



Point of Service Health Plan

Effective June 1, 2007

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SUMMARY PLAN DESCRIPTION

This booklet contains a general description of your benefits and is written to help you understand them. The details of your coverage are limited to the terms and conditions specified in this Summary Plan Description which will now be referred to as the Plan. You may examine the Plan or obtain copies of it at any time. It is on file with Drake University.

This Plan was established for the exclusive benefit of the employees and retirees of Drake University with the intention it will continue indefinitely. However, Drake University reserves the right to amend, modify or terminate this Plan at any time without prior notice to the Plan participants. Any amendment or modification will be in writing, effected through a written resolution signed by the President of Drake University or his/her designee, and will be binding. If this Plan is terminated, you may not receive benefits for claims incurred on or after the effective date of termination.

In addition, this Plan may not discriminate against you based on: health status; medical condition (including both physical and mental illnesses); claims experience; receipt of health care; medical history; genetic information; medical evidence of good health (including participation in certain dangerous recreational activities and conditions arising out of acts of domestic violence); and disability as mandated by the Health Insurance Portability and Accountability Act of 1996.

Based on the factors described above, this Plan may not require any individual (as a condition of enrollment or continued enrollment under this Plan) to pay a premium or contribution which is greater than the premium or contribution paid by a similarly situated individual enrolled in this Plan. Nothing in the preceding sentence will be construed: (a) to restrict the amount that may be charged for coverage under this Plan; or (b) to prevent this Plan from establishing premium discounts or rebates or modifying otherwise applicable coinsurance amounts, co-pays or deductibles in return for adherence to programs of health promotion and disease prevention.

INTRODUCTION

This Plan is designed to cover your various health care expenses. This is a self-funded Plan of benefits which provides each covered person with a lifetime maximum of \$3,000,000 coverage for health care needs.

It is important you understand this Plan in order to use it effectively. You are encouraged to take the time to read this booklet to gain a basic understanding of your benefits. The "Benefit Summary" which follows provides a brief review of the allowable benefits. The "What Are Covered Expenses?" section provides greater detail regarding your benefits. Specially designated sections outline care not covered by this Plan.

If you have any questions about this Plan of benefits, please contact First Administrators, Inc. Correspondence can be mailed to:

First Administrators, Inc.
P.O. Box 9900
Sioux City, IA 51102-0479

or you may call:

Nationwide(800) 206-0827
Sioux City 712-279-8400

NETWORK INTRODUCTION

This Plan utilizes a preferred provider network. Through this network, a select group of hospitals and physicians have agreed to deliver care at a reduced rate.

The preferred provider network's goal is to contain spiraling health care costs through utilization management and to do this without sacrificing the quality or the comprehensive nature of the benefits provided to you. Participating physicians must follow specific guidelines and when applicable, utilize outpatient services whenever possible, eliminate unnecessary inpatient hospital stays, and make wise use of outpatient diagnostic testing and second surgical opinions. A directory of these providers can be furnished to you, without charge.

You always have freedom of choice. You may use the services of any provider. However, if you do go to a physician or hospital affiliated with the preferred provider network, your out-of-pocket costs may be less. Please refer to the benefit summary for specific information.

Please see your identification card for your participating provider network. Participating physicians within your Network area can be located at:

SelectFirst™

www.firstadministrators.com.

Beech Street

www.beechstreet.com.

PROTECTED HEALTH INFORMATION

PLAN SPONSOR'S CERTIFICATION OF COMPLIANCE

The Company is the Plan Sponsor of this Plan, unless you have been notified, in writing, that another entity is your Plan Sponsor. Your Plan, any business associate servicing your Plan, or the Benefit Services Administrator cannot disclose protected health information to your Plan Sponsor unless the Plan Sponsor agrees to abide by the provisions outlined in this section.

The Plan Sponsor of your Plan has provided certification they agree to abide by these provisions.

PURPOSE OF DISCLOSURE TO PLAN SPONSOR

Your Plan, any business associate servicing your Plan, or the Benefit Services Administrator will disclose protected health information to your Plan Sponsor only to permit the Plan Sponsor to administer the Plan consistent with the requirements of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations (45 Code of Federal Regulations Parts 160-64). Any disclosure to and use by your Plan Sponsor of protected health information will be subject to and must be consistent with the provisions outlined in the "Restrictions on Plan Sponsor's Use and Disclosure of Protected Health Information" and "Adequate Separation Between the Plan Sponsor and the Plan" sections that follow.

Neither your Plan, nor the Benefit Services Administrator, nor any business associate servicing your Plan will disclose protected health information to your Plan Sponsor unless the disclosures are explained in the Notice of Privacy Practices distributed to plan participants.

Neither your Plan, nor the Benefit Services Administrator, nor any business associate servicing your Plan will disclose protected health information to your Plan Sponsor for the purpose of employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

RESTRICTIONS ON PLAN SPONSOR'S USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Your Plan Sponsor:

- (a) will not use or further disclose protected health information, except as permitted or required by law;
- (b) will ensure that any agent, including any subcontractor, to whom it provides protected health information, agrees to the same restrictions and conditions that apply to the Plan Sponsor;
- (c) will not use or disclose protected health information for employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor;
- (d) will report to the Plan, promptly upon the learning of, any use or disclosure of protected health information that is inconsistent with the uses and disclosures stated in the provisions outlined in this section ("Protected Health Information");
- (e) will make protected health information available to Plan participants in accordance with 45 CFR § 164.524;
- (f) will make protected health information available for amendment, and will, on notice, amend protected health information in accordance with 45 CFR § 164.526;
- (g) will track disclosures it may make of protected health information so that it can provide the information required by your Plan to account for disclosures in accordance with 45 CFR § 164.528;
- (h) will make its internal practices, books, and records relating to its use and disclosure of protected health information available to your Plan, and to the U.S. Department of Health and Human Services to determine compliance with 45 CFR Parts 160-64;

When protected health information is no longer needed for the plan administrative functions for which the disclosure was made, your Plan Sponsor will, if feasible, return or destroy all protected health information, in whatever form or medium received from the Plan, including all copies of any data or compilations derived from and/or revealing member identity. If it is not feasible to return or destroy all of the protected health information, your Plan Sponsor will limit the use or disclosure of protected health information it cannot feasibly return or destroy to those purposes that make the return or destruction of the information infeasible.

ADEQUATE SEPARATION BETWEEN THE PLAN SPONSOR AND THE PLAN

Certain individuals under the control of your Plan Sponsor may be given access to protected health information received from the Plan, a business associate servicing the group health plan, or the Benefit Services Administrator. This class of employees will be identified by the Plan Sponsor to the Plan and the Benefit Services Administrator from time to time as required under 45 Code of Federal Regulations §164.504. These individuals include all those who may receive protected health information relating to payment under, health care operations of, or other matters pertaining to the Plan in the ordinary course of business.

These individuals will have access to protected health information only to perform the plan administration functions that the Plan Sponsor provides for the Plan.

Individuals granted access to protected health information will be subject to disciplinary action and sanctions, including loss of employment or termination of affiliation with the Plan Sponsor, for any use or disclosure of protected health information in violation of or noncompliance with the provisions outlined in this section ("Protected Health Information"). The Plan Sponsor will promptly report such violation or noncompliance to the Plan, and will cooperate with the Plan to correct the violation or noncompliance, to impose appropriate disciplinary action or sanctions on each employee causing the violation or noncompliance, and to mitigate any negative effect the violation or noncompliance may have on the member, the privacy of whose protected health information may have been compromised by the violation or noncompliance.

The sponsor will ensure that these provisions for adequate separation between the sponsor and the Plan are supported by reasonable and appropriate security measures.

SECURITY OF ELECTRONIC PROTECTED HEALTH INFORMATION

Title II of the Health Insurance Portability and Accountability Act of 1996 and the security regulations issued thereunder (collectively "HIPAA") requires Group Health Plans to secure participants' private health information that it creates, receives, maintains, or transmits electronically. This Plan will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic health information, and will require its agents and contractors to do the same. Reporting of known security incidents to the Plan is part of those safeguards.

This Plan has established safeguards that are supported by reasonable and appropriate security measures to ensure that the Plan does not disclose, or permit one of its agents or contractors to disclose, Protected Health Information to the entity adopting this Plan.

**DRAKE UNIVERSITY POINT OF SERVICE HEALTH PLAN
BENEFIT SUMMARY**

Administered by First Administrators, Inc.

Group #: 92400

Effective Date: June 1, 2007

All benefits are subject to the following deductibles, coinsurance percentages and maximums unless otherwise stated.

| MEDICAL BENEFITS | PATIENT'S LIABILITY | | GENERAL PLAN LIMITS | PAGE |
|--|---------------------|----------------------|--|------|
| | NETWORK PROVIDER | NON NETWORK PROVIDER | | |
| Medical Deductible: - Per Individual/CAL YR - Per Family/CAL YR | \$250 \$500 | \$1000 \$2000 | No fourth quarter carryover. The deductible is waived when an Office Services Co-Pay is taken. <i>The Network and Non-Network deductibles are mutually exclusive.</i> | 28 |
| Out-of-Pocket Maximums: - Per Individual/CAL YR - Per Family/CAL YR | \$1250 \$2500 | \$2500 \$5000 | Includes Calendar Year Deductibles, Co-Pays and Coinsurance amounts. Excludes Hospital Preadmission Certification Penalty, Mental Health and Chemical Dependency benefits, Vision hardware, and Prescription Drug Program Co-Pays. <i>The Network and Non-Network out-of-pocket maximums are mutually exclusive.</i> | 28 |
| Office Services Co-Pay** | \$15/visit | \$30/visit | Co-Pay applies with or without office visit charges. Co-Pay is waived for Preventive Care services and Well-Baby/Well-Child Care. After Non-Network Co-Pay, Non-Network services may be subject to balance billing. | 28 |

** **Except:** Anesthesia; Cardiac Rehabilitations; Diabetic Self-Management Education Program; Chemotherapy; Interpretations (which are separate from an office visit); Occupational Therapy; Physical Therapy; Radiation Therapy; Respiratory/Inhalation Therapy; Speech Therapy; Preventive Care Benefits (Routine and Well-child Care) and Mandatory Second Surgical Opinions.

Note: The Office Services Co-Pay will apply to providers rendering services in an outpatient or ambulatory facility if the physician does not have a local office.

NETWORK NOTES:

1. When a covered participant is referred by a **Network** provider to a **Non-Network** provider, eligible expenses for the **Non-Network** provider will be considered at the **Network** benefit level.
2. When a covered participant is assigned to the Beech Street Network and sees a Select First provider, eligible expenses will be considered at the **Network** benefit level.
3. When a covered participant resides outside the **Network** area, or is traveling outside the **Network** area for reasons other than medical care (e.g., business or vacation), and a **Non-Network** provider is used, eligible expenses from the **Non-Network** provider will be considered at the **Non-Network** benefit level.
4. Services and/or treatment provided by a **Non-Network** provider when there is no **Network** provider available within the **Network** area will be considered at the **Network** benefit level.
5. If a participant requires treatment for a medical emergency, whether in or out of the network area, eligible expenses from a **Non-Network** provider will be considered at the **Network** benefit level.
6. **Non-Network** emergency room physician charges will be considered at the **Network** benefit level when services are provided in a **Network** facility.
7. Ancillary services provided by a **Non-Network** provider in a **Network** facility will be considered at the **Network** benefit level.
8. Interpretation of x-ray and laboratory results ordered by a **Network** provider and provided by a **Non-Network** provider will be considered at the **Network** benefit level.
9. Charges for interpretation of x-ray or laboratory services performed in an independent radiology or pathology facility and billed by the **Network** physician ordering the services will be considered in the same manner as any other x-ray or laboratory service performed in a **Network** provider's office.

The eligible expense for all of the above situations, unless otherwise specified, is determined by the provider and type of service, not the benefit level, as explained under the *What Are Covered Expenses?* Section. The eligible expense is based on the Network fee schedule or discount, the maximum allowable fee, or the actual amount charged.

BENEFIT SUMMARY (Cont.)

| Utilization Review: | | The Utilization Review program includes Preadmission Certification, Pre-procedure Review, Prenatal Screening Program and Case Management administered by First Administrators, Inc. | | 25 |
|--|--------------------------|---|---|------|
| Preadmission Certification: | | Failure to comply with the Hospital Preadmission Certification provision will result in a \$500 penalty applied to hospital-related inpatient charges. Pre-certification must take place prior to a planned admission or within two business days following an emergency admission. The Preadmission Certification penalty is waived for maternity lengths of stay of less than 48 hours for normal vaginal delivery and 96 hours for a cesarean section. Penalties do not apply to out-of-pocket maximums. | | |
| Pre-Procedure Review: | | Specified surgical procedures performed without pre-procedure review will result in a \$500 non-compliance penalty. The non-compliance penalty will not apply to out-of-pocket maximums. See Pre-Procedure List. | | |
| If applicable, Office Services Co-Pay will apply to all the following benefits unless there is a separate Co-Pay indicated below. | | | | |
| MEDICAL BENEFITS | NETWORK PROVIDER | NON NETWORK PROVIDER | GENERAL PLAN LIMITS | PAGE |
| Allergy Testing and Injections | 80% | 70% | Includes injections, testing, and serum. Injections covered at 100% if the purpose of the office visit is for an injection only. | 34 |
| Ambulance Benefits | 100% | 100% | Limited to local air or ground. | 34 |
| Ambulatory/Outpatient Surgery Facility Care | 80% | 70% | | 31 |
| Anesthesia | 80% | 70% | Includes anesthesia administered by a CRNA. | 30 |
| Biologically Based Mental Illness | 80% | 70% | | - |
| Birthing Care Center Benefits | 80% | 70% | | 32 |
| Cardiac Rehabilitation | 80% | 70% | Limited to phase I (inpatient) and phase II (outpatient) treatment only; phase III treatment (diet, exercise, healthy lifestyle programs) is excluded. | - |
| Chiropractic Services (Manual/Mechanical Manipulation of Spinal Column) | 80% | 70% | Includes Manipulation, x-rays, and office visits. | 34 |
| Consultations - Inpatient - Outpatient | 80% 80% | 70% 70% | | 29 |
| Contraceptive Management Benefits | 80% | 70% | Includes injectable contraceptives (e.g., Depo-Provera), implantable contraceptives (e.g., Norplant), contraceptive device (e.g., IUD), and surgical removal of contraceptives. | 34 |
| Dental Services and Oral Surgery Covered Under the Medical Plan | 80% | 70% | Limited to services provided within 6 months of accidental injury. | 33 |
| Diabetic Self-Management Program | 80% | 70% | | 34 |
| Diagnostic X-ray & Laboratory Benefits - Outpatient | 80% | 70% | | 32 |
| Durable Medical Equipment | 80% | 70% | Prior approval is recommended. Rental limited to purchase price. | 34 |
| Emergency Room Services | 80% | 70% | | 34 |
| Hemodialysis | 80% | 70% | Kidney Disease Treatment | 34 |
| Home Health Care Services | 80% | 70% | Prior approval is recommended. Limited to 100 visits per calendar year. | 30 |
| Home Infusion | 80% | 70% | Prior approval is recommended. | - |
| Hospice Care - Inpatient - Outpatient - Respite Care - Bereavement | 80% 80% 80% 80% | 70% 70% 70% 70% | Prior approval is recommended. Subject to Case Management approval. Limited to services provided by the Hospice provider. | 31 |
| Hospital Benefits | 80% | 70% | Limited to semi-private room rate for the level of care the patient is receiving. Includes hospital take home drugs. | 29 |

BENEFIT SUMMARY (Cont.)

| MEDICAL BENEFITS | NETWORK PROVIDER | NON NETWORK PROVIDER | GENERAL PLAN LIMITS | PAGE |
|--|-------------------------|-----------------------------|--|-------------|
| Infertility | 80% | 70% | Limited to employee, covered spouse or covered domestic partner. Limited to \$30,000/lifetime/participant (includes prescription drugs). Includes reversal of elective sterilization. | 33 |
| Maternity Benefits - Inpatient Newborn Care | 80% | 70% | Payable for all female participants. Office Services Co-Pay will apply for the OB global physician's fee. Paid as part of mother's charges as long as mother is necessarily confined. Includes nursery room and board, physician visits and circumcision. | 32 |
| Mental Health and Chemical Dependency Benefits | | | Chemical Dependency treatment is limited to \$200,000 per lifetime. Participant coinsurance amounts do not apply to the out-of-pocket maximum. | 29 |
| - Inpatient | 80% | 70% | Includes Partial Hospitalization (1 day = 1 inpatient day) Limited to 30 days per calendar year. | |
| - Outpatient | 80% | 70% | Outpatient/Office limited to 50 visits per calendar year. | |
| - Office | ** | ** | Subject to Office Services Co-Pay. | |
| Morbid Obesity | 80% | 70% | Excludes weight loss classes. | - |
| Nursing Facility Benefits | 80% | 70% | Limited to semi-private room rate. Limited to 120 days per illness or injury. Services must follow a hospital stay of 3 days or more and begin no later than 14 days following that inpatient stay. | 29 |
| Physician Services | | | | 34 |
| - Inpatient | 100% | 70% | Limited to one visit per day per specialty unless additional visits are medically necessary. | |
| - Outpatient | 100% | 70% | | |
| Preadmission Testing | | | | - |
| - Outpatient | 80% | 70% | | |
| Prescription Drugs | 80% | 70% | Includes only those allowable drugs, medications and supplies that are not payable under the Prescription Drug Card. | - |
| Preventive Care Services | 100% | 100% | Limited to \$500 per calendar year for participants age 7 and older. The Office Services Co-Pay and Plan Deductible do not apply for benefits \$500 and less. Eligible charges exceeding \$500 will be subject to the Office Services Co-Pay, Deductible and Coinsurance. There is no limit on the benefits paid for Preventive Services in excess of \$500. Includes: - physician office visit - examinations - mammogram - routine x-ray/lab - immunizations - cancer screenings - prostate screenings - services for screening of "family history of" - pap smears - office visits for contraceptive management - routine hearing exams - vision examinations (including eyewear exam) - three (3) nutritional counseling visits/CAL YR | 33 |
| Private Duty Nursing | 80% | 70% | | 34 |
| Prosthetic Devices | 80% | 70% | Includes artificial limbs and eyes, hip prosthesis, lens implant following cataract surgery and breast implants following a mastectomy. Limited to one per lifetime unless medically necessary due to circumstances such as physical growth. | 34 |

BENEFIT SUMMARY (Cont.)

| MEDICAL BENEFITS | NETWORK PROVIDER | NON NETWORK PROVIDER | GENERAL PLAN LIMITS | PAGE |
|---|--------------------------|-----------------------------|---|-------------|
| Radiation Therapy and Chemotherapy | 80% | 70% | | 34 |
| Second/Third Surgical Opinion - Mandatory | 100% | 100% | Limited to opinions required by the Pre-procedure Review program. | 26 |
| - Voluntary | 100% | 100% | Limited to opinions required by the Pre-procedure Review program. | 31 |
| Surgical Benefits - Inpatient - Outpatient - Assistant Surgeon | 80% 80% 80% | 70% 70% 70% | Limited to 20% of the eligible expense for the primary surgery. | 30 |
| Therapy Benefits (Outpatient) - Respiratory/Inhalation Therapy - Occupational Therapy - Speech Therapy - Physical Therapy | 80% 80% 80% 80% | 70% 70% 70% 70% | Excludes occupational therapy supplies. | 34 |
| Transplant Benefits - Meals/Lodging/Travel | 80% 100% | 70% 100% | Includes heart, heart/lung, liver, pancreas, kidney, bone marrow and cornea. Limited to \$10,000 per transplant. Travel, meals, and lodging for the recipient and a companion will be covered if the transplant facility is more than 100 miles from the recipient's home. This benefit does not include ambulance expenses for the covered recipient. | 32 |
| Urgent Care Facility | 80% | 70% | | - |
| Vision Hardware Benefits | 80% | 80% | The calendar year deductible is waived. Participant coinsurance amounts do not apply to the out-of-pocket maximum. Limited to \$150 per calendar year. Includes eyeglass frames, lenses, and contact lenses. | - |
| Well-Baby/Well-Child Care | 100% | 100% | Limited to children up to age 7. Office Services Co-Pay and Deductible is waived. Includes routine exams, routine labs/x-rays, immunizations, nutritional counseling, and one eye exam per calendar year. | - |
| MEDICAL PLAN'S MAXIMUM LIABILITY | | | | |
| Lifetime Maximum: | \$3,000,000 | | | 28 |
| Claims must be received within 12 months of the date services were incurred. | | | | |

PRESCRIPTION DRUG CARD PROGRAM BENEFITS

| PRESCRIPTION DRUG BENEFITS | PATIENT'S LIABILITY | GENERAL PLAN LIMITS | PAGE |
|---|--|---|------|
| Stand-alone Drug Program Prescription Drug Card - Generic - 30-day supply - 60-day supply - 90-day supply - Brand Name - 30-day supply - 60-day supply - 90-day supply | \$10 Co-Pay \$20 Co-Pay \$30 Co-Pay the lesser of 30% or \$50 the lesser of 30% or \$100 the lesser of 30% or \$150 | Maintenance drugs can be purchased in a 60-day or 90-day supply at retail pharmacies. Maintenance drugs can be purchased in a 90-day supply through the mail order pharmacy program. | 38 |

PRESCRIPTION PLAN INCLUSIONS and EXCLUSIONS

Inclusions: State legend prescription drugs · compounded medication of which at least one ingredient is a prescription legend drug · insulin and insulin syringes on prescription · diabetic supplies · glucose test strips (blood and urine) · lancets · oral contraceptives · non-oral systemic contraceptives such as Nuvaring®, Ortho Evra®, Depo-Provera®, Lunelle® · diaphragms · self-administration syringes · asthma and respiratory supplies including spacers (peak flow meters limited to one per calendar year; nebulizers limited to two per calendar year) · multi-vitamins, vitamin and mineral-containing products, multi-vitamins with iron, multi-vitamins with fluoride, hematonic vitamins, prenatal vitamins · Imitrex® · Epipen® · Glucagon® · Retin-A® products (up to age 35) · medications used for erectile dysfunction · immunosuppressant medications.

Exclusions: Non-legend drugs (except insulin) · blood glucose monitors · lancet devices · allergy syringes · bandages and wraps · catheters and catheter supplies · durable home medical equipment and supplies · compression stockings and other support garments · monitoring devices · chemotherapy supplies · dialysis supplies and equipment · surgical supplies · enteral and parenteral feeding supplies and equipment · dialysis supplies · devices or supplies of any type including but not limited to therapeutic devices and artificial appliances · immunization agents · vaccines, serum, toxoids and allergens · anesthetic agents · diagnostic agents · anorexic agents or medications for weight loss/reduction · diet supplements · medications for the cosmetic alteration of the skin · topical minoxidil and other treatments for baldness or thinning of the hair or hair loss · post-coital medications such as Preven®, Plan B®, Mifeprex® · condoms, spermicides · fertility agents · smoking cessation and deterrent agents · charges for injection or administration of a drug · drugs which are entirely consumed at the time and place of prescribing · prescriptions which are covered under workers' compensation law or which are covered without charge under any government program · experimental drugs or drugs labeled "Caution - limited by federal law to investigational use" · medication which is to be taken by or administered to a beneficiary while a patient is in a licensed hospital, nursing home, or similar institution, which operates or allows to be operated on its premises a facility for dispensing pharmaceuticals · refills in excess of the number specified or authorized by the prescriber or any refill dispensed after one year from the prescriber's original order · mailing and delivery charges (standard delivery services are included) · drugs which were distributed by the manufacturer as samples · unapproved uses of drugs, i.e. uses that are not approved by the United States Food and Drug Administration or peer-reviewed medical journals · prescription medications determined to be "less than effective" by the Drug Efficacy Study Implementation Program (DESI).

DRUGS REQUIRING PRIOR AUTHORIZATION TO BE INCLUDED:

Self-injectible medications · monoclonal antibodies, blood or blood plasma products and their derivatives · anti-narcolepsy/ADHD agents · Retin-A® products (age 35 and older) · growth hormones · anabolic steroids · Accutane®.

GENERIC DRUGS

Your drug benefit program is designed to help restore your health by helping you receive the most effective, affordable medications to treat your medical condition or disease state. This plan encourages you to obtain high-quality generic drugs. Generic drugs provide the same effectiveness and safety as their brand name counterparts, but save a substantial amount of money. If you request a brand name medication when there is a generic available, you will be required to pay the difference in cost between the generic and the brand name medication in addition to the co-pay.

COORDINATION OF BENEFITS

Coordination of Benefits is a common provision in most benefit plans. It applies when a member has more than one health coverage plan in effect at the time services are rendered. Specific, industry-wide rules exist for determining which plan pays first (PRIMARY) on these expenses and which plan pays next (SECONDARY). In cases where NPS is the PRIMARY prescription benefits plan, claims should be electronically submitted for payment by your pharmacy provider to NPS and no further paperwork is needed. In cases where NPS is the SECONDARY prescription benefits plan, an original receipt used for tax or insurance purposes (not a cash register receipt) must be submitted to NPS using a paper claim form obtained from NPS or the Drake University Human Resources Department.

COVERAGE AND ELIGIBILITY

EMPLOYEE ELIGIBILITY

An employee is eligible for medical and prescription drug coverage if he/she is a regular full-time employee at least nine (9) months per calendar year and is scheduled to work thirty-two (32) or more hours each week. If the employee ceases to work, or is no longer scheduled to work thirty-two (32) or more hours a week, he/she ceases to be a covered employee under this Plan. An employee is also eligible if he/she is a participant in an approved transitional or other leave program pursuant to a formal written plan of Drake University. A finding by a government or other agency that an individual providing services to Drake University should have been classified as an employee by the employer, is not sufficient to establish eligibility under this Plan.

EMPLOYEE ENROLLMENT AND EFFECTIVE DATE

This Plan is effective on the first day of the month following your hire date providing you enroll for coverage within thirty-one (31) days following the completion of the waiting period.

If you are eligible for coverage, but are not actively at work on the day your coverage is scheduled to begin because of any reason other than a medical condition or disability, this Plan will become effective the day you return to active work. This actively at work provision will not delay the effective date of coverage if the sole reason you are not working is because the day is not a regularly scheduled work day.

If you do not apply to become a covered employee by completing an enrollment form or application within the thirty-one (31) day period following the date you are eligible, you will only be able to enroll during the open enrollment period. For further details, see the section on the **Open Enrollment Period**.

In some cases, there may be "special" circumstances that will allow you to enroll for coverage without being considered a late enrollee. For further details on these circumstances, see the section on **Special Enrollment Periods**.

EMPLOYEE TERMINATION OF COVERAGE

Coverage will end on the earliest of the following dates:

- (a) the last day of the month in which your active employment with Drake University is terminated;
- (b) the last day of the month you cease to be in a class of employees eligible for coverage;
- (c) the end of the period for which you have made contributions if you fail to make the next required contribution;
- (d) the date this Plan is terminated with respect to Drake University, and there is no successor plan;
- (e) the date you receive the lifetime maximum benefit, as specified by this Plan; or
- (f) the last day of the month you voluntarily elect to be terminated from this Plan, subject to the pre-tax premium rules as outlined in this booklet.

If you cease active employment due to layoff or authorized leave of absence participation may be continued pursuant to rules adopted by Drake University and applied on a uniform basis to all covered employees similarly situated. Also, participation may be continued if you are on an approved disability leave of absence pursuant to rules adopted by Drake University and applied on a uniform basis to all covered employees similarly situated.

Unless otherwise specified under this Plan, when coverage terminates, benefits will not be provided for any services after the termination date even though these services are furnished as a result of an injury or illness that occurred prior to termination of coverage.

RETIREE ELIGIBILITY

Retired employees of Drake University and their covered dependents are eligible for medical and prescription drug coverage if either of the following conditions is met:

- an individual employed prior to January 1, 1982, who has been a full-time continuous employee for ten (10) or more years, is age fifty-five (55) or older, and makes the required contribution; is under age sixty-five (65), and not otherwise eligible for Medicare; or

- an individual employed on or after January 1, 1982, who has been a full-time continuous employee for fifteen (15) or more years, is age sixty (60) or older, and makes the required contributions, is under age sixty-five (65), and not otherwise eligible for Medicare.

An eligible retiree, as defined above, must elect to enroll within sixty (60) days of retirement in order to receive a contribution from Drake University.

Retired employees who were hired prior to September 15, 1994, are required to pay a portion of the premium. Retired employees hired on or after September 15, 1994 are required to pay the full cost of the premium.

RETIREE ENROLLMENT AND EFFECTIVE DATE

Retired employees and their covered dependents are eligible to continue coverage under this Plan provided one of the conditions listed in the previous section are met. Furthermore, on the date of retirement, coverage will continue as long as the retiree has elected to continue this coverage and there is no break in coverage.

RETIREE TERMINATION OF COVERAGE

Coverage will end on the earliest of the following dates:

- the last day of the month the covered retiree ceases to be in a class of retirees eligible for coverage;
- the last day of the month this Plan is terminated with respect to an entire class of retirees to which such covered retiree belongs for coverage;
- the end of the period for which the covered retiree has made contributions if the covered retiree fails to make the next required contribution;
- the date this Plan is terminated with respect to Drake University, and there is no successor plan;
- the date the covered retiree receives the maximum lifetime benefit specified by this Plan;
- the last day of the month the covered retiree voluntarily elects to be terminated from the Plan; or
- the last day of the month preceding the effective date of coverage under Medicare.

If a covered retiree wishes to cancel coverage, the retiree must notify Drake University prior to the desired date of cancellation. If coverage is cancelled eligibility for a contribution from Drake University ends.

Unless otherwise specified under this Plan, when coverage terminates, benefits will not be provided for any services after the termination date even though these services are furnished as a result of an injury or illness that occurred prior to termination of coverage.

DEPENDENT ELIGIBILITY

A covered employee or retiree may choose to cover his/her dependents (as defined) under this Plan.

Coverage is provided for a domestic partner who satisfies the following criteria:

- is at least eighteen (18) years of age and of the same gender as the employee;
- has executed a notarized "relationship contract", which obligates each partner to provide support for the other and to act as each other's sole domestic partner indefinitely;
- is not able to qualify for coverage as a common law spouse;
- is not legally married or covered under any other domestic partnership arrangement with Drake University;
- is not related by blood closer than would bar marriage in the state of Iowa, and each partner is mentally competent to consent to the contract; and
- the partners have been residing together for at least six (6) continuous months immediately prior to filing the "Affidavit of Domestic Partnership".

A covered employee's or retiree's unmarried dependent children may be covered until they reach the age of nineteen (19). They may be covered until the age of twenty-six (26) if they are unmarried, full-time students in an accredited school.

Dependent children include natural children, adopted children (as defined), stepchildren, grandchildren or children for whom the employee or retiree has legal guardianship who are unmarried.

If both the employee and spouse are Drake University employees and they have no dependent children, each must enroll for single coverage.

If both parents are covered under this Plan as employees or retirees, a child can be covered as a

dependent of only one parent. No one covered under this Plan as an employee or retiree can also be covered as a dependent.

Adopted Child

The term "dependent" found in this Plan shall include any unmarried child meeting the dependent eligibility requirements of this Plan who, prior to age eighteen (18), has been placed for adoption or who has been adopted by the participant.

Such a child shall be eligible for coverage as of the date of placement for adoption, or as of the date of actual adoption, whichever occurs first.

Coverage under this Plan for the adopted child shall be the same coverage which is available to all other dependent children under this Plan except that all pre-existing condition exclusions or additional waiting periods will be waived for such a child provided the child is enrolled within the time periods specified under the section entitled **Dependent Enrollment and Effective Date**.

QMCSO Provision

This Plan will provide benefits to the child(ren) of a participant if a Qualified Medical Child Support Order (QMCSO) is issued regardless of whether the child(ren) reside with the participant. If a QMCSO is issued, then the child(ren) shall become alternate recipient(s) of the benefits under this Plan, subject to the limitations, restrictions, provisions and procedures as any other participant. A properly completed National Medical Support Notice (NMSN) will be treated as a QMCSO and will have the same force and effect.

Procedural QMCSO Requirements

Within a reasonable period of time following receipt of a medical child support order, the Plan Administrator will notify the participant and each child specified in the order whether the order is or is not a Qualified Medical Child Support Order. A QMCSO is an order which creates or recognizes the right of an alternate recipient (participant's child who is recognized under the order as having a right to be enrolled under this Plan) or assigns to the alternate recipient the right to receive benefits. To be considered a Qualified Medical Child Support Order the medical child support order must contain the following information:

- the name and last known mailing address of the participant and the name and address of each child to be covered by this Plan;
- a reasonable description of the type of coverage to be provided by this Plan to each

named child, or the manner in which the type of coverage is to be determined; and

- the period to which such order applies.

If the order **is** determined to be a Qualified Order, each named child will be covered by this Plan in the same manner as any other dependent child is covered by this Plan.

Coverage for a child under a QMCSO will begin on the latest of the following dates:

- (a) if the employee already has coverage in force, the child will be covered as of the date specified in the order or, if no date is specified in the Order, the date the QMCSO is received;
- (b) if the employee is within the waiting period as specified under the section entitled "Effective Date", the child will become effective the same date the employee's coverage is effective; or
- (c) if the employee is otherwise eligible but previously waived coverage, the employee's and the child's coverage will become effective as of the date specified in (a) above.

Each named child will be considered a participant under this Plan but may designate another person, such as a custodial parent or legal guardian, to receive copies of explanations of benefits, checks and other material which would otherwise be sent directly to the named child.

If it is determined that the order **is not** a Qualified Order, each named child may appeal that decision by submitting a written letter of appeal to the Plan Administrator. The Plan Administrator shall review the appeal and reply in writing within thirty (30) days of receipt of the appeal.

This Plan will not provide any type or form of benefit, or any option, not otherwise provided under this Plan and all other dependent eligibility, effective date and termination provisions will apply.

DEPENDENT ENROLLMENT AND EFFECTIVE DATE

Generally, coverage for dependents will become effective on the same day the employee's or retiree's coverage begins. Any new dependent can become a covered dependent as of one of the following applicable dates:

- (a) the eligibility date for which written application is made and delivered to the Plan Administrator, if made on or before the date the individual becomes a dependent;
- (b) the eligibility date for which such written application is received when the application is

made and delivered to the Plan Administrator within thirty-one (31) days after the individual becomes a dependent; or

- (c) the eligibility date determined under the terms of an applicable special enrollment period. In some cases, such as marriage, birth, adoption, and placement for adoption, there may be special circumstances that will allow a dependent to enroll for coverage after the initial enrollment period without being considered a late enrollee. For further details on these circumstances, see the section on **Special Enrollment Periods**.

A covered dependent who becomes eligible as an employee under this Plan will be considered to have satisfied his/her waiting period and his/her pre-existing condition exclusion period on the date he/she becomes so eligible if, on that date, he/she has fully satisfied the waiting period and pre-existing condition exclusion period.

If the employee is absent from active work because of any reason other than his/her medical condition or disability when coverage for his/her dependents would otherwise take effect, coverage for the dependents will become effective only upon the employee's return to active work.

A dependent of an eligible retiree may continue coverage under this Plan as a retiree if they meet the following conditions:

- spouse, domestic partner or eligible dependent child, as defined by this Plan, of an eligible retiree;
- eligible retiree in this reference includes those retirees that meet one of the two conditions set forth above to be eligible for and enrolled in Medicare; and
- under age sixty-five (65) and not otherwise eligible for Medicare.

DEPENDENT TERMINATION OF COVERAGE

Coverage will end on the earliest of the following dates:

- (a) the last day of the month in which the dependent ceases to be a covered dependent as defined by this Plan;
- (b) in the event of a legal separation or divorce, coverage for the employee's or retiree's spouse/domestic partner will cease at the end of the month in which the event occurred;

- (c) the last day of the month the covered dependent ceases to be in a class of dependents eligible for coverage;
- (d) the end of the period for which the employee or retiree has made contributions for a dependent's coverage if the next required contribution is not made;
- (e) the date this Plan is terminated with respect to Drake University, and there is no successor plan;
- (f) the date the covered dependent receives the maximum lifetime benefit, as specified by this Plan;
- (g) the last day of the month the covered dependent voluntarily elects to be terminated from this Plan; subject to the pre-tax premium rules as outlined in this booklet;
- (h) August 31st if the dependent is a full-time student during the spring semester with plans to return to school for the fall semester, but fails to return to school at the end of the summer break; or
- (i) the last day of the month preceding the effective date of coverage under Medicare.

If the covered dependent wishes to cancel coverage, he/she must notify Drake University prior to the desired date of cancellation.

Unless otherwise specified under this Plan, when coverage terminates, benefits will not be provided for any services after the termination date even though these services are furnished as a result of an injury that occurred prior to termination of coverage.

SPECIAL ENROLLMENT PERIODS

Special Enrollment rights are provided both to current employees who were eligible but declined enrollment in the Plan when first offered because they were covered under another plan and to individuals acquiring a dependent. These special enrollment rights permit these individuals to enroll without having to wait until the Plan's next regular enrollment period. If an individual requests enrollment while the individual is entitled to special enrollment, the individual is a special enrollee, even if the request for enrollment coincides with a late enrollment opportunity. **All special enrollment events must be requested within thirty-one (31) days from the date of the event.**

Pre-existing condition exclusion periods for special enrollees may not exceed twelve (12) months.

Individuals Losing Other Coverage

This Plan will permit a current employee, retiree or dependent who is eligible, but not enrolled, to enroll for coverage under the terms of this Plan if **each** of the following conditions is met:

- (a) the current employee, retiree or dependent was covered under another group health plan or had other health insurance coverage at the time coverage under this Plan was offered;
- (b) the current employee or retiree stated in writing at the time this Plan was offered, that the reason for declining enrollment was due to having coverage under another group health plan or due to having other health insurance coverage, but only if this Plan required such a written statement at that time and provided the current employee or retiree with notice of the requirement (and consequences of the requirement) at that time;
- (c) the current employee, retiree or dependent lost other coverage pursuant to one of the following events:
 - the current employee, retiree or dependent was under COBRA and the COBRA coverage was exhausted;
 - the current employee, retiree or dependent was not under COBRA and the other coverage was terminated as a result of loss of eligibility (including as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours worked);
 - the current employee, retiree or dependent moved out of an HMO service area with no other option available;
 - the current employee, retiree or dependent met or exceeded a lifetime limit on all benefits (the event for reaching the lifetime limit is the earliest date that a claim is denied);
 - the Plan is no longer offering benefits to a class of similarly situated individuals;
 - the benefit package option is no longer being offered and no substitute is available; or
 - employer contributions were terminated; and
- (d) under the terms of this Plan, the current employee or retiree requests enrollment into this Plan not later than thirty one (31) days after the date of exhaustion of COBRA coverage or the termination of coverage or

employer contribution, as described in (c) above.

For an eligible current employee, retiree or dependent who has met **each** of the conditions specified above, this Plan will be effective on the date the other coverage was lost.

If the employee is enrolled at the time of the Special Enrollment event, the eligible dependents must be enrolled in the same Plan.

Dependent Beneficiaries

This Plan will provide a dependent special enrollment period during which the person may be enrolled under this Plan as a dependent of the current employee or retiree (and, if not otherwise enrolled, the current employee and/or spouse/domestic partner may be enrolled at the same time):

- (a) if the current employee or retiree has coverage under this Plan (or the current employee or retiree has met any waiting period applicable to becoming covered under this Plan and is eligible to be enrolled under this Plan, but failed to enroll during a previous enrollment period); and
- (b) if a person becomes a dependent of the current employee or retiree through marriage, birth, or adoption or placement for adoption.

In the case of the birth or adoption of a child, the spouse/domestic partner and/or other dependents of the current employee or retiree may also be enrolled as a dependent if the spouse/domestic partner and/or other dependent are otherwise eligible for coverage.

The dependent special enrollment period will be a period of thirty-one (31) days beginning on the date of marriage, birth, adoption or placement for adoption.

If the current employee or retiree is enrolled at the time of the Special Enrollment event, the eligible dependents must be enrolled in the same Plan.

If a current employee or retiree requests enrollment for a dependent during the special enrollment period, the coverage for the dependent will become effective:

- (a) in the case of marriage, as of the date of the marriage;
- (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.

An enrollment form or application will be required to be submitted for all newborns before coverage will begin.

DEPENDENT CHILDREN WITH DISABILITIES

Coverage of an unmarried dependent child shall not cease because of attainment of the termination age specified in this Plan, while coverage is in force and the child otherwise qualifies as a dependent, if the child:

- (a) is incapable of self-sustaining employment by reason of a permanent, handicapping mental or physical disability; and
- (b) became so disabled prior to attainment of the termination age specified in this Plan.

You must submit to Drake University, within thirty-one (31) days of such dependent's attainment of the termination age, written proof of the disability as described and continue to pay premiums, if any, for the dependent's coverage. The coverage of any such dependent will be subject to all other termination provisions of this Plan.

Drake University, upon receipt of proof of the disability, shall have the right and opportunity to have a physician it designates examine any such dependent when and as often as Drake University may reasonably require. Drake University will not require the dependent to be examined more than once each year after such disability has continued on an uninterrupted basis for at least two (2) years following the date the initial written proof of disability was received.

All rights under the provisions of this section shall automatically and immediately cease on the earliest of the following dates:

- (a) the date the dependent's disability as described no longer exists;
- (b) the date the dependent fails to submit to any required medical examination;
- (c) the date you fail to submit any required proof of the uninterrupted existence of the dependent's disability; or
- (d) the date the dependent otherwise ceases to qualify as a dependent except for the attainment of the maximum age as specified by this Plan.

OPEN ENROLLMENT PERIOD

Drake University will offer an annual enrollment period during which an eligible employee may elect to participate in the Plan, add or remove eligible dependents, waive coverage or change plans. All new participants added during the enrollment period are subject to an eighteen (18) month pre-existing condition exclusion period. The enrollment period will be held annually during the month of April with a June effective date.

FAMILY AND MEDICAL LEAVE ACT OF 1993

This Act requires an employer which employs fifty (50) or more employees (within a seventy-five (75) mile radius) to allow an employee who has been employed for twelve (12) months or more and accumulated hours of service in excess of 1,250 hours from the date of employment or the end of the last qualified leave, to take a total of twelve (12) weeks of leave during any twelve (12) month period, as defined by the employer, for: the birth of a child; placement of a child with the employee for adoption or foster care; care for a spouse, child or parent of the employee if the individual has a serious health condition; or a serious health condition which prevents the employee from performing a function of his/her regular position.

Any employee taking a leave shall be entitled to continue to use his/her benefits during the duration of the leave if he/she participates in a "group health plan" as defined in §5000(b)(1) of the Internal Revenue Code of 1986. The employer must continue the benefits at the level and under the conditions of coverage that would have been provided if the employee had remained employed. If the employee who is responsible for payment misses a premium payment during the leave of absence, the employer may terminate coverage provided that the employee has been given notification of termination and a grace period as defined by the FMLA. If the benefits are terminated during the leave, the employee is entitled to be fully reinstated upon returning to work. If the employee for any reason fails to return from the leave, the employer may recover from the employee the premium or portion of the premium that the employer paid, provided the employee fails to return to work for any reason other than the

recurrence of the health condition or circumstances beyond the control of the employee.

Leave taken under the Act does not constitute a "qualifying event" so as to trigger COBRA rights. However, a qualifying event triggering COBRA coverage may occur when it becomes known that the employee is not returning to work. Therefore, if an employee does not return at the end of twelve (12) weeks Family and Medical Leave, the COBRA qualifying event occurs at that time.

This is only a summary of the Family and Medical Leave Act of 1993. Please see your employer for more information.

THE UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994

The Plan Sponsor shall fully comply with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). If any part of this Plan is found to be in conflict with this Act, the conflicting provision shall be null and void. All other benefits and exclusions of the Plan will remain effective to the extent there is no conflict with this Act.

USERRA provides for, among other employment rights and benefits, continuation of health care coverage to a covered employee and covered dependents, during a period of active service or training with any of the Uniformed Services. The Plan provides that a covered employee may elect to continue such coverages in effect at the time the employee is called to active service. The maximum period of coverage for the employee and the covered employee's dependents under such an election shall be the lesser of:

- the twenty-four (24) month period beginning on the date on which the person's absence begins; or
- the period beginning on the date on which the covered employee's absence begins and ending on the day after the date on which the covered employee fails to apply for or return to a position of employment as follows:
 - for service of less than thirty-one (31) days, no later than the beginning of the first full regularly scheduled work period on the first full calendar day following the completion of the period of service and the expiration of

eight (8) hours after a period allowing for the safe transportation from the place of service to the covered employee's residence or as soon as reasonably possible after such eight (8) hour period;

- for service of more than thirty (30) days but less than one hundred eighty one (181) days, no later than fourteen (14) days after the completion of the period of service or as soon as reasonably possible after such period;
- for service of more than one hundred eighty (180) days, no later than ninety (90) days after the completion of the period of service; or
- for a covered employee who is hospitalized or convalescing from an illness or injury incurred in or aggravated during the performance of service in the uniformed services, at the end of the period that is necessary for the covered employee to recover from such illness or injury. Such period of recovery may not exceed two (2) years.

A covered employee who elects to continue health plan coverage under the Plan during a period of active service in the Uniformed Services may be required to pay not more than 102% of the full premium under the plan associated with such coverage for the employer's other employees, except that in the case of a covered employee who performs service in the uniformed services for less than thirty-one (31) days, such covered employee may not be required to pay more than the employee share, if any, for such coverage. Continuation coverage cannot be discontinued merely because activated military personnel receive health coverage as active duty members of the Uniformed Services, and their family members are eligible to receive coverage under the Department of Defense's managed health care program, TRICARE.

In the case of a covered employee whose coverage under a health plan was terminated by reason of services in the Uniformed Services, the pre-existing exclusion and waiting period may not be imposed in connection with the reinstatement of such coverage upon reemployment under this Act. This applies to the covered employee who is reemployed and any dependent whose coverage is reinstated. The waiver of the pre-existing exclusion shall not apply to illness or injury which occurred or was aggravated during performance of service in the Uniformed Services.

“Uniformed Services” shall include full time and reserve components of the United States Army, Navy, Air Force, Marines, Coast Guard, Army National Guard, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or emergency.

If you are a covered employee called to a period of active service in the Uniformed Service, you should check with the Plan Administrator for a more complete explanation of your rights and obligations under USERRA.

In the event of a conflict between this provision and USERRA, the provisions of USERRA, as interpreted by us or your former employer, will apply.

COVERAGE CONTINUATION UNDER FEDERAL LAW - COBRA

The following information about the participant’s right to continue his/her health care coverage in the Plan is important.

Please read it very carefully.

COBRA continuation coverage is a temporary extension of group health coverage under the Plan under certain circumstances when coverage would otherwise end. The right to COBRA coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA coverage can become available to the participant when he/she would otherwise lose group health coverage under the Plan. It can also become available to the participant’s spouse and dependent children, if they are covered under the Plan, when they would otherwise lose their group health coverage under the Plan. The following paragraphs generally explain COBRA coverage, when it may become available to the participant and his/her family, and what the participant needs to do to protect the right to receive it.

COBRA (and the description of COBRA coverage contained in this Plan) applies only to the benefits offered under the Plan and not to any other benefits offered under the Plan or by Drake University (such as life insurance, disability, or accidental death or dismemberment benefits). The Plan provides no greater COBRA rights than what COBRA requires - nothing in this SPD is intended to expand the participant's rights beyond COBRA's requirements.

For additional information about your rights and obligations under the Plan and under federal law, you should contact Drake University, who is the Plan Administrator.

WHAT IS COBRA COVERAGE?

COBRA coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a “qualifying event.” Specific qualifying events are listed below in the section entitled “Who is Entitled to Elect COBRA?”

After a qualifying event occurs and any required notice of that event is properly provided to the Plan Administrator, COBRA coverage must be offered to each person losing Plan coverage who is a “qualified beneficiary.” The participant, his/her spouse, and dependent children could become qualified beneficiaries and would be entitled to elect COBRA if coverage under the Plan is lost because of the qualifying event. (Certain newborns, newly adopted children, and alternate recipients under QMCSO’s may also be qualified beneficiaries. This is discussed in more detail in separate paragraphs below.)

COBRA coverage is the same coverage that the Plan gives to other participants or beneficiaries under the Plan who are not receiving COBRA coverage. Each qualified beneficiary who elects COBRA will have the same rights under the Plan as other participants or beneficiaries covered under the component or components of the Plan elected by the qualified beneficiary, including open enrollment and special enrollment rights. Under the Plan, qualified beneficiaries who elect COBRA must pay for COBRA coverage.

Additional information about the Plan is available in other portions of this SPD.

WHO IS ENTITLED TO ELECT COBRA?

The employee will be entitled to elect COBRA if he/she loses his/her group health coverage under the Plan because his/her hours of employment are reduced; or his/her employment ends for any reason other than his/her gross misconduct.

As the spouse of an employee, the spouse will be entitled to elect COBRA if he/she loses his/her group health coverage under the Plan because any of the following qualifying events happens:

- the employee dies;
- the employee’s hours of employment are reduced;

- the employee's employment ends for any reason other than his or her gross misconduct;
- the employee becomes entitled to Medicare benefits prior to his/her qualifying event; or
- the spouse becomes divorced or legally separated from the employee.

As the dependent child of an employee, the dependent child will be entitled to elect COBRA if he/she loses his/her group health coverage under the Plan because any of the following qualifying events happens:

- the parent-employee dies;
- the parent-employee's hours of employment are reduced;
- the parent-employee's employment ends for any reason other than his or her gross misconduct;
- the parent-employee becomes entitled to Medicare benefits;
- the parents become divorced or legally separated; or
- the dependent stops being eligible for coverage under the Plan as a "dependent child."

If an employee takes FMLA leave and does not return to work at the end of the leave, the employee (and the employee's spouse and dependent children, if any) will be entitled to elect COBRA if (1) they were covered under the Plan on the day before the FMLA leave began (or became covered during the FMLA leave); and (2) they will lose Plan coverage because of the employee's failure to return to work at the end of the leave. (This means that some individuals may be entitled to elect COBRA at the end of an FMLA leave even if they were not covered under the Plan during the leave.) COBRA coverage elected in these circumstances will begin on the last day of the FMLA leave, with the same eighteen (18) month maximum coverage period (subject to extension or early termination) generally applicable to the COBRA qualifying events of termination of employment and reduction of hours. (See the section below entitled "Length of COBRA Coverage.")

WHEN IS COBRA COVERAGE AVAILABLE?

When the qualifying event is the end of employment, reduction of hours of employment, or death of the employee, the Plan will offer COBRA coverage to qualified beneficiaries. The participant need not notify the Plan Administrator of any of these three qualifying events.

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), a COBRA election will be available only if the participant notifies the Plan Administrator in writing within sixty (60) days after the later of (1) the date of the qualifying event; and (2) the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the qualifying event.

The written notice must include the plan name or group name, the employee's name, the employee's Social Security Number, the dependent's name and a description of the event.

If these procedures are not followed, or if the written notice is not provided to the Plan Administrator during the sixty (60) day notice period, **THE PARTICIPANT WILL LOSE HIS/HER RIGHT TO ELECT COBRA.**

ELECTING COBRA COVERAGE

To elect COBRA, the participant must complete the Election Form that is part of the Plan's COBRA election notice and submit it to the Plan Administrator. An election notice will be provided to qualified beneficiaries at the time of a qualifying event. The participant may also obtain a copy of the Election Form from the Plan Administrator. Under federal law, the participant must have sixty (60) days after the date the qualified beneficiary plan coverage terminates, or, if later, sixty (60) days after the date of the COBRA election notice provided to him/her at the time of his/her qualifying event to decide whether he/she wants to elect COBRA under the Plan.

Mail the completed Election Form to:

Claim Technologies Incorporated
100 Court Avenue
Suite 306
Des Moines, IA 50309-2200

The Election Form must be completed in writing and mailed to the address specified above. The following are not acceptable as COBRA elections and will not preserve COBRA rights: oral communications regarding COBRA coverage, including in-person or telephone statements about an individual's COBRA coverage, and electronic communications, including email and faxed communications.

The election must be postmarked no later than sixty (60) days after the date of the COBRA election notice provided at the time of the qualifying event.

IF THE PARTICIPANT DOES NOT SUBMIT A COMPLETED ELECTION FORM BY THIS DUE DATE, HE/SHE WILL LOSE HIS OR HER RIGHT TO ELECT COBRA.

If the participant rejects COBRA before the due date, he/she may change his/her mind as long as he/she furnishes a completed Election Form before the due date. The Plan will only provide continuation coverage beginning on the date the waiver of coverage is revoked.

The participant does not have to send any payment with his/her Election Form when he/she elect COBRA. Important additional information about payment for COBRA coverage is included below.

Each qualified beneficiary will have an independent right to elect COBRA. For example, the employee's spouse may elect COBRA even if the employee does not. COBRA may be elected for only one, several, or for all dependent children who are qualified beneficiaries. Covered employees and spouses (if the spouse is a qualified beneficiary) may elect COBRA on behalf of all of the qualified beneficiaries, and parents may elect COBRA on behalf of their children. Any qualified beneficiary for whom COBRA is not elected within the sixty (60) day election period specified in the Plan's COBRA election notice **WILL LOSE HIS OR HER RIGHT TO ELECT COBRA COVERAGE.**

When the participant completes the Election Form, he/she must notify the Plan Administrator if any qualified beneficiary has become entitled to Medicare and, if so, the date of Medicare entitlement. If the participant becomes entitled to Medicare (or first learns that he/she is entitled to Medicare) after submitting the Election Form, immediately notify the Plan Administrator of the date of the Medicare entitlement at the address specified above for delivery of the Election Form.

Qualified beneficiaries who are entitled to elect COBRA may do so even if they have other group health plan coverage or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, as discussed in more detail below, a qualified beneficiary's COBRA coverage will terminate automatically if, after electing COBRA, he or she becomes entitled to Medicare benefits or becomes covered under other group health plan coverage (but only after any applicable pre-existing condition exclusions of that other plan have been exhausted or satisfied). See the section below entitled "Termination of COBRA Coverage Before the End of the Maximum Coverage Period."

SPECIAL CONSIDERATIONS IN DECIDING WHETHER TO ELECT COBRA

In considering whether to elect COBRA, the participant should take into account that a failure to elect COBRA will affect his/her future rights under federal law. First, he/she can lose the right to avoid having pre-existing condition exclusions applied to the participant by other group health plans if he/she has a sixty-three (63) day gap in health coverage, and election of COBRA may help avoid such a gap. Second, the participant will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if he/she elect COBRA coverage and do not exhaust COBRA coverage for the maximum time available. Finally, the participant should take into account that he/she has special enrollment rights under federal law. The participant has the right to request special enrollment in another group health plan for which he/she is otherwise eligible (such as a plan sponsored by the spouse's employer) within thirty (30) days after the participant's group health coverage under the Plan ends because of one of the qualifying events listed above. The participant will also have the same special enrollment right at the end of COBRA coverage if he/she gets COBRA coverage for the maximum time available.

LENGTH OF COBRA COVERAGE

COBRA coverage is a temporary continuation of coverage. The COBRA coverage periods described below are maximum coverage periods. COBRA coverage can end before the end of the maximum coverage period for several reasons, which are described in the section below entitled "Termination of COBRA Coverage Before the End of the Maximum Coverage Period."

When Plan coverage is lost due to the death of the employee, the covered employee's divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA coverage can last for up to a total of thirty-six (36) months.

When Plan coverage is lost due to the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than eighteen (18) months before the qualifying event, COBRA coverage for qualified beneficiaries (other than the employee) who lose coverage as a result of the qualifying event can last until up to thirty-six (36) months after the date of Medicare entitlement. For

example, if a covered employee becomes entitled to Medicare eight (8) months before the date on which his employment terminates, COBRA coverage under the Plan's Medical and Dental components for his spouse and children who lost coverage as a result of his termination can last up to thirty-six (36) months after the date of Medicare entitlement, which is equal to twenty-eight (28) months after the date of the qualifying event (thirty-six (36) months minus eight (8) months). This COBRA coverage period is available only if the covered employee becomes entitled to Medicare within eighteen (18) months BEFORE the termination or reduction of hours.

Otherwise, when Plan coverage is lost due to the end of employment or reduction of the employee's hours of employment, COBRA coverage generally can last for only up to a total of eighteen (18) months.

EXTENSION OF MAXIMUM COVERAGE PERIOD

If the qualifying event that resulted in the participant's COBRA election was the covered employee's termination of employment or reduction of hours, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. The participant must notify the Plan Administrator of a disability or a second qualifying event in order to extend the period of COBRA coverage. Failure to provide notice of a disability or second qualifying event will eliminate the right to extend the period of COBRA coverage. Along with the notice of a disability, the qualified beneficiary must also supply a copy of the Social Security Administration disability determination.

If a qualified beneficiary is determined by the Social Security Administration to be disabled and the participant notifies the Plan Administrator in a timely fashion, all of the qualified beneficiaries in the family may be entitled to receive up to an additional eleven (11) months of COBRA coverage, for a total maximum of twenty-nine (29) months. This extension is available only for qualified beneficiaries who are receiving COBRA coverage because of a qualifying event that was the covered employee's termination of employment or reduction of hours. The qualified beneficiary must be determined disabled at any time during the first sixty (60) days of COBRA coverage. Each qualified beneficiary will be entitled to the disability extension if one of them qualifies.

The disability extension is available only if the participant notifies the Plan Administrator in writing of the Social Security Administration's determination of disability within sixty (60) days after the latest of:

- the date of the Social Security Administration's disability determination;
- the date of the covered employee's termination of employment or reduction of hours; or
- the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the covered employee's termination of employment or reduction of hours.

The written notice must include the plan name or group name, the employee's name, the employee's Social Security Number, the dependent's name and a description of the event.

The participant must also provide this notice within eighteen (18) months after the covered employee's termination of employment or reduction of hours in order to be entitled to a disability extension.

If these procedures are not followed or if the written notice is not provided to the Plan Administrator during the sixty (60) day notice period and within eighteen (18) months after the covered employee's termination of employment or reduction of hours, **THEN THERE WILL BE NO DISABILITY EXTENSION OF COBRA COVERAGE.**

An extension of coverage will be available to spouses and dependent children who are receiving COBRA coverage if a second qualifying event occurs during the eighteen (18) months (or, in the case of a disability extension, the twenty-nine (29) months) following the covered employee's termination of employment or reduction of hours. The maximum amount of COBRA coverage available when a second qualifying event occurs is thirty-six (36) months. Such second qualifying events may include the death of a covered employee, divorce or legal separation from the covered employee, or a dependent child's ceasing to be eligible for coverage as a dependent under the Plan. These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the Plan if the first qualifying event had not occurred. (This extension is not available under the Plan when a covered employee becomes entitled to Medicare.)

This extension due to a second qualifying event is available only if the participant notifies the Plan Administrator in writing of the second qualifying event within sixty (60) days after the later of (1) the

date of the second qualifying event; and (2) the date on which the qualified beneficiary would lose coverage under the terms of the Plan as a result of the second qualifying event (if it had occurred while the qualified beneficiary was still covered under the Plan).

If these procedures are not followed or if the written notice is not provided to the Plan Administrator during the sixty (60) day notice period, **THERE WILL BE NO EXTENSION OF COBRA COVERAGE DUE TO A SECOND QUALIFYING EVENT.**

In addition to the regular COBRA termination events specified later in this section, the disability extension period will end the first of the month beginning more than thirty (30) days following recovery.

Example: If disability ends June 10, coverage will continue through the month of July (7/31).

TERMINATION OF COBRA COVERAGE BEFORE THE END OF THE MAXIMUM COVERAGE PERIOD

COBRA coverage will automatically terminate before the end of the maximum period if:

- any required premium is not paid in full on time;
- a qualified beneficiary becomes covered, after electing COBRA, under another group health plan (but only after any pre-existing condition exclusions of that other plan for a pre-existing condition of the qualified beneficiary have been exhausted or satisfied);
- a qualified beneficiary becomes entitled to Medicare benefits after electing COBRA;
- the employer ceases to provide any group health plan for its employees; or
- during a disability extension period, the disabled qualified beneficiary is determined by the Social Security Administration to be no longer disabled. For more information about the disability extension period, see the section above entitled "Extension of Maximum Coverage Period."

COBRA coverage may also be terminated for any reason the Plan would terminate coverage of a participant or beneficiary not receiving COBRA coverage (such as fraud).

The participant must notify the Plan Administrator in writing within thirty (30) days if, after electing COBRA, a qualified beneficiary becomes entitled to

Medicare or becomes covered under other group health plan coverage (but only after any pre-existing condition exclusions of that other plan for a pre-existing condition of the qualified beneficiary have been exhausted or satisfied).

COBRA coverage will terminate (retroactively if applicable) as of the date of Medicare entitlement or as of the beginning date of the other group health coverage (after exhaustion or satisfaction of any pre-existing condition exclusions for a pre-existing condition of the qualified beneficiary). The Plan Administrator will require repayment to the Plan of all benefits paid after the termination date, regardless of whether or when the participant provides notice to the Plan Administrator of Medicare entitlement or other group health plan coverage.

If a disabled qualified beneficiary is determined by the Social Security Administration to no longer be disabled, the participant must notify the Plan Administrator of that fact within thirty (30) days after the Social Security Administration's determination.

If the Social Security Administration's determination that the qualified beneficiary is no longer disabled occurs during a disability extension period, COBRA coverage for all qualified beneficiaries will terminate (retroactively if applicable) as of the first day of the month that is more than thirty (30) days after the Social Security Administration's determination that the qualified beneficiary is no longer disabled. Drake University will require repayment to the Plan of all benefits paid after the termination date, regardless of whether or when the participant provides notice to the Plan Administrator that the disabled qualified beneficiary is no longer disabled. (For more information about the disability extension period, see the section above entitled "Extension of Maximum Coverage Period)."

COST OF COBRA COVERAGE

Each qualified beneficiary is required to pay the entire cost of COBRA coverage. The amount a qualified beneficiary may be required to pay may not exceed 102% (or, in the case of an extension of COBRA coverage due to a disability, 150%) of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving COBRA coverage. The amount of the COBRA premiums may change from time to time during the period of COBRA coverage and will most likely increase over time. The participant will be notified of COBRA premium changes.

PAYMENT FOR COBRA COVERAGE

All COBRA premiums must be paid by check or money order.

The participant's first payment and all monthly payments for COBRA coverage must be made payable to CTIA COBRA Account and mailed to:

Claim Technologies Incorporated
100 Court Avenue
Suite 306
Des Moines, IA 50309-2200

The payment is considered to have been made on the date that it is postmarked. The participant will not be considered to have made any payment by mailing a check if his/her check is returned due to insufficient funds or otherwise.

If the participant elects COBRA, he/she does not have to send any payment with the Election Form. However, he/she must make his/her first payment for COBRA coverage not later than forty-five (45) days after the date of election. (This is the date the Election Form is postmarked, if mailed, or the date the Election Form is received by the individual at the address specified for delivery of the Election Form, if hand-delivered). See the section above entitled "Electing COBRA Coverage."

The first payment must cover the cost of COBRA coverage from the time coverage under the Plan would have otherwise terminated up through the end of the month before the month in which the participant makes his/her first payment. For example, Sue's employment terminated on September 30, and she loses coverage on September 30. Sue elects COBRA on November 15. Her initial premium payment equals the premiums for October and November and is due on or before December 30, the 45th day after the date of her COBRA election. The participant is responsible for making sure that the amount of his/her first payment is correct. He/she may contact the Plan Administrator to confirm the correct amount of the first payment.

Claims for reimbursement will not be processed and paid until the participant has elected COBRA and make the first payment for it.

If the participant does not make the first payment for COBRA coverage in full within forty-five (45) days after the date of his/her election, he/she will lose all COBRA rights under the plan.

After the participant makes his/her first payment for COBRA coverage, he/she will be required to make monthly payments for each subsequent month of COBRA coverage. The amount due for each

month for each qualified beneficiary will be disclosed in the election notice provided at the time of the qualifying event. Under the Plan, each of these monthly payments for COBRA coverage is due on the first day of the month for that month's COBRA coverage. If the participant makes a monthly payment on or before the first day of the month to which it applies, his/her COBRA coverage under the Plan will continue for that month without any break. The Plan Administrator will not send periodic notices of payments due for these coverage periods (that is, we will not send a bill for the COBRA coverage - it is the participant's responsibility to pay his/her COBRA premiums on time).

Although monthly payments are due on the first day of each month of COBRA coverage, the participant will be given a grace period of thirty (30) days after the first day of the month to make each monthly payment. COBRA coverage will be provided for each month as long as payment for that month is made before the end of the grace period for that payment. However, if the participant pays a monthly payment later than the first day of the month to which it applies, but before the end of the grace period for the month, his/her coverage under the Plan will be suspended as of the first day of the month and then retroactively reinstated (going back to the first day of the month) when the monthly payment is received. This means that any claim submitted for benefits while coverage is suspended may be denied and may have to be resubmitted once coverage is reinstated.

If the participant fails to make a monthly payment before the end of the grace period for that month, **HE OR SHE WILL LOSE ALL RIGHTS TO COBRA COVERAGE UNDER THE PLAN.**

MORE INFORMATION ABOUT INDIVIDUALS WHO MAY BE QUALIFIED BENEFICIARIES

A child born to, adopted by, or placed for adoption with a covered employee during a period of COBRA coverage is considered to be a qualified beneficiary provided that, if the covered employee is a qualified beneficiary, the covered employee has elected COBRA coverage for himself or herself. The child's COBRA coverage begins when the child is enrolled in the Plan, whether through special enrollment or open enrollment, and it lasts for as long as COBRA coverage lasts for other family members of the employee. To be enrolled in the Plan, the child must satisfy the otherwise applicable Plan eligibility requirements (for example, regarding age).

A child of the covered employee who is receiving benefits under the Plan pursuant to a Qualified Medical Child Support Order (QMCSO) received by Drake University during the covered employee's period of employment with Drake University is entitled to the same rights to elect COBRA as an eligible dependent child of the covered employee.

ASSISTANCE WITH QUESTIONS

Questions concerning the Plan or the participant's COBRA rights should be addressed to the contact or contacts identified below. For more information about rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), 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) or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

KEEP THE PLAN INFORMED OF ADDRESS CHANGES

In order to protect the participant family's rights, he/she should keep the Plan Administrator informed of any changes in the addresses of family members. The participant should also keep a copy, for his/her records, of any notices sent to the Plan Administrator.

PLAN CONTACT INFORMATION

The participant may obtain information about the Plan and COBRA coverage on request from:

Claim Technologies Incorporated
100 Court Avenue
Suite 306
Des Moines, IA 50309-2200

The contact information for the Plan may change from time to time. The most recent information will be included in the Plan's most recent SPD (if the participant is not sure whether this is the Plan's most recent SPD, he/she may request the most recent one from the Benefit Services Administrator or the Plan Administrator).

CREDITABLE COVERAGE PROVISION

Qualifying periods of time during which a participant had "creditable coverage" will be applied toward the satisfaction of the participant's pre-existing condition exclusion period. Prior carriers or employers will provide certification regarding a participant's prior coverage. In addition, the participant may request a certificate of creditable coverage under this Plan at any time from the Benefit Services Administrator or the Plan Administrator, up to twenty-four (24) months after the participant's coverage ceases. This certification will be used to determine what portion of the participant's pre-existing condition exclusion period, if any, must still be satisfied.

Written Requests for Certificates must include:

- the last name of the individual for whom the Certificate is requested;
- the last date that the individual was covered under the plan;
- the name of the participant that enrolled the individual in the plan;
- a telephone number to reach the individual for whom the Certificate is requested, in the event of any difficulties;
- the name of the person making the request and evidence of that person's authority to request and receive the Certificate on behalf of the individual;
- the address to which the Certificate should be mailed; and
- the requestor's signature.

After receiving a request that meets these requirements, the plan will act in a reasonable and prompt fashion to provide the Certificate.

Prior coverage does not qualify under this provision if there is a break in coverage of sixty-three (63) consecutive days or more. Waiting periods are not considered periods without coverage nor are they counted as creditable coverage. Refer to the **Definitions** section for a definition of "Creditable Coverage."

As required by the Trade Act of 2002, the days between the date an individual loses group health coverage and the first day of the second COBRA election period are not taken into account in determining whether a significant break in coverage has occurred.

PRE-EXISTING CONDITION EXCLUSION PERIOD

This Plan includes an exclusion period for new participants with pre-existing (not otherwise excludable) medical conditions. A pre-existing medical condition is an injury or illness which was present prior to the participant's date of enrollment (see definition) for which any medical advice, diagnosis, care or treatment (including having a prescription for legend drugs, whether or not the drugs are taken) was provided or recommended by a physician prior to the participant's date of enrollment. Genetic information is not treated as a pre-existing condition in the absence of a diagnosis of a condition related to the genetic information.

The pre-existing condition exclusion period works as follows:

If a participant has a pre-existing, allowable medical condition (physical or mental) within the six (6) month period prior to his/her date of enrollment for medical coverage (this six (6) month period is called the look-back period), that allowable condition will not be covered by this Plan until twelve (12) months following the participant's date of enrollment.

If a participant is a late enrollee, the twelve (12) month pre-existing condition exclusion period mentioned in the prior paragraph will be extended to eighteen (18) months.

The twelve (12) month (or eighteen (18) month) pre-existing condition exclusion period will be reduced by the length of the aggregate period of any creditable prior coverage.

This Plan will apply the standard method of counting creditable coverage. The standard method of counting creditable coverage determines an individual's creditable coverage without reference to specific benefits provided during the individual's prior coverage periods.

Charges incurred during the twelve (12) month or eighteen (18) month pre-existing condition exclusion period will be reviewed by the Benefit Services Administrator and allowable conditions which appear to be pre-existing will be investigated.

Benefits will be available for all covered services with the exception of the allowable condition(s) specifically identified as being pre-existing.

The pre-existing condition exclusion period never applies to pregnancy. In addition, a pre-existing condition exclusion period will not be applied to a

newborn, an adopted child who is under age eighteen (18) at the time of the adoption, or a child placed for adoption who is under age eighteen (18) at the time of placement for adoption, if the child becomes covered under a group health plan or other creditable coverage within thirty (30) days of the birth, adoption, or placement for adoption. This exception does not apply, however, after the child has a break in coverage of sixty-three (63) or more consecutive days.

PRE-TAX PREMIUM PROGRAM

The pre-tax premium program allows you to purchase this Plan with pre-tax dollars. Under the pre-tax premium program, the money that you would normally have deducted on an after-tax basis would instead be deducted on a pre-tax basis through salary redirection. The advantage of the pre-tax premium program is that you pay no FICA (Social Security) taxes or federal income taxes on the pre-tax premium contributions you make. Furthermore, your premium is also exempt from state income taxes in most states. This means a higher take-home pay for you, than if you purchased this Plan with after-tax dollars.

The pre-tax premium program is available to you if you meet the eligibility requirements under this Plan. Your premium will automatically be deducted from your paycheck on a pre-tax basis. Your enrollment regarding the tax status of your premiums will continue in effect until you change it. You can make this change only during the period prior to the start of each Plan Year as designated by the Plan Administrator or if you experience a family status change, as defined by the Internal Revenue Service.

Your choices are in effect for the entire Plan Year. Only under special circumstances, such as changes in family status including, but not limited to: marriage, divorce, legal separation death of a spouse or child, birth or adoption of a child, the termination or commencement of your spouse's employment, a significant increase in your costs with respect to this Plan, the switching from part-time to full-time employment status, or the reverse, by you or your spouse or the taking of an unpaid leave of absence by you or your spouse - may you apply to change your selected benefits. The change must be consistent with the family status change, to the extent that it is necessary or appropriate, as a result of the family status change.

Note: Because the premium contributions you make to this Plan are not taxed as wages for Social Security purposes, your ultimate Social Security benefits might be somewhat less than they could have been. This depends on many things, including

your earnings history, whether you are above or below the Social Security "wage base," and what happens to the Social Security laws between now and when you retire.

SPECIAL FEATURES TO CONTROL COSTS

To ensure that cost-effective services are provided, the Utilization Review Company places responsibility for benefit management with physicians, as they control health care utilization. When benefit management procedures are not followed, the result will be a reduction in payment to contracting providers for which the patient is not liable.

UTILIZATION REVIEW

The utilization review program reviews the medical necessity of hospital inpatient and nursing facility admissions for all medical, surgical, mental health, chemical dependency and rehabilitation admissions. The utilization review provisions do not apply when Medicare is the primary payer.

When you receive care from a SelectFirst™ provider, they will handle the preadmission certification for you. If a penalty for failure to comply is involved, you are not responsible.

However, if you seek care from Beech Street Network or from Non-Network Providers, you are responsible for compliance with the utilization review provisions as described in the following sections, and any penalties incurred will be your responsibility.

The utilization review unit is staffed with registered, licensed nurses with at least five (5) years of medical/surgical or mental health/chemical dependency experience.

Their phone lines are available twenty-four (24) hours per day, every day of the year.

The utilization review coordinator can be reached at:

Nationwide..... 1-800-344-5822

If services are determined to be not medically necessary or not covered by this Plan, benefits will be denied.

Important Note: If you disagree with a reduction in or denial of benefits, please see the Claim Determination and Claim Review Procedure section for information on how to file an appeal. These sections also outline the time frames in which the Plan must respond to your claim and/or appeal.

Preadmission Certification

SelectFirst™ Providers

All scheduled inpatient admissions for SelectFirst™ participants must be pre-certified by SelectFirst™ before hospitalization occurs. It is the SelectFirst™ physician's responsibility to obtain this preadmission certification for all scheduled hospitalizations.

Beech Street and other Non-Network Providers

If a participant obtains services from a non-SelectFirst™ hospital, it is the responsibility of the patient to pre-certify the hospital admission. **The participant** will be responsible for any penalty for failure to pre-certify.

Each hospital, rehabilitation or nursing facility stay, planned or unplanned, requires preadmission certification. Preadmission certification includes physician review, continued stay review, and discharge planning.

Planned inpatient stays must be reported to the utilization review unit prior to the actual admission. Unplanned/Urgent Care admissions must be reported **within two (2) business days** following the date of admission.

A request for pre-certification will be accepted from anyone familiar with the patient, but ultimate responsibility remains the patient's. In most cases certification is given during the initial conversation. If all of the necessary information cannot be obtained, the nurse reviewer will follow-up immediately. If, for some reason, an inpatient stay does not meet the criteria, the nurse reviewer will consult with a physician reviewer and respond to the appropriate parties.

Physician Review

Nurse reviewers certify the majority of inpatient stays, but if the participant's condition or treatment plan does not satisfy certain criteria, consultation begins with a physician reviewer. The selection of a physician reviewer depends on the patient's diagnosis and the procedures that have been or will be involved in the course of treatment. The physician selected will represent a medical specialty which is directly related to the patient's condition.

The attending physicians' name(s) will be shared with the physician reviewer after a decision is made. Then the attending physician is encouraged to talk with the physician reviewer about any questions or concerns regarding the decision.

In the event of a denial or reduction of benefits, the participant (or his/her authorized representative), the attending physician and the hospital are notified immediately. Such a decision can be appealed within one hundred eighty (180) days. In this case, First Administrators, Inc. will contact other physicians to review the admission. If any of these physicians decides to approve benefits, the decision will be reversed.

Continued Stay Review

The utilization review staff does not assign lengths of stay when an inpatient stay is certified. Each admission is closely monitored to verify that services being provided remain medically necessary. This review begins on the second day of a hospital stay. Physician reviewers are consulted whenever services being provided or requested do not meet medical necessity standards.

Discharge Planning

Discharge planning begins the day of admission. The purpose of this provision is to ensure maximum coordination among the family, health care provider and utilization review staff in the event discharge to alternative care is warranted. Every effort is made throughout each stay to maintain patient care in the most cost-effective setting while not sacrificing the quality of care.

If you fail to comply with any part of the preadmission certification provision, a \$500 penalty will be applied to your hospital charges. This penalty will not apply to your out-of-pocket maximums.

This penalty will be waived for maternity stays with a duration of forty-eight (48) hours for a normal vaginal delivery, or ninety-six (96) hours for a cesarean section. Penalties may be applied to maternity stays which exceed these guidelines.

Pre-Procedure Review Program

First Administrators, Inc. will review elective inpatient and outpatient surgical procedures for the purpose of determining their medical necessity. If the proposed surgical procedure is to be provided on an inpatient basis, preadmission certification will be required.

When a physician recommends you or one of your dependents undergo one of the procedures on the following list, you or your physician must contact the Benefit Services Administrator before the procedure is performed.

Listed below are the surgical procedures requiring Pre-Procedure Review:

The list of surgical procedures is subject to change at any time.

- Adenoidectomy and/or tonsillectomy
- Blepharoplasty (eyelid surgery)
- Bunionectomy and/or hammertoe (multiple)
- Coronary artery bypass (heart surgery)
- Ganglionectomy
- Gastric surgery for obesity
- Hernia surgery
- Hysterectomy
- Jaw surgery
- Joint replacement surgery
- Laminectomy (back surgery)
- Mammoplasty (breast surgery)
- Marsupialization of Bartholin's cyst
- Meatotomy
- Nasal polypectomy
- Organ transplant (except for bone marrow, cornea, kidney, and skin transplants)
- Percutaneous transluminal coronary angioplasty ("balloon" procedure of the coronary arteries)
- Radial keratotomy (eye surgery)
- Rhinoplasty (nose bone surgery)
- Septoplasty (nose cartilage surgery)
- Tenotomy
- TURP (Transurethral Resection of Prostate)
- Varicose vein surgery

If you fail to comply with the pre-procedure review provision, a \$500 penalty will be applied to your charges. This \$500 penalty will not apply to your out-of-pocket maximum.

Prenatal Screening

This program is designed to assist expectant mothers during pregnancy. Each expectant mother covered by this Plan will be asked to participate. The goal is to assist expectant mothers and their physicians, by detection of possible complications, thus hopefully preventing pre-term labor and premature birth.

You will be responsible for contacting the pre-certification department at First Administrators, Inc. to obtain "certification" during the **first trimester** of pregnancy and to respond to a checklist. Questions

asked will focus on medical history, obstetrical history and everyday habits. Upon evaluation, if no special needs appear, the prenatal screening process is complete. If special needs appear, Case Management will monitor your pregnancy as needed.

Case Management Administration

Individual case management (ICM) is a program designed to assist you with a potentially long-term, high-cost or catastrophic illness and/or injury. The objective is to offer alternatives to traditional care settings. Health care benefits are tailored to meet medical needs while promoting quality and cost-effective outcomes. Case management administration is performed on a case-by-case basis. Benefits may include supplies or services which are not normally a covered benefit under this Plan. Individual case management's goal is to return people to productive lives after a catastrophic illness or injury whenever possible.

Examples of the types of conditions requiring an evaluation are:

- AIDS, brain tumors, cancer, gastrointestinal conditions, head and spinal cord injuries, severe burns and/or strokes.

HOW SELECTFIRST™ WORKS

PAYMENT METHOD

A provision of the SelectFirst™ contract provides that all services performed within the SelectFirst™ area are based upon a fee schedule or discount. You are responsible for the difference between the amount billed and the payment if you choose to obtain services from a non- SelectFirst™ provider. Services provided by non- SelectFirst™ providers outside the SelectFirst™ area will be subject to the lesser of the actual amount charged or the maximum allowable fee.

NON-SELECTFIRST™ PROVIDERS UNDER THE SUPERVISION OF SELECTFIRST™ PROVIDERS

When services are performed by a non-SelectFirst™ licensed practitioner under the direct supervision of a SelectFirst™ provider, charges for the non-SelectFirst™ provider will be payable at the SelectFirst™ reimbursement level.

Office visits will **not** be subject to a second co-pay if the SelectFirst™ provider also provided services on the same day as the licensed practitioner.

HOW THE MEDICAL PLAN WORKS

DESCRIPTION OF MEDICAL BENEFITS

Individual Deductible

If you have individual coverage, unless otherwise specified, you will be responsible for the individual calendar year deductible amount specified in the benefit summary before any medical benefits will be paid by this Plan. The amount of individual deductible is determined by the type of provider you receive treatment from (Network or non-Network) and whether the treatment was incurred in or out of the Network area.

Family Deductible

If you choose to take family coverage, the total deductible you and your covered dependents will have to pay in a calendar year will never be more than the family deductible amount specified in the benefit summary; each participant's responsibility will be limited to the individual deductible amount specified in the benefit summary. The family deductible is the same no matter how many dependents you have. Like the individual deductible, the amount of family deductible is determined by the type of provider you receive treatment from (Network or non-Network) and whether the treatment was incurred in or out of the Network area. See the benefit summary for family deductible amounts.

Office Services Co-Pay

In most cases, each separate visit to a physician's office will require a Office Services Co-Pay. This co-pay applies as shown in the benefit summary.

Coinsurance

Once you have paid your calendar year deductible, this Plan will pay the coinsurance percentages of the covered medical expenses outlined in the benefit summary.

Out-of-Pocket Maximum

There are limits on how much you will have to pay per individual, or per family, in allowable medical expenses per calendar year. The benefit summary specifies what the out-of-pocket maximum includes and what it excludes. The out-of-pocket maximum never includes ineligible charges. Once you meet the out-of-pocket maximum, this Plan pays 100% of the allowable expenses.

Plan Maximum

All allowable medical expenses under this Plan are limited to an overall lifetime maximum benefit for each participant. This lifetime maximum applies across all plans or options sponsored by the employer for all eligible expenses.

The lifetime maximum benefit paid under any predecessor plan(s), this Plan, and any subsequent plan(s) will be as specified in the benefit summary.

In addition, this Plan may contain other calendar year or lifetime benefit maximums. These maximums are included in the overall medical lifetime maximum benefit.

WHAT ARE COVERED EXPENSES?

All services must be medically necessary. The Benefit Services Administrator determines what is medically necessary, however, if necessary, the Plan Administrator makes the final determination whether a service is medically necessary, and that decision is final and conclusive. This Plan may include benefits not normally considered medically necessary. These are specifically included as benefits on the following pages.

The fact that a physician or dentist may have prescribed, ordered, recommended, or approved the provision of certain services or supplies does not necessarily mean such services or supplies are medically necessary or make the service a covered expense.

Following is an explanation of the covered expenses under this Plan. If you receive services and/or treatment from a Network provider, expenses are subject to the Network's pricing agreement. If you receive services and/or treatment from a non-Network physician or from a physician out of the Network area, covered expenses are subject to the lesser of the actual amount charged or the maximum allowable fee.

HOSPITAL BENEFITS

Hospital benefits include the daily room and board charge for each day of confinement, up to the semi-private room rate for the level of care the patient is receiving. If the hospital does not have semi-private rooms, benefits will be paid at the lowest private room rate. Charges for special care units (e.g., isolation or intensive care rooms and operating rooms) are covered provided the level of care was prescribed by a physician and deemed to be medically necessary.

Hospital confinements must be a result of an injury or illness. This will not apply when charges are incurred in connection with services for a newborn child. If the child is a "well-baby," but the mother remains necessarily confined to the hospital, an additional inpatient day shall also be available for the newborn.

Payment will be made for hospital miscellaneous charges such as oxygen tents and surgical supplies during a period of confinement for which room and board benefits are payable.

Personal convenience items, including, but not limited to, televisions, telephones and admission kits are not payable expenses under this Plan.

IN-HOSPITAL PHYSICIAN BENEFITS

In-hospital services by a physician for treatment of an injury or illness are covered benefits of this Plan.

This benefit also includes consultations by other physicians, if medically necessary and recommended by the attending physician. The consulting physician must be conferring in a medical specialty different than the specialty of the attending physician or any other consulting physician.

MENTAL HEALTH AND CHEMICAL DEPENDENCY BENEFITS

This Plan provides benefits for the following mental health and chemical dependency related services. Benefits are subject to the limits shown on the Benefit Summary.

Hospital Inpatient Benefits

Benefits include daily room and board charges up to the hospital's room rate. Unless otherwise excluded, this Plan will provide benefits for hospital miscellaneous charges such as therapy and supplies incurred during the time room and board benefits are payable.

Hospital Outpatient and Physician Office Benefits

Unless otherwise excluded, this Plan will provide benefits for medically necessary services including partial hospitalization and therapy and supplies provided in an outpatient or office setting.

NURSING FACILITY BENEFITS

Benefits are provided for a nursing facility if the care is medically necessary to treat an injury or illness and is prescribed by a physician. Nursing facility benefits for each participant are limited as specified in the benefit summary. Services must be medically necessary and care cannot be of a custodial nature.

Nursing facilities are used by those who require rehabilitation or additional time to recover from an injury or illness but do not need the acute care provided in a hospital.

Payable charges for services include room and board (including general nursing care), special treatment rooms, x-ray and laboratory examinations, physical, occupational or speech therapy, oxygen and other gas therapy and any other services customarily provided by a nursing facility. Room and board charges will be limited to the semi-private room rate for the level of care the patient is receiving in the nursing facility.

Nursing facility benefits do not include services in connection with a mental health or chemical dependency disorder.

HOME HEALTH CARE BENEFITS

Home health care benefits consist of the following medically necessary services for the treatment of an injury or illness when prescribed by a physician:

- part-time nursing care provided in your home by a registered nurse (RN), a licensed practical nurse (LPN), or a licensed public health nurse (LPHN);
- physical, occupational or speech therapy provided in your home;
- physical, occupational or speech therapy, or the use of medical appliances or equipment, provided on an outpatient basis by a home health agency, a hospital, or other facility under an arrangement with a home health care agency;
- medical supplies, drugs and medications prescribed by a physician; and
- laboratory services by or on behalf of a hospital.

Home health care benefits for each participant are limited as specified in the benefit summary.

Home health care benefits will not include any services performed by a member of your immediate family or a person ordinarily residing in your home. Home health care benefits do not include meals, personal convenience items or housekeeping services. No home health care services are payable for the treatment of a mental health or chemical dependency disorder.

Prior approval by the Benefit Services Administrator before services commence is recommended.

SURGICAL BENEFITS

Surgical benefits include professional fees for performing a covered surgical procedure to treat an injury or illness. Services may be provided on an

inpatient or outpatient basis at a hospital, in an ambulatory surgery center or in a physician's office. Surgical benefits include:

- surgical, operative and cutting procedures, and major endoscopic procedures;
- treatment of fractures or dislocations or suturing of wounds;
- cutting procedures for the treatment of oral diseases or extraction of impacted teeth. Extraction of impacted teeth is covered if the patient has a non-dental physical condition which requires inpatient hospitalization;
- medically necessary surgical assistance by a physician. Benefits are not provided if the assistant is an intern, resident, or member of the hospital staff or is compensated by the hospital. The surgical procedure and medical condition of the participant must require the services of a surgical assistant. Benefits are limited to 20% of the eligible expense for the surgical procedure performed; and
- administration of anesthesia in connection with a surgical procedure if the anesthetic is administered by a physician or certified registered nurse anesthetist (CRNA), other than the operating or assistant surgeon, the physician is not employed or compensated by the institution in which the surgery is performed and the physician bills for the administration of the anesthetics.

Compensation for usual pre-operative and post-operative care is included in the payment for surgical services.

Benefits for multiple surgical procedures will be considered at 100% of the eligible expense for the primary procedure and 50% of the eligible expense for the secondary procedure and 25% for any remaining procedures.

Benefits for two like surgical procedures (i.e., bilateral procedures) will be considered at 150% of the eligible expense for the procedure.

This Plan is in compliance with the Women's Health and Cancer Rights Act of 1998 and, for individuals who choose breast reconstruction surgery, the Plan will allow benefits for reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and physical complications of all stages of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the patient.

AMBULATORY/OUTPATIENT SURGERY BENEFITS

Outpatient surgeries can be performed either in the outpatient department of a hospital, an independent surgery center or in a physician's office. Facility charges are also benefits covered by this Plan.

AMBULATORY/OUTPATIENT SURGERY FACILITY BENEFITS

This benefit includes coverage for the facility charges of an "ambulatory surgery center." An ambulatory surgery center is any public or private establishment with an organized medical staff of physicians, with permanent facilities that are equipped and operated primarily for the purpose of performing outpatient surgical procedures, with continuous physician services and registered professional nursing services whenever a patient is in the facility, and which does not provide services or other accommodations for patients to stay overnight.

VOLUNTARY SECOND/THIRD SURGICAL OPINION PROVISION

The voluntary second/third surgical opinion program's goal is to provide sufficient information before you, or one of your dependents, decide to have elective surgery. This information may be valuable and help you decide whether to use an alternative treatment for your medical condition.

Whenever possible, the specialist providing the second (or third) opinion should use the same test results as used by your first physician. Duplicate laboratory tests or x-rays taken are not usually medically necessary. You should bring copies of your original test results to the specialist when you have the second opinion.

The final decision on whether or not to have surgery is yours. While the intent is not to limit your access to medical care, this Plan wants you to be informed and comfortable with your decision to have surgery.

HOSPICE CARE BENEFITS

Hospice services are those which help terminally ill participants and their families continue life with minimal disruption of normal activities.

The decisions relating to patient care are shared by an interdisciplinary hospice care team. The team is responsible for assuring continuity of care and

providing professional management of all services. The attending physician is considered a member of this team. The attending physician updates, reviews, and approves the care plan as often as appropriate to meet the changing needs of the hospice patient and his/her family. The physician remains the primary provider of medical care.

Services reimbursed by this Plan for hospice care must be necessary for the palliation or management of the terminal illness and related conditions. Services covered must be consistent with the plan of care of the hospice care team. All services must be prescribed by and under the supervision of the attending physician and approval from the Benefit Services Administrator should be obtained prior to commencement of hospice care.

The following types of hospice expenses are covered by this Plan:

- room and board in a hospice facility, hospital (up to the facility's semi-private room rate for the level of care being provided);
- part-time or intermittent nursing care by a registered nurse (RN) or licensed practical nurse (LPN) for up to eight (8) hours in any one day;
- other necessary services such as medical supplies, medicines, drugs, physician's services and the rental or purchase of durable medical equipment;
- psychological and dietary counseling;
- physical and occupational therapy;
- part-time or intermittent home health aide services consisting mainly of caring for the individual for up to eight (8) hours in any one day;
- bereavement counseling provided by the Hospice provider;
- assessment of the individual's social, emotional and medical needs, and the home and family situation; and
- respite care which is furnished during a period of time when the participant's family or usual caretaker cannot, or will not, attend to the participant's needs.

Some items **not** covered under hospice care are:

- funeral arrangement;
- pastoral counseling;
- financial or legal counseling which includes estate planning or the drafting of a will;

- homemaker or caretaker services which are not solely related to care of the participant, including sitter or companion services for either the participant who is ill or other members of the family;
- transportation; and
- house cleaning and maintenance of the house.

ORGAN AND/OR TISSUE TRANSPLANT BENEFITS

Benefits are payable for participant charges of transplant services. Prior approval is recommended prior to any transplant services being provided.

Covered human-to-human transplants include the following procedures: heart; heart/lung; liver; cornea; kidney; pancreas; bone marrow; and other transplant procedures which are considered non-experimental or non-investigational as approved by this Plan.

Benefits include:

- organ procurement which consists of removing, preserving and transporting the donated organ;
- transportation of the recipient and a companion to and from the site of the transplant. Reasonable and necessary lodging and meal costs incurred by such companions are also covered. Each participant is limited to the maximum specified in the benefit summary; and
- private nursing care by a registered nurse (RN) and/or a licensed practical nurse (LPN).

If a covered transplant procedure is not performed as scheduled due to the intended recipient's medical condition or death, benefits will be paid for charges incurred for procurement and transportation as described above.

When both the recipient and donor are covered by this Plan, services will be covered for each patient. If only the recipient is covered by this Plan, services for both the recipient and donor will be covered, unless benefits for the donor are available under any other form of health care coverage. If the donor is covered under this Plan but the recipient is not covered, no expenses will be covered for either the recipient or the donor.

Some items **not** covered under transplant benefits are:

- any services or supplies related to transplants involving mechanical organs; and

- expenses associated with the purchase of any organ.

Refer to the benefit summary for specific limitations.

OUTPATIENT DIAGNOSTIC X-RAY AND LABORATORY BENEFITS

Benefits are payable for outpatient diagnostic x-ray or laboratory services which are provided or recommended by a physician. They may be performed in your physician's office, the outpatient department of a hospital or in a free-standing diagnostic lab or x-ray center.

MATERNITY BENEFITS

Expenses incurred by all female participants of this Plan as the result of pregnancy will be covered in the same manner as services for any other illness. Benefits will be paid according to the Plan provision for the type of expense incurred, i.e., hospital expenses under the hospital expense benefit, obstetrical delivery under the surgical expense benefit, etc.

This Plan is in compliance with The Newborns' and Mothers' Health Protection Act of 1996. This act specifies that if plans provide maternity benefits for mothers and newborns, those benefits must include a minimum forty-eight (48) hour hospital confinement following a vaginal delivery or a minimum ninety-six (96) hour hospital confinement following a cesarean delivery. Earlier discharges are permitted if the attending physician and the mother agree to an earlier discharge. Penalties cannot be applied if inpatient maternity stays that are within these time frames are not pre-certified. However, penalties may be applied to maternity stays that exceed these timeframes, if not pre-certified.

Inpatient Newborn Benefits

Expenses incurred for care of a newborn will be considered part of the mother's maternity expenses and will be paid as part of her claim until she is discharged from the hospital. Once the mother is discharged, plan provisions will apply (i.e. deductible and out of pocket).

BIRTHING CENTER BENEFITS

Birth centers provide care for pregnant women through the services of a nurse midwife. A nurse midwife provides obstetric services with an obstetrician on twenty-four (24) hour medical back-up in case of complications. The mother and baby are usually discharged from the center within 10-12

hours after birth with home follow-up visits provided. Services may vary from center to center.

Covered services include the room and board charges and eligible expenses for any necessary services and supplies while confined. Benefits are limited to expenses incurred while confined for a period of time not to exceed twenty-four (24) hours. Expenses incurred beyond the initial twenty-four (24) hour period may be covered expenses under other benefits of this Plan.

INFERTILITY BENEFITS

Services or supplies related to the diagnosis or treatment of female or male infertility will be covered, but limited to a lifetime maximum payment as specified in the benefit summary for the employee or spouse/domestic partner.

DENTAL SERVICES COVERED UNDER MEDICAL BENEFITS

The following services, including those services billed by a dentist, are covered under the medical portion of this Plan;

- jaw and natural teeth repair if due to, and incurred within six months after an accidental injury (excludes treatment for injuries associated with the act of mastication);

- the correction of congenital abnormalities of the jaw;
- reduction of fractures of the facial bones;
- excision of the mandibular joints;
- excision of lesions;
- incision of accessory sinus, mouth, salivary glands, or ducts; and
- inpatient surgical removal of impacted teeth if hospitalization is required because of a hazardous medical condition (e.g., hemophilia).

PREVENTIVE CARE BENEFITS

This Plan has been designed to encourage you to promote good health by providing benefits for certain preventive care.

Services indicating a diagnosis of “family history of” will be considered preventive care.

Routine x-ray and laboratory services will be considered routine preventive care. This includes routine pap smears and mammograms.

Please refer to the Benefit Summary for a complete list of covered expenses and the limitations applicable to each benefit.

Provided below is a list of other medical services covered by this Plan:

OTHER COVERED MEDICAL CARE

- (1) allergy tests, allergy serum and allergy injections;
- (2) professional air or ground ambulance service to the nearest, local adequate hospital or nursing facility for medically necessary treatment of an injury or illness;
- (3) unreplaced blood, blood plasma and blood plasma expanders, and their administration;
- (4) Diabetes Education/Supplies
 - Blood glucose meters and glucose strips for home use.
 - Self-management training and education for the treatment of all types of diabetes mellitus when prescribed by a licensed physician and provided by a state-certified program. This includes up to ten (10) hours of initial outpatient training provided within a twelve (12) month period for each individual who meets any of the following conditions:
 - A new onset of diabetes.
 - Poor glycemic control as evidenced by a glycosylated hemoglobin of nine and five-tenths or more in the ninety (90) days before attending the training.
 - A change in the treatment regimen from no diabetes medications to any diabetes medications, or from oral diabetes medication to insulin.
 - High risk for complications based on poor glycemic control; documented acute episodes of severe hypoglycemia or acute severe hyperglycemia occurring in the past year during which the individual needed third-party assistance for either emergency room visits or hospitalization.
 - High risk based on documented complications of a lack of feeling in the foot or other foot complications such as foot ulcer or amputation, pre-proliferative or proliferative retinopathy or prior laser treatment of the eye, or kidney complications related to diabetes, such as macroalbuminuria or elevated creatinine.

An individual who received the initial training will be eligible for a follow-up session of as long as one hour annually;

- (5) charges for injectable contraceptives (e.g., Depo-Provera), implantable contraceptives (e.g., Norplant), contraceptive devices (e.g., IUD, diaphragm, cervical cap), and surgical removal of contraceptive devices and implantable contraceptives;
- (6) purchase or rental up to the purchase price of durable medical and mechanical equipment which is medically necessary for the treatment of the patient, such as wheelchairs and hospital beds (equipment that is not available for purchase will require continuous rental);
- (7) hemodialysis (kidney disease treatment);
- (8) manual, mechanical manipulation of the spinal column and related x-ray and office visit services (chiropractic benefits);
- (9) medically necessary supplies, including, but not limited to, casts, splints and braces;
- (10) private duty nursing services of a registered nurse (RN) in or out of a hospital or a licensed practical nurse (LPN) in a hospital. Private duty nursing services are covered only to the extent that they are medically necessary and prescribed by a physician. Payment is not made for services which are custodial;
- (11) oxygen and equipment for its administration;
- (12) physician's professional services provided in a hospital's outpatient or emergency room facility, the physician's office, or the participant's home;
- (13) physical therapy provided by a licensed physical therapist;
- (14) prosthetic appliances including artificial limbs and eyes, hip prosthesis, lens implant following cataract surgery and breast implants following a mastectomy. Limited to one each per lifetime unless medically necessary due to circumstances such as physical growth;
- (15) any court ordered rehabilitative treatment, service or supply;
- (16) radiation therapy and chemotherapy;
- (17) speech, occupational and inhalation/respiratory therapy (limited to a medical condition) under the supervision of a physician. Occupational therapy supplies are not a covered benefit of this Plan;

Provided below is a list of other medical services covered by this Plan:

- | | |
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| <p>(18) the initial pair of contacts or eyeglasses following cataract surgery;</p> <p>(19) services to diagnose behavioral disorders (i.e., attention deficit disorder or developmental delays). Behavioral modification is not covered by this Plan;</p> | <p>(20) elective sterilizations, such as tubal ligations and vasectomies; and</p> <p>(21) insulin pumps and related supplies (i.e., catheters and syringes). Limited to a ninety (90) day supply per claim. Refills will be covered after sixty-eight (68) days (75% of 90 day).</p> |
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Certain medical services are not covered under this Plan. No claims will be paid for:

MEDICAL EXCLUSIONS

- (1) any confinement, treatment, service, or supply if not recommended and approved by a physician and deemed to be not medically necessary for the condition of the participant, or any surgery or other type of medical treatment performed on an elective, non-medically necessary basis unless otherwise specified as covered by this Plan;
- (2) any confinement, treatment, service, or supply in or by a government owned or operated facility, or where care is provided at government expense, i.e., a VA facility, unless there is a legal obligation for the participant to pay for such treatment or service in the absence of coverage. If the injury or illness is non-service related, this Plan will be liable for benefits for covered services;
- (3) any injury sustained or illness contracted while on duty with any military, naval, or air force of any country or international organization or the result of an act of declared or undeclared war (including resistance to armed aggression) occurring while a participant under this Plan;
- (4) Network discount amounts, "cash discounts", over-the-counter (OTC) items, and sales tax. Surcharges and/or taxes for reimbursement of uncompensated care costs or other taxes imposed by a governmental body are eligible expenses under this Plan;
- (5) the portion of a charge for services and supplies in excess of the maximum allowable fee allowance and/or the Network fee schedule;
- (6) charges for which the participant would not be responsible in the absence of this Plan;
- (7) expenses applied toward satisfaction of the deductibles or coinsurance expenses of this Plan;
- (8) services provided by a family member, whether relationship is by blood or marriage, or by any person who regularly resides in the participant's home;
- (9) charges incurred while engaging in an illegal occupation, commission of or attempted commission of an assault or a felonious act;
- (10) charges due to insurrection or voluntary participation in a riot;
- (11) pre-existing conditions as defined by this Plan;
- (12) any charges which exceed a benefit maximum;
- (13) charges incurred while the participant is not eligible for coverage;
- (14) charges for a dependent for any medical expense for which he/she is entitled to benefits as an employee or former employee of Drake University;
- (15) hospital admissions which are primarily for diagnostic evaluations, physical therapy, or occupational therapy, unless medically necessary;
- (16) charges for services in connection with one or more corns, calluses or toenails, unless the charges are for the partial or complete removal of nail roots or reasonably necessary in the treatment of a metabolic or peripheral vascular disease;
- (17) orthotic foot devices such as arch supports and in-shoe supports, orthopedic shoes, elastic supports or exams to prescribe or fit such foot devices, supports, or shoes;
- (18) charges for services in connection with weak, strained or flat feet, any instability or imbalance of the foot, any metatarsalgia or bunion unless the charges are for an open cutting operation;
- (19) biofeedback;
- (20) cosmetic surgery, except for treatment by a physician to correct a condition resulting from an accident (within twelve (12) months of the accident) or for the treatment of a congenital condition of a dependent child covered by this Plan;
- (21) hearing aids or the fitting and/or repair of such hearing appliances;
- (22) any charges for custodial care, domiciliary care, or rest cures. Additionally, expenses incurred for accommodations (including room and board and other institutional services) and nursing services for a participant because of age or a mental or physical condition primarily to assist the participant in daily living activities will be considered custodial care. The fact that the participant is also receiving medical services

Certain medical services are not covered under this Plan. No claims will be paid for:

- that are merely maintenance care that cannot reasonably be expected to substantially improve a medical condition will not prevent this limitation from applying;
- (23) acupuncture or acupressure therapy;
 - (24) experimental or investigational services;
 - (25) benefits will not be provided for an elective, induced abortion, unless determined to be medically necessary;
 - (26) sex transformation counseling or surgery, or treatment related to a sexual dysfunction or a gender identification problem;
 - (27) nonprescription medicines, vitamins, nutrients, and food supplements, even if prescribed or administered by a physician;
 - (28) blood or blood plasma that is replaced by or for the patient (the charge usually made by the provider when there is no insurance, not to exceed the prevailing charge in the area for a service of the same nature and duration and performed by a person of similar training and experience or for a substantially equivalent supply);
 - (29) any services or supplies provided for weight reduction classes;
 - (30) radial keratotomy surgery if done for the purpose of correcting refractive errors;
 - (31) services and supplies for recreational or educational therapy or forms of nonmedical self-help or self-cure;
 - (32) cost of travel or lodging related to getting medical treatment, or travel, even if recommended by a physician, unless specified as a covered benefit of this Plan;
 - (33) marital or family counseling;
 - (34) personal convenience items, including, but not limited to, air conditioners or dehumidifiers, which can be used in the absence of an injury or illness;
 - (35) routine physical examinations or screening procedures for non-preventive purposes, including, but not limited to, those for family history, employment, travel, insurance, school and camp;
 - (36) nicotine transdermal systems, and any other nicotine-containing smoking deterrent or smoking cessation product, whether or not they require a physician's prescription;
 - (37) hospital and professional services to which the participant is entitled without charge or to which the participant is entitled by any governmental program, except state Medicaid programs;
 - (38) respirators; and
 - (39) any injury or illness for which the participant is entitled to compensation under any Worker's Compensation law or act (not including self-employment).

PRESCRIPTION DRUG BENEFITS

Your prescription drug benefits are administered through a program called National Pharmaceutical Services (NPS). Under Federal Law, prescription drugs are only obtainable with a physician's prescription and must be dispensed by a licensed pharmacist.

Prescription drugs can be purchased from any participating pharmacy. At the time of purchase, present your identification card to the pharmacist. Co-pays or coinsurance are required at the time of purchase and are as listed in the benefit summary. Generic drugs are recommended unless the physician requests dispense as written, i.e., the physician specifically requests a brand name drug. If you specifically request a brand name drug when a generic is available, you will be responsible for the cost difference between the preferred drug and the generic drug in addition to the co-pay. You are limited as shown in the Schedule of Benefits.

When you purchase a prescription from a non-participating pharmacy, you will need to pay the full price and submit your receipt and a claim form to NPS. Because discounts are available when purchases are made through a participating pharmacy, you may not receive full reimbursement for your purchase at a non-participating pharmacy.

For information on prescription drug coverage, prior authorizations or claim forms please contact NPS at:

www.pti-nps.com, or 1-800-546-5677

Important Note: If you disagree with a reduction in or denial of benefits, please see the Claim Determination and Claim Review Procedure sections for information on how to file an appeal. These sections also outline the time frames in which the Plan must respond to your claim and/or appeal.

MAIL ORDER PRESCRIPTION DRUG BENEFITS

This Plan includes a mail order drug benefit for the purchase of maintenance drugs. Maintenance drugs are those medications which your physician has prescribed to treat an ongoing condition such as high blood pressure, diabetes or heart condition.

The mail order drug program is administered by NPS and can save you time by providing as much as a ninety (90) day supply for one mail order prescription co-pay or coinsurance. You are required to pay the generic/brand prescription co-pay or coinsurance as shown in the benefit summary at the time of purchase.

To take advantage of this optional benefit, please request a kit from your Human Resources Department or call First Administrators, Inc.

Please refer to the benefit summary for specific limitations.

Important Note: If you disagree with a reduction in or denial of benefits, please see the Claim Determination and Claim Review Procedure sections for information on how to file an appeal. These sections also outline the time frames in which the Plan must respond to your claim and/or appeal.

OTHER FACTS YOU SHOULD KNOW ABOUT YOUR HEALTH PLAN

COORDINATION OF BENEFITS

Coordination of benefits (COB) refers to a process that is utilized when you (or a family member) have other insurance or coverage that provides the same or similar benefits as this Plan. The benefits payable under this Plan, when combined with the benefits paid under your other coverage, will not be more than 100 percent of either our payment arrangement amount or the other carrier's payment arrangement amount.

This Plan, utilizing its normal benefit calculation method, will determine the amount to be paid and then subtract the payment(s) made by plans determined to be primary. The sum of all payments will never exceed the actual charge.

When you receive services, you need to let us know that you have other coverage. Other coverage includes: group insurance; other group benefit plans (e.g., HMOs, PPOs, and self-insured programs); Medicare or other governmental benefits; and the medical benefits coverage in your automobile insurance (whether issued on a fault or no fault basis). To help us coordinate your benefits, you should:

- Inform your provider by giving him/her information about your other coverage at the time you receive services. Your provider will pass the information on to us when the claim is filed.
- Indicate that you have other coverage when you fill out a claim form by completing the appropriate boxes on the form. You will receive a letter from us if we need any additional information.

It is important that you provide us with the requested information concerning your other coverage. If you do not give us the necessary information, your claims will be denied.

The following guidelines will be used to determine which plan will be primary:

- (a) If one plan has a COB provision and the other does not, the plan without a COB clause will be primary;

- (b) The medical benefits of your auto coverage will pay before this Plan if the auto coverage does not contain a coordination of benefits provision that specifies it is secondary or excess to health insurance or health benefit plans;
- (c) If both plans have a COB clause, the plan covering you as an employee will be primary over the plan covering you as a dependent;
- (d) If you are the main person covered under both plans (you are not a dependent under either plan), the plan that has provided coverage the longest will be primary;
- (e) The plan covering you as an active participant will pay before the plan covering you as an inactive participant. Participants in retiree plans, COBRA or other similar continuation coverage are considered inactive participants;
- (f) For a dependent child, the primary plan is the plan of the parent whose birthday (excluding year of birth) occurs earlier in the calendar year. For example, if the father's birthday is June 1 and the mother's birthday is May 1, the mother's plan would be primary for the children;
- (g) If both parents have the same birth month and day, the plan which has been in effect longest would be primary;
- (h) When the parents of a dependent child are divorced or separated and the parent with custody has not remarried, that parent's plan is primary for the child. The plan of the parent without custody pays second. When the parent with custody has remarried, that parent's plan is primary, the stepparent's plan is secondary and the plan of the parent without custody will be coverage of last resort. If there is a court decree which stipulates which parent has financial responsibility for the medical bills for the dependent child, the benefits of that parent's plan will be determined before the benefits of any other plans which cover the child as a dependent; and
- (i) If none of the guidelines listed above apply, the plan which has covered you or your dependent the longest will be primary.

Special Rules for SelectFirst™ Providers

If this Plan is the secondary payer, and the provider is a SelectFirst™ participating provider, the billed charges will be subject to the SelectFirst™ fee schedule or discount. This Plan's payments as secondary payer, combined with the primary payer's payment, will never exceed the allowable payment according to the SelectFirst™ fee schedule or discount arrangement.

MEDICARE AS SECONDARY PAYER

Since 1980, Congress has passed legislation making Medicare the secondary payer and group health plans the primary payer in a variety of situations. These laws apply only if you have both Medicare and health coverage under this Plan and this Plan has the minimum required number of employees as described in the following paragraphs.

Working Aged

This provision applies only to group health plans of employers with at least twenty (20) employees for each working day for at least twenty (20) calendar weeks in the current or preceding year. Under this provision, Medicare is the secondary payer if the beneficiary is both of the following:

- age sixty-five (65) or older; and
- a current employee or spouse of a current employee covered by an employer group health plan.

Working Disabled

This provision applies only to group health plans of employers that had at least 100 full-time, part-time, or leased employees on at least 50% of the regular business days during the preceding calendar year. Under this provision, Medicare is the secondary payer if the beneficiary is all of the following:

- under age sixty-five (65);
- a recipient of Medicare disability benefits; and
- a current employee, or a spouse or dependent of a current employee, covered by an employer group health plan.

End-Stage Renal Disease (ESRD)

The ESRD requirements apply to group health plans of all employers, regardless of the number of employees. Under these provisions, Medicare is

the secondary payer during the first thirty (30) months of Medicare coverage if both of the following are true:

- the beneficiary has Medicare coverage as an ESRD patient; and
- the beneficiary is covered by an employer group health plan.

If the beneficiary is already covered by Medicare due to age or disability and becomes eligible for Medicare ESRD coverage, Medicare generally is the secondary payer during the first thirty (30) months of ESRD eligibility. However, if the group health plan is secondary to Medicare (based on other Medicare secondary payer requirements) at the time the beneficiary becomes covered for ESRD, the group plan remains secondary to Medicare.

The above provisions are a general summary of the laws, which may change from time to time. For more information, contact your employer or the Social Security Administration.

MEDICARE AS PRIMARY PAYER

When the foregoing subsection "Medicare as Secondary Payer" does not apply, benefits otherwise payable under this Plan for allowable expenses shall be reduced so that the sum of benefits payable under this Plan and Medicare shall not exceed the total of such allowable expense. Benefits shall be payable under this Plan after Medicare benefits have been paid whether or not such participant is disabled and not in an active employment status and under or over age sixty-five (65), other than as specified for an ESRD beneficiary in the foregoing subsection.

Benefits shall be considered payable by Medicare for purposes of this section whether or not the participant eligible for Medicare benefits:

- has enrolled in or applied for benefits under Medicare;
- has failed to take any other action required by Medicare to qualify for benefits; or
- received benefits payable by Medicare if services were received in a facility to which Medicare would have paid.

In the event a participant enters into a private contract with a Physician in accordance with Medicare private contracting arrangements, this Plan shall not coordinate benefits or assume a primary payer position on any such participant.

RELEASE OF INFORMATION

The Benefit Services Administrator may, without notice to or consent of the covered person, release to or obtain from any insurance company or other organization or person any information regarding coverage, expenses, and benefits which the Benefit Services Administrator, at its sole discretion, considers necessary to apply the provisions of this Plan.

RIGHT OF RECOVERY

Whenever benefits have been paid in excess of the minimum amount necessary to satisfy the intent of the Coordination of Benefits provision (***established so a covered person cannot profit from this Plan***), the Plan Administrator will have the right to recover those payments to the extent of the excess amount from any one or more of the following as the Plan Administrator determines:

- any persons to whom such payments were made; or
- any insurance companies or any other organizations.

The Plan Administrator will also have the right to cause the payment of any amounts it determines to be warranted to satisfy the intent of the Coordination of Benefits provision of this Plan to any organizations making payments under other plans which should have been made under this Plan.

THIRD PARTY REIMBURSEMENT

If benefits have been paid or are payable under this Plan for services received by a participant, and it is later established that the charges for these services were not paid or are not payable by the participant or that the participant was otherwise reimbursed or may be reimbursed, except by insurers of policies of health insurance issued to the participant as an individual, this Plan will be entitled to a refund of the amount of the benefits paid which are in excess of the benefits that would have been payable based on the actual charges incurred and paid.

SUBROGATION

Payment Condition

The Plan, in its sole discretion, may elect to conditionally advance payment of medical benefits in those situations where an injury,

sickness, disease or disability is caused in whole or in part by, or results from the acts or omissions of Covered Employee or their dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this section as "Plan Beneficiary") or a third party, where other insurance is available, including but not limited to no-fault, uninsured motorist, underinsured motorist, and medical payment provisions (collectively "Coverage").

Plan Beneficiary, his or her attorney, and/or legal guardian of a minor or incapacitated individual agrees that acceptance of the Plan's payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain one hundred percent (100%) of the Plan's payment of benefits or the full extent of payment from any one or combination of first and third party sources in trust, without disruption except for reimbursement to the Plan or the Plan's assignee. By accepting benefits the Plan Beneficiary agrees the Plan shall have an equitable lien on any funds received by the Plan Beneficiary and/or their attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The Plan Beneficiary agrees to include the Plan's name as a co-payee on any and all settlement drafts.

In the event a Plan Beneficiary settles, recovers, or is reimbursed by any third party or Coverage, the Plan Beneficiary agrees to reimburse the Plan for all benefits paid or that will be paid. If the Plan Beneficiary fails to reimburse the Plan out of any judgment or settlement received, the Plan Beneficiary will be responsible for any and all expenses (fees and costs) associated with the Plan's attempt to recover such money.

Subrogation

As a condition to participating in and receiving benefits under this Plan, the Plan Beneficiary agrees to subrogate the Plan to any and all claims, causes of action or rights that may arise against any person, corporation and/or entity and to any Coverage to which the Plan Beneficiary is entitled, regardless of how classified or characterized.

If a Plan Beneficiary receives or becomes entitled to receive benefits, an automatic equitable subrogation lien attaches in favor of the Plan to any claim, which any Plan Beneficiary may have against any party causing the sickness or injury to

the extent of such payment by the Plan plus reasonable costs of collection.

The Plan may in its own name or in the name of the Plan Beneficiary commence a proceeding or pursue a claim against any third party or Coverage for the recovery of all damages to the full extent of the value of any such benefits or payments advanced by the Plan.

If the Plan Beneficiary fails to file a claim or pursue damages against:

- a) the responsible party, its insurer, or any other source on behalf of that party;
- b) any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
- c) any policy of insurance from any insurance company or guarantor of a third party;
- d) worker's compensation or other liability insurance company; or,
- e) any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverages.

the Plan Beneficiary authorizes the Plan to pursue, sue, compromise or settle any such claims in the Plan Beneficiary's and/or the Plan's name and agrees to fully cooperate with the Plan in the prosecution of any such claims. The Plan Beneficiary assigns all rights to the Plan or its assignee to pursue a claim and the recovery of all expenses from any and all sources listed above.

Right of Reimbursement

The Plan shall be entitled to recover 100% of the benefits paid, without deduction for attorneys' fees and costs or application of the common fund doctrine, make whole doctrine, or any other similar legal theory, without regard to whether the Plan Beneficiary is fully compensated by his/her recovery from all sources. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any state prohibiting assignment of rights which interferes with or compromises in any way the Plan's equitable subrogation lien. The obligation exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses. If the Plan Beneficiary's recovery

is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved.

No court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of litigation may be deducted from the Plan's recovery without the prior, expressed written consent of the Plan.

The Plan's right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of the Plan Beneficiary, whether under the doctrines of causation, comparative fault or contributory negligence, or other similar doctrine in law.

Accordingly, any lien reduction statutes, which attempt to apply such laws and reduce a subrogating Plan's recovery will not be applicable to the Plan and will not reduce the Plan's reimbursement rights.

These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgment of these rights is required by the Plan and signed by the Plan Beneficiary.

This provision shall not limit any other remedies of the Plan provided by law. These rights of subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable sickness, injury, disease or disability.

Excess Insurance

If at the time of injury, sickness, disease or disability there is available, or potentially available any Coverage (including but not limited to Coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of Coverage. The Plan's benefits shall be excess to:

- a) the responsible party, its insurer, or any other source on behalf of that party;
- b) any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
- c) any policy of insurance from any insurance company or guarantor of a third party;
- d) worker's compensation or other liability insurance company; or
- e) any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverages.

Wrongful Death Claims

In the event that the Plan Beneficiary dies as a result of his or her injuries and a wrongful death or survivor claim is asserted against a third party or any Coverage, the Plan's subrogation and reimbursement rights shall still apply.

Obligations

It is the Plan Beneficiary's obligation:

- a) to cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the Plan's rights;
- b) to provide the Plan with pertinent information regarding the sickness, disease, disability, or injury, including accident reports, settlement information and any other requested additional information;
- c) to take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights;
- d) to do nothing to prejudice the Plan's rights of subrogation and reimbursement;
- e) to promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received; and
- f) to not settle or release, without the prior consent of the Plan, any claim to the extent that the Plan Beneficiary may have against any responsible party or Coverage.

If the Plan Beneficiary and/or his or her attorney fails to reimburse the Plan for all benefits paid or to be paid, as a result of said injury or condition, out of any proceeds, judgment or settlement received, the Plan Beneficiary will be responsible for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Plan Beneficiary.

Offset

Failure by the Plan Beneficiary and/or his or her attorney to comply with any of these requirements may, at the Plan's discretion, result in a forfeiture of payment by the Plan of medical benefits and any funds or payments due under this Plan may be withheld until the Plan Beneficiary satisfies his or her obligation.

Minor Status

In the event the Plan Beneficiary is a minor as that term is defined by applicable law, the minor's parents or court-appointed guardian shall cooperate in any and all actions by the Plan to seek and obtain requisite court approval to bind the minor and his or her estate insofar as these subrogation and reimbursement provisions are concerned.

If the minor's parents or court-appointed guardian fail to take such action, the Plan shall have no obligation to advance payment of medical benefits on behalf of the minor. Any court costs or legal fees associated with obtaining such approval shall be paid by the minor's parents or court-appointed guardian.

Language Interpretation

The Plan Administrator retains sole, full and final discretionary authority to construe and interpret the language of this provision, to determine all questions of fact and law arising under this provision, and to administer the Plan's subrogation and reimbursement rights. The Plan Administrator may amend the Plan at any time without notice.

Severability

In the event that any section of this provision is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining sections of this provision and Plan. The section shall be fully severable. The Plan shall be construed and enforced as if such invalid or illegal sections had never been inserted in the Plan.

WORKERS' COMPENSATION

This Plan is not meant to be a substitute for workers' compensation. Any benefits paid by this Plan which are determined to be the liability of any workers' compensation plan of benefits will be refunded to this Plan by the participant and/or his/her heirs or estate. Any participant hereby agrees to reimburse this Plan for any payments so made under this Plan out of any monies recovered from any workers' compensation plan as the result of judgment, settlement or otherwise, and the participant does agree to take such action, to furnish such information and assistance, and to execute and deliver all necessary instruments as the Plan Administrator may require to facilitate the enforcement of this Plan's rights and not to prejudice those rights. Any portion of any settlement that is agreed upon which is for future

expenses will also be recoverable under this Plan, as those expenses occur.

OVERPAYMENT OF CLAIMS

Each participant hereby authorizes the deduction of any excess benefit received or benefits which should not have been paid, from any present or future compensation payments.

CONFORMITY WITH LAW

To the extent not pre-empted by ERISA, this Plan shall be governed by the laws of the state of Iowa. If any provision of this Plan is contrary to any law to which it is subject, or if a law relevant to this Plan is not specifically addressed within the contents of pertinent documents, such provision will be amended to satisfy the law's minimum requirement.

CLAIMS FILING AND APPEALS

ASSIGNMENT OF BENEFITS

In Network Area

Because of a contractual agreement with SelectFirst™, benefits will be automatically assigned to participating providers. This Plan will not honor assignment of benefits received for any other physicians or facilities. These benefits will be sent directly to the participant. Providers who do not participate in this network will not have benefits directly assigned to them. It is the participant's responsibility to make full payment to a non-participating provider.

Out-of-Area

This Plan accepts all assignments of benefits to make direct payments to providers of service, including, but not limited to, physicians, hospitals, and nursing facilities.

In General

Unless applicable law otherwise requires, no amount payable at any time will be subject in any manner to alienation by anticipation, sale, transfer, assignment, bankruptcy, pledge, attachment, charge or encumbrance of any kind and any attempt to alienate, sell, transfer, assign, pledge, attach, charge or otherwise encumber any amount, whether presently or at a later date payable, will be void. This Plan will not be liable for, or subject to, the debts or liabilities of any person entitled to any amount payable under this Plan. If by reason of the bankruptcy or other event happening at any such time such amount would not be enjoyed by them, then the Plan Administrator in its sole discretion, may terminate their interest in any such amount and will hold or apply it to or for the benefit of the participant, their spouse, children or other dependents, or any of them, in such manner as the Plan Administrator may deem proper.

FILING OF CLAIMS

SelectFirst™ Participating Physicians

SelectFirst™ physicians agree to submit claims for all covered services provided to SelectFirst™ participants.

SelectFirst™ Participating Hospitals

Participating hospitals are required to submit billings for covered services provided to SelectFirst™ participants.

All Other Providers

Claims must be received within twelve (12) months of the day charges are incurred to be eligible for benefits.

Whenever you obtain healthcare services you should present your healthcare identification card. Instructions for billing by the provider of care or the member are included on the member identification card. Physicians, hospitals, and clinics may file claims for you; however you are ultimately responsible for the filing of your claims.

A paper claim will be considered filed when a healthcare claim has been received by the Benefit Services Administrator (if the claim requires off-site PPO pricing, the date the priced claim is received from the PPO vendor). Electronic claims are considered received the day subsequent to the transmission of the claim by the provider. There are specific fields that are required for each type of claim to constitute a "clean claim". This criteria is available, upon request, from the Benefit Services Administrator.

For claims not filed by the provider of service, the following steps should be taken to ensure that claims are filed correctly. Your employer will provide you with claim forms.

- (1) Claims must be received within twelve (12) months of the day charges are incurred.
- (2) Complete the personal section of the claim form. Be sure to indicate any other group, franchise or association-sponsored plan you have in addition to this Plan.
- (3) Sign the assignment of benefits portion of the claim form. Unless assigned, benefit payments will be directed to you.
- (4) Either have the provider complete the appropriate section or attach the original itemized bill to the claim form. This bill should identify the patient, the date, the nature of treatment or service and the amount charged. Canceled checks or cash receipts do not contain the information needed to process a claim.
- (5) Sign and date the form in the authorization section.
- (6) Use a separate claim form for each member of the family and retain a copy for your files.

(7) All claims should be mailed to:

First Administrators, Inc.
Claims Department
P.O. Box 9900
Sioux City, IA 51102-0479

CLAIM DETERMINATION

This section describes the procedures the Plan will follow in making a determination on a claim for benefits. A claim is any request for a plan benefit, made by a claimant or a representative of a claimant, that complies with the Plan's reasonable procedure for making benefit claims.

Upon receipt of a claim, the Plan must respond to the participant within the time frames stated below. These time frames are the maximum number of calendar days in which a determination must be made and communicated to the participant.

Urgent Care Claims

An urgent care claim is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the participant or the participant's ability to regain maximum function, or, in the opinion of a physician with knowledge of the participant's medical condition, would subject the participant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

The participant's physician may determine if the claim is an urgent care claim. Otherwise, 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.

A response to an urgent care claim will be provided within seventy-two (72) hours of the receipt of the claim by the Plan. If a participant fails to provide sufficient information, the Plan will notify the participant within twenty-four (24) hours of receiving the claim of the specific information necessary to complete the claim. The participant will then have forty-eight (48) hours to provide the additional information and, once received, a decision will be communicated within forty-eight (48) hours. Without complete information, the claim will be denied.

Urgent care claims include, but are not limited to, requests for pre-certification. Please see the Utilization Review section for further information.

Pre-Service Claims

A pre-service claim is any claim for a benefit under this Plan with respect to which the terms of the Plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

If the participant fails to follow the Plan's procedures for filing a pre-service claim, the Plan will notify the participant of the failure and the proper procedures to be followed within five (5) days of such failure. Otherwise, a response to a pre-service claim will be provided within fifteen (15) days of the receipt of the claim by the Plan. This period may be extended one time by the Plan for up to fifteen (15) days if an extension is necessary due to matters beyond control of the Plan. The participant will be notified of the extension prior to the expiration of the initial fifteen (15) day period, the circumstances requiring the extension and the date by which a decision is expected. If the extension is necessary due to the failure of the participant to provide sufficient information, the Plan will notify the participant of the specific information necessary to complete the claim. The participant will then have forty-five (45) days to provide the additional information and, once received, a decision will be communicated within fifteen (15) days. Without complete information, the claim will be denied. If the Plan does not provide a notice of extension within fifteen (15) days, the participant has the right to begin an appeal, as outlined in the Claim Review Procedures section.

Pre-service claims include, but are not limited to, requests for pre-certification. Please see the Utilization Review section for further information.

Concurrent Care Claims

Concurrent Care is an ongoing course of treatment (inpatient or outpatient) to be provided over a period of time or number of treatments which has been approved by the Plan. If ongoing treatment benefits are reduced or terminated by the Plan before the end of the period for which such treatment was approved, the participant will be notified sufficiently in advance to allow the participant to appeal the adverse determination and obtain a decision on the appeal before the reduction or termination goes into effect.

If a participant requests an extension of a course of treatment that is an urgent care claim as defined above, the Plan will notify the participants of its determination within twenty-four (24) hours of the Plan's receipt of the request.

If the participant requests an extension of a course of treatment that is not an urgent care claim, the request will be considered a new claim and will be subject to the time frames and procedures that are appropriate to the type of claim (i.e., pre-service or post-service). Please refer to the appropriate section for timelines and procedures specific to these types of claims.

Post-Service Claims

A post-service claim is any claim for a benefit that is not a pre-service claim. Post-service claims are claims for services already received by the participant.

The Plan will respond to a post-service claim within thirty (30) days of receipt. This period may be extended one time by the Plan for up to fifteen (15) days if an extension is necessary due to matters beyond control of the Plan. The participant will be notified of the extension prior to the expiration of the initial thirty (30) day period and will be given the date by which a decision is expected. If the Plan does not provide a notice of extension within thirty (30) days, the participant has the right to begin an appeal, as outlined in the Claim Review Procedure section.

If a participant fails to provide sufficient information, the participant will be notified within thirty (30) days of the Plan's receipt of the claim of the specific information necessary to complete the claim. The participant will then have forty-five (45) days from receipt of the notice to provide the additional information, and once received, a decision will be communicated within fifteen (15) days. Without complete information, your claim will be denied.

NOTIFICATION OF DECISION

If a claim has been wholly or partially denied, written notification will be provided by the Plan which will describe:

- (a) the specific reason(s) for the denial;
- (b) reference to the specific Plan provision(s) on which the denial is based;
- (c) 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;
- (d) an explanation of this Plan's claims review procedure, including a statement of the claimant's right to bring civil action under ERISA section 502(2) following an adverse benefit determination;

- (e) a copy of any internal rule, guideline, protocol or other similar criterion relied upon in denying the claim or in lieu thereof, a statement that such information is available free of charge upon request;
- (f) An explanation of the scientific or clinical judgment relied upon in denying the claim based on medical necessity, experimental treatment or similar exclusion or limit, applying the terms of the Plan to the participant's medical circumstances or, in lieu thereof, a statement that such information is available free of charge upon request; and
- (g) For urgent care claims, a description of the expedited appeal process.

For urgent care claims, this information may be provided to the participant orally, provided that written notification is furnished within three (3) days of the oral notification.

CLAIM REVIEW PROCEDURE

Claim Inquiry

If a claim has been wholly or partially denied, and if the claimant does not agree with the decision to reduction, or if the claimant has a complaint regarding a claim, he/she may make an inquiry by calling the number listed on the Notification of Decision.

Filing an Appeal

In case of an adverse benefit determination, the claimant has the right to a full and fair review. An adverse benefit determination is a denial reduction or termination of a benefit.

With the exception of urgent care claims, the request to review a claim must be in writing and must be submitted to the address on the notification of decision. This request must be submitted within 180 days following the receipt of the adverse benefit determination. For information on appealing an adverse benefit determination of an urgent care claim, see the Urgent Care Claim section below.

The claimant may submit written comments, documents, or other information in support of the appeal. The participant will be provided, upon request and free of charge, reasonable access to and copies of all relevant records used in making the decision. The review will take into account all information regarding the denied or reduced claim whether or not presented or available at the initial determination.

The review will be conducted by someone other than the original decision maker(s) and without regard to the original decision. If a decision requires medical judgment, an appropriate medical expert who was not previously involved in your case will be consulted. If the decision on appeal is adverse, you may request in writing the identity of the medical expert who was consulted.

Urgent Care Claims

For appeals involving urgent care claims, the claimant may request either orally or in writing an expedited appeal. For an expedited appeal, information, including the decision, will be communicated by telephone, facsimile, or other similarly prompt method.

Notification of the decision on appeal will be provided within seventy-two (72) hours of the Plan's receipt of the appeal request.

Pre-Service Claims

For appeals involving pre-service claims, notification of the decision will be provided within thirty (30) days of the Plan's receipt of the appeal request.

Concurrent Care Claims

If a participant appeals an adverse benefit determination of a claim involving an ongoing course of treatment, the decision on appeal will be made according to the time frames and procedures that are appropriate to the type of claim (i.e., urgent care, pre-service or post-service). Please refer to the appropriate section for timeliness and procedures specific to these types of claims.

Post-Service Claims

For appeals involving post-service claims, notification of the decision will be provided within sixty (60) days of the Plan's receipt of the appeal request.

NOTIFICATION OF DECISION ON APPEAL

If the decision on appeal is adverse, written notification will be provided by the Plan that will describe:

- (a) specific reason(s) for adverse determination;
- (b) reference to the specific Plan provision(s) on which determination is based;
- (c) a statement that the participant is entitled to receive, upon request and at no cost, reasonable access to, and copies of all

documents, records and other information relevant to the participant's claim for benefits;

- (d) a statement describing any voluntary appeal procedures offered by the Plan and the participant's right to obtain information about such procedures, as well as the right to bring civil action as described in ERISA Section 502(a);
- (e) a copy of any internal rule, guideline, protocol or other similar criterion if relied upon in making the adverse determination or, in lieu thereof, a statement that such information is available free of charge upon request; and
- (f) an explanation of the scientific or clinical judgment relied upon in making the adverse determination, based on medical necessity, experimental treatment or similar exclusion or limit, applying the terms of the Plan to the participant's medical circumstances or, in lieu thereof, a statement that such information is available free of charge upon request.

AUTHORIZED REPRESENTATIVE

You may authorize another person to represent you and with whom you want us to communicate regarding specific claims or an appeal. This authorization must be in writing, signed and dated by you, and include all the information required in our Authorized Representative form. This form is available from your employer. In a medically urgent situation your treating health care practitioner may act as your authorized representative without completion of the Authorized Representative form. An assignment of benefits, release of information, or other similar form that you may sign at the request of your health care provider does not make your provider an authorized representative. You can revoke the authorized representative at any time, and you can authorize only one person as your representative at a time.

DEFINITIONS

"ACCIDENTAL INJURY" means an injury, independent of disease or bodily infirmity of any other cause, which happens by chance.

"ACTIVELY AT WORK" means the performance of the essential functions of the participant's regular position including duties performed on sabbatical, with or without reasonable accommodation, at the participant's normal place of work or any other location directed or approved by Drake University.

"ACTIVELY AT WORK ON A FULL-TIME BASIS" means an employee must work for Drake University at his normal place of work or such other place or places as directed by Drake University in the course of such work for at least nine months per calendar year and for no less than thirty two (32) hours per week.

"ADOPTED CHILD(REN)" means any child legally placed in an employee's home by an adoption agency who meets the eligibility requirements of this Plan, whether or not the adoption is final. Placement is defined as the assumption and retention of a legal obligation for total or partial support of a child in anticipation of adoption of such child.

"ADVERSE BENEFIT DETERMINATION" means a denial, reduction, or termination of a benefit.

"ALLOWABLE EXPENSES" mean the portion of an eligible expense actually payable by this Plan, after taking into account co-pay, deductible, and coinsurance amounts, any applicable benefit maximum or maximums, and any other limitation or exclusion provided for under this Plan. This calculation is based on the payment method utilized by this Plan.

"ALTERNATE RECIPIENT" means any child of a participant who is recognized under a Qualified Medical Child Support Order (QMCSO) as having a right to enrollment in this Plan with respect to such participant.

"AMBULATORY/OUTPATIENT SURGERY FACILITY" provides surgical services on an outpatient basis for patients who do not need to occupy an inpatient, acute care hospital bed.

"AMENDMENT" means a formal document that changes a provision of this Plan, duly signed by the authorized person or persons as designated by Drake University.

"BENEFIT SERVICES ADMINISTRATOR" means First Administrators, Inc. an Iowa corporation.

"BENEFITS" mean those medically necessary services and supplies that qualify for payment under this Plan.

"BIRTHING CENTER" provides obstetrical care and related services on an outpatient basis.

"BRAND NAME PRESCRIPTION DRUG" means the pharmaceutical products manufactured and sold under the name assigned by the developer/manufacturer.

"BUSINESS ASSOCIATE" means a person or organization that performs a function or activity on behalf of a covered entity, but is not part of the covered entity's workforce. A business associate can also be a covered entity in its own right. (Also see Part II, 45 CFR 160.103).

"CALENDAR YEAR" means the twelve (12) month period commencing January 1 and ending the next following December 31.

"CHEMICAL DEPENDENCY" means any condition resulting from dependency on or abuse of a psychoactive substance as described in the *Diagnostic and Statistical Manual of Mental Disorders, Third Edition - Revised*, (DSM-III-R), published by the American Psychiatric Association or subsequent revisions to DSM-III-R.

"CHEMICAL DEPENDENCY FACILITY" is a licensed, free-standing facility approved by this Plan to provide treatment for chemical dependency conditions.

"CHILD(REN)" means unmarried child(ren) of a covered employee, under age nineteen (19), including natural children, adopted children (as defined), stepchildren, grandchildren or children for whom the employee or retiree has legal guardianship who are unmarried.

"CLAIM" means any request for a Plan benefit made by a claimant or a representative of a claimant that complies with the Plan's reasonable procedure for making benefit claims.

"COINSURANCE" means the percentage(s) of eligible expenses allocable to the participant and the employer after any applicable co-pays, calendar year deductibles, or non-compliance penalties have been applied.

"COMMUNITY MENTAL HEALTH CENTER" or "MENTAL HEALTH CLINIC" means a facility established for the purpose of providing consultation, diagnosis, and treatment in

connection with a mental health disorder, and approved as such by a state department or agency having authority over such facilities.

"CO-PAY" means the predetermined amount paid by the participant on a per item or per service basis.

"COSMETIC SERVICES" means treatment or surgical procedures intended to improve physical appearance, but which do not treat illness, restore, or materially improve a deficiency in normal physiological function. Cosmetic Services performed to alleviate psychological distress are not covered by the Plan.

"COVERED DEPENDENT" means a spouse/domestic partner or a dependent child who has satisfied the definition of dependent and the eligibility requirements.

"COVERED EMPLOYEE" means any employee who is eligible for benefits as specified, and enrolled.

"COVERED EXPENSES" means those expenses covered by this Plan, including the hospital, surgical, and medical care expenses described in this booklet. However, expenses are not covered if they are expressly excluded, are not medically necessary, are experimental or investigational in nature, or if they exceed the maximum amount considered by this Plan. See also the definitions of eligible expenses and allowable expenses.

"CREDITABLE COVERAGE" means coverage under a group health plan (including a governmental or church plan), health insurance coverage (either group or individual insurance, including COBRA continuation coverage, or short-term "bridge" policy), Medicare, Medicaid, military-sponsored health care, a program of the Indian Health Service, a state health benefit risk pool, the Federal Employees Health Benefits Plan (FEHBP), a public health plan as defined in subsequent HCFA Centers for Medicare and Medicaid Services regulations, state Children's Health Insurance Program (S-Chip), public health plans provided by a foreign country or a political subdivision and any health benefit plan under Peace Corps Act 5(e).

"Creditable Coverage" does **not** include accident or disability income, liability, workers' compensation, automobile medical insurance, health coverage for limited benefits, such as limited scope dental or vision benefits or long-term care plans, or plans under which health benefits are secondary or incidental.

"CUSTODIAL CARE" helps you with your daily living activities. This type of care does not require the continuing attention and assistance of licensed medical or trained paramedical personnel. Some examples of custodial care are assistance in walking and getting in and out of bed; aid in bathing, dressing, feeding and other forms of assistance with normal bodily functions, preparation of special diets; and supervision of medication which usually can be self-administered. Custodial care is not a benefit under this Plan.

"DEDUCTIBLE" is the amount for covered services you pay before this Plan begins paying benefits.

"DEPENDENT" means any one or more of the following:

- (a) The spouse/domestic partner of an employee/retiree;
- (b) Unmarried children of an employee/retiree under the age of nineteen (19), including natural children, adopted children (as defined), stepchildren, grandchildren for whom the employee/retiree or their spouse/domestic partner have custody if custody is required by a court order and children for whom the employee/retiree has been granted legal custody;
- (c) Unmarried children of an employee/retiree including natural children, adopted children (as defined), stepchildren, grandchildren for whom the employee/retiree or their spouse/domestic partner have custody if custody is required by a court order and children for whom the employee/retiree has been granted legal custody who have attained age nineteen (19) but who have not attained age twenty-six (26) and who are full-time students in an accredited educational institution; and
- (d) Unmarried children of an employee/retiree, natural children, adopted children (as defined), stepchildren or grandchildren for whom the employee/retiree or their spouse/domestic partner have custody if custody is required by a court order and children for whom the employee/retiree has been granted legal custody are incapable of self-sustaining employment due to mental or physical disability, provided such disability commenced prior to attainment of the termination age specified in this Plan and such children were covered prior to attainment of such age and continuously thereafter under this Plan or a predecessor plan.

"DISABLED" means the temporary inability of a covered employee to perform each and every regular duty pertaining to his/her occupation or employment for compensation or profit, or the temporary inability of a covered dependent to engage in the normal activities of a person in good health of like age and sex.

"DOMESTIC PARTNER" means an individual who:

- is at least eighteen (18) years of age and of the same gender as the employee;
- has executed a notarized "relationship contract", which obligates each partner to provide support for the other and to act as each other's sole domestic partner indefinitely;
- is not able to qualify for coverage as a common law spouse;
- is not legally married or covered under any other domestic partnership arrangement with Drake University;
- is not related by blood closer than would bar marriage in the state of Iowa, and each partner is mentally competent to consent to the contract; and
- the partners have been residing together for at least six (6) continuous months immediately prior to filing the "Affidavit of Domestic Partnership".

"DOMICILIARY CARE" means inpatient institutional care provided to the participant not because it is medically necessary, but because care in the home setting is not available, is unsuitable, or members of the patient's family are unwilling to provide care. Institutionalization because of abandonment constitutes domiciliary care. Domiciliary care is not a benefit under this Plan. Some examples of domiciliary care for which benefits are not payable:

- home care is not available, such as where institutionalization is primarily because parents work or where a hospital stay is extended beyond what is medically necessary because the patient lives alone;
- home care is not suitable, such as where a child is institutionalized because a parent(s) is an alcoholic who is not responsible enough to care for the child or because someone in the home has a contagious disease; or
- the family is unwilling to care for a person in the home, such as where a family does not

want to handle a child who is difficult to manage.

"DURABLE MEDICAL EQUIPMENT" means medical equipment not otherwise excluded, which is designed for repeated use, is primarily and customarily used to serve a medical purpose, and is not useful to a person in the absence of an injury or illness. For the purpose of determining whether a piece of equipment constitutes durable medical equipment for coverage under this Plan, First Administrators, Inc. may consult the equipment list compiled from time to time for use in the administration of the Medicare program. Examples of durable medical equipment include, but are not limited to, wheelchairs, hospital beds, and respirators. Air conditioners, humidifiers, dehumidifiers, air purifiers, and other similar convenience items are not considered durable medical equipment.

"EFFECTIVE DATE" means the first day that benefits under this Plan would be in effect, after satisfaction of the waiting period, if applicable, and any other provisions or limitations contained herein.

"ELECTIVE SURGICAL PROCEDURE" means a non-emergency surgery that can be scheduled at any time without risking the patient's life or risking serious impairment to the patient's bodily functions.

"ELIGIBLE EXPENSE" means the portion of a covered expense which is considered for payment under this Plan. If the course or manner of treatment of a condition is expressly excluded by this Plan, is not medically necessary, is experimental, investigational or otherwise regarded by the Plan Administrator to be ineffective treatment for the condition, or not included because of any reason described in the Plan, then the expense for the treatment is not eligible. See the definition of allowable expense for a description of how this Plan computes the portion of an eligible expense which it will pay.

"EMERGENCY" means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson, possessing an average knowledge of health and medicine, could reasonably expect absence of immediate medical attention to result in one of the following:

- Placing the health of the individual or, with respect to a pregnant woman, the health of the woman and her unborn child, in serious jeopardy;

- Serious impairment to bodily function; or
- Serious dysfunction of any bodily organ or part.

"**EMPLOYEE**" means any individual who is employed by Drake University.

"**ENROLLMENT DATE**" or "**DATE OF ENROLLMENT**" means the first day of a participant's waiting period under this Plan (typically, the date the employee's employment begins). The enrollment date for a late enrollee, or anyone who enrolls during a special enrollment period, is the first day of coverage under this Plan. For those to whom no waiting period applies, the enrollment date is the date of employment.

"**ERISA**" means the Employee Retirement Income Security Act of 1974, a federal law protecting your rights under this Plan.

"**EXPERIMENTAL OR INVESTIGATIONAL SERVICES OR SUPPLIES**" mean that one or more of the following is true:

- the device, drug or medicine 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 device, drug or medicine is furnished;
- 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 and approval, and furthermore, that the treating facility's Institutional Review Board is reviewing such drug, device, treatment or procedure as being experimental or investigational;
- reliable evidence shows that the treatment, procedure, device, drug or medicine is the subject of ongoing phase I, II or III clinical trials or is under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis; and/or
- reliable evidence shows that the consensus of opinion among experts regarding the treatment, procedure, device, drug or medicine 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 the standard means of treatment or diagnosis.

Reliable evidence means 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 treatment, procedure, device, drug or medicine; or the written informed consent used by the treating facility or by another facility studying substantially the same treatment, procedure, device, drug or medicine.

In addition, no reimbursement is available for payments of any: (1) treatments, services or supplies that are educational or provided primarily for research; or (2) treatments, procedures, devices, drugs or medicines or other expense relating to transplants of nonhuman organs.

"**FEE SCHEDULE**" means a contractually specified amount payable for physician's services within the Network area.

"**FULL-TIME STUDENT**" means a covered dependent who meets the age requirements of this Plan, is enrolled in a full-time (as defined by the institution they are attending) course of study in an approved institution of higher learning and is principally dependent upon the covered employee/retiree, covered spouse/domestic partner for his/her support and maintenance as defined by the Internal Revenue Service for tax purposes. Dependents who are attending, full-time, other institutions for advanced education (i.e., trade schools), will also be considered full-time students.

"**GENERIC PRESCRIPTION DRUGS**" mean the pharmaceutical products manufactured and sold under their common chemical or non-proprietary name. The generic equivalent of a brand name drug must meet the same standards for safety, purity, strength, and effectiveness as the brand name drug. Both have the identical chemical composition and therapeutic effect.

"**HIPAA**" means the Health Insurance Portability and Accountability Act, a Federal law that allows persons to qualify immediately for comparable health insurance coverage when they change their employment relationships. Title II, Subtitle F, of HIPAA gives Health and Human Services (HHS) the authority to mandate the use of standards for the electronic exchange of health care data; to specify what medical and administrative code sets should be used within those standards; to require the use of national identification systems for health care patients, providers, payers (or plans) and

employers (or sponsors); and to specify the types of measures required to protect the security and privacy of personally identifiable health care information. (Also known as the Kennedy-Kassebaum Bill, the Kassebaum-Kennedy Bill, K2, or Public Law 104-191).

"HOME HEALTH AGENCY" is a Medicare approved association or organization which provides skilled nursing care in your home.

"HOME HEALTH SERVICES" are health care services performed in your home by a home health agency.

"HOSPICE" provides care (usually in the home) for patients who are terminally ill and have a life expectancy of six (6) months or less. The Hospice must be accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), be Medicare approved, and/or be licensed by the state in which it operates.

"HOSPICE SERVICES" include home health care plus respite services.

"HOSPITAL" is an institution that primarily provides diagnostic and therapeutic services for surgical and medical diagnosis, treatment and care of injured or ill persons. The facility must be licensed as a hospital under applicable laws.

"HOSPITAL CONFINEMENT" means being registered for a minimum of eighteen (18) hours as a bed patient in a hospital, nursing facility or chemical dependency facility upon the recommendation of a physician or as a patient in a hospital because of a surgical operation or receiving emergency care in a hospital for an injury within forty-eight (48) hours after the injury is received.

"ILLNESS" means any bodily disorder, bodily injury, disease or mental health condition including pregnancy and complications of pregnancy.

"IMMEDIATE FAMILY" means a participant's legal spouse/domestic partner, parents, children, grandparents and siblings (brothers and/or sisters). This includes such persons whether related by blood or marriage (in-laws).

"IMMUNIZATION" is an injection with a specific antigen to promote antibody formation to make you immune to a disease or less susceptible to a contagious disease.

"INFERTILITY" means the inability or diminished ability to produce offspring.

"INJURY" means a physical condition which is the result of an accident caused by an external force

and occurring while this Plan is in effect, with respect to that participant, and which results in loss covered by this Plan; or a condition caused as the result of an incident which is precipitated by an act of unusual circumstances likely to result in unexpected consequences; the condition must be an instantaneous one, rather than one which continues, progresses or develops.

"INPATIENT" means being confined in a hospital or a nursing facility as a resident patient and subject to at least one day's room and board charges by the hospital, nursing facility or chemical dependency facility.

"INTENSIVE CARE UNIT" means a unit exclusively reserved for critically and seriously ill or injured patients requiring constant audiovisual observation as prescribed by the attending physician which provides room and board, specialized registered nurse (RN) and other nursing care, and special equipment or supplies immediately available on a stand-by basis segregated from the rest of the hospital's facilities.

"LATE ENROLLEE" means a participant or beneficiary who enrolls under this Plan other than during: (a) the first period in which the individual is eligible to enroll under this Plan; or (b) a special enrollment period.

"LEGEND DRUGS" mean those drugs classified within any of the five categories for drugs that come under the jurisdiction of the most recent Controlled Substance Act and which may only be dispensed by a licensed pharmacist upon the written prescription of a physician. Compounded medications of which at least one ingredient is classified as noted above shall be included.

"LICENSED PRACTICAL NURSE" means an individual who has received specialized nursing training and practical nursing experience and who is licensed to perform nursing services by the state in which he/she performs such services, other than one who ordinarily resides in the participant's home or who is a member of the participant's immediate family.

"LICENSED PUBLIC HEALTH NURSE" means a professional nurse who has the right to use the title registered nurse (RN), other than one who ordinarily resides in the patient's home or who is a member of the patient's immediate family, and who has extended their study in the public health field.

"LIFETIME" means the period of time a person is actually a participant under this Plan, commencing with the original effective date, and is not intended to imply or suggest benefits beyond an individual's

termination date or this Plan's termination date as herein specified.

"LOCAL AIR AND GROUND AMBULANCE" means medically necessary transportation to an appropriate inpatient or outpatient facility in the surrounding area where the ambulance transportation originated. To determine if the ambulance transportation is covered, this Plan considers if no other method of transportation is appropriate, that the services necessary to treat the injury or illness are not available in the hospital, nursing facility or chemical dependency facility in which the participant is an inpatient or outpatient and the point of destination is the nearest one with adequate and appropriate methods of care.

"MAINTENANCE DRUG" means the prescription drugs and medications which are prescribed to treat a chronic medical condition, such as hypertension, diabetes, and certain heart conditions.

"MAXIMUM ALLOWABLE FEE" means an amount established, using various methodologies, for covered services and supplies. The settlement amount is based on the lesser of the covered charge for a service or supply or the maximum allowable fee.

Information regarding the calculation and determination of the maximum allowable fee is available to you. Upon receiving your request for such information, First Administrators, Inc. or your group health plan sponsor will provide the following:

- the frequency of the determination of the maximum allowable fee;
- a general description of the methodology used to determine the maximum allowable fee, including geographic locations; and
- the percentile that determines the maximum benefit that we will pay for any procedure, if the maximum allowable fee is determined by taking a sample of fees submitted on actual claims and then determining the benefit by selecting a percentile of those fees.

"MAXIMUM LIFETIME BENEFIT" means the highest dollar amount of allowable expenses that could be paid to or on behalf of any participant during the participant's lifetime, subject to the terms of this Plan.

"MEDICALLY NECESSARY" means that a procedure, service or supply is all of the following:

- appropriate and necessary for the diagnosis and treatment of your injury or illness;

- consistent with professionally recognized standards of health care determined within the state in which you reside and given at the right time and in the right setting;
- not more costly than alternative services that would be effective for diagnosis and treatment of your condition; and
- enables the patient to make reasonable progress in treatment.

"MEDICARE" is the federal government's health insurance program established under Title XVIII of the Social Security Act for people age 65 and older and people of any age entitled to monthly disability benefits under the Social Security or Railroad Retirement Program. It is also available for those with chronic renal disease who require hemodialysis or kidney transplant.

"MENTAL HEALTH DISORDER" means any disorder classified in the *Diagnostic and Statistical Manual of Mental Disorders, Third Edition-Revised* (DSM-III-R), or subsequent revisions to DSM-III-R, and includes behavioral or psychological conditions not attributable to a mental disorder that are the focus of professional attention or treatment, but only to the extent services for such conditions are otherwise considered to be benefits under this Plan.

"NETWORK AREA" means the area encompassing the contracting Network.

"NETWORK MEMBER" or "NETWORK PROVIDER" means a contracted health care provider who is a member of a preferred provider organization utilized by this Plan.

"NON-NETWORK MEMBER" or "NON-NETWORK PROVIDER" means any health care provider who is not a contracting member of a preferred provider organization utilized by this Plan.

"NON-RESIDENTIAL TREATMENT PROGRAM" means a program established for the purpose of providing non-residential treatment of chemical dependency and approved as such by a state department or agency having authority over such programs.

"NOTIFICATION OF DECISION" means delivery or furnishing of information by the Plan to an individual regarding decision of the claim for benefits. Information is considered delivered or furnished as of the date it is mailed by or verbally provided by the Plan.

"NURSING FACILITY" provides continuous skilled nursing services as ordered and certified by your

attending physician. A registered nurse (RN) must supervise services and supplies on a twenty-four (24) hour basis. A nursing facility must also be licensed under the laws of the state in which it operates.

"OUT-OF-POCKET MAXIMUM" is a specified amount that you must pay for covered services, out of your pocket, in a calendar year. Your out-of-pocket maximum is satisfied as indicated on the benefit summary. Once you meet the out-of-pocket maximum, this Plan pays 100% of the allowable expenses.

"OUTPATIENT" means a participant who receives treatment at a hospital, clinic or dispensary or other medical care facility but is not confined to continuous twenty-four (24) hour inpatient care.

"PARTICIPANT" means any covered employee and any covered dependent.

"PHYSICIAN" means a provider of medical services legally licensed to practice medicine and surgery or any other legally licensed practitioner of the healing arts rendering, within the scope of the individual's license, services which are covered under this program and for which benefits are required to be provided by law when rendered by such a practitioner. In no event will the term "physician" include a resident physician, intern, or other individual in training, or a member of the participant's family.

"PLAN" means this Drake University Health Plan, as set forth herein, and as from time to time amended, which is administered by First Administrators, Inc., the Benefits Services Administrator.

"PLAN ADMINISTRATOR" means the person or persons appointed to administer this Plan, if any, otherwise, Drake University.

"PLAN SPONSOR" means an entity that sponsors a health plan. This can be an employer, a union or some other entity. (Also see Part II, 45 CFR 164.501).

"PLAN YEAR" means the twelve (12) consecutive month period commencing on June 1 and ending on the next following May 31.

"POST-SERVICE CLAIM" means a claim for benefits under the Plan that is not a pre-service claim. Post-service claims are claims for services already received by the participant.

"PREADMISSION TEST" means any diagnostic test or study required as part of a hospital's admission policy or which is necessary for a scheduled surgical procedure, and which is performed prior to a hospital confinement.

"PRE-EXISTING CONDITION" means any limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the effective date of coverage, whether or not any medical advice, diagnosis, care or treatment was recommended or received before that day.

"PREFERRED PROVIDER ORGANIZATION" means an organization composed of a group of health care providers who have contracted to offer their services at a discount rate in accordance with the formal agreement between the company and the preferred provider organization.

"PRESCRIPTION DRUG" means covered legend drugs, medicines or medications prescribed by a physician and dispensed by a licensed pharmacist necessary to treat an injury or illness.

"PRE-SERVICE CLAIM" means any claim for a benefit under this Plan with respect to which the terms of the Plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

"PRIVATE DUTY NURSING" means continuous bedside nursing service, rendered by one nurse to one patient, either in a hospital, nursing facility, hospice facility or the patient's home, as opposed to general duty nursing, which renders services to a number of patients in an inpatient setting.

"PROCUREMENT COSTS" mean those charges for services associated with the procurement of a human organ for transplant, including, but not limited to, surgical removal of an organ from a living donor, pathology and radiology services and services necessary to preserve the viability of the organ to be transplanted.

"PROSTHESIS" or "PROSTHETIC APPLIANCE" means a device used as an artificial substitute to replace a limb or an eye, used to improve, aid or augment the performance of a natural function. In no event will the term "prosthesis" include devices such as eyeglasses, hearing aids, orthopedic shoes, arch supports, orthotic devices, trusses, or examinations for the prescription or fitting thereof.

"PROTECTED HEALTH INFORMATION (PHI)" means individually identifiable health information (any health information that can be tied back to an individual). (See Part II, 45 CFR 164.501).

"PSYCHOLOGIST" means a person who holds a Ph.D. in clinical psychology, is recognized by the American Board of Examiners in Professional Psychology and who is licensed in and performs such services in accordance with the laws of the state in which such services are provided.

"QUALIFIED BENEFICIARY" means a participant who qualifies for continuation of coverage under the provisions of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, as then constituted or later amended.

"QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)" means a judgment, decree or order (including judicially approved settlement agreements having the effect of an order) which provides for child support with respect to a child of a participant under this Plan or provides health benefit coverage to such a child, and qualifies with the requirements set forth in this Plan. The QMCSO must be a judgment or decree issued by a court of competent jurisdiction or a state agency that administers child support enforcement programs.

"REGISTERED NURSE" means a professional nurse who has the right to use the title registered nurse (RN), other than one who ordinarily resides in the patient's home or who is a member of the patient's immediate family.

"REHABILITATION INSTITUTION" means a legally constituted and operated institution (other than a hospital) established to provide medical treatment for patients who require inpatient care for chemical dependency, but do not currently require continuous hospital services for such condition, and which has permanent facilities for inpatient medical care on the premises, including twenty-four (24) hour nursing service under the supervision of a full-time registered nurse (RN), and maintains daily medical records on all patients. In no event will the term "rehabilitation institution" include any institution, or part thereof, which is used principally as a rest facility or nursing facility, a facility for the aged, or one providing primarily custodial care.

"REINSURER" means the insurance company providing the excess risk insurance maintained by Drake University.

"RESIDENTIAL TREATMENT PROGRAM" means a program provided by a facility established for the purpose of residential treatment of chemical dependency and approved as such by a state department or agency having authority over such programs.

"RETIREE" means:

- (a) an individual employed prior to January 1, 1982, who has been a full-time continuous employee for ten or more years, is age fifty-five (55) or older, and makes the required contribution, is under age sixty-five (65) and not otherwise eligible for Medicare; or;
- (b) an individual employed on or after January 1, 1982, who has been a full-time continuous employee for fifteen (15) or more years, is age sixty (60) or older, and makes the required contribution, is under age sixty-five (65), and not otherwise eligible for Medicare; and
- (c) an eligible retiree, as defined above, who enrolled within sixty (60) days of retirement.

"ROOM AND BOARD" means all charges commonly made by a hospital for room and meals and for all general services and activities essential to the care of registered bed patients.

"SECOND SURGICAL OPINION" means a consultation with another physician which the Plan allows to determine the appropriateness of a surgical procedure as the preferred course of treatment as recommended by the attending physician.

"SPECIAL CARE UNIT" means a section, ward, or wing within the hospital which is separated from other hospital facilities and:

- (a) is operated exclusively for the purpose of providing professional care and treatment for critical injuries or illnesses;
- (b) has special supplies and equipment, necessary for such care and treatment, available on a standby basis for immediate use; and
- (c) provides room and board and constant observation and care by a registered nurse (RN) and other specially trained hospital personnel.

"SPOUSE" means a person to whom a covered employee is legally married, as determined and defined by the laws of the state of the covered employee's residence. In addition, if you are a covered employee and have a common law marriage or domestic partnership, coverage for your spouse/domestic partner and dependent children may be obtained. However, certain requirements must be met, as determined by Drake University and by the laws of the state in which you live. Please contact Drake University for specific details.

"STEPCHILD" means any unmarried biological or adopted child of the spouse/domestic partner of an employee who has not reached the age of nineteen (19), and any unmarried biological or adopted child of the spouse/domestic partner of an employee who has not yet reached the age of twenty-six (26) and is a full-time student in an accredited school.

"SURGICAL PROCEDURE" means cutting, suturing, treatment of burns, correction of fractures, reduction of dislocations, manipulation of joints under general anesthesia, electro-cauterization, tapping (paracentesis), application of plaster casts, administration of pneumothorax, endoscopy, the injection of sclerosing solutions, and obstetrical procedures.

"TERMINALLY ILL" means having a life expectancy of six months or less due to an illness from which the participant is not expected to recover. This is usually a chronic illness or condition for which there is no known cure.

"TOTAL DISABILITY" and "TOTALLY DISABLED" mean:

(a) In the case of the covered employee, due to illness or injury, he or she is wholly and continuously prevented from performing the material duties of his or her regular occupation, including any occupation for which the employee is reasonably qualified by reason of education, training or experience;

(b) In the case of a covered dependent, due to illness or injury, he or she is wholly and continuously prevented from engaging in substantially all of the material activities of a person of the same gender and age who is in good health.

"URGENT CARE CLAIM" means any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the participant or the participant's ability to regain maximum function, or, in the opinion of a physician with knowledge of the participant's medical condition, would subject the participant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

"VISIT" means each attendance to the covered participant by a physician or medical practitioner (i.e., consultation or treatment).

"WAITING PERIOD" means the period that must pass before coverage for an employee or dependent who is otherwise eligible to enroll under the terms of the Plan can become effective.

"WELL-BABY CARE" or "WELL-CHILD CARE" means pediatric preventive services appropriate to the age of a child from birth to age seven, and to include well-child care to age seven, as defined by current Recommendations for Preventive Pediatric Health Care of the American Academy of Pediatrics. Pediatric preventive services shall include, at minimum, a history and complete physical examination as well as developmental assessment, anticipatory guidance, immunizations, and laboratory services including, but not limited to, screening for lead exposure as well as blood levels.

Group plans which provided coverage for pediatric vaccines as of May 1, 1993, may not reduce or eliminate this coverage. Failure to comply will result in an excise tax penalty equal to the penalty for plans that fail to provide COBRA coverage.

STATEMENT OF RIGHTS

As a participant in this Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). These rights are provided to you below, as required by federal law and regulation.

ERISA provides that all Plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office, all plan documents, including insurance contracts, bargaining agreements and copies of all documents such as annual reports (Form 5500) filed by this Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration (EBSA).

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, bargaining agreements, copies of the latest annual report (Form 5500) and updated Plan Descriptions. The Plan Administrator may make a reasonable charge for the copies.

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

Continue Group Health Plan Coverage

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

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

existing condition exclusion for twelve (12) months after your enrollment date in your coverage.

Prudent Actions By Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes obligations upon the persons who are responsible for the operation of this employee benefit Plan. These persons are referred to as "fiduciaries" in the law. Fiduciaries must act solely in the interest of their Plan duties. Fiduciaries who violate ERISA may be removed and required to make good any losses they have caused this Plan.

The employer of a Plan participant may not fire or discriminate against that participant to prevent him or her from obtaining or exercising his or her rights under ERISA.

Enforce Your Rights

If a participant is denied a benefit in full or in part, he or she has a right to know why this was done, to obtain copies of the documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the Plan and do not receive them within thirty (30) days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in full or in part, you may file suit in a state or Federal court. In addition, if a participant disagrees with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, he or she may file suit in Federal court. If Plan fiduciaries are misusing this Plan's money, or if a participant is discriminated against for asserting his or her rights, a participant has the right to file a suit in a Federal court or request assistance from the U.S. Department of Labor. If the participant is successful in the lawsuit, the court may require the other party to pay the participant's legal costs, including attorney's fees. If the participant is unsuccessful, the court may require the participant to pay these costs and fees, for example if it finds the claim was frivolous.

Assistance with your Questions

If a participant has any questions about this Plan, the participant should contact the Plan Administrator. If the participant has any questions about this statement or about his or her rights under ERISA, or if the participant needs assistance in obtaining documents from the Plan Administrator, the participant should contact the nearest office of the Employee Benefits Security

Administration, U.S. Department of Labor, listed in their telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. The participant may also obtain certain publications about his or her rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

INFORMATION REQUIREMENTS OF ERISA

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| Named Fiduciary/ Plan Sponsor: | Drake University 1331 27 th Street, The Point Des Moines, Iowa 50311 |
| Employer Identification #: | 42-0680460 |
| Plan Number: | 501 |
| Group Number: | 92400 |
| Plan Year Ends: | May 31st |
| Participants: | All active full-time employees and any person who has met the Plan's requirements for retirement |
| Plan Administrator and Agent for Legal Process of Plan: | Drake University 1331 27 th Street, The Point Des Moines, Iowa 50311 |
| Plan Costs: | The Plan Sponsor and the employees pay the costs of this Plan. |
| Type of Benefits: | Medical, and Prescription Drug Benefits |
| Type of Administration: | Contract Administration |
| Third Party Administrator: | First Administrators, Inc. P.O. Box 8150 Rapid City, SD 57709-8150 |
| Authority to Amend Plan: | President of Drake University or his/her designee |
| Administration and Plan Administrator Authority: | <p>The Plan is administered through the local offices of the Plan Administrator to which the participant is associated. The Plan Administrator has retained the services of an Independent Benefit Services Administrator experienced in claims processing.</p> <p>The Plan is a legal entity. Legal notices may be filed with, and legal process served upon, the Benefit Services Administrator and Plan Administrator.</p> <p>The Plan Administrator has the full and final authority to decide all questions or controversies of whatever character arising in any manner between any parties or persons in connection with the Plan or the interpretation thereof, including the construction of the language of the Summary Plan Description, and any writing, decision, benefit eligibility and determination, instrument or accounts in connection with same and with the operation of this Plan or otherwise, which shall be binding upon all persons dealing with this Plan or claiming any benefits thereunder, except to the extent that the Plan Administrator may subsequently</p> |

If your employer is unable to fund this Plan, you may be financially responsible for any incurred and unpaid claims. The Benefit Services Administrator assumes no financial liability.

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