

University System *of* New Hampshire



**GROUP MEDICAL BENEFITS PLAN
OPTION A
SUMMARY PLAN DESCRIPTION**

Effective: January 1, 2001
Revised: March 1, 2010

Administered by:



**UNIVERSITY SYSTEM OF NEW HAMPSHIRE
OPTION A
GROUP MEDICAL BENEFITS PLAN**

INTRODUCTION

This is a summary of the University System of New Hampshire Group Medical Benefits Plan (the "Plan").

This booklet is provided to help you understand how the Plan works. It highlights what types of expenses are covered under the Plan, definitions you need to know, how to file claims and what your legal rights are under the Plan.

University System of New Hampshire is sponsoring this plan for University System of New Hampshire which provides medical benefits for all covered employees and their covered dependent(s). Stop loss reinsurance has been purchased to protect the Plan Sponsor from unpredictable claims experience.

Each covered person is entitled to the benefits outlined in this Plan Document. To obtain benefits from the Plan, the covered person must ultimately submit a diagnostic bill to the Contract Administrator, Employee Benefit Plan Administration, LLC dba Employee Benefit Plan Administration (EBPA), for processing. This claim submission is required for reimbursement to the employee or direct payment to the service provider by the University System of New Hampshire Group Medical Benefits Plan.

In any event where a question may arise as to a claim for benefits or denial of a claim for benefits, the Employer, the Contract Administrator (the third party administrator) and any other persons that may be associated with the Plan's operation will be guided solely by this Plan document, which is also the Summary Plan Description.

A clerical error will neither invalidate the employee's coverage if otherwise validly in force nor continue coverage otherwise validly terminated.

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GENERAL INFORMATION

Name of the Plan: University System of New Hampshire Group Medical Benefits Plan

Plan Sponsor/Plan Administrator: University System of New Hampshire
25 Concord Road
Durham, NH 03824-3545
(603) 862-1800

Plan Number: 501

Group Number: 10200

Plan(s) Covered: Medical

Federal Tax Identification Number: 02-6000937

Plan Effective Date: January 1, 2001

Plan Anniversary Date: January 1st

Plan Year Ends: December 31st

Plan Revision Date: March 1, 2010 – This document replaces the previous Group Medical Benefits Plan Document in its entirety. All claims incurred prior to March 1, 2010 will be governed by the terms of the Plan in effect prior to this revision date.

Contract Administrator/Pre-Certification Administrator:

Employee Benefit Plan Administration, LLC dba Employee Benefit Plan
Administration (EBPA)
P.O. Box 2000
Exeter, NH 03833-2000
Customer Service: (603) 778-7106 or (800) 578-3272 (EBPA)
Pre-Certification: (800) 204-5990

Agency for Service of Legal Process: University System of New Hampshire

Contributions: The Plan is contributory.

Eligibility Requirements: Faculty members as set forth in the Collective Bargaining Agreement hired on or after July 1, 2003, except for those with a written offer letter prior to July 1, 2003 are eligible for coverage. USY V.A. 5.2 Enrollment Coverage. USY V.A. 5.2.1 Open Enrollment. Once each year, faculty and staff members will be given the opportunity to make changes or initially select their plan options for medical, dental, life, and long term disability selections. This period is called "open enrollment" and lasts approximately thirty (30) days. It occurs in the fall of each year with new coverage effective on January 1 of the following year. USY V.A. 5.2.1.1 Coverage selections made by a faculty/staff member are irrevocable during the plan year and may be changed only during the annual open enrollment, unless the faculty/staff member has a change in family status as noted in section USY V.A. 5.2.2 Change in Family Status. A change in family status is defined as a marriage, same-sex domestic partnership (through December 31, 2009 or domestic partners with USNH approved hardship thereafter), civil union, divorce or legal separation, addition of a dependent by birth or adoption, gain or loss of spouse's employment, involuntary loss of spouse's medical coverage, death of a spouse or dependent, change in USNH employment status from part-time to full-time or vice versa, or taking an unpaid leave of absence. USY V.A. 5.2.2.1 Faculty and Staff members must notify USNH of a change in status within 30 days of the qualifying event in order to be eligible to change their coverage selection. Changes in coverage must be consistent with the change in status and, based on proper notification, will be effective on the date of the event.

Dependent Children's Coverage: Unmarried dependent children under age nineteen (19) or full-time students enrolled at an accredited school or college, including regular vacations, up to twenty-five (25) years of age.

Eligibility Date:

1. If enrollment is completed within sixty (60) days of employment, benefits are effective on the first day of the month following completion of enrollment materials. Completion of Enrollment/Applications (Medical and/or Dental) and the date of receipt by the UNH Human Resources office will dictate which month the benefits become effective.
2. If newly appointed faculty members currently do not have medical coverage for themselves or their spouse, same-sex domestic partner (through December 31, 2009 or domestic partners with USNH approved hardship thereafter), civil union partner, or dependent(s) and are not eligible to continue medical benefits under COBRA and/or are not otherwise eligible to receive medical benefits from an employer sponsored medical plan as an employee, spouse, same-sex domestic partner (through December 31, 2009 or domestic partners with USNH approved hardship thereafter), civil union partner, or dependent, they may complete a "Request for Waiver of Policy" to become eligible for coverage on either of the following dates: (a) effective on the date of appointment if enrollment form is completed and received by UNH Human Resources within the first thirty (30) days of employment; or (b) effective on the date the enrollment form is completed and received by UNH Human Resources if the form is received between the 31st and 60th date of employment. The signed "Request for Waiver of Policy" must be submitted to UNH Human Resources sixty (60) days prior to the appointment.

Termination Date: See "Termination of Benefits" section.



**University System of New Hampshire
Option A
Schedule of Benefits**

Benefit	
Deductible (per calendar year) * One person in the family must completely satisfy the first \$1,250 of the family calendar year deductible; the second \$1,250 may be satisfied by any combination of covered family members, but no individual must satisfy more than the personal deductible amount.	\$1,250 per individual \$2,500 per family*
Plan Coinsurance	100%
Out-of-Pocket Maximum (per calendar year)	\$1,250 per individual \$2,500 per family
Preventive Care	100%
Inpatient Mental Health/Substance Abuse	Deductible; 100%
Outpatient Mental Health/Substance Abuse	Deductible; 100%
Rehabilitative Care	Deductible; 100% to a maximum of 365 days per lifetime
Bereavement Services	Deductible; 50%
Inpatient Pre-Admission Certification Penalty	80% to a maximum of \$500 non-compliance penalty
Prescription Drug Benefit (Retail – 34 day or 100 unit supply)	Generic Copayment: \$7 Preferred Brand Copayment: \$15 Non-Preferred Brand Copayment: \$15
Mail Service Program (Mail Order – 90 day supply)	Generic Copayment: \$0 Preferred Brand Copayment: \$0 Non-Preferred Brand Copayment: \$0
Lifetime Benefit Maximum Per individual.	\$2,000,000

NOTES:

1. All Plan benefits are subject to reasonable and customary allowances. See the “Plan Details” and “Medical Covered Expenses” sections for additional information.
2. This Plan is participating with preferred provider network(s). The preferred providers will bill EBPA directly and write off charges that exceed the Plan’s R&C allowances.
3. Pre-admission penalties are not applied to the deductible or out-of-pocket maximum.
4. All other covered benefits not listed above will be subject to the calendar year deductible and payable at 100%.
5. There is no copayment for generic or brand name prescriptions for a three (3) months supply of maintenance or long-term medications if ordered through Mail Service Program.
6. The lifetime maximum in one plan option applies across all plan options sponsored by the Plan Administrator.

GENERAL PROVISIONS

PLAN ENROLLMENT

Eligibility: Only employees who satisfy the eligibility requirements set forth in the “General Information” section are eligible for coverage under this Plan. The dependent(s) of a covered employee will become eligible for coverage on the date of the employee’s eligibility for coverage or on the date which the employee acquires the dependent.

If an employee and spouse are both eligible for coverage as employees under the Plan, only one (1) will be eligible to enroll dependent(s). Also, an employee cannot be covered as an employee and a dependent.

Plan Enrollment: An employee must enroll themselves and/or their dependents for coverage within sixty (60) days of their eligibility date. The employee and dependents will be enrolled when a benefit enrollment form is completed and received by UNH Human Resources within the time limit. Should the enrollment occur more than sixty (60) days following the eligibility date, the employee and/or dependents will be eligible to enroll during the open enrollment period or under the “Special Enrollment Periods” provision as described below. Should multiple plan options exist, an employee may switch plan options during an annual open enrollment period or special enrollment period.

If newly appointed faculty members currently do not have medical coverage for themselves or their spouse, same-sex domestic partner (through December 31, 2009 or domestic partners with USNH approved hardship thereafter), civil union partner, or dependent(s) and are not eligible to continue medical benefits under COBRA and/or are not otherwise eligible to receive medical benefits from an employer sponsored medical plan as an employee, spouse, same-sex domestic partner (through December 31, 2009 or domestic partners with USNH approved hardship thereafter), civil union partner, or dependent, they may complete a “Request for Waiver of Policy” to become eligible for coverage on either of the following dates: (a) effective on the date of appointment if enrollment form is completed and received by UNH Human Resources within the first thirty (30) days of employment; or (b) effective on the date the enrollment form is completed and received by UNH Human Resources if the form is received between the 31st and 60th date of employment. The signed “Request for Waiver of Policy” must be submitted to UNH Human Resources sixty (60) days prior to the appointment.

Annual Open Enrollment Period: There will be an open enrollment period during the fall of each year. If the employee completes the benefit enrollment and it is received by Human Resource or System Benefits Office during the open enrollment period the elected coverage will become effective on the first (1st) day of January following this election.

Special Enrollment Periods: Individuals are eligible for special enrollment for the following reasons:

1. If an employee acquires a dependent through marriage, same-sex domestic partnership (through December 31, 2009 or domestic partners with USNH approved hardship thereafter), civil union, birth, adoption, or placement for adoption, the dependent (and if not otherwise enrolled, the employee and eligible dependents) may be enrolled under this Plan. The request to enroll must be within thirty (30) days of the event. If enrollment is not requested within thirty (30) days following the event, the dependents will only be eligible to enroll during the annual open enrollment period. The effective date of coverage for dependents and/or employees enrolling during a special enrollment period will be the date of the event.

2. If an employee declines enrollment in the Plan for themselves or their dependents because the employee or dependents have other health coverage, the employee may in the future be able to enroll themselves and/or their dependents in the Plan, provided they are otherwise eligible for coverage under the terms of the Plan, they meet certain conditions including any one of those set forth below and they request enrollment within thirty (30) days of that condition being satisfied:
- when enrollment was declined under this Plan for employee and/or dependent coverage, the employee and/or dependent had COBRA continuation coverage under another health plan, and COBRA continuation coverage under that other plan has since been exhausted; or
 - if the other coverage that applied to the employee and/or dependent when coverage was declined was not COBRA continuation coverage, employer contributions toward the other coverage have ceased, regardless of whether coverage under the other employer's plan has terminated; or
 - if the other coverage that applied to the employee and/or dependent when coverage was declined was not COBRA continuation coverage, the other coverage has been terminated as a result of:
 - a. loss of eligibility as a result of legal separation, dissolution of same-sex domestic partnership, termination of a civil union, divorce, death, termination of employment, or reduction in the number of hours of employment, and any loss of eligibility after a period that is measured by reference to any of the foregoing; or
 - b. the employee and/or dependent having reached their lifetime benefit maximum under the other coverage; or
 - c. the employee and/or dependent moving out of an HMO service area if HMO coverage terminates for that reason and, no other plan options are available to the employee/dependent; or
 - d. the other plan ceasing to offer coverage to the group of similarly situated individuals that include the employee and/or dependent; or
 - e. the dependent losing dependent status per plan terms; or
 - f. the other plan terminating a benefit package option and no substitution is offered.

The effective date of coverage will be the date following the date of the loss of the other coverage. The Plan's waiting period will not be applied.

3. If an employee's or dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility, or if the employee or dependent becomes eligible for a state-granted premium subsidy towards employer health coverage under either Medicaid or CHIP, the employee may request to be enrolled in this Plan. The employee's request to enroll must be made within sixty (60) days of the date on which the employee or dependent either (a) loses eligibility under Medicaid or CHIP or (b) becomes eligible for a state-granted premium subsidy towards employer health coverage under either Medicaid or CHIP. The effective date of coverage will be the first day of the month following the employee's request to enroll in this Plan.

Qualified Medical Child Support Orders: If an employee is required to provide benefits for his dependent child under the direction of a court order and the employee is not enrolled in the Plan, the employee may enroll himself and his dependent child provided enrollment is requested within thirty (30) days of issuance of the court order. The Plan's open enrollment provision will not apply. The effective date of coverage will be the date of the court order. However, if the employee has not yet satisfied the Plan's waiting period, coverage will become effective after satisfaction of such waiting period.

Change of Full-Time Student Status: If a dependent child age nineteen (19) to twenty-five (25) is not currently eligible under the Plan and becomes a full-time student at an accredited school or college, the employee may enroll the dependent in the Plan, provided the enrollment form is received within thirty (30) days of the dependent's return to school. The effective date of coverage will be the first day of school. If the request for enrollment is after thirty (30) days from the date of the dependent's return to school, the dependent will only be eligible to enroll during the Plan's next annual open enrollment period.

Approved Temporary Leave of Absence (with regard to medical coverage only): Employment for the purpose of the Plan will be deemed to be continued by the employer following the date of an approved temporary leave of absence, or subject to USNH policy.

Michelle's Law: Coverage under the Plan will be continued by the employer following the date of an approved leave of absence or reduction in hours resulting in the loss of "full-time" student status for a seriously ill college student for a period of up to one (1) year, or until the student's coverage under the Plan ends as a result of the application of another Plan provision such as exceeding the Plan's eligibility age or the parent's termination of employment. The dependent child must be a child of a covered employee who is eligible solely because of his/her status as a "full-time" student at a college, university or other post-secondary educational institution; the dependent must have been enrolled in the group health plan before the first day of the leave; and the medically necessary leave of absence must be caused by a serious illness or injury and must be certified in writing by a treating physician.

COORDINATION OF BENEFITS (COB)

This Coordination of Benefits (COB) provision pertains to the USNH Plan when an employee or the employees' covered dependent has health care coverage under more than one plan. If this COB provision applies, the order of benefit determination rules should be looked at first. These rules determine whether the benefits of this Plan are determined before or after those of "other coverage." The USNH Plan is set up to process claims using the Standard Coordination of Benefits provision. The benefits of this Plan:

1. Shall not be reduced when, under the Order of Benefit Determination Rules, this Plan determines its benefits before other coverage; but
2. May be reduced when, under the Order of Benefit Determination Rules, the other coverage determines its benefits first. The total of all benefits payable in any calendar year will not exceed 100% of the "allowable expenses" incurred during that calendar year.

An "allowable expense" is any necessary reasonable and customary expense covered by this Plan.

"Other Coverage" is any of these, which provides benefits or services for, or because of, medical or dental care or treatment:

1. Coverage under a governmental program provided or required by law. This does not include a state plan under Medicaid (Title XIX, Grants to States of Medical Assistance Programs, of the United States Social Security Act as amended). Medical benefits coverage in Group, Group-type and individual automobile no fault and traditional automobile "fault"-type contracts, which will be considered primary for any automobile accident-related medical expenses. Uninsured motorist insurance and automobile medical payment benefits shall be considered part of any automobile insurance.
2. Group insurance or other coverage for a group of individuals, including prepayment, Group practice or individual practice coverage, but not student accident or student accident and health coverage, for which the student or parent pays the entire premium.

When a claim is made, the primary plan pays its benefits without regard to any other plans. The secondary plan adjusts its benefits so that the total benefits payable under all plans will not exceed 100% of the allowable expenses. No Plan pays more than it would without the coordination provision.

A Plan without a coordinating provision is always the primary plan. If all plans have such a provision:

1. The Plan covering the patient directly, rather than as an employee's dependent, is primary and the other is secondary (Plan benefits will only be coordinated with similar benefits provided under the other Plan(s) for which a claim may be made);
2. If a child is covered under both parents' Plans, the Plan of the parent born earliest in the calendar year is primary, except that in the case of a dependent child:
 - a. when the parents are separated or divorced and the parent with custody of the child has not remarried, the benefits of a Plan which covers the child as a dependent of the parent with custody of the child will be determined before the benefits of a Plan which covers the child as a dependent of the parent without custody.

- b. when the parents are divorced and the parent with custody of the child has remarried, the benefits of a Plan which covers the child as a dependent of the parent with custody shall be determined before the benefits of a Plan which covers that child as a dependent of the stepparent, and the benefits of a Plan which covers that child as a dependent of the stepparent will be determined before the benefits of a Plan which covers that child as a dependent of the parent without custody.

Notwithstanding (a) and (b) above if there is a court decree which would otherwise establish financial responsibility for the medical, dental or other healthcare expenses with respect to the child, the benefits of a Plan which covers the child as a dependent of the parent with such financial responsibility shall be determined before the benefits of any other Plan which covers that child as a dependent child.

3. If neither (1) nor (2) applies the plan covering the patient longest is primary.

When this Plan is the secondary plan, the secondary payer pays up to 100% of its normal liability for services not previously paid by the other insurance, provided that the balance does not exceed the Plans normal benefit payment. The employees' responsibility (i.e. copays, deductible or coinsurance) is reduced or waived by any payment made by the primary carrier. In the event an individual who is eligible for benefits under this Plan and another plan or plans does not make claim for benefits under such other plan or plans the benefits payable under this Plan will be reduced to the extent of benefits that would have been payable under the other plan or plans had claim been made for such benefits.

In order to obtain all benefits available a claim should be filed under each Plan.

For the purpose of coordination of benefits the Plan Administrator or agent thereof:

1. May release to or obtain from any other organizations or individuals any claim information, and any individual claiming benefits under this Plan shall furnish the Plan Administrator or the agent of the Plan Administrator with any information which may be required;
2. Has the right to pay to any other organizations an amount it shall determine to be warranted, if payments which should have been made under this Plan have been made by such organizations under other Plans; and
3. Has the right if any overpayment is made under this Plan because of failure to report other coverage or other reason to recover such excess payment from any individual to whom, or for, or with respect to whom such payments were made any other insurance companies or any other organizations.

Coordination with Medicare: The term "Medicare" means the Health Insurance provided by Title XVII of the Social Security Act as amended.

If a covered person meets the eligibility requirements for any coverage under Medicare and if the amount of benefits payable for expenses which are incurred by such person in accordance with the terms of any coverage included in this Plan plus the amount of benefits provided for the same expense under full Medicare coverage exceeds the total amount of such expenses. The amount of benefits payable under any coverage in this Plan will be reduced to the extent necessary so that the amount of benefits payable for such expenses under such coverage and the amount of benefits available under full Medicare coverage for the same expenses will not exceed the total amount of such expenses.

Coordination with Prescription Claims: There is no coordination of benefits with prescription drugs.

TERMINATION OF BENEFITS

An employee's and/or a dependent's coverage under the Plan will terminate:

1. on the date the Plan terminates; or
2. on the date an employee withdraws from the Plan; or
3. on the date an employee is terminated, unless continuation of coverage, as provided herein, is elected; or
4. on the date a dependent withdraws from the Plan or a dependent ceases to meet the definition of a dependent as defined herein or dependent coverage is discontinued under the Plan for any reason, unless continuation of coverage, as provided herein, is elected; or
5. on the date an employee or dependent enters the military, naval, or air force of any country or international organization on a full-time, active duty basis other than scheduled drills or other training not exceeding one (1) month in any calendar year (see Military Leave section below); or
6. on the last date of the period for which contribution has been made if the employee fails to make any required contribution.

MILITARY LEAVE

The Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA") provides special continuation coverage to covered employees who otherwise lose health insurance coverage under the Plan because they leave employment to serve in the uniformed services. Under USERRA, affected covered employees and their dependents must be offered the right to continue coverage for up to twenty-four (24) months. The employer may charge 102% of the applicable premium, provided the length of the military leave is longer than thirty (30) days. However, on the date that the employee completes his active duty and returns to full-time employment, the employee and his eligible dependents will be re-enrolled in the Plan and coverage will be provided immediately. However, any limitations on the employee's or dependent's coverage which were in affect before the active military duty leave will continue to apply.

EXTENSION OF MEDICAL BENEFITS

If the covered person terminates while they are totally disabled and before the applicable maximum benefit has been paid, benefits for that disability only will continue to be payable for covered expenses incurred during a period beginning with the date of such termination and ending on the earliest to occur of the following:

- the date on which the total disability terminates;
- the date on which the covered person becomes eligible for medical benefits under another group coverage or Medicare;
- the date on which the maximum benefit has been paid;
- at the end of a twelve (12) month period after such termination of coverage; or
- the date on which the Plan terminates.

EXTENSION OF BENEFITS (COBRA)

Qualified beneficiaries may elect to continue coverage under the Plan when their coverage terminates due to a “qualifying event.” Depending on the type of qualifying event, “qualified beneficiaries” can include the employee covered under the Plan and the employee’s covered dependents. These rights are protected under the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1986.

A child who is born to or placed for adoption with the covered employee during a period of COBRA coverage will be eligible to become a qualified beneficiary. In accordance with the terms of the Plan and the requirements of federal law, these qualified beneficiaries can be added to COBRA coverage upon proper notification to the Plan Administrator of the birth or adoption.

Continuation coverage is the same coverage that the Plan gives to other participants or beneficiaries under the Plan who are not receiving continuation coverage. Each qualified beneficiary who elects continuation coverage will have the same rights under the Plan as other participants or beneficiaries covered under the Plan.

The employee has the right to choose COBRA continuation of coverage under the Plan if coverage terminates for any of the following qualifying events:

1. The employee’s termination of employment for reasons other than gross misconduct.
2. The employee’s retirement or reduction in hours of employment.

The employee’s spouse has the right to choose COBRA continuation of coverage under the Plan if coverage terminates for any of the following qualifying events:

1. The employee’s termination of employment for reasons other than gross misconduct.
2. The employee’s retirement or reduction in hours of employment.
3. The employee’s death.
4. The employee’s divorce, legal separation, or termination of a civil union.
5. The employee becomes enrolled in Medicare benefits (Part A, Part B or both).

The employee’s dependent children have the right to choose COBRA continuation of coverage under the Plan if coverage terminates for any of the following qualifying events:

1. The employee’s termination of employment for reasons other than gross misconduct.
2. The employee’s retirement or reduction in hours of employment.
3. The employee’s death.
4. The employee’s divorce, legal separation, or termination of a civil union.
5. The employee becomes enrolled in Medicare benefits (Part A, Part B or both).
6. The employee’s dependent child ceases to be an eligible dependent as such term is defined in the Plan.

Similar rights may apply to certain retirees, spouses, and dependent children if the employer commences a bankruptcy proceeding and these individuals lose coverage.

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or enrollment of the employee in Medicare (Part A, Part B, or both), the employer must notify the Contract Administrator of the qualifying event within thirty (30) days of any of these events on the form provided by the Contract Administrator to the employer.

For the other qualifying events (divorce, legal separation of the employee and spouse, termination of a civil union, or a dependent child's losing eligibility for coverage as a dependent child), the qualified beneficiary must notify the Plan Administrator. The Plan Administrator must be notified in writing within sixty (60) days after the qualifying event occurs.

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. The Plan Administrator must notify the qualified beneficiary in writing of their right to COBRA continuation of coverage within fourteen (14) days from the date the Plan Administrator is notified of a qualifying event.

The qualified beneficiary has sixty (60) days from the date of the written notice or qualifying event, whichever is later, to notify the Plan Administrator of their decision to elect COBRA continuation of coverage. To receive COBRA continuation of coverage, no evidence of insurability will be required, but a monthly premium will be charged. If continuation of coverage is not elected on a timely basis, group health insurance coverage will end.

If Medicare entitlement occurs prior to a qualifying event, then COBRA begins on the date of Medicare entitlement.

For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the day following the date of the qualifying event.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's divorce, legal separation, termination of a civil union, or a dependent child losing eligibility as a dependent child, COBRA continuation coverage lasts for up to thirty-six (36) months.

If a qualifying event that is a termination of employment or reduction of hours occurs within eighteen (18) months after the covered employee becomes enrolled in Medicare, then the maximum coverage period for the spouse and dependent children who are qualified beneficiaries receiving COBRA coverage will end thirty-six (36) months from the date the employee became enrolled in Medicare (but the covered employees' maximum coverage period will be eighteen (18) months). This extension is available only if the covered employee becomes enrolled in Medicare within eighteen (18) months before the termination of employment or reduction of hours occurs.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage lasts for up to eighteen (18) months. There are two ways in which this eighteen (18) month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

If a qualified beneficiary is determined by the Social Security Administration to be disabled at any time during the first sixty (60) days of COBRA continuation coverage and the Plan Administrator is notified in a timely fashion, the employee and his covered dependents can receive up to an additional eleven (11) months of COBRA continuation coverage, for a total maximum of twenty-nine (29) months. The qualified beneficiary must make sure that the Plan Administrator is notified in writing of the Social Security Administration's determination within sixty (60) days of the date of the determination and before the end of the eighteen (18) month period of COBRA continuation coverage. If a qualified beneficiary is determined by the Social Security Administration to no longer be disabled, then the beneficiary must notify the Plan within thirty (30) days of determination by the Social Security Administration.

Second qualifying event extension of 18-month period of continuation coverage

If the employee's family experiences another qualifying event while receiving COBRA continuation coverage, the spouse and dependent children can get additional months of COBRA continuation coverage, up to a maximum of thirty-six (36) months. This extension is available to the spouse and dependent children if the former employee dies, gets divorced, legally separated, or terminates a civil union. This extension may be available to a spouse or dependents if the former employee enrolls in Medicare. The extension is also available to a dependent child when that child stops being eligible under the Plan as a dependent child. **In all of these cases, the qualified beneficiary must make sure that the Plan Administrator is notified in writing of the second qualifying event within sixty (60) days of the second qualifying event.**

In no event will COBRA coverage continue beyond thirty-six (36) months from the date of the original qualifying event.

Monthly Premium

1. The monthly premium will be 102% or, if applicable, 150% of the applicable premium (which for self-funded plans, is based on reasonable actuarial estimates or on past costs). All premium payments are due in advance and include the cost of the next month of COBRA continuation of coverage.
2. The initial premium payment is due within forty-five (45) days of electing COBRA continuation of coverage. The payment must cover all premiums due from the date of the qualifying event.
3. The maximum grace period for payment of monthly COBRA coverage premiums will not exceed thirty (30) days from the due date established by the Plan Administrator or their authorized agent.

Termination of COBRA continuation coverage

COBRA continuation of coverage may be terminated prior to the expiration of the applicable time period as follows:

1. The Plan Administrator no longer provides group health and/or dental coverage to any of its employees.
2. The applicable monthly premium for COBRA coverage is not paid within thirty (30) days of the established due date.
3. The person who has elected COBRA coverage becomes enrolled in Medicare benefits (Part A, Part B or both). COBRA coverage will terminate on the first day of the person's birthday month. Should the person's birthday be on the first day of the month, then COBRA coverage will terminate on the first day of the month prior to the person's birthday.
4. The qualified beneficiary who has elected COBRA coverage becomes covered under another group health and/or dental plan which does not contain any exclusion or limitation with respect to any preexisting condition of such covered person.

(NOTE: Should COBRA continuation provide coverage for such "preexisting" conditions, COBRA continuation of coverage will be primary for the applicable preexisting conditions only and will provide secondary coverage to all other covered expenses.)

5. The unique disability continuation period will end as of the first day of month that begins more than thirty (30) days after the date of final determination under the Social Security Act that the qualified beneficiary is no longer disabled.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) restricts the extent to which group health plans may impose pre-existing condition limitations. HIPAA coordinates COBRA's other coverage cut-off rule with these new limits as follows.

If the covered employee becomes covered by another group health plan and that plan contains a pre-existing condition limitation that affects the covered employee, the covered employee's COBRA coverage cannot be terminated. However, if the other plan's pre-existing condition rule does not apply to the covered employee by reason of HIPAA's restrictions on pre-existing condition clauses, the Plan may terminate the covered employee's COBRA coverage.

The covered employee does not have to show that he or she is insurable to choose continuation coverage. However, continuation coverage under COBRA is provided subject to the covered employee's eligibility for coverage; the Plan Administrator reserves the right to terminate the covered employee's coverage retroactively if he or she is determined to be ineligible.

Trade Act of 2002

Pursuant to the Trade Act of 2002, special COBRA rights apply to employees who have been terminated or experienced a reduction of hours and who qualify for a trade readjustment allowance or alternative trade adjustment assistance under another federal law called the Trade Act of 1974. These employees are entitled to a second opportunity to elect COBRA coverage for themselves and certain family members (if they did not already elect COBRA coverage), but only within a limited period of sixty (60) days (or less) and only during the (6) six months immediately after their group health plan coverage ended. In addition, the Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance (eligible individuals). Under the new tax provisions eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. If you have questions about these new tax provisions, you may call the Health Care Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact/2002act_index.asp.

If you qualify or may qualify for assistance under the Trade Act of 2002, contact the Plan Administrator for additional information. You must contact the Plan Administrator promptly after qualifying for assistance under the Trade Act of 2002 or you will lose your special COBRA rights.

The American Recovery and Reinvestment Act of 2009

The American Recovery and Reinvestment Act ("ARRA") provides a reduction in premiums and, in some cases, additional opportunities to elect continued group health coverage under COBRA for individuals who become eligible for COBRA coverage as a result of an involuntary termination of employment occurring between September 1, 2008 and December 31, 2009. The premium reduction and additional election opportunities may also apply to members of the employee's family who were covered under the group health plan at the time of the employee's involuntary termination. ARRA's premium reduction and additional election opportunity provisions will expire on December 31, 2009, and therefore will not be available to employees who are involuntarily terminated after December 31, 2009, unless ARRA is further extended by Congress.

If you believe you qualify or may qualify for assistance under ARRA, contact the Plan Administrator for additional information.

If you believe you are eligible for a reduction in COBRA premiums as a result of ARRA, but your employer disagrees, you have the right to appeal to the U.S. Department of Labor for an expedited review of your employer's decision. For more information, go to <http://www.dol.gov/recovery>.

Keep Plan Informed of Address Changes

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

PLAN DETAILS

Preferred Provider Network Program

The Plan includes access to selected preferred provider network(s) in order to obtain discounts from participating providers for covered medical care. The plan identification card identifies the selected preferred provider network(s) and a current list of the participating providers will be furnished to covered persons automatically by the Plan Sponsor. Use of the network is voluntary and the benefits of utilizing participating providers include provider fee discounts, direct billing to the Plan for covered services, and network provider write-offs of any charges in excess of the discounted fee schedule.

Medical Deductible Carry-Over Provision: If, after September 30th of any year, a covered person incurs services for which any or all of the medical deductible amount must be paid, then that portion of the medical deductible paid by the covered person after September 30th will be deemed to have been paid toward the next year's medical deductible as well.

Common Accident Provision: If the deductible amount applies to accident expenses and if two (2) or more members of the same family incur covered expenses due to disabilities resulting from injuries sustained in any one (1) accident, the deductible amount will be applied only once with respect to all covered expenses incurred as a result of that accident during the calendar year in which the accident occurs.

Preventive Care: Charges for routine annual physical examinations and associated tests and screening, well-baby care, and well-adult care are covered expenses. Charges can include, but are not limited to, examinations (including breast and pelvic), immunizations, consultations, laboratory tests, pap smears (including laboratory fees), x-rays, mammograms, bone density screening, PSA tests, and EKG's. Colonoscopies for covered persons age fifty (50) and older are covered expenses to a maximum of one (1) every five (5) years or more frequently if recommended by a physician. Benefits are payable at 100%.

Inpatient Mental Health/Substance Abuse: Charges for inpatient mental health and substance abuse services, as defined herein, are covered expenses. Benefits are subject to the calendar year deductible and payable at 100%.

Outpatient Mental Health/Substance Abuse: Charges for outpatient mental health and substance abuse services, as defined herein, are covered expenses. Benefits are subject to the calendar year deductible and payable at 100%.

Rehabilitative Care: Charges for rehabilitative care, as defined herein, are covered expenses. Benefits are subject to the calendar year deductible and payable at 100% to a maximum of three hundred and sixty-five (365) days per covered person per lifetime.

Bereavement Services: Charges for bereavement services, as defined herein, are covered expenses. Benefits are subject to the calendar year deductible and payable at 50%.

Inpatient Pre-Admission Certification Penalty: The Plan requires that all non-emergency hospital admissions be pre-certified and authorized by the Contract Administrator. This does not include hospital stays in connection with childbirth for the mother or newborn child which are forty-eight (48) hours or less for vaginal deliveries, or ninety-six (96) hours or less for cesarean section deliveries. When a doctor recommends that the employee or dependent be admitted to a hospital, **it is the employee's responsibility** to notify the Plan and to obtain pre-certification and authorization of the hospital admission. **It is the employee's responsibility** to be sure that in the event of an **emergency admission**, the Contract Administrator is notified within **forty-eight (48) hours**. Failing to obtain pre-certification will not result in a rejection of the claim, but a penalty of **20% to a maximum of \$500**, whichever is less will be applied. In the event that an employee or dependent incur expenses for services which have not been pre-certified and authorized, a thorough review will be conducted of the services to determine medical necessity at the point of claim. If the review process identifies care which is not medically necessary, services will not be covered under the Plan.

In order for the Plan to approve the inpatient stay, the attending physician must certify to the Contract Administrator that, in the physician's professional opinion, the stay is necessary for the condition. The Plan reserves the right to request an independent medical opinion by a physician of the Plan's choice.

Retail Prescription Drug Plan: The Plan includes a prescription drug program. Prescriptions filled at participating pharmacies are limited to a maximum thirty-four (34) day or one hundred (100) supply, whichever is greater. Individual prescriptions are subject to the copayments listed below. The balance of the covered prescription expense will be paid at 100%.

<u>Generic Copayment</u>	<u>Preferred Brand Copayment</u>	<u>Non-Preferred Brand Copayment</u>
\$7	\$15	\$15

A list of participating pharmacies can be obtained from your Human Resource Office.

Prescriptions purchased at non-participating pharmacies will **not** be considered covered expenses.

Mail Service Prescription Drug Program: Maintenance drugs to treat illnesses should be purchased through the mail order program. These illnesses usually include: diabetes, epilepsy, anemia, chronic constipation, arthritis, high blood pressure, tuberculosis, various gastric disease, emphysema, menopause, mental and nervous disorders, thyroid disease, adrenal disease, ulcers, and any other condition that requires continuous medication. Mail order prescriptions are limited to a maximum ninety (90) day supply. Mail order prescriptions are payable at 100%.

MEDICAL COVERED EXPENSES

Expenses incurred for the following medical, health care services, and supplies will be considered a covered expense, provided the expenses are (i) medically necessary to treat an illness or injury, (ii) prescribed by an attending physician, and (iii) are incurred during a period that coverage was in effect in accordance with the applicable provisions of the Plan. Payment of such expenses will be subject to all applicable deductible, coinsurance limits, the maximum individual limit, and all other limitations described herein.

1. Inpatient hospital charges for room and board, operating room, x-rays, physical therapy, radiation therapy, chemotherapy, prescription drugs, anesthesia, laboratory expenses, intensive care unit, and other necessary services and supplies during any one (1) period of hospital confinement, as shown below. Should the facility have no semi-private rooms or less expensive accommodations available, or the patient’s condition requires the employee or the employee’s covered dependent to be isolated for their own health or the health of others, the private room rate will be allowed.

Room and Board:

semi-private room allowance.....semi-private room rate
 private room allowance.....semi-private room rate
 intensive care allowance.....actual charge (not to exceed R&C allowance)

2. Outpatient hospital charges for necessary services and supplies incurred as a result of an illness, accident, or as a result of outpatient surgery performed (if performed on the same day), including charges for x-ray and laboratory expenses, physical therapy, radiation therapy, and chemotherapy.
3. Charges for inpatient physician visits while the employee or their dependents are hospital confined as a result of an illness or an accidental injury. No benefits will be paid for more than one (1) visit per day by any one (1) physician or for the treatment received in connection with, on, or after the date of an operation for which a surgical expense benefit is payable under the Plan if such treatment is given by the physician who performed the operation.
4. All charges of a professional anesthesiologist, radiologist, or pathologist.
5. Charges for pre-admission testing, exams, x-ray and laboratory examinations on an outpatient basis made within one (1) week of a scheduled hospital admission and related to a condition previously diagnosed.
6. Charges for medically necessary ground ambulance service to or from a hospital for inpatient care or for outpatients receiving accident or illness care. The hospital must be the nearest hospital that would ordinarily be expected to have the appropriate facilities for the treatment of the illness or injury involved. In exceptional situations, transportation beyond the institution where the covered person would normally receive care will be covered only if the evidence clearly establishes that such other institution is the nearest one with appropriate facilities. Air ambulance is considered a covered expense if it is medically necessary and the ground ambulance is not advisable.
7. Emergency room charges for treatment of an illness or an accidental injury.

8. Diagnostic x-rays and laboratory charges for expenses incurred as a result of an illness or injury. No benefits are payable for dental care except as provided for in this Plan.
9. Charges for treatment by a qualified physiotherapist, occupational therapist, or speech therapist, except for the treatment of a learning disability as diagnosed by a physician.
10. Charges for dental services rendered by a physician, dentist, or oral surgeon for the treatment of a fractured jaw, or injury to sound natural teeth incurred as a result of an accident. Charges for the treatment of temporomandibular joint syndrome (TMJ), with a medical diagnosis will be covered.
11. Charges for physician's surgical services for treatment of an injury or illness, if performed in an inpatient or outpatient unit of a hospital, a free standing facility, a physician's office, or a dentist or an oral surgeon's services for the treatment of an accidental injury to sound natural teeth will be considered a covered expense.
12. Charges for medically necessary private duty nursing care rendered on an outpatient basis by a registered graduate nurse (RN) or, services of a licensed practical nurse (LPN) when certified by the attending physician and a registered graduate nurse (RN) is not available, but only for nursing duties and excluding custodial care.
13. Charges for x-ray, laboratory, and radium expenses excluding dental x-rays, unless rendered for the treatment of a fractured jaw, or injury to sound natural teeth as a result of an accident will be considered covered expenses.
14. Charges for the professional services of a legally qualified physician for the care of a covered illness or accidental injury.
15. Charges for physician's home and office visits when the employee or his dependent incur expenses as a result of an illness or accidental injury.
16. Charges for services of a surgeon and an assistant surgeon if two (2) or more procedures are performed during the course of a single operation through the same incision or in the same operative field. The fees will be limited to the reasonable and customary allowance. Benefits are payable for the professional services of a legally qualified physician in rendering technical assistance to the operating surgeon when required in connection with a surgical procedure performed on an inpatient basis (benefits will not exceed twenty-five (25%) of the reasonable and customary allowance for the procedure performed). However, no benefits are payable for surgical assistance rendered in a hospital where it is routinely available as a service provided by a hospital intern, resident, or house officer.
17. Charges for medically necessary dressings and medicines for which a physician's prescription is required and dispensed by a licensed pharmacy.
18. Charges for diabetic supplies such as insulin, accustrips, lancets, and syringes necessary for the administration of prescription drugs and professional instructions, not including printed material for their use.
19. Charges for oxygen and the rental of equipment for its administration.
20. Charges for rehabilitative care, as defined herein, to a lifetime maximum of three hundred sixty-five (365) days.

21. Charges for sterilizations and reverse sterilizations.
22. Charges for artificial limbs or eyes, casts, splints, trusses, crutches, braces (except dental), orthotics, prescribed corrective appliances inside shoes, rental or purchase (if appropriate) of a wheelchair or hospital type bed and the rental of durable medical equipment which has no personal use in the absence of the condition for which it was prescribed (rental charges will not exceed the retail purchase price of such equipment). The replacement of prosthetic devices are covered only if it is required because of the covered person's physical change.
23. Charges for elective abortions.
24. Charges for expendable supplies, blood, and blood derivatives.
25. Charges for maternity care including prenatal, delivery, and postpartum care as well as charges arising from complications that may occur during maternity and delivery.
26. Convalescent Hospital/Extended Care Facility/Skilled Nursing Facility charges, but not in excess of a daily charge for room and board, services, and supplies equal to one-half (1/2) of the discharging hospital's semi-private room rate; provided however, the confinement in such a hospital or facility begins not more than fourteen (14) days after a period of confinement in a general hospital of at least three (3) consecutive days. The covered person must be under the care of an attending physician who determines the continuing need for the hospital or facility stay.
27. Newborn care charges are a covered expense for an employee's newborn dependents. Charges for care of newborn children to include hospital charges for nursery room and board and miscellaneous expenses, charges by a pediatrician for attendance at a cesarean section, charges for physician examination for a newborn while hospital confined and charges for circumcisions if performed while the newborn is in the hospital at the time of birth.
28. Organ transplant benefits to include charges for organ transplants and peripheral stem cell transplants for the treatment of cancer are considered a covered expense when the transplant procedure is not considered experimental/investigative and the covered person is considered an eligible recipient. Donor charges are considered a covered expense provided the donor is a blood relative and charges are not covered under any insurance policy the donor may hold. Donor charges are limited to:
 - a) evaluating the organ or tissue;
 - b) removing the organ or tissue from the donor; and
 - c) transporting the organ or tissue from within the United States and Canada to the transplant site.
29. Hospice care charges for terminally ill patients with a life expectancy of six (6) months or less. Benefits are payable for up to six (6) months of services, as set forth herein. The following benefits are provided for hospice care, notwithstanding anything to the contrary herein:
 - a) skilled nursing, up to two (2) visits per day;
 - b) physical, speech and occupational therapy;
 - c) medical social services;
 - d) nutritional counseling;
 - e) medication and supplies;
 - f) home health aide visits, up to one hundred (100) hours per month;
 - g) homemaker services, up to one hundred (100) hours per month;

- h) continuous/respite care – relief of the primary caregiver, up to five (5) days of twenty-four (24) hour care per episode (sickness or other crisis of the primary caregiver);
- i) room and board charges of a hospice facility;
- j) charges of a hospice facility for other services and supplies;
- k) part-time nursing care by or under the supervision of a registered graduate nurse (R.N.);
- l) counseling services by a licensed clinical social worker or a licensed pastoral counselor for the patient and for other covered persons in the patient’s family (services by a licensed pastoral counselor to a member of their congregation in the course of duties to which such person is called as a pastor or minister will not be covered expenses under the Plan). Counseling services received in connection with bereavement will not be considered to have been received due to mental illness; or
- m) bereavement counseling services by a licensed clinical social worker or a licensed pastoral counselor for covered persons in the patient’s family within six (6) months after the patient’s death, up to fifteen (15) visits per family (services by a licensed pastoral counselor to a member of their congregation in the course of duties to which such person is called as a pastor or minister will not be covered expenses under the Plan). Counseling services received in connection with bereavement will not be considered to have been received due to mental illness.

30. **Preventive Care:** Charges for routine annual physical examinations and associated tests and screening, well-baby care, and well-adult care are covered expenses. Charges can include, but are not limited to, examinations (including breast and pelvic), immunizations, consultations, laboratory tests, pap smears (including laboratory fees), x-rays, mammograms, bone density screening, PSA tests, and EKG’s. Colonoscopies for covered persons age fifty (50) and older are covered expenses to a maximum of one (1) every five (5) years or more frequently if recommended by a physician.

31. **Mental Health Care and Substance Abuse:** Charges resulting from inpatient mental health care and alcohol and/or drug addiction in a hospital, public, or licensed mental hospital, or drug/alcohol abuse treatment facility, or for the services and supplies furnished on an outpatient basis by a comprehensive health service organization, community mental health center or other mental health clinic, day treatment center which furnishes mental health services with the approval of the appropriate governmental regulator authority, board certified physician, a licensed psychologist, clinical or certified social worker, pastoral counselor, or certified alcohol counselor (C.A.C.) will be considered a covered expense.

32. **Home Health Care:** Charges for the following services or supplies furnished to the covered person at home:
- a) Part-time intermittent nursing care by or under the supervision of a registered professional nurse (RN); and/or visits by persons who have completed a home health aide training course under the supervision of registered nurse for the purpose of giving personal care to the patient.
 - b) Physician's home and office visits, physical therapy, occupational therapy, and speech therapy.
 - c) Medical supplies, laboratory services, drugs, and equipment prescribed by a physician to the extent such items would have been covered if you or your dependent had been hospitalized.
 - d) **Exclusions and Limitations:** In no event will home health care expenses include charges for loss resulting from services solely for custodial care, transportation services, any period during which you or your dependent are not under the continuing care of a physician, injury, or sickness arising out of or in the course of employment, declared or undeclared war or act of war.
33. Any taxes and/or surcharges applied to a covered expense are considered eligible expenses when the tax or surcharge is mandated by state or federal government.
34. Any of the following services in connection with a mastectomy:
- a) all stages of reconstruction of the breast on which the mastectomy is performed;
 - b) surgery and reconstruction of the other breast to produce a symmetrical appearance; and
 - c) prostheses and treatment of physical complications of the mastectomy, including lymphedema.

The Women's Health and Cancer Rights Act of 1998 requires the Plan Sponsor to notify you, as a covered participant or dependent under this Plan, of your rights related to benefits provided through the Plan in connection with a mastectomy. You as a covered participant or dependent under this Plan have rights for coverage to be provided in a manner determined in consultation with your attending physician for the above referenced services.

35. Charges for mastectomy bras are a covered expense to a maximum of two (2) bras per covered person per calendar year.
36. Charges for a wig or hairpiece are a covered expense if the covered person has been diagnosed with cancer, and the treatment for the condition has caused hair loss. Benefits will not exceed one (1) wig per covered person every five (5) calendar years.
37. Charges for the initial pair of lenses when necessitated as a result of a surgical procedure (only one (1) pair of lenses as a result of anyone surgery will be eligible charges).

38. Charges for childbirth in a birthing center.
39. Charges for a second surgical opinion on a pending surgical procedure are covered expenses. If the second opinion disagrees with the first opinion, the Plan will pay for a third opinion. A board certified physician must provide the second and third opinions. It is not mandatory that a second surgical opinion be obtained.
40. Charges for acupuncture.

GENERAL MEDICAL EXCLUSIONS AND LIMITATIONS

1. Expenses for confinement, treatment, services, or supplies except to the extent herein provided which are:
 - a) not furnished or ordered by a recognized provider and not medically necessary to diagnose or treat a sickness or injury;
 - b) experimental or investigational in nature.
2. Expenses for services for disease or injury sustained as a result of war, declared or undeclared. For all purposes of this Plan, terrorism is considered an act of war.
3. Expenses for services for disease or injury sustained as a result of participation in a riot or civil disobedience, or while committing or attempting to commit a criminal act or engage in an illegal activity.
4. Expenses incurred in connection with any accidental bodily injury or illness arising out of or in the course of any employment, regardless of whether the employment is for profit or compensation. This exclusion applies to all covered individuals, including but not limited to, self employed individuals who choose not to provide themselves with insurance coverages such as, but not limited to, workers' compensation and occupational disease, regardless of whether such coverage or coverages are required by law.
5. Expenses incurred while on full-time active duty in the armed forces of any country, combination of countries or international authority.
6. Expenses for dental services, except to the extent herein provided.
7. Expenses for vision therapy or orthoptics, except following surgery to the muscles controlling the eye or in treatment of strabismus.
8. Expenses incurred for or in connection with eye refractions and any corrective treatment or surgery to correct a refractive error (i.e. such as hyperopia, myopia, astigmatism, or radial keratotomy, etc.) or eye examinations for the purpose of prescribing corrective lenses or fitting or actual cost of corrective lenses except to the extent herein provided (i.e. intra-ocular implant of lenses in the treatment of cataracts).
9. Expenses for hearing examinations or hearing aids.
10. Expenses for treatment, services, supplies, and facilities provided by or in a hospital owned or operated by any government or agency thereof where such care is provided at government expense under a plan or program established pursuant to the laws or regulations of any government or under a plan or program under which any government participates other than as an employer. The term "any government" includes the federal, veteran, state, provincial, municipal, local government, or any political subdivision thereof, of the United States or any other country. The Plan will not exclude benefits for a covered person who receives billable medical care at any of the above facilities.
11. Expenses for treatment, services, or supplies provided by the employee, spouse, parent, son, daughter, brother, or sister of a covered person or by a member of the covered person's household.

12. Expenses for which there is no legal obligation to pay or for which no charges would be made if the person had no medical or dental coverage.
13. Expenses for services for which the covered person recovers the cost by legal action or settlement.
14. Expenses for transsexual surgery or related procedures.
15. Expenses for rehabilitative care, as defined herein, in excess of three hundred sixty-five (365) days confinement.
16. Expenses for cosmetic or reconstructive surgery except for expenses:
 - a) incurred within two (2) years after an accident, to repair or alleviate the damage from an accident; or
 - b) incurred for reconstructive surgery following a mastectomy or for surgery and reconstruction of the other breast to produce symmetrical appearance; or
 - c) incurred as a result of a birth defect.
17. Expenses solely for custodial care, except as provided herein. Custodial care is care designed essentially to help a person in the activities of daily living and which does not require the continuous attention of trained medical or paramedical personnel.
18. Expenses for routine foot care by a podiatrist defined as the preventive maintenance and care (including cutting, debridement, trimming, reduction or removal) of calluses, clavi, corns, dystrophic nails, excrescences, helomas, hyperkeratosis, onychia, onychocryptosis, and tyloids except where a systemic condition has resulted in severe circulatory impairment or desensitization in the feet as these conditions make it hazardous for the cutting of nails, corns, etc., to be performed by a nonprofessional person.
19. Expenses for telephone, radio, television, and beautification services or for the preparation of reports, evaluations and forms, phone consultations, or for missed appointments or for time spent traveling or in connection therewith that may be incurred by the physician or dentist or other health care professional in the course of rendering services.
20. Expenses incurred for artificial insemination, in-vitro fertilization, embryo transplantation, hormone therapy or gamete intra-fallopian transfer (GIFT), or other procedures which are intended to result in pregnancy.
21. Routine or elective expenses except as set forth herein. [i.e. shoe inserts, ankle pads, printed material, arch supports, elastic stockings, fluoride, over-the-counter vitamins, prenatal vitamins, birth control methods, nutritional or dietary counseling, food supplements, and any "over the counter drug" which can be purchased with or without a prescription or when no injury or illness is involved].
22. Expenses incurred prior to the covered person's effective date of coverage or following the termination date of coverage.
23. Expenses in excess of the reasonable and customary charges in the locality where it is rendered or in excess of the lifetime maximum benefit stated herein.

24. Expenses for massage therapy or rolfing.
25. Expenses for surrogacy.
26. Expenses for female libido enhancement drugs and male impotence medications, including Viagra.
27. Expenses for smoking cessation methods and aids; whether or not under the direction of a physician.
28. Services, supplies, care, and/or treatment of an injury or sickness that results from engaging in hazardous pursuit, hobby, or activity. A pursuit, hobby or activity is hazardous if it involves or exposes an individual to risk of a degree or nature not customarily undertaken in the course of the covered person's customary occupation or if it involves leisure time activities commonly considered as involving unusual or exceptional risks, characterized by a constant threat of danger or risk of bodily harm, including but not limited to: hang gliding, skydiving, bungee jumping, parasailing, use of all terrain vehicles, rock climbing, use of explosives, automobile, motorcycle, aircraft, or speed boat racing, reckless operation of a vehicles or other machinery, and travel to countries with advisory warnings.
29. Expenses for chiropractic care.
30. Expenses for marital counseling.
31. Expenses for home health care transportation.
32. Expenses for speech therapy for any condition that does not have its basis in a medically proven organic pathology.
33. Expense for equipment which has personal use in the absence of the condition for which it is prescribed, including but not limited to air conditioners, air purifiers, dehumidifiers, humidifiers, waterbeds and exercise equipment.
34. Expenses for health club memberships or fees.
35. Expenses for learning disorders, educational, academic N.I.Q. testing.
36. Expenses for routine physical examinations, except as set forth under the preventive care chart.
37. Expenses for treatment on or to the teeth or gums, including oral surgery, except to the extent herein provided.
38. Expenses for holistic, homeopathic, or naturopathic services.
39. Expenses in excess of the calendar year/lifetime maximums as set forth herein.
40. Expenses related to "Never Events." These events are procedures performed on the wrong side, wrong body part, wrong procedure or wrong person. These "Never Events" are not medically necessary as they are not required to diagnose or treat an illness, injury, disease or its symptoms and are not consistent with generally accepted standards of medical practice.

CLAIM FILING PROCEDURES

Written notice of the employee or the employee's dependent's claim (proof of claim) must be given to the Contract Administrator as soon as is reasonably possible but within twelve (12) months after the occurrence or commencement of any loss covered by the Plan. Failure to furnish written proof of claim within the time required will invalidate the claim. It is the employee's responsibility to inform his provider(s) of this claim submission time limit.

Filing a Medical Claim:

To obtain benefits under this Plan, a diagnostic bill must be submitted that provides sufficient information, including the employee's name, claimant's name, claimant's address, and Plan number to allow the Contract Administrator to properly adjudicate each claim. The Contract Administrator may require additional forms and information to assist them in this process.

Mail all medical claims to:

Employee Benefit Plan Administration (EBPA)
P.O. Box 2000
Exeter, NH 03833-2000
(603) 778-7106
(800) 578-EBPA (3272)

[Should the employee have any questions, please feel free to call or write to the Contract Administrator.]

MISCELLANEOUS PROVISIONS

Discharge: All plan benefits made in accordance with the terms and provisions contained herein will discharge the Plan Sponsor from all future liability to the extent of the payments so made.

Discretionary Authority: The Plan Administrator has the authority to interpret the Plan and to determine all questions that arise under it. This will include, but is not limited to: satisfaction of eligibility requirements, determination of medical necessity, and interpretation of terms contained in this document. The Plan Administrator's decisions will be binding on all employees, dependents, and beneficiaries.

Except for functions reserved by the Plan to the Employer or Board of Directors, the Plan Administrator will control and manage the operation and administration of the Plan. The Plan Administrator will designate one or more named fiduciaries under the Plan, each with complete authority to review all denied claims for benefits under the Plan with respect to which it has been designated named fiduciary (including, but not limited to, the denial of certification of medical necessity of hospital or medical treatment). In exercising its fiduciary responsibilities, the named fiduciary will have discretionary authority to determine whether and to what extent participants and beneficiaries are entitled to benefits and to construe disputed or doubtful Plan terms. The named fiduciary will be deemed to have properly exercised such authority unless it has abused its discretion hereunder by acting arbitrarily and capriciously.

Family and Medical Leave Policy: All eligible employees have the right to take family and medical leave according to the provisions of the federal and state laws as amended from time to time.

Increases/Decreases in Coverage: Any amendments to the Plan providing an increase in the amount of a covered employee's and/or dependent's coverage will become effective as of the date of such amendment, provided coverage is in effect on the date of such amendment. Any amendment to the Plan providing a decrease in the amount of a covered employee's and/or dependent's coverage will begin on the effective date of such amendment.

Invalidity of Certain Provisions: If any provisions of the Plan will be held invalid or unenforceable, such invalidity or enforceability will not affect any other provision herein and this Plan will be construed and enforced as if such provisions had not been included.

Medicare Provision: All eligible employees and their dependents, age sixty-five (65) and over, who are eligible for coverage under the Plan, will be provided with coverage under this Plan on the same basis as available to covered employees under the age of sixty-five (65). Each employee over the age of sixty-five (65) has the right to reject the employer provided group health plan and elect to have Medicare for the employee and their spouse as their only coverage. Should the employee elect this option, Medicare will become the employee's health insurance coverage. The absence of any written documentation to the contrary will construe this Plan as primary.

For an eligible employee or dependent under age sixty-five (65), if Medicare eligibility is due solely to end-stage renal disease (ESRD), the Plan will be primary only during the first thirty (30) months of Medicare coverage. Thereafter, the Plan will be secondary with respect to Medicare Coverage. If an eligible employee or dependent is under age sixty-five (65) when Medicare eligibility is due solely to ESRD, and the employee or dependent subsequently attains age sixty-five (65), the Plan will be primary for a full thirty (30) months from the date of ESRD eligibility. Thereafter, Medicare will be primary and the Plan will be secondary. If an eligible employee or dependent is age sixty-five (65) or over, working and develops or is undergoing treatment for ESRD, the Plan will be primary for a full thirty (30) months from the date of ESRD eligibility. Thereafter, Medicare will be primary and the Plan will be secondary.

This provision will comply with the Social Security Act as amended from time to time.

Qualified Medical Child Support Orders: Participants and beneficiaries may obtain upon request from the Contract Administrator, without charge, a copy of the Plan's procedures relating to qualified medical child support orders.

Right to Make Payments: The Plan Administrator has the right to pay any other organization as needed to properly deliver plan benefits. These payments that are made in good faith are considered benefits paid under this Plan. Also, they discharge the Plan Administrator from further liability to the extent that payments are made.

Right to Receive and Release Necessary Information: For the purpose of determining the applicability of and implementing the terms of this provision of this Plan, or any provision of similar purpose of another plan, the Plan Administrator may release to or obtain from any other insurance company or other organization or person any information with respect to any person which the Contract Administrator deems to be necessary for such purposes. Any person claiming benefits under this Plan will furnish to the Contract Administrator such information as may be required to implement this provision in accordance with the HIPAA Privacy Requirements.

Right to Recovery: Whenever the Plan has allowed benefits to be paid which have been paid or should have been paid by any other plan, or which were erroneously paid, the Plan will have the right to recover any such excess payments from the appropriate party.

Right to Amend the Plan: The Board of Trustees of USNH, as authorized by the Plan Sponsor, has the authority to amend the Plan Document, modifying any of the provisions herein, or terminating the Plan at any time without the consent of or notice to any covered person hereunder. The Plan may be amended, modified, or terminated as required by plan utilization, costs, market forces, federal legislation, or other general business concerns of the Plan Sponsor. When a Plan amendment, modification, or termination is executed, the Plan Sponsor will provide notice of such action, in writing, to all covered persons.

Should the Plan be amended and, thereby, terminated, the Plan Administrator will provide for:

- First: Payment of benefits to each covered person of all covered expenses for services which were incurred while the Plan was in effect.
- Second: Payment of expenses incurred in the liquidation and distribution of the Plan and any payments due to the Plan Administrator.
- Third: Direct disposition of all assets, if applicable, held in the Plan to covered persons as determined by the Plan Administrator, subject to the limitations contained herein and any applicable requirements of law or regulation.

Subrogation, Reimbursement & Third Party Recovery Provision:

WHEN THIS PROVISION APPLIES: 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 Persons, Plan Beneficiaries, and/or their dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this section as "Covered Person(s)") 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").

If you, your spouse, one of your dependents, or anyone who receives benefits under this Plan becomes ill or is injured and is entitled to receive money from any source, including but not limited to any party's liability insurance or uninsured/underinsured motorist proceeds, then the Plan may elect, but is not required, to conditionally advance payment or extend credit 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 a third party, or from the acts or omissions of covered persons and their dependents where any insurance coverage, no-fault, uninsured motorist, underinsured motorist, medical payment provision or other insurance policies or funds is available. If at the time of injury, sickness, disease or disability there is available, or potentially available (based on information known or provided to the Plan, or to the Plan Beneficiary) any other 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.

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 they have or that may arise against any person, corporation and/or other entity and to any Coverage for which the Plan Beneficiary claims an entitlement to benefits under this Plan, regardless of how classified or characterized and to reimburse the Plan for any such benefits paid when recovery is made. The employee or covered person agrees that acceptance of benefits is constructive notice of this provision in its entirety and agrees to reimburse the Plan one hundred percent (100%) of benefits provided without reduction for attorney's fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise. The person receiving benefits further agrees that the plan shall have an equitable lien on any funds received by said person and/or their attorney, if any, from any source for any purpose and shall be held in trust until such time as the obligation under this provision is fully satisfied. If the employee or covered person retains an attorney, then the employee or covered person agrees to only retain one who will not assert the Common Fund or Made-Whole Doctrines. The Plan will not pay or be responsible, without its written consent, for any fees or costs associated with a Plan Beneficiary pursuing a claim against any Coverage. The Plan Beneficiary agrees to hold the Plan harmless against any claims made against the Plan by the attorneys retained by the Plan Beneficiary. Failure to comply with any of these requirements by the Plan Beneficiary, his or her attorney or guardian may, at the Plan's discretion, result in 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. If the Plan Beneficiary 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, judgement 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.

No court costs, expert fees, attorney's fees, filing fees, or other costs or expenses of a litigation nature may be deducted from the Plan's recovery without prior, expressed written consent of the Plan. Reimbursement shall be made immediately upon collection of any sum(s) recovered regardless of its legal, financial, or other sufficiency. If the injured person is a minor, any amount recovered by the minor, the minor's trustee, guardian, parent, or other representative, shall be subject to this provision regardless of state law and/or whether the minor's representative has access or control of any recovery funds.

The employee or covered person agrees to the following: (i) to sign any documents requested by the Plan including but not limited to reimbursement and/or subrogation agreements as the Plan or its agent(s) may request, (ii) 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 and (iii) 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. Also, the employee or covered person agrees to furnish any other information as may be requested by the Plan or its agent(s). Failure or refusal to execute such agreements or furnish information does not preclude the Plan from exercising its right to subrogation or obtaining full reimbursement. Any settlement or recovery received shall first be deemed for reimbursement of medical expenses paid by the Plan. Any excess after one hundred percent (100%) reimbursement of the Plan may be divided up between the employee or covered person and their attorney if applicable. Any accident related claims made after satisfaction of this obligation shall be paid by the employee or covered person and not the Plan.

The Plan will not pay or be responsible, without its written consent, for any fees or costs associated with a Plan Beneficiary pursuing a claim against any Coverage. The Plan Beneficiary agrees to hold the Plan harmless against any claims made against the Plan by the attorneys retained by the Plan Beneficiary.

The employee or covered person agrees to take no action which in any way prejudices the rights of the Plan. If it becomes necessary for the Plan to enforce this provision by initiating any action against the employee or covered person, then the employee or covered person agrees to pay the Plan's attorney's fees and costs associated with the action regardless of the action's outcome.

The Plan Sponsor has sole discretion to interpret the terms of this provision in its entirety and reserves the right to make changes as it deems necessary. Furthermore, the Plan may reduce or deny future benefits by the amount of any recovery received, but not reimbursed, by the Participant as it relates to an accident or injury for which the Plan paid benefits.

If the employee or covered person takes no action to recover money from any source, then the employee or covered person agrees to allow the Plan to initiate its own direct action for reimbursement.

These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgement of these rights is required by the Plan and signed by the employee or covered person.

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 still apply.

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.

The Use and Disclosure of Protected Health Information:

A. Use and Disclosure of Protected Health Information (PHI)

The Plan will use and/or disclose protected health information (PHI) to the extent of and in accordance with the uses and disclosures permitted or required by the Health Insurance Portability and Accountability Act of 1996 and regulations promulgated pursuant thereto ("HIPAA"). Specifically, to the extent allowed by law, the Plan will use and disclose PHI for purposes related to health care treatment, payment for health care, and health care operations.

B. The Plan Will Use and Disclose PHI in accordance with and as Required by Law and as Permitted by Authorization of the Plan Participant or Beneficiary

The Plan will disclose PHI in accordance with and as required by law. For example, (i) the Plan may disclose summary health information to the Plan Sponsor if the Plan Sponsor requests the summary information for the purpose of obtaining premium bids for health insurance coverage under the Plan, or for modifying, amending or terminating the Plan; (ii) the Plan may disclose to the Plan Sponsor information on whether an individual is participating in the Plan or is enrolled in or has disenrolled from a health insurance issuer or HMO offered by the Plan; and (iii) to the extent allowed by law, the Plan may use and disclose PHI for purposes related to health care treatment, payment for health care, and health care operations. Except for these uses and disclosures, the Plan shall obtain a written authorization from the individual who is the subject of the PHI prior to a disclosure. "Summary health information" means information that may be individually identifiable health information and that summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom the Plan Sponsor has provided health benefits under the Plan; and from which identifying information has been deleted, except that geographic information may be aggregated at the level of a five digit zip code.

C. For Purposes of This Section, University System of New Hampshire Is the Plan Sponsor

The Plan has received a certification from the Plan Sponsor that the Plan documents have been amended to incorporate the provisions set forth in D, below.

D. With Respect to PHI, the Plan Sponsor Agrees to the Following Conditions

The Plan Sponsor agrees to:

- not use or further disclose PHI other than as permitted or required by the Plan documents or as required by law;
- ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;
- not use or disclose PHI for employment-related actions and decisions unless authorized by an individual;
- not use or disclose PHI in connection with any other benefit or employee benefit plan of the Plan Sponsor unless authorized by an individual;
- report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which it becomes aware;
- make PHI available to an individual in accordance with HIPAA's access requirements;
- make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;
- make available the information required to provide an accounting of disclosures;
- make internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the U.S. Secretary of Health and Human Services for the purposes of determining the Plan's compliance with HIPAA; and
- if feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form, and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible); and
- implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the electronic protected health information; and
- ensure adequate separation required by 164.504(f)(2)(iii) is supported by reasonable and appropriate security measures.

E. Adequate Separation Between the Plan and the Plan Sponsor Must Be Maintained

In accordance with HIPAA, only the following employees or classes of employees may be given access to PHI:

- the Associate Director of Human Resources; and
- staff designated by the Associate Director of Human Resources.

The following employees, classes of employees or other persons under the Plan Sponsor's control may have access to PHI including PHI relating to payment under, health care operations of, or other matters pertaining to the Plan in the ordinary course of business:

- Finance Controller or staff designated by the Finance Controller
- Director of Internal Audit or staff designated by the Director of Internal Audit
- General Counsel or staff designated by the General Counsel

F. Limitations of PHI Access and Disclosure

The persons described in section E may only have access to and use and disclose PHI for plan administration functions that the Plan Sponsor performs for the Plan.

G. Noncompliance Issues

If the persons described in section E do not comply with this Plan document, the Plan Sponsor shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

H. Security Requirements

The security rule requires plans to comply with four (4) general requirements. The plan must:

- ensure the confidentiality, integrity, and availability of all electronic protected health information that it creates, receives, maintains, or transmits;
- protect against any reasonably anticipated threats or hazards to the security or integrity of the electronic protected health information;
- protect against any reasonably anticipated uses or disclosures of electronic protected health information that are not permitted or required under HIPAA; and
- ensure compliance with the security standards by its workforce.

DEFINITIONS

The following words and phrases are included here for explanatory purposes only. This list is not intended to include all terms used herein. Any word or phrase not specifically defined below will have its usual and customary meaning. The inclusion of any word or phrase below is not intended to imply that coverage is provided under the Plan with respect to any such condition, service, facility, or person.

Accident: An unforeseen or unexplained sudden injury occurring by chance without intent or volition.

Active Service: An employee will be considered in active service with the employer on a day which is one of the employee's scheduled work days if he is performing in the customary manner all of the regular duties of their employment with the employer on that day, either at one of the employer's business establishments or at some location to which the employer's business requires him to travel. A regular vacation day, properly scheduled in accordance with normal practices and policies of University System of New Hampshire will qualify as a scheduled work day for purposes of this definition.

Aggregate: The combined total of all family members.

Ambulatory Surgical Center: A facility which is not physically attached to a health care facility, which provides surgical treatment to patients not requiring hospitalization, and does not include the offices of private physicians or dentists whether in an individual or group practice.

Birthing Center: A public or private facility, other than private offices or clinics of physicians, which meets the free standing birthing center requirements of the State Department of Health in the state where the covered person receives the services.

The birthing center must provide: a facility which has been established, equipped, and operated for the purpose of providing prenatal care, delivery, immediate postpartum care and care of a child born at the center; supervision of at least one (1) specialist in obstetrics and gynecology; a physician or certified nurse midwife at all births and immediate postpartum period; extended staff privileges to physicians who practice obstetrics and gynecology in a area hospital; at least two (2) beds or two (2) birthing rooms; full-time nursing services directed by an R.N. or certified nurse midwife; arrangements for diagnostic x-ray and lab services; and the capacity to administer local anesthetic or to perform minor surgery.

In addition, the facility must only accept patients with low risk pregnancies, have a written agreement with a hospital for emergency transfers and maintain medical records on each patient and child.

Civil Union Partner: A legal union of a same-sex couple, documented by an authorized person in the state in which the employee and partner reside. A civil union will be required as of January 1, 2010 to be covered under the Plan.

Claim for benefits: A request for a Plan benefit or benefits made by a claimant in accordance with the Plan's procedure for filing benefit claims. This includes any Pre-Service Claims and any Post-Service Claims.

Coinsurance: Coinsurance percentages represent the portions of covered expenses paid by the covered person and by the Plan after satisfaction of any applicable deductible. These percentages apply only to covered expenses which do not exceed the reasonable and customary charges. The covered person is responsible for all non-covered expenses and any amount which exceeds the reasonable and customary charge for covered expenses.

Contract Administrator: Third party claims administrator, hired by the Plan Sponsor to handle the day-to-day administration of the Plan, including:

1. reviewing and processing claims for proper benefit payments and providing explanation of benefits to covered employees and/or providers;
2. remitting benefit payments for covered expenses under the Plan to covered employees and/or providers;
3. reviewing all claims appeals.

Contributory Coverage: Plan benefits for which an employee enrolls and agrees to make any required contributions toward the cost of coverage.

Convalescent Hospital/Extended Care Facility/Skilled Nursing Facility: An institution which is licensed pursuant to state and/or local laws and is operated primarily for the purpose of providing treatment for individuals convalescing from injury or illness, including that part or unit of a hospital which is similarly constituted and operated, and:

1. Has organized facilities for medical treatment and provides for twenty-four (24) hour nursing service under the full-time supervision of a physician or a registered nurse. Full-time supervision means a physician or a registered nurse is regularly on the premises at least forty (40) hours per week;
2. Maintains daily clinical records concerning each patient and has a written agreement or arrangement with a physician to provide services and emergency care for its patients;
3. Provides appropriate methods for dispensing and administering drugs and medicines;
4. Has transfer agreements with one (1) or more hospitals, a utilization review procedures in effect, and operational policies developed with the advice of and reviewed by a professional group including at least one (1) physician. A convalescent hospital/extended care facility will not include any institution which is a rest home for the aged, or a place for the treatment of mental disease, drug addiction or alcoholism, or a nursing home.
5. Qualifies as an "extended care facility" under the health insurance provided by Title XVIII of the Social Security Act, at the time.

Covered Person: A covered employee or a covered dependent as determined under the applicable Plan provision.

Creditable Coverage: Coverage with a previous carrier that is credited toward the preexisting condition limitation provision of this Plan. Creditable coverage includes Medicare, Medicaid, state health benefits risk pool coverage, group health plans, etc. Waiting periods are not considered breaks in coverage. Days in a waiting period are not creditable coverage.

Custodial Care: Care which is designed essentially to help a person in the activities of daily living and which does not require the continuous attention of trained medical or paramedical personnel. Custodial care includes services that could be performed by a relative or friend with minimal instruction or supervision.

Custodial Parent: The parent awarded custody by court decree. If there is no court decree, the custodial parent is the one with whom the child resides for more than half the year.

Day of Confinement: Any period of twenty-four (24) hours or any part thereof for which a full charge for room and board is made by a hospital.

Deductible: The amount of covered expenses the covered employee must pay during each calendar year before the Plan will consider expenses for reimbursement. The individual deductible applies separately to each covered person. The family deductible is the maximum deductible applied to each family. One person in the family must completely satisfy the individual calendar year deductible amount; the remaining family deductible amount may be satisfied by any combination of covered family members, but no individual must satisfy more than the personal deductible amount. When the family deductible is satisfied, no further deductible will be applied for any covered family member during the remainder of that calendar year.

Dental Services: Procedures involving the teeth, gums, or supporting structures.

Dentist: A duly licensed doctor of dentistry and a dental professional or practitioner who is duly licensed under appropriate state licensing authorities, provided a benefit is claimed for services which are within the scope of such person's license and for which a reimbursement under the Plan would be made had such services been performed by a doctor of dentistry, and under applicable state laws, such professional or practitioner must be treated under the Plan in the same manner as if such services were provided by a doctor of dentistry.

Dependent:

1. The lawful spouse or civil union partner of an eligible employee provided such spouse or civil union partner is not legally separated from employee, or same-sex domestic partner (to qualify for coverage, you must file an Affidavit of Same-Sex Domestic Partnership with the UNH Benefits Office and provide any additional required documentation prior to January 1, 2010. As of January 1, 2010, same sex partners need to be in a legally recognized civil union in order to be eligible for coverage under this Plan); or
2. the unmarried child of an eligible employee who has not attained their nineteenth (19th) birthday and who is primarily dependent upon the employee for support and maintenance and can be claimed as a dependent for federal income tax purposes; dependent children of your same-sex domestic partner (through December 31, 2009 or domestic partners with USNH approved hardship thereafter) or civil union partner may be eligible for coverage if they reside with you and are listed on your partner's income tax return as a dependents; or

3. the unmarried child of an eligible employee, as defined herein, who has attained their nineteenth (19th), but not yet attained his twenty-fifth (25th) birthday, and only during the time such child is enrolled as a full-time student in an accredited secondary school or college, including regular vacations.

The word "child", as used above, will include an eligible employee's natural child, a legally adopted child (including a child in the custody of the employee under an interim court order of adoption, whether or not a final adoption order is ever issued), a stepchild, a foster child, the child of a same-sex domestic partner (through December 31, 2009 or domestic partners with USNH approved hardship thereafter), the child of a civil union partner, or a child for whom legal guardianship has been granted, all of whom are dependent upon the eligible employee for support and maintenance but excludes a child who is eligible for:

1. Employee coverage under this Plan;
2. Employee coverage under another group health and/or dental plan.

Should an employee have a child covered under the Plan who reaches the age at which the child would otherwise cease to be a covered person and if such child is then mentally or physically handicapped and incapable of earning his own living, the Plan will continue to consider such child as a dependent beyond such age, while such child remains in such condition, subject to all of the terms of the Plan, provided the employee has, within thirty-one (31) days of the date on which the child attained such age, submitted proof of the child's incapacity, as described above.

The Plan Sponsor will have the right to require satisfactory proof of continuance of such mental or physical incapacity and the right to examine such child at any time after receiving proof of the child's incapacity. Upon failure to submit such required proof or to permit such an examination when requested by the Plan Sponsor, or when the child ceases to be so incapacitated, coverage with respect to the child will cease. This continuation of coverage will be subject to all the provisions of the "Termination of Benefits" section of this Plan except as modified herein.

Dependent Coverage: Plan benefits extended to the dependent(s) of a covered employee.

Effective Date: The date the Plan becomes liable to provide coverage under the terms of the Plan.

Eligibility Date: The date an employee and/or their dependent(s) become eligible to enroll in the Plan.

Employee: Any employees who qualify for employee coverage under the eligibility requirements set forth in the "General Information" section contained herein. The definition of an employee does not include independent contractors, contingent workers, or leased employees.

Employee Coverage: Group medical benefits provided under the Plan on behalf of a covered employee.

Employer: The company providing employment to the covered employees (University System of New Hampshire).

Enrollment Date: The first day of coverage under the Plan or, if there is a waiting period, the first day of the waiting period. This date is frequently, but not always, the date of hire.

Expense: A charge a covered person is legally obligated to pay. An expense is deemed to be incurred on the date the service or supply is furnished.

Experimental/Investigative: A drug, device, medical treatment or procedure is experimental or investigative:

- a) if the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or
- b) if the drug, device, medical treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment, or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval; or
- c) if reliable evidence shows that the drug, device, medical treatment, or procedure is the subject of on-going phase I or phase II clinical trials, is the research, experimental, study or investigational arm of on-going phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or
- d) if reliable evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment, or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

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

Fiduciary: A fiduciary exercises discretionary authority or control over management of the Plan or the disposition of its assets; renders investment advice to the Plan; or has discretionary authority or responsibility in the administration of the Plan.

Health Care Operations: include, but are not limited to the following activities:

- quality assessment;
- population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting health care providers and patients with information about treatment alternatives and related functions;
- rating provider and plan performance, including accreditation, certification, licensing or credentialing activities;
- underwriting, premium rating and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing or placing a contract for reinsurance of risk relating to health care claims (including stop-loss insurance and excess of loss insurance);
- conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;

- business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the Plan, including formulary development and administration, development or improvement of payment methods or coverage policies;
- business management and general administrative activities of the Plan, including, but not limited to:
 - a) management activities relating to the implementation of and compliance with HIPAA's administrative simplification requirements, or
 - b) customer service, including the provision of data analyses for policyholders, plan sponsors or other customers;
- resolution of internal grievances;
- the sale, transfer, merger, or consolidation of all or part of the "covered entity" within the meaning of HIPAA with another covered entity, or an entity that following such activity will become a covered entity and due diligence related to such activity; and
- consistent with the applicable requirements of the regulations issued under HIPAA, creating de-identified health information or a limited data set, and fundraising for the benefit of the "covered entity" within the meaning of HIPAA.

Health Care Professional: A physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with State law.

Home Health Care Agency: A licensed and state approved home health care facility possessing a valid certificate of approval issued in accordance with Title XVIII of the Social Security Act and licensed and approved by the appropriate state authorities which specializes in providing health care and therapeutic services to a person in such person's home.

Home Health Care Plan: A program for care and treatment of a covered person established and approved, in writing, by such covered person's attending physician, together with such physician's certification that the proper treatment of the injury or sickness would require confinement as a resident inpatient in a hospital or confinement in a skilled nursing facility as defined in Title XVIII of the Social Security Act, at the time, in the absence of services and supplies provided as part of the home health care plan.

Hospice: An agency that provides counseling and incidental medical services for a terminally ill individual who has been diagnosed by a physician as having a life expectancy of six (6) months or less. Room and board may be provided. The agency must meet all of the following tests: (i) approved under any required state or governmental Certificate of Need; (ii) provides twenty-four (24) hour a day, seven (7) day a week service; (iii) it is under the full-time supervision of at least one (1) duly qualified physician; (iv) has a nurse coordinator who is a registered graduate nurse with at least four (4) years of full-time clinical experience. Two (2) of these years must involve caring for terminally ill patients; (v) has a social service coordinator who is licensed in the area in which it is located; (vi) the main purpose of the agency is to provide hospice services; (vii) has a full-time administrator; (viii) maintains written records of services given to each patient; (ix) its employees are bonded; (x) it provides malpractice and malplacement insurance; (xi) is established and operated in accordance with any applicable state laws.

Hospital: A duly licensed, if required, and legally-constituted and operated institution which is primarily engaged in providing diagnostic services, therapeutic services for diagnosis, care and treatment of sick or injured persons on an inpatient and/or outpatient basis, and which provides such care and treatment: (i) under the supervision of one (1) or more physicians, (ii) with twenty-four (24) hour nursing service under the supervision of one (1) or more physicians licensed to practice medicine; and (iii) which has organized facilities for laboratory and diagnostic work and major surgery. The term "Hospital" will not include, other than incidentally, an institution which is primarily a rest home, a nursing home, a convalescent home, a rehabilitation center, an extended care facility, a place (primarily) for the treatment of tuberculosis, mental, emotional, drug or alcoholic disorders, or a home for the aged. Services rendered in the infirmary or clinic of a college, university, or private boarding school will be eligible expenses. In such instances, if a covered person is confined in a school facility that does not meet the definition of a hospital because it has no operating room, benefits may be paid, provided the charges for such confinement do not exceed the reasonable and customary charges for the disability involved.

Hospital Confinement: Being registered as a bed-patient in a hospital upon the recommendation of a physician, or as a result of a surgical operation, or by reason of receiving emergency medical care.

Illness: Sickness or disease which results in expenses for medical care, services, and supplies covered by the Plan. Such expense must be incurred while the covered person, whose illness is the basis of the claim, is covered under the Plan. Medical expenses incurred by a covered person because of pregnancy will be covered to the same extent as any other illness.

Injury: Accidental bodily harm resulting from an accident.

Inpatient Basis: Hospital confinement including one (1) or more days of confinement for which a room and board charge is made by a hospital.

Intensive Care Unit: An accommodation in or part of a hospital, other than a post-operative recovery room, which, in addition to providing room and board:

1. Is established by the hospital for the purpose of providing formal intensive care;
2. Is exclusively reserved for critically ill patients requiring constant audio/visual observation prescribed by a physician and performed by a physician or by a specifically trained registered nurse; and
3. Provides all necessary lifesaving equipment, drugs, and supplies in the immediate vicinity on a standby basis.

Licensed Pastoral Counselor: An individual who is licensed by the State of New Hampshire under RSA 330-B and who by virtue of professional education and experience would be eligible for fellowship in the American Association of Pastoral Counselors.

Maximum Medical Lifetime Benefits: The maximum lifetime benefit amount under this Plan for all covered medical expenses incurred by a covered person. See amounts on the "Schedule of Benefits".

Medical Emergency: The sudden, unexpected onset of a medical condition with severe symptoms that are considered hazardous to the patient's life, health, or physical well-being, requiring urgent and immediate medical attention.

Medical Intervention: Any medical treatment, service procedure, facility, equipment, drug, device, or supply.

Medically Necessary: Health care services, supplies, or treatment will be considered medically necessary if:

- a) there is a sickness or injury which requires treatment; or
- b) the confinement, service, or supply used to treat the sickness or injury is:
 - required;
 - generally professionally accepted as usual, customary, and effective means of treating the sickness or injury in the United States; and
 - approved by regulatory authorities such as the Food & Drug Administration; and
- c) diagnostic x-rays and laboratory tests when they are performed due to definite symptoms of sickness or injury, or they reveal the need for treatment.

Mental Hospital: An institution (other than a hospital as defined) which specializes in the diagnosis and treatment of mental illness or functional nervous disorders and which is operated pursuant to law and meets all of the following requirements:

- 1. Is licensed to give medical treatment and is operated under the supervision of a physician;
- 2. Offers nursing services by registered graduate nurses (RN) or licensed practical nurses (LPN) and provides, on the premises, all the necessary facilities for medical treatment;
- 3. Is not, other than incidentally, a place of rest or a place for the aged, drug addicts, or alcoholics; or a place for convalescent, custodial, or educational care.

Mental Illness: Neuroses, psychoneuroses, psychoses, and other mental and emotional disorders falling within any of the diagnostic categories in the mental disorders section of the international classification of diseases.

Never Events: These events, as defined by The National quality Forum, a private organization whose members include the American Medical Association (AMA), are "errors in medical care that are clearly identifiable, preventable, and serious in their consequences for patients, and that indicate a real problem in the safety and credibility of a health care facility."

Newborn Care Charges: Charges for care of newborn children as more specifically defined herein.

Non-Contributory Coverage: Plan benefits for which the employee enrolls and for which he is not required to make contribution toward the cost of coverage.

Out-of-Pocket Maximum: Under the terms of this Plan, the maximum amount any individual covered under the Plan would be required to pay toward the reasonable and customary (R&C) allowance on all covered expenses during a calendar year. The out-of-pocket maximum will be determined by adding the deductible and employee share of coinsurance amounts as set forth by this Plan.

Outpatient Basis: Any hospital expenses incurred for which no room and board charge is made.

Outpatient Mental Health Treatment Facility: A comprehensive, health service organization, a licensed or accredited hospital, or community mental health center or other mental health clinic or day care center which furnished mental health services with the approval of the appropriate governmental authority, any public or private facility or portion thereof providing services especially for the diagnosis, evaluation, service or treatment of mental illness or emotional disorder.

Payment: Includes activities undertaken by the Plan to obtain premiums or determine or fulfill its responsibility for the coverage and provision of plan benefits or to obtain or provide reimbursement for the provision of health care that relate to an individual to whom health care is provided. These activities include, but are not limited to, the following:

- determination of eligibility, coverage and cost sharing amounts (for example, cost of a benefit, plan maximums and copayments as determined for an individual's claim);
- coordination of benefits;
- adjudication of health benefit claims (including appeals and other payment disputes);
- subrogation of health benefit claims;
- establishing employee contributions;
- risk adjusting amounts due based on enrollee health status and demographic characteristics;
- billing, collection activities and related health care data processing;
- claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes and responding to participant inquiries about payments;
- obtaining payment under a contract for reinsurance (including stop-loss and excess of loss insurance);
- medical necessity reviews or reviews of appropriateness of care or justification of charges;
- utilization review, including precertification, preauthorization, concurrent review and retrospective review; and
- disclosure to consumer reporting agencies related to the collection of premiums or reimbursement (the following PHI may be disclosed for payment purposes: name and address, date of birth, Social Security number, payment history, account number and name and address of the provider and/or health plan).

Physician: A duly licensed doctor of medicine, a medical professional, or a practitioner who is duly licensed under appropriate state licensing authorities, provided: (i) a benefit is claimed for services which are within the scope of such person's license and for which a reimbursement under the Plan would be made had such services been performed by a doctor of medicine, and (ii) under applicable state laws, such professional or practitioner must be treated under the Plan in the same manner as if such services were provided by a medical doctor.

Plan: The University System of New Hampshire Group Medical Benefits Plan, as described herein.

Plan Administrator: University System of New Hampshire

Plan Anniversary Date: The date occurring in each calendar year which is an anniversary of the effective date of the Plan.

Plan Document: The master contract which describes the terms of coverage and association between the Contract Administrator and the Plan Sponsor.

Plan Sponsor: University System of New Hampshire

Prior Plan: The prior group medical plan offered by the Plan Sponsor.

Protected Health Information: Health information, including demographic information, which is collected from an individual, and which;

- is created or received by the Plan;
- relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and
 - a) that identifies the individual; or
 - b) with respect to which there is a reasonable basis to believe that the information can be used to identify the individual; and
- is transmitted by electronic media, maintained in any electronic medium, or transmitted or maintained in any other form or medium. Protected Health Information excludes information in education records covered by the Family Educational Right and Privacy Act, records described at 20 U.S.C. 1232(g)(a)(4)(B)(iv), and employment records held by the Plan Sponsor in its role as employer.

Qualified Beneficiary: Any covered person who loses coverage as a result of a qualifying event described in the "Extension of Benefits" section. These beneficiaries are:

1. covered employees (and their spouses, same-sex domestic partner (through December 31, 2009 or domestic partners with USNH approved hardship thereafter), civil union partner, and dependent children) who have been terminated for reasons other than the covered employee's gross misconduct, or have had their hours reduced (resulting in a loss of coverage);
2. widowed spouses, same-sex domestic partners (through December 31, 2009 or domestic partners with USNH approved hardship thereafter), civil union partners, and dependent children;
3. divorced or legally separated spouses and their dependent children;
4. Medicare ineligible spouses and their dependent children;
5. a covered dependent child who no longer meets the Plan's definition of a covered dependent child;
6. a child born to, or placed for adoption with the covered employee during the period of COBRA coverage;
7. dependents satisfying the requirements of a same-sex domestic partner (through December 31, 2009 or domestic partners with USNH approved hardship thereafter) or civil union partner, as defined herein.

Reasonable and Customary Allowance (R&C): A maximum allowable charge for each covered medical and dental service provided for under the Plan, as established for this Plan, solely by a national firm. The following is used as a guide: This allowance schedule is intended to include all charges provided, in the geographical area where the covered expense is incurred, by properly licensed medical and dental care providers, and which do not exceed the usual fees charged for comparable services. For the purposes of this Plan, the term reasonable and customary extends to a preferred provider negotiated fee allowance, where appropriate.

Rehabilitation Hospital: A facility which meets all requirements of a hospital (as defined herein) other than the "surgical facilities" requirements and, in addition, meets the following criteria:

1. It must be accredited by the Joint Commission of Accreditation of Hospitals and be approved for Federal Medicare Benefits as a qualified hospital;
2. It must maintain transfer agreements with acute care facilities to handle surgical and/or medical emergencies;
3. It must maintain a utilization review committee.

Rehabilitative Care: Necessary inpatient medical care (as prescribed by a physician) rendered in a rehabilitation hospital (as defined herein) excluding custodial care or occupational training.

Residential Treatment Facility: A child care institution that provides residential care and treatment for emotionally disturbed children and adolescents. The facility must be accredited as a residential treatment facility by the Council on Accreditation of Hospitals or the American Association of Psychiatric Services for Children.

Same Sex Domestic Partner (only applies to same sex domestic partners covered under the plan as of December 31, 2009. Effective January 1, 2010, same sex partners need to be in a legally recognized civil union in order to be eligible for coverage under the Plan):

1. Partners must be of the same gender;
2. Partners must be at least eighteen (18) years of age and are mentally competent to contract;
3. The partners are responsible for each other's common welfare and financial obligations;
4. The partnership must have been in existence for the past six (6) consecutive months and Plan to remain so indefinitely;
5. Partners are not legally married, cannot be related by blood to a degree that would prohibit marriage, nor allowed to marry each other in the state of New Hampshire.

Substance Abuse: Any use of alcohol or drugs which produces a state of psychological and/or physical dependence.

Substance Abuse Treatment Facility:

1. A public or private facility providing services especially for detoxification or rehabilitation of substance abusers and which is licensed to provide such services;
2. A comprehensive health service organization, community mental health clinic or day care center which furnishes mental health services with the approval of the appropriate governmental authority, any public or private facility or portion thereof providing services especially for the rehabilitation of substance abusers and which is licensed to provide such services.

Totally Disabled: A covered person will be considered totally disabled if, as a result of an illness or an accidental injury, such covered person is unable to engage in any gainful occupation for which they are reasonably fitted by education, training, or experience, and is not performing work of any kind for wage or profit. A covered dependent will be considered totally disabled if because of an illness or an accidental injury such covered dependent is prevented from engaging in all the normal activities of a person of like age and sex who is in good health.

Treatment: The provision, coordination, or management of health care and related services by one or more health care providers, including the coordination or management of health care by a health care provider with a third party; consultation between health care providers relating to a patient; and the referral of a patient for health care from one health care provider to another.

Waiting Period: The period of time between the employee's enrollment date and the employee's first date of coverage under the Plan.

PLAN DOCUMENT ACCEPTANCE PAGE

APPROVED AND ACCEPTED

This Plan Document, known as the University System of New Hampshire Group Medical Benefits Plan Option A, is hereby executed at:

_____, on _____
(City) (State) (Date)

BY: _____

TITLE: _____