims are subject to the rules on Post-Service Claims described below.

A Physician with knowledge of the claimant's medical condition may determine if a Claim is one involving Urgent Care. The Claims Administrator will defer to the attending provider's determination that the Claim involves Urgent Care. If there is no such Physician, an individual acting on behalf of the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine may make the determination.

In the case of a Claim involving Urgent Care, responses must be made as soon as possible consistent with the medical urgency involved, and no later than the following times:

Notification to claimant of Claim determination	72 hours
Insufficient information on the Claim, or failure to follow the Plan's procedure for filing a Claim:	
Notification to claimant, orally or in writing	24 hours
Response by claimant, orally or in writing	48 hours
Benefit determination, orally or in writing	48 hours
Notification of Adverse Benefit Determination on Appeal	72 hours

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. Alternatively, the claimant may request an expedited review under the External Review Process.

Concurrent Care Claims

A Concurrent Care Claim is a special type of Claim that arises if the Plan informs a claimant that benefits for a course of treatment that has been previously approved for a period of time or number of treatments is to be reduced or eliminated. In that case, the Plan must notify the claimant sufficiently in advance of the effective date of the reduction or elimination of treatment to allow the claimant to file an Appeal. This rule does not apply if benefits are reduced or eliminated due to Plan amendment or termination. A similar process applies for Claims based on a rescission of coverage for fraud or misrepresentation. Concurrent Care Claims can be a Urgent Care or Pre-Service Claim.

In the case of a Concurrent Care Claim, the following timetable applies:

Notification to claimant of benefit reduction	Sufficiently prior to scheduled termination of course of treatment to allow claimant to appeal
Notification to claimant of Claim approval	Within the timelines for Urgent Care or Pre-Service Claims as applicable
Notification to claimant of initial Adverse Benefit Determination	Urgent Care: within 24 hours where claim is made within 24 hours of end of period or number of treatments. Otherwise, within the timelines for Urgent Care of Pre-Service Claims as applicable
Extension for matters beyond the control of the Plan (for non-Urgent Claims only):	
Notification to claimant	Before end of initial claim determination period
Length of extension	15 days
Extension for insufficient information on the Claim (for non-Urgent Claims only):	

Notification to claimant	Before end of initial claim determination period
Response by claimant	45 days
Length of extension	15 days from receipt of information from claimant
Notification to claimant of rescission	30 days prior to rescission
Notification of determination on Appeal of Claims involving Urgent Care	72 hours
Notification of Adverse Benefit Determination on Appeal for non-Urgent Claims	As soon as feasible, but not more than 30 days
Notification of Adverse Benefit Determination on Appeal for Rescission Claims	30 days prior to rescission
Notification, orally or in writing, of failure to follow the Plan's procedures for filing a Claim	Within the timelines for Urgent Care or Pre-Service Claims as applicable

Pre-Service Claim

A Pre-Service Claim means any Claim for a benefit under this 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. Please see the Cost Management section of this booklet for further information about Pre-Service Claims.

In the case of a Pre-Service Claim, the following timetable applies:

Notification to claimant of Benefit Determination	15 days
Extension for matters beyond the control of the Plan:	
Notification to claimant	Before end of initial claim determination period
Length of extension	15 days
Extension for insufficient information on the Claim:	
Notification to claimant	Before end of initial claim determination period
Response by claimant	45 days
Length of extension	15 days from receipt of information from claimant
Notification, orally or in writing, of failure to follow the Plan's procedures for filing a Claim	5 days
Notification of Benefit Determination on Appeal	30 days

Post-Service Claim

A Post-Service Claim means any Claim for a Plan benefit that is not an Urgent Care Claim or a Pre-Service Claim; in other words, a Claim that is a request for payment under the Plan for medical services already received by the claimant.

In the case of a Post-Service Claim, the following timetable applies:

Notification to claimant of Benefit Determination	30 days
Extension for matters beyond the control of the Plan:	
Notification to claimant	Before end of initial claim determination period
Length of extension	15 days
Extension for insufficient information on the Claim:	
Notification to claimant	Before end of initial claim determination period
Response by claimant	45 days
Length of extension	15 days from receipt of information from claimant
Notification of Benefit Determination on Appeal	60 days

Notice to claimant of Adverse Benefit Determinations

If a Claim is denied in whole or in part, the denial is considered to be an Adverse Benefit Determination. Except with Urgent Care Claims, when the notification may be oral followed by written or electronic notification within three days of the oral notification, the Plan Sponsor shall provide written or electronic notification of the Adverse Benefit Determination. The notice will state in a culturally and linguistically appropriate manner and in a manner calculated to be understood by the claimant:

(1) Information sufficient to allow the claimant to identify the Claim involved (including date of service, the healthcare provider, and the claim amount, if applicable), and a statement that the diagnosis code and treatment code and their corresponding meanings will be provided to the claimant as soon as feasible upon request.

(2) The specific reason or reasons for the adverse determination, including the denial code and its corresponding meaning, and a description of the Plan's standard, if any, that was used in denying the Claim.

(3) Reference to the specific Plan provisions on which the determination was based.

(4) 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.

(5) A description of the Plan's internal and external Appeal procedures. This description will include information on how to initiate the Appeal and the time limits applicable to such procedures, the right to obtain information about the claims procedures, and in the case of an Urgent Care Claim, an explanation of the expedited review methods available for such Claims, and the right to sue in federal court after exhausting the Plan’s claims procedures.

(6) 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 a 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.

(7) If the Adverse Benefit Determination is based on the Medical Necessity or Experimental or Investigational 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, will be provided. If this is not practical, a statement will be included that such explanation will be provided free of charge, upon request.

(8) Information about the availability of and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under applicable federal law to assist individuals with the internal claims and appeals and external review process.

Appeals

When a claimant receives notification of an Adverse Benefit Determination, the claimant generally has 180 days following receipt of the notification in which to file a written request for an Appeal of the decision. However, for Concurrent Care Claims, the Claimant must file the Appeal prior to the scheduled reduction or termination of treatment. For a claim based on rescission of coverage, the claimant must file the Appeal within 30 days. A claimant may submit written comments, documents, records, and other information relating to the Claim. A Claimant also has the right to review the Claim file, and is permitted to present evidence and testimony as part of the appeals process.

The Plan Sponsor shall provide the claimant, as soon as possible and sufficiently in advance of the time within which a final determination on Appeal is required to allow the claimant time to respond, any new or additional evidence that is relied upon, considered or generated by or at the direction of the Plan. This evidence shall be provided free of charge.

A document, record, or other information shall be considered relevant to a Claim if it:

(1) was relied upon in making the benefit determination;

(2) was submitted, considered, or generated in the course of making the benefit determination, without regard to whether it was relied upon in making the benefit determination;

(3) demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that benefit determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all claimants; or

(4) constituted a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit.

The period of time within which a benefit determination on Appeal is required to be made shall begin at the time an Appeal is filed in writing in accordance with the procedures of the Plan. This timing is without regard to whether all the necessary information accompanies the filing.

Before the Plan Sponsor issues its Final Adverse Benefit Determination based on a new or additional rationale, the claimant must be provided, free of charge, with a copy of the rationale. The rationale must be provided as soon as possible and sufficiently in advance of the time within which a final determination on Appeal is required to allow the claimant time to respond.

The review shall 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 shall 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.

If the Appeal of a Claim is denied, in whole or in part, the Claims Administrator, on behalf of the Plan Sponsor shall provide written notification of the Adverse Benefit Determination on Appeal. The notice will state, in a culturally and linguistically appropriate manner and in a manner calculated to be understood by the claimant:

(1) Information sufficient to allow the claimant to identify the Claim involved (including date of service, the healthcare provider, and the claim amount, if applicable), and a statement that the diagnosis code and treatment code and their corresponding meanings will be provided to the claimant as soon as feasible upon request.

(2) The specific reason or reasons for the adverse determination, including the denial code and its corresponding meaning, and a description of the Plan's standard, if any, that was used in denying the Claim.

(3) Reference to the specific Plan provisions on which the determination was based.

(4) 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.

(5) A description of the Plan's internal and external review procedures and the time limits applicable to such procedures.

(6) 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.

(7) 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 a 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.

(8) If the Adverse Benefit Determination is based on the Medical Necessity or Experimental or Investigational 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, will be provided. If this is not practical, a statement will be included that such explanation will be provided free of charge, upon request.

(9) A statement of the right to sue in federal court.

(10) Information about the availability of and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under applicable federal law to assist individuals with the internal claims and appeals and external review process.

EXTERNAL REVIEW PROCESS

If a claimant receives a Final Adverse Benefit Determination under the Plan’s internal Claims and Appeals Procedures, described above, he or she may request that the Claim be reviewed under the Plan’s External Review process. This Plan’s External Review process operates in accordance with KRS 304.17A-623 (the “Statute”), in the event of a conflict between the language in this document and the Statute, the Statute shall control. The External Review process is available if the Plan Sponsor, its designee, or agent has rendered an adverse determination; the covered person has completed the Plan’s internal appeal process or the Plan Sponsor has failed to make a timely determination or notification; the Plan Sponsor and the covered person may however, jointly agree to waive the internal appeal requirement.

The Plan Sponsor will determine, within 5 business days, whether this determination is based on the criteria described above and whether:

1. The claimant is or was covered under the Plan at the time the Claim was made or incurred;

2. The entire course of treatment or service will cost the covered person at least one hundred dollars ($100) if the covered person had no insurance.

The request for External Review must be filed in writing within 60 days after receipt of the Final Adverse Benefit Determination. As part of the request the covered person shall provide to the Plan Sponsor or its designee written consent authorizing the independent review entity to obtain all necessary medical records from the Plan Sponsor or Claims Administrator and any provider utilized for review purposes regarding the decision to deny, limit, reduce or terminate coverage.

Within one business day after completion of this preliminary review, the Claims Administrator, on behalf of the Plan Sponsor, will provide written notification to the claimant of whether the claim is eligible for External Review. If the request is complete but not eligible for External Review, the Claims Administrator, on behalf of the Plan Sponsor, will notify the claimant of the reasons for its ineligibility.

If the request for review is not complete, the notice will describe the information needed to complete it. The claimant will have 48 hours or until the last day of the 60-day filling period, whichever is later, to submit the additional information.

If the request is eligible for the External Review process, the Claim will be assigned to an independent review entity in accordance with the guidelines for this process as established by the Kentucky Department of Insurance.

Generally, a claimant must exhaust the Plan's Claims and Procedures in order to be eligible for the External Review process. However, in some cases the Plan provides for an expedited External Review if the covered person is hospitalized, or if, in the opinion of the treating provider, review under the standard time frame could, in the absence of immediate medical attention, result in any of the following:

1. Placing the health of the covered person or, with respect to a pregnant woman, the health of the covered person or her unborn child in serious jeopardy;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of a bodily organ or part.

Requests for expedited External Review shall be forwarded by the Claims Administrator to the independent review entity within twenty-four (24) hours of receipt by the Claims Administrator . A determination shall be made by the independent review entity within twenty-four (24) hours from the receipt of all information required from the Claims Administrator.

COORDINATION OF BENEFITS

Coordination of the benefit plans. Coordination of benefits sets out rules for the order of payment of Covered Charges when two or more plans -- including Medicare -- are paying. When a Covered Person is covered by this Plan and another plan, or the Covered Person's Spouse is covered by this Plan and by another plan or the couple's Covered children are covered under two or more plans, the plans will coordinate benefits when a claim is received.

The plan that pays first according to the rules will pay as if there were no other plan involved. The secondary and subsequent plans will pay the balance up to each one's plan formula minus whatever the primary plan paid. This is called non-duplication of benefits. The total reimbursement will never be more than the amount that would have been paid if the secondary plan had been the primary plan -- 50% or 80% or 100% -- whatever it may be. The balance due, if any, is the responsibility of the Covered Person.

Benefit plan. This provision will coordinate the medical benefits of a benefit plan. The term benefit plan means this Plan or any one of the following plans:

(1) Group or group-type plans, including franchise or blanket benefit plans.

(2) Blue Cross and Blue Shield group plans.

(3) Group practice and other group prepayment plans.

(4) Federal government plans or programs. This includes, but is not limited to, Medicare and Tricare.

(5) Other plans required or provided by law. This does not include Medicaid or any benefit plan like it that, by its terms, does not allow coordination.

(6) No Fault Auto Insurance, by whatever name it is called, when not prohibited by law.

Allowable Charge. For a charge to be allowable it must be a Usual and Reasonable Charge and at least part of it must be covered under this Plan.

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

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

Automobile limitations. When medical payments are available under vehicle insurance, the Plan shall always be considered the secondary carrier regardless of the individual's election under PIP (personal injury protection) coverage with the auto carrier.

Benefit plan payment order. When two or more plans provide benefits for the same Allowable Charge, benefit payment will follow these rules:

(1) Plans that do not have a coordination provision, or one like it, will pay first. Plans with such a provision will be considered after those without one.

(2) Plans with a coordination provision will pay their benefits up to the Allowable Charge:

(a) The benefits of the plan which covers the person directly (that is, as an employee, member or subscriber) ("Plan A") are determined before those of the plan which covers the person as a dependent ("Plan B").

(b) The benefits of a benefit plan which covers a person as an Employee who is neither laid off nor retired are determined before those of a benefit plan which covers that person as a

laid-off or Retired Employee. The benefits of a benefit plan which covers a person as a Dependent of an Employee who is neither laid off nor retired are determined before those of a benefit plan which covers a person as a Dependent of a laid off or Retired Employee. If the other benefit plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.

(c) The benefits of a benefit plan which covers a person as an Employee who is neither laid off nor retired or a Dependent of an Employee who is neither laid off nor retired are determined before those of a plan which covers the person as a COBRA beneficiary.

(d) When a child is covered as a Dependent and the parents are not separated or divorced, these rules will apply:

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

(ii) If both parents have the same birthday, the benefits of the benefit plan which has covered the parent for the longer time are determined before those of the benefit plan which covers the other parent.

(e) When a child's parents are divorced or legally separated, these rules will apply:

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

(ii) This rule applies when the parent with custody of the child has remarried. The benefit plan of the parent with custody will be considered first. The benefit plan of the stepparent that covers the child as a Dependent will be considered next. The benefit plan of the parent without custody will be considered last.

(iii) This rule will be in place of items (i) and (ii) above when it applies. A court decree may state which parent is financially responsible for medical and dental benefits of the child. In this case, the benefit plan of that parent will be considered before other plans that cover the child as a Dependent.

(iv) If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined above when a child is covered as a Dependent and the parents are not separated or divorced.

(v) For parents who were never married to each other, the rules apply as set out above as long as paternity has been established.

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

(3) Medicare will pay primary, secondary or last to the extent stated in federal law. When Medicare would be the primary payer if the person had enrolled in Medicare, this Plan will base its payment upon benefits that would have been paid by Medicare under Parts A and B regardless of whether or not the person was enrolled under any of these parts. The Plan reserves the right to coordinate benefits with respect to Medicare Part D. The Plan Sponsor will make this determination based on the information available through CMS. If CMS does not provide sufficient information to determine the amount Medicare would pay, the Plan Sponsor will make reasonable assumptions based on published Medicare fee schedules.

(4) If a Plan Participant is under a disability extension from a previous benefit plan, that benefit plan will pay first and this Plan will pay second.

(5) The Plan will pay primary to Tricare and a State child health plan to the extent required by federal law.

Claims determination period. Benefits will be coordinated on a Calendar Year basis. This is called the claims determination period.

Right to receive or release necessary information. To make this provision work, this Plan may give or obtain needed information from another insurer or any other organization or person. This information may be given or obtained without the consent of or notice to any other person. A Covered Person will give this Plan the information it asks for about other plans and their payment of Allowable Charges.

Facility of payment. This Plan may repay other plans for benefits paid that the Plan Sponsor determines it should have paid. That repayment will count as a valid payment under this Plan.

Right of recovery. This Plan may pay benefits that should be paid by another benefit plan. In this case this Plan may recover the amount paid from the other benefit plan or the Covered Person. That repayment will count as a valid payment under the other benefit plan.

Further, this Plan may pay benefits that are later found to be greater than the Allowable Charge. In this case, this Plan may recover the amount of the overpayment from the source to which it was paid.

THIRD PARTY RECOVERY PROVISION

RIGHT OF SUBROGATION AND REFUND

When this provision applies. The Covered Person may incur medical or dental charges due to Injuries which may be caused by the act or omission of a Third Party or a Third Party may be responsible for payment. In such circumstances, the Covered Person may have a claim against that Third Party, or insurer, for payment of the medical or dental charges. Accepting benefits under this Plan for those incurred medical or dental expenses automatically assigns to the Plan any rights the Covered Person may have to Recover payments from any Third Party or insurer. This Subrogation right allows the Plan to pursue any claim which the Covered Person has against any Third Party, or insurer, whether or not the Covered Person chooses to pursue that claim. The Plan may make a claim directly against the Third Party or insurer, but in any event, the Plan has a lien on any amount Recovered by the Covered Person whether or not designated as payment for medical expenses. This lien shall remain in effect until the Plan is repaid in full.

The payment for benefits received by a Covered Person under the Plan shall be made in accordance with the assignment of rights by or on behalf of the Covered Person as required by Medicaid.

In any case in which the Plan has a legal liability to make payments for benefits received by a Covered Person, to the extent that payment has been made through Medicaid, the payment for benefits under the Plan shall be made in accordance with any state law that has provided that the state has acquired the rights of the Covered Person to the payments of those benefits.

The Covered Person:

(1) Automatically assigns to the Plan his or her rights against any Third Party or insurer when this provision applies; and

(2) Must repay to the Plan the benefits paid on his or her behalf out of the Recovery made from the Third Party or insurer.

Amount subject to Subrogation or Refund. The Covered Person agrees to recognize the Plan's right to Subrogation and reimbursement. These rights provide the Plan with a 100%, first dollar priority over any and all Recoveries and funds paid by a Third Party to a Covered Person relative to the Injury or Sickness, including a priority over any claim for non-medical or dental charges, attorney fees, or other costs and expenses. Accepting benefits under this Plan for those incurred medical or dental expenses automatically assigns to the Plan any and all rights the Covered Person may have to recover payments from any responsible third party. Further, accepting benefits under this Plan for those incurred medical or dental expenses automatically assigns to the Plan the Covered Person's Third Party Claims.

Notwithstanding its priority to funds, the Plan's Subrogation and Refund rights, as well as the rights assigned to it, are limited to the extent to which the Plan has made, or will make, payments for medical or dental charges as well as any costs and fees associated with the enforcement of its rights under the Plan. The Plan reserves the right to be reimbursed for its court costs and attorneys' fees if the Plan needs to file suit in order to Recover payment for medical or dental expenses from the Covered Person. Also, the Plan's right to Subrogation still applies if the Recovery received by the Covered Person is less than the claimed damage, and, as a result, the claimant is not made whole.

When a right of Recovery exists, the Covered Person will execute and deliver all required instruments and papers as well as doing whatever else is needed to secure the Plan's right of Subrogation as a condition to having the Plan make payments. In addition, the Covered Person will do nothing to prejudice the right of the Plan to Subrogate.

Conditions Precedent to Coverage. The Plan shall have no obligation whatsoever to pay medical or dental benefits to a Covered Person if a Covered Person refuses to cooperate with the Plan's reimbursement and Subrogation rights or refuses to execute and deliver such papers as the Plan may require in furtherance of its reimbursement and Subrogation rights. Further, in the event the Covered Person is a minor, the Plan shall have no obligation to pay any medical or dental benefits incurred on account of Injury or Sickness caused by a responsible Third Party until after the Covered Person or his authorized legal representative obtains valid court recognition and approval of the Plan's 100%, first dollar reimbursement and Subrogation rights on all

Recoveries, as well as approval for the execution of any papers necessary for the enforcement thereof, as described herein.

Defined terms: "Covered Person" means anyone covered under the Plan, including minor dependents.

"Recover," "Recovered," "Recovery" or "Recoveries" means all monies paid to the Covered Person by way of judgment, settlement, or otherwise to compensate for all losses caused by the Injury or Sickness, whether or not said losses reflect medical or dental charges covered by the Plan. "Recoveries" further includes, but is not limited to, recoveries for medical or dental expenses, attorneys' fees, costs and expenses, pain and suffering, loss of consortium, wrongful death, lost wages and any other recovery of any form of damages or compensation whatsoever.

"Refund" means repayment to the Plan for medical or dental benefits that it has paid toward care and treatment of the Injury or Sickness.

"Subrogation" means the Plan's right to pursue and place a lien upon the Covered Person's claims for medical or dental charges against the other person.

"Third Party" means any Third Party including another person or a business entity.

Recovery from another plan under which the Covered Person is covered. This right of Refund also applies when a Covered Person Recovers under an uninsured or underinsured motorist plan (which will be treated as Third Party coverage when reimbursement or Subrogation is in order), homeowner's plan, renter's plan, medical malpractice plan or any liability plan.

Rights of Plan Sponsor. The Plan Sponsor has a right to request reports on and approve of all settlements.

CONTINUATION COVERAGE RIGHTS UNDER COBRA

The University of the Cumberlands, a church plan not subject to ERISA, has elected to offer certain Employees and their families covered under University of the Cumberlands Employee Medical Benefit Plan (the “Plan”) the opportunity to elect a temporary extension of health coverage consistent with the Consolidated Omnibus Budget Reconciliation Act of 1985 (“COBRA”) (which will be referred to in this section as "COBRA continuation coverage") where coverage under the Plan would otherwise end. The University of the Cumberlands, a church plan not subject to ERISA, reserves the right to terminate the offer of temporary extension of health coverage consistent with COBRA at any time with or without advance notice.

The Plan Sponsor is University of the Cumberlands, 6184 College Station Drive, Williamsburg, Kentucky, 40769, (606) 539-4211. COBRA continuation coverage for the Plan is administered by ARC Administrators (the “COBRA Administrator”), P.O Box 12290, Lexington, Kentucky 40582, (877) 309-2955. Complete instructions on COBRA, as well as election forms and other information, will be provided by the Plan Sponsor or its designee to Plan Participants who become Qualified Beneficiaries under COBRA.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse’s plan), even if that plan generally doesn’t accept late enrollees.

What is COBRA continuation coverage? COBRA continuation coverage is the temporary extension of group health plan coverage that must be offered to certain Plan Participants and their eligible family members (called "Qualified Beneficiaries") at group rates. The right to COBRA continuation coverage is triggered by the occurrence of a life event that results in the loss of coverage under the terms of the Plan (the "Qualifying Event"). The coverage must be identical to the Plan coverage that the Qualified Beneficiary had immediately before the Qualifying Event, or if the coverage has been changed, the coverage must be identical to the coverage provided to similarly situated active employees who have not experienced a Qualifying Event (in other words, similarly situated non-COBRA beneficiaries).

Who can become a Qualified Beneficiary? In general, a Qualified Beneficiary can be:

(1) Any individual who, on the day before a Qualifying Event, is covered under a Plan by virtue of being on that day either a covered Employee, the Spouse of a covered Employee, or a Dependent child of a covered Employee. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

(2) Any child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, and any individual who is covered by the Plan as an alternate recipient under a qualified medical support order. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

(3) A covered Employee who retired on or before the date of substantial elimination of Plan coverage which is the result of a bankruptcy proceeding under Title 11 of the U.S. Code with respect to the Employer, as is the Spouse, surviving Spouse or Dependent child of such a covered Employee if, on the day before the bankruptcy Qualifying Event, the Spouse, surviving Spouse or Dependent child was a beneficiary under the Plan.

The term "covered Employee" includes any eligible individual who is provided coverage under the Plan due to his or her performance of services for the employer sponsoring the Plan.

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

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

What is a Qualifying Event? A Qualifying Event is any of the following if the Plan participant loses coverage (i.e.: cease to be covered under the same terms and conditions as in effect immediately before the Qualifying Event) as a result of the event, in the absence of COBRA continuation coverage:

(1) The death of a covered Employee.

(2) The termination (other than by reason of the Employee's gross misconduct), or reduction of hours, of a covered Employee's employment.

(3) The divorce or legal separation of a covered Employee from the Employee's Spouse. If the Employee reduces or eliminates the Employee's Spouse's Plan coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a Qualifying Event even though the Spouse's coverage was reduced or eliminated before the divorce or legal separation.

(4) A covered Employee's enrollment in any part of the Medicare program.

(5) A Dependent child's ceasing to satisfy the Plan's requirements for a Dependent child (for example, attainment of the maximum age for dependency under the Plan).

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

If the Qualifying Event causes the covered Employee, or the covered Spouse or a Dependent child of the covered Employee, to cease to be covered under the Plan under the same terms and conditions as in effect immediately before the Qualifying Event, the persons losing such coverage become Qualified Beneficiaries under COBRA if all the other conditions of COBRA are also met. For example, any increase in contribution that must be paid by a covered Employee, or the Spouse, or a Dependent child of the covered Employee, for coverage under the Plan that results from the occurrence of one of the events listed above is a loss of coverage.

The taking of leave under the Family and Medical Leave Act of 1993 ("FMLA") does not constitute a Qualifying Event. A Qualifying Event will occur, however, if an Employee does not return to employment at the end of the FMLA leave and all other COBRA continuation coverage conditions are present. If a Qualifying Event occurs, it occurs on the last day of FMLA leave and the applicable maximum coverage period is measured from this date (unless coverage is lost at a later date and the Plan provides for the extension of the required periods, in which case the maximum coverage date is measured from the date when the coverage is lost.) Note that the covered Employee and family members will be entitled to COBRA continuation coverage even if they failed to pay the employee portion of premiums for coverage under the Plan during the FMLA leave.

What factors should be considered when determining to elect COBRA continuation coverage? You should take into account that a failure to continue your group health coverage will affect your rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied by other group health plans if there is more than a 63-day gap in health coverage and election of COBRA continuation coverage may help you avoid such a gap. (These pre-existing condition exclusions will only apply during Plan Years that begin before January 1, 2014.) Finally, you should take into account that you have special enrollment rights under federal law (HIPAA). You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your Spouse's employer) within 30 days after Plan coverage ends due to a Qualifying Event listed above. You will also have the same special right at the end

of COBRA continuation coverage if you get COBRA continuation coverage for the maximum time available to you.

Are there other coverage options besides COBRA Continuation Coverage? Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

What is the procedure for obtaining COBRA continuation coverage? The Plan has conditioned the availability of COBRA continuation coverage upon the timely election of such coverage. An election is timely if it is made during the election period.

What is the election period and how long must it last? The election period is the time period within which the Qualified Beneficiary must elect COBRA continuation coverage under the Plan. The election period must begin no later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event and ends 60 days after the later of the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event or the date notice is provided to the Qualified Beneficiary of her or his right to elect COBRA continuation coverage. If coverage is not elected within the 60 day period, all rights to elect COBRA continuation coverage are forfeited.

Note: If a covered Employee who has been terminated or experienced a reduction of hours qualifies for a trade readjustment allowance or alternative trade adjustment assistance under a federal law called the Trade Act of 2002, and the Employee and his or her covered Dependents have not elected COBRA coverage within the normal election period, a second opportunity to elect COBRA coverage will be made available for themselves and certain family members, but only within a limited period of 60 days or less and only during the six months immediately after their group health plan coverage ended. Any person who qualifies or thinks that he and/or his family members may qualify for assistance under this special provision should contact the COBRA Administrator for further information about the special second election period.

The Trade Act of 2002 also created a tax credit for certain TAA-eligible individuals and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) (eligible individuals). Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. If you have questions about these new tax provisions, you may call the Health Coverage Tax Credit Consumer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact.

Is a covered Employee or Qualified Beneficiary responsible for informing the COBRA Administrator of the occurrence of a Qualifying Event? The Plan will offer COBRA continuation coverage to Qualified Beneficiaries only after the COBRA Administrator has been timely notified that a Qualifying Event has occurred. The employer will notify the COBRA Administrator of the Qualifying Event within 30 days following the date coverage ends when the Qualifying Event is:

(1) The end of employment or reduction of hours of employment,

(2) Death of the Employee,

(3) Commencement of a proceeding in bankruptcy with respect to the employer, or

(4) Entitlement of the employee to any part of Medicare.

IMPORTANT:

For the other Qualifying Events (divorce or legal separation of the Employee and Spouse or a Dependent child's losing eligibility for coverage as a Dependent child), you or someone on your behalf must notify the COBRA Administrator in writing within 60 days after the Qualifying Event occurs, using the procedures specified below. If these procedures are not followed or if the notice is not provided in writing to the COBRA Administrator during the 60-day notice period, any Spouse or Dependent child

who loses coverage will not be offered the option to elect continuation coverage. You must send this notice to the COBRA Administrator.

NOTICE PROCEDURES:

Any notice that you provide must be ***in writing***. Oral notice, including notice by telephone, is not acceptable. You must mail, fax or hand-deliver your notice to the following address:

Mail to ATTN COBRA:
ARC Administrators
P.O. Box 12290
Lexington, KY 40582

Fax to ATTN COBRA:
859-243-0381

In Person Delivery:
ARC Administrators
333 W Vine Street, Ste 900
Lexington, Kentucky 40507

If mailed, your notice must be postmarked no later than the last day of the required notice period. Any notice you provide must state:

- the **name of the plan or plans** under which you lost or are losing coverage,
- the **name and address of the Employee** covered under the plan,
- the **name(s) and address(es) of the Qualified Beneficiary(ies)**, and
- the **Qualifying Event** and the **date** it happened.

If the Qualifying Event is a **divorce or legal separation**, your notice must include **a copy of the divorce decree or the legal separation agreement.**

Be aware that there are other notice requirements in other contexts, for example, in order to qualify for a disability extension.

Once the COBRA Administrator receives *timely notice* that a Qualifying Event has occurred, COBRA continuation coverage will be offered to each of the Qualified Beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA continuation coverage. Covered Employees may elect COBRA continuation coverage for their Spouses, and parents may elect COBRA continuation coverage on behalf of their children. For each Qualified Beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that plan coverage would otherwise have been lost. If you or your Spouse or Dependent children do not elect continuation coverage within the 60-day election period described above, the right to elect continuation coverage will be lost.

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

Is COBRA coverage available if a Qualified Beneficiary has other group health plan coverage or Medicare? Qualified beneficiaries who are entitled to elect COBRA continuation coverage may do so even if they are covered under another group health plan or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, a Qualified Beneficiary's COBRA coverage will terminate automatically if, after electing COBRA, he or she becomes entitled to Medicare or becomes covered under other group health plan coverage (but only after any applicable preexisting condition exclusions of that other plan have been exhausted or satisfied).

When may a Qualified Beneficiary's COBRA continuation coverage be terminated? During the election period, a Qualified Beneficiary may waive COBRA continuation coverage. Except for an interruption of coverage

in connection with a waiver, COBRA continuation coverage that has been elected for a Qualified Beneficiary must extend for at least the period beginning on the date of the Qualifying Event and ending not before the earliest of the following dates:

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

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

(3) The date upon which the Employer ceases to provide any group health plan (including a successor plan) to any employee.

(4) The date, after the date of the election, that the Qualified Beneficiary first becomes covered under any other Plan that does not contain any exclusion or limitation with respect to any pre-existing condition, other than such an exclusion or limitation that does not apply to, or is satisfied by, the Qualified Beneficiary.

(5) The date, after the date of the election, that the Qualified Beneficiary first becomes entitled to Medicare (either part A or part B, whichever occurs earlier).

(6) In the case of a Qualified Beneficiary entitled to a disability extension, the later of:

(a) (i) 29 months after the date of the Qualifying Event, or (ii) the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier; or

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

The Plan can terminate for cause the coverage of a Qualified Beneficiary on the same basis that the Plan terminates for cause the coverage of similarly situated non-COBRA beneficiaries, for example, for the submission of a fraudulent claim.

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

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

(1) In the case of a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period ends 18 months after the Qualifying Event if there is not a disability extension and 29 months after the Qualifying Event if there is a disability extension.

(2) In the case of a covered Employee's enrollment in the Medicare program before experiencing a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period for Qualified Beneficiaries ends on the later of:

(a) 36 months after the date the covered Employee becomes enrolled in the Medicare program. This extension does not apply to the covered Employee; or

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

(3) In the case of a Qualified Beneficiary who is a child born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, the maximum coverage period is the

maximum coverage period applicable to the Qualifying Event giving rise to the period of COBRA continuation coverage during which the child was born or placed for adoption.

(4) In the case of any other Qualifying Event than that described above, the maximum coverage period ends 36 months after the Qualifying Event.

Under what circumstances can the maximum coverage period be expanded? If a Qualifying Event that gives rise to an 18-month or 29-month maximum coverage period is followed, within that 18- or 29-month period, by a second Qualifying Event that gives rise to a 36-months maximum coverage period, the original period is expanded to 36 months, but only for individuals who are Qualified Beneficiaries at the time of and with respect to both Qualifying Events. In no circumstance can the COBRA maximum coverage period be expanded to more than 36 months after the date of the first Qualifying Event. The COBRA Administrator must be notified of the second Qualifying Event within 60 days of the second Qualifying Event. This notice must be sent to the COBRA Administrator in accordance with the procedures above.

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

Does the Plan require payment for COBRA continuation coverage? For any period of COBRA continuation coverage under the Plan, Qualified Beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. Qualified Beneficiaries will pay up to 102% of the applicable premium and up to 150% of the applicable premium for any expanded period of COBRA continuation coverage covering a disabled Qualified Beneficiary due to a disability extension. The Plan will terminate a Qualified Beneficiary's COBRA continuation coverage as of the first day of any period for which timely payment is not made.

Must the Plan allow payment for COBRA continuation coverage to be made in monthly installments? Yes. The Plan is also permitted to allow for payment at other intervals.

What is Timely Payment for payment for COBRA continuation coverage? Timely Payment means a payment made no later than 30 days after the first day of the coverage period. Payment that is made to the COBRA Administrator by a later date is also considered Timely Payment if either under the terms of the Plan, covered employees or Qualified Beneficiaries are allowed until that later date to pay for their coverage for the period or under the terms of an arrangement between the Employer and the entity that provides Plan benefits on the Employer's behalf, the Employer is allowed until that later date to pay for coverage of similarly situated non-COBRA beneficiaries for the period.

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

If Timely Payment is made to the COBRA Administrator in an amount that is not significantly less than the amount the Plan requires to be paid for a period of coverage, then the amount paid will be deemed to satisfy the Plan's requirement for the amount to be paid, unless the COBRA Administrator notifies the Qualified Beneficiary of the amount of the deficiency and grants a reasonable period of time for payment of the deficiency to be made. A "reasonable period of time" is 30 days after the notice is provided. A shortfall in a Timely Payment is not significant if it is no greater than the lesser of $50 or 10% of the required amount.

IF YOU HAVE QUESTIONS

If you have questions about your COBRA continuation coverage, you should contact the COBRA Administrator. For more information about your rights under COBRA, the Health Insurance Portability and Accountability Act (HIPAA), the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available

through EBSA's website at www.dol.gov/ebsa. .) For more information about the Marketplace, visit www.HealthCare.gov.

KEEP YOUR PLAN SPONSOR AND COBRA ADMINISTRATOR INFORMED OF ADDRESS CHANGES
In order to protect your family's rights, you should keep the Plan Sponsor and the COBRA Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the COBRA Administrator.

RESPONSIBILITIES OF THE PLAN SPONSOR

The University of the Cumberlands Employee Medical Benefit Plan is the benefit plan of the Plan Sponsor, the University of the Cumberlands.

The Plan Sponsor shall administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this Plan that the Plan Sponsor shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits, to decide disputes which may arise relative to a Plan Participant's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Sponsor will be final and binding on all interested parties.

DUTIES OF THE PLAN SPONSOR.

(1) To administer the Plan in accordance with its terms.

(2) To interpret the Plan, including the right to remedy possible ambiguities, inconsistencies or omissions.

(3) To decide disputes which may arise relative to a Plan Participant's rights.

(4) To prescribe procedures for filing a claim for benefits and to review claim denials.

(5) To keep and maintain the Plan documents and all other records pertaining to the Plan.

(6) To appoint a Claims Administrator to pay claims.

(7) To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate.

PLAN SPONSOR COMPENSATION. The Plan Sponsor serves **without** compensation; however, all expenses for plan administration, including compensation for hired services, will be paid by the Plan.

CLAIMS ADMINISTRATOR IS NOT A FIDUCIARY. A Claims Administrator is **not** a fiduciary under the Plan by virtue of paying claims in accordance with the Plan's rules as established by the Plan Sponsor.

COMPLIANCE WITH HIPAA PRIVACY STANDARDS. Certain members of the Employer's workforce perform services in connection with administration of the Plan. In order to perform these services, it is necessary for these employees from time to time to have access to Protected Health Information (as defined below).

Under the Standards for Privacy of Individually Identifiable Health Information (45 CFR Part 164, the "Privacy Standards"), these employees are permitted to have such access only if the Plan is amended in accordance with the Privacy Standards.

Therefore, the Employer is amending the Plan as follows:

(1) **General.** The Plan shall not disclose Protected Health Information to any member of the Employer's workforce unless each of the conditions set out in this HIPAA Privacy section is met. "Protected Health Information" shall have the same definition as set out in the Privacy Standards but generally shall mean individually identifiable health information about the past, present or future physical or mental health or condition of an individual, including genetic information and information about treatment or payment for treatment.

(2) **Permitted Uses and Disclosures.** Protected Health Information disclosed to members of the Employer's workforce shall be used or disclosed by them only for purposes of Plan administrative functions. The Plan's administrative functions shall include all Plan payment and health care operations. The terms "payment" and "health care operations" shall have the same definitions as set out in the Privacy Standards, but the term "payment" generally shall mean activities taken with respect to payment of premiums or contributions, or to determine or fulfill Plan responsibilities with respect to coverage, provision of benefits, or reimbursement for health care. "Health care operations" generally shall mean activities on behalf of the Plan that are related to quality assessment; evaluation, training or accreditation of health care providers; underwriting, premium rating and other functions related to obtaining or renewing an insurance contract, including stop-loss insurance; medical review; legal services or auditing functions; or business planning, management and general administrative activities. However, Protected Health information that consists of genetic information will not be used for underwriting purposes.

(3) **Authorized Employees.** The Plan shall disclose Protected Health Information only to members of the Employer's workforce who are designated and are authorized to receive such Protected Health Information, and only to the extent and in the minimum amount necessary for these persons to perform duties with respect to the Plan. For purposes of this HIPAA Privacy section, "members of the Employer's workforce" shall refer to all employees and other persons under the control of the Employer.

(a) **Updates Required.** The Employer shall amend the Plan promptly with respect to any changes in the members of its workforce who are authorized to receive Protected Health Information.

(b) **Use and Disclosure Restricted.** An authorized member of the Employer's workforce who receives Protected Health Information shall use or disclose the Protected Health Information only to the extent necessary to perform his or her duties with respect to the Plan.

(c) **Resolution of Issues of Noncompliance.** In the event that any member of the Employer's workforce uses or discloses Protected Health Information other than as permitted by the Privacy Standards, the incident shall be reported to the privacy official. The privacy official shall take appropriate action, including:

(i) Investigation of the incident to determine whether the breach occurred inadvertently, through negligence, or deliberately; whether there is a pattern of breaches; and the degree of harm caused by the breach;

(ii) Applying appropriate sanctions against the persons causing the breach, which, depending upon the nature of the breach, may include, oral or written reprimand, additional training, or termination of employment;

(iii) Mitigating any harm caused by the breach, to the extent practicable; and

(iv) Documentation of the incident and all actions taken to resolve the issue and mitigate any damages.

(4) Certification of Employer. The Employer must provide certification to the Plan that it agrees to:

(a) Not use or further disclose the Protected Health Information other than as permitted or required by the Plan documents or as required by law;

(b) Ensure that any agent or subcontractor, to whom it provides Protected Health Information received from the Plan, agrees to the same restrictions and conditions that apply to the Employer with respect to such information;

(c) Not use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer;

(d) Report to the Plan any use or disclosure of the Protected Health Information of which it becomes aware that is inconsistent with the uses or disclosures permitted by this Amendment, or required by law;

(e) Make available Protected Health Information to individual Plan members in accordance with Section 164.524 of the Privacy Standards;

(f) Make available Protected Health Information for amendment by individual Plan members and incorporate any amendments to Protected Health Information in accordance with Section 164.526 of the Privacy Standards;

(g) Make available the Protected Health Information required to provide any accounting of disclosures to individual Plan members in accordance with Section 164.528 of the Privacy Standards;

(h) Make its internal practices, books and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Department of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Standards;

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

(j) Ensure the adequate separation between the Plan and member of the Employer's workforce, as required by Section 164.504(f)(2)(iii) of the Privacy Standards.

The following members of University of the Cumberlands workforce are designated as authorized to receive Protected Health Information from University of the Cumberlands Employee Medical Benefit Plan ("the Plan") in order to perform their duties with respect to the Plan:

The Privacy Official: Vice President – Business Services

Human Resources Staff (as approved by the Vice President – Business Services)

COMPLIANCE WITH HIPAA ELECTRONIC SECURITY STANDARDS. Under the Security Standards for the Protection of Electronic Protected Health Information (45 CFR Part 164.300 et. seq., the "Security Standards"), the Plan documents must be amended to reflect certain obligations required of the Employer.

Therefore, the Employer is amending the Plan as follows:

(1) The Employer agrees to implement reasonable and appropriate administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of Electronic Protected Health Information that the Employer creates, maintains or transmits on behalf of the Plan. "Electronic Protected Health Information" shall have the same definition as set out in the Security Standards, but generally shall mean Protected Health Information that is transmitted by or maintained in electronic media.

(2) The Employer shall ensure that any agent or subcontractor to whom it provides Electronic Protected Health Information shall agree, in writing, to implement reasonable and appropriate security measures to protect the Electronic Protected Health Information.

(3) The Employer shall ensure that reasonable and appropriate security measures are implemented to comply with the conditions and requirements set forth in Compliance With HIPAA Privacy Standards provisions (3) Authorized Employees and (4) Certification of Employers.

(4) The Employer shall report to the Plan any security incident (as defined in Section 164.304 of the Security Standards) of which the Employer becomes aware.

FUNDING THE PLAN AND PAYMENT OF BENEFITS

The cost of the Plan is funded as follows:

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

The level of any Employee contributions will be set by the Plan Sponsor. These Employee contributions will be used in funding the cost of the Plan as soon as practicable after they have been received from the Employee or withheld from the Employee's pay through payroll deduction.

Benefits are paid directly from the Plan through the Claims Administrator.

PLAN IS NOT AN EMPLOYMENT CONTRACT

The Plan is not to be construed as a contract for or of employment.

CLERICAL ERROR

Any clerical error by the Plan Sponsor or an agent of the Plan Sponsor in keeping pertinent records or a delay in making any changes will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered.

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

AMENDING AND TERMINATING THE PLAN

If the Plan is terminated, the rights of the Plan Participants are limited to expenses incurred before termination.

The Employer reserves the right, at any time, to amend, suspend or terminate the Plan in whole or in part. This includes amending the benefits under the Plan or the Trust agreement (if any).

GENERAL PLAN INFORMATION

TYPE OF ADMINISTRATION

The Plan is a self-funded group health Plan and the administration is provided through a Third Party Claims Administrator. The funding for the benefits is derived from the funds of the Employer and contributions made by covered Employees. The Plan is not insured.

PLAN NAME

University of the Cumberlands Employee Medical Benefit Plan

PLAN NUMBER: 501

TAX ID NUMBER: 61-0470593

ORIGINAL PLAN EFFECTIVE DATE: November 1, 1995

CURRENT PLAN EFFECTIVE DATE: November 1, 2014

PLAN YEAR: November 1 to October 31

EMPLOYER INFORMATION

University of the Cumberlands
6184 College Station Drive
Williamsburg, Kentucky 40769
(606) 539-4211

PLAN SPONSOR

University of Cumberlands
Attention: Vice President-Business Services
6184 College Station Drive
Williamsburg, Kentucky 40769
(606) 539-4211

CLAIMS ADMINISTRATOR

ARC Administrators
P.O. Box 12990
Lexington, Kentucky 40582
(877) 309-2955

BY THIS AGREEMENT, University of the Cumberlands Employee Medical Benefit Plan is hereby adopted as shown.

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

By _____
University of the Cumberlands

Date _____

Witness_____

Date _____