

# INDEPENDENT COLLEGES AND UNIVERSITIES BENEFITS ASSOCIATION, INC.

## MEDICAL, BEHAVIORAL HEALTH, AND PRESCRIPTION DRUG PLAN DOCUMENT

April 1, 2011

THIS DOCUMENT IS FOR ALL EMPLOYEES AND OTHER BENEFICIARIES ELIGIBLE FOR BENEFITS UNDER  
THE INDEPENDENT COLLEGES AND UNIVERSITIES BENEFITS ASSOCIATION  
MEDICAL, BEHAVIORAL HEALTH, AND PRESCRIPTION DRUG PLAN



INDEPENDENT COLLEGES AND UNIVERSITIES BENEFITS ASSOCIATION, INC.

ORLANDO, FLORIDA

[HTTP://ICUBABENEFITS.ORG](http://icubabenefits.org)

866-377-5102



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## ARTICLE ONE

### INTRODUCTION

The Independent Colleges and Universities Benefits Association, Inc. Medical, Behavioral Health, and Prescription Drug Plan (the "Plan") was adopted on April 1, 2003 by the six founding Member Institutions of the Independent Colleges and Universities Benefits Association, Inc. ("ICUBA"). There are currently 19 Member Institutions:

Barry University (effective 1/1/2006)  
Beacon College (effective 10/1/2005)  
The Bolles School (effective 7/1/2010)  
Central Florida Area Health Education Center (effective 4/1/2011)  
Clearwater Christian College (effective 4/1/2003)  
Edward Waters College (effective 11/1/2003)  
Everglades Area Health Education Center (effective 4/1/2011)  
Florida Institute of Technology (effective 4/1/2003)  
Florida Memorial University (effective 1/1/2008)  
Nova Southeastern University (effective 4/1/2003)  
Palm Beach Atlantic University (effective 4/1/2003)  
The Poynter Institute (effective 1/1/2011)  
Rollins College (effective 4/1/2003)  
Saint Edward's School (effective 9/1/2009)  
Saint Leo University (effective 6/1/2003)  
St. Mark's Episcopal Day School (effective 7/1/2011)  
Saint Paul's School (effective 7/1/2010)  
San Jose Episcopal Day School (effective 7/1/2010)  
Tampa Preparatory School (effective 5/1/2011)  
The University of Tampa (effective 6/1/2003)

On March 14, 2003, the Florida Department of Financial Services granted ICUBA a Certificate of Authority to operate as a self-funded non-profit Multiple Employer Welfare Arrangement operating as a health care cooperative pursuant to Section 624.436, Florida Statutes.

This document amends and restates the Plan, effective April 1, 2011. A current version of the Plan will always be available on ICUBA's website at <http://icubabenefits.org>.

The Plan has been approved by the Board of Directors of ICUBA. It is intended to meet the requirements of the Employee Retirement Income Security Act of 1974 ("ERISA"). In addition, the Plan is a Voluntary Employees' Beneficiary Association and is intended to meet the requirements of Section 501(c)(9) of the Internal Revenue Code of 1986 (the "Code") and the Regulations promulgated thereunder, as amended from time to time.

This document and any amendments constitute the governing document of the Plan. The Plan is designed and administered exclusively for the benefit of eligible beneficiaries. You are entitled to coverage under the Plan if the eligibility provisions of the Plan have been satisfied. A clerical error shall not invalidate Your Benefits under the Plan if You are otherwise entitled to Benefits under the Plan.



The Board of Directors intends to maintain the Plan indefinitely. However, the Board of Directors has the right to modify or terminate the Plan at any time, and for any reason, as to any part or in its entirety, **without advance notice**. If the Plan is amended or terminated, You may not receive Benefits described in the Plan after the effective date of such amendment or termination. Any such amendment or termination shall not affect Your right to Benefits for Claims incurred prior to such amendment or termination. If the Plan is amended, You may be entitled to receive different Benefits or Benefits under different conditions. However, if the Plan is terminated, all Benefit coverage will end. This may happen at any time. If the Plan is terminated, You will not have any vested rights under the Plan. You may, however, have a vested right to a benefit under Your Employer's Health Reimbursement Account Plan, if any (see Your Health Reimbursement Account Plan Document).

**Oral statements or representations by anyone, which are contrary to this Plan document are not authoritative sources of information and may not be relied upon.**

### Advice on Reading this Document

Some of the terms used in this Plan Document begin with a capital letter. These terms have special meaning under the Plan and are defined in the Glossary, which is located at the end of this Plan Document. Other capitalized terms used within this Plan Document may be defined within their relevant Article. When reading the provisions of the Plan, You can refer to the Glossary at the end of this Plan Document. Becoming familiar with the terms defined therein will give You a better understanding of the procedures and Benefits described herein.

There are seventeen riders that accompany this Plan. Depending upon Your Employer, these riders may or may not apply to You. It is important that You read the attached riders and determine whether they apply to You.

**This Plan Document constitutes the Summary Plan Description required by ERISA Section 102.**



## ARTICLE TWO

### PLAN IDENTIFYING INFORMATION

<b>NAME OF THE PLAN</b>	Independent Colleges and Universities Benefits Association, Inc. Medical, Behavioral Health, and Prescription Drug Plan
<b>TYPE OF PLAN</b>	Self-Funded Non-Profit Medical, Behavioral Health, and Prescription Drug Plan
<b>FUNDING MEDIUM AND TYPE OF PLAN ADMINISTRATION</b>	Blue Cross Blue Shield of Florida (BCBSFL) is the claims administrator and processes claims under the Medical program through Blue Cross Blue Shield of Florida. Walgreens Health Initiatives (WHI) is the pharmacy benefit manager under the Prescription Drug program. MHNet Behavioral Health is the claims administrator and processes all behavioral health claims. BCBSFL, WHI, and MHNet Behavioral Health do not serve as insurers, but as Claims processors and Network Providers. Claims are paid out of the assets of ICUBA, which receives contributions from Member Institutions and Participants, and holds those assets in trust for the exclusive benefit of Beneficiaries. MHNet Behavioral Health provides Employee Assistance Program Services on a capitated fee basis.
<b>ADDRESS OF PLAN</b>	ICUBA 4850 Millenia Blvd., Suite 329 Orlando, FL 32839
<b>AGENT FOR SERVICE OF LEGAL PROCESS</b>	Mark S. Weinstein, President & CEO 4850 Millenia Blvd., Suite 329 Orlando, FL 32839
<b>PLAN NUMBER</b>	501
<b>PLAN SPONSOR</b>	Independent Colleges and Universities Benefits Association, Inc.
<b>EMPLOYER IDENTIFICATION NUMBER (EIN)</b>	42-1576411
<b>PLAN EFFECTIVE DATE</b>	April 1, 2003
<b>RESTATEMENT EFFECTIVE DATE</b>	April 1, 2011
<b>PLAN RENEWAL DATE</b>	April 1 of each year



**PLAN YEAR (4/1-3/31) END**

March 31 of each year

**NAMED FIDUCIARY AND  
PLAN ADMINISTRATOR**

The Board of Directors of the Independent Colleges  
and Universities Benefits Association, Inc.

**MEDICAL PRECERTIFICATION PROVIDER**

Blue Cross Blue Shield of Florida  
P.O. Box 1798, Jacksonville, FL 32231  
1-800-955-5692

**PRESCRIPTION DRUG  
PRECERTIFICATION PROVIDER**

Walgreens Health Initiatives  
1411 Lake Cook Road, Deerfield, IL 60015  
1-800-492-2507

**MENTAL HEALTH  
PRECERTIFICATION PROVIDER**

MHNet Behavioral Health  
P.O. Box 209010, Austin, TX 78720-9010  
1-877-398-5816

**BOARD OF DIRECTORS**

Chairperson: Randy T. Livingston, Vice President for Financial  
Affairs, Clearwater Christian College  
Vice-Chairperson: Bruce Edwards, Vice President for  
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Maria Martinez, Assistant Vice President Human Resources and  
Risk Management, Rollins College

Donna B. Popovich, Executive Director Human Resources, The  
University of Tampa

Michael Q. Rogers, Director Human Resources and  
Administrative Services, Edward Waters College

Valerie Williams, Director Human Resource Management, Florida  
Memorial University

Beth Zamerski, CFO, Saint Edward's School



"THE BENEFITS AND COVERAGES DESCRIBED HEREIN ARE PROVIDED THROUGH A TRUST. THE TRUST IS ESTABLISHED AND FUNDED BY A GROUP OF EMPLOYERS AND IS NOT PROTECTED BY A GUARANTY FUND IN THE EVENT OF INSOLVENCY. PARTICIPATING EMPLOYERS ARE ASSESSABLE FOR ANY LOSSES INCURRED BY THE TRUST."



## ARTICLE THREE

### BLUE CROSS BLUE SHIELD OF FLORIDA (BCBSFL) SERVICES

This section explains various services provided by BCBSFL: Your Identification Card, Your Network of Choices, Care Consultants, Health Dialog<sup>®</sup>, Pregnancy Support, and the Blue Cross Blue Shield of Florida website.

Non-English-speaking members have access to clear Benefits information through an AT&T interpreter line. Blue Cross Blue Shield of Florida Member Service representatives are trained to make the connection, call toll-free at 1-800-664-5295, Care Consultants are available by calling 1-888-476-2227 or you may contact Health Dialog<sup>®</sup> 24/7 at 1-877-789-2583.

#### YOUR IDENTIFICATION CARD

The Blue Cross and Blue Shield suitcase on Your Blue Cross Blue Shield of Florida PPO Identification (ID) Card is recognized throughout the country and around the world. Carry Your ID Card with You at all times, destroy any previously issued cards, and show this card to the Hospital or other Professional Provider whenever You need Medical Care.

1. When You or one of Your Dependents receives professional health care services:
  - a. show Your ID Card to the Hospital or other professional health care Provider; and
  - b. ask the Provider to file a Claim for You.
  
2. The following information will be displayed on Your ID Card :
  - a. Your name;
  - b. Your identification number;
  - c. Your group number;
  - d. Customer Service toll-free number at 1-800-664-5295 (on back of card) or online at [www.BCBSFL.com/MyBlueService](http://www.BCBSFL.com/MyBlueService) ;
  - e. Precertification toll-free number at 1-800-955-5692, option 3 (on back of card);
  - f. 24/7 health information and support number at 1-877-789-2583 (on back of card);
  - g. MHNet Mental Health, Substance Abuse, and Employee Assistance Program number at 1-877-398-5816 (on back of card); and
  - h. PPO in "suitcase" symbol.



3. There is a logo of a suitcase with “PPO” inside it on Your ID Card. This PPO suitcase logo lets Hospitals and Providers know that You are a member of a Blue Cross and Blue Shield PPO, and that You have access to PPO Providers nationwide and world wide.
4. Protect Your Card
  - a. If Your card is lost or stolen, please contact Blue Cross Blue Shield of Florida Member Service immediately at 1-800-664-5295. Only You or Your covered Dependents are permitted to use this card. It is illegal to loan Your card to persons who are not eligible to use Your Blue Cross Blue Shield of Florida Benefits.
  - b. To request additional ID Cards, contact Member Customer Service at 1-800-664-5295 or request cards online by going to the My BlueService<sup>SM</sup> website at <http://www.BCBSFL.com>.

## YOUR NETWORK OF CHOICES

ICUBA offers two different Medical networks, a Behavioral Health network, and a Prescription Drug network. All plans also have Non-network benefits as they are all PPO programs which allow You to get the care You want from the Provider you select. It is important to utilize Network benefits whenever possible in order to receive the maximum benefit available to you.

**Medical:** You may choose between two PPO Networks, Blue Choice which is listed on the Blue Cross Blue Shield website as Preferred Patient Care (PPO) or Blue Options which is listed on the Blue Cross Blue Shield website as Network Blue.

### 1. Network Care

- Network care is care You receive from Providers in the program’s Network. This Network includes Primary Care Physicians and a range of Specialists, as well as Hospitals and a variety of treatment facilities in the communities where You live and across the country. To locate the Provider nearest You or to check that Your current Provider is in the Network, call Blue Card Access at 1-800-810-BLUE (1-800-810-2583) or go to <http://www.BCBS.com>. For the PPO Network, select Preferred Patient Care “PPO”. For Blue Options Providers, select “Network Blue”.
- When You receive health care through Network Providers, You enjoy maximum coverage and maximum convenience. You present Your ID Card to the Provider who submits Your Claim to Blue Cross Blue Shield of Florida.

### 2. Non-Network Care

- Non-Network care is care You receive from Providers who are not in the Network.
- Even when You go outside of the Network, You will still be covered for eligible services. However, Your Benefits will be paid at lower, Non-Network levels. If You go to a Blue Cross Blue Shield of



Florida Traditional indemnity Provider that is not in the PPO Network, You may have less of a financial obligation than going to a Non-Network Provider that does not participate in any BCBSFL Network.

- You may be responsible for paying the difference, if any, between the Provider's actual charge and the Blue Cross Blue Shield of Florida payment.
- You may be responsible for filing Your Claim.

3. NetworkBlue (Blue Options) Selection Criteria:

- *Network Access:* Is there a Network need for the Physician's specialty in the community?
- *Members Served:* Review the Networks in which the Physician participates today and the number of BCBSFL members served.
- *Relationship History:* Review how active a Physician has been in supporting care and relationship programs as well as advisory boards used to improve care and service.
- *Past Performance Compared to Peers:* Review Physician's overall performance in BCBSFL's Networks and compare Physician's performance to peers in that specialty and that community. Patient severity of illness and catastrophic cases are acknowledged and adjusted. The patients' age and sex are incorporated along with visits and services provided.
- *Year-Over-Year Performance:* Review year-over-year performance to see if there are any performance trends. Look at the Physician's performance ranking compared to peers.

4. Enhancing Performance for Physicians Not Selected to Participate in NetworkBlue:

- The base report covers more than 25 indicators that include peer and community comparisons for: setting of care, types of services rendered, cost and utilization statistics that are severity adjusted, top procedures performed, and top episode treatment groups. Any Physician not selected can re-apply for NetworkBlue after one year, allowing BCBSFL an opportunity to measure changes in practice patterns.

5. For help with a Claim or a question about Your Benefits, You can call 1-800-664-5295 or log onto Blue Cross Blue Shield of Florida's website, <http://www.BCBSFL.com/MyBlueService>, and connect to My Blue Service<sup>SM</sup>. A Blue Cross Blue Shield of Florida customer service representative can also help You with any coverage inquiry. Representatives are trained to answer Your questions quickly, politely, and accurately.

**Behavioral Health and Substance Abuse:** In order to determine if a Behavioral Health or Substance Abuse Provider is a Network provider, You must logon to <http://www.mhnet.com>, username: ICUBA;



password: 8773985816, then select Provider Search. You may also call MHNNet Behavioral Health 24-hours a day at 1-877-398-5816 and speak live to a trained counselor.

**Prescription Drug:** In order to determine if a Prescription Drug Provider is a Network provider, logon to [www.walgreenshealth.com](http://www.walgreenshealth.com) and select Pharmacy Locator. You may also call Walgreens Health Initiatives 24-hours a day at 1-800-207-2568.

## CARE CONSULTANTS

BCBSFL'S team of Care Consultants understand the big picture when it comes to the healthcare delivery system. They are there to save You money and find quality care by keeping You informed about Your options before You go to the doctor, the hospital, an imaging center, or an emergency room. They can answer Your questions about Plan provisions, treatment choices, cost savings options, community resources and more. The Care Consultants role is to make Your health care decisions easier and ultimately, save You time and money.

When is a good time to call the Care Consultants? Anytime You need help making important health care decisions, such as before You get medical treatment from a doctor or facility, before You buy expensive medical equipment, or the moment You have trouble getting care or coordinating care with multiple providers.

By calling the Care Consultants at 1-888-476-2227, Monday through Friday, 8 AM to 9 PM, You can speak to health experts, such as Registered Nurses, Plan Benefits Specialists and Community Resource Professionals, who will work together to save You time, money and hassle. You will then have the information before You go such as the cost of the same procedure, same quality at different locations, who are the in network providers in Your area, and can receive benefits authorizations for certain procedures.

You can also shop for doctors visits, imaging tests, surgeries and other procedures by logging onto [www.bcbsfl.com/MyBlueService](http://www.bcbsfl.com/MyBlueService). See Living Healthy and select Care Comparison. You will find over 55 of the most common medical procedures and easy to use features that will let You compare costs and save.

## HEALTH DIALOG®

Health Dialog® is a product of Health Dialog Services Corporation. Health Dialog's® program provides information and support, and is specially designed for Covered Persons who have everyday health concerns or ongoing (chronic) health concerns. Health Dialog® will help You work with Your doctors so that You can make informed health care decisions and improve the management of Your health. Health Dialog's programs will help You understand Your choices and get the information You need most when weighing important health related decisions. Health Dialog's® programs include the following:

1. **Health Coaches** – Health Coaching is the most personal aspect of Health Dialog's® support programs and is available 24 hours a day, 7 days a week. Health Coaches are specially trained health professionals (such as nurses, respiratory therapists and nutritionists). They can provide You with relevant on-the-spot medical information and offer health-related videos/DVDs and materials. You can even speak with the same Health Coach each time You call. Some of the reasons You may call are:
  - Your doctor has recommended a certain medical test and You'd like more information about it.



- You or a family member has been diagnosed with a particular illness and you want to know what to expect.
  - Your doctor suggests surgery for lower back pain, but you want information about possible alternatives.
  - You want to discuss any health care problem or issue, in confidence, with a Health Coach.
  - You are planning a hospital admission and need assistance in planning your options once you have been discharged.
2. Immediate Health Care Assessment – You can also phone Health Dialog® about an immediate illness or injury. When you do, a Health Coach can perform a comprehensive health care assessment to help you determine your next step.
  3. Web Tools – The Dialog Center®, a medical information and support website operated and maintained by Health Dialog®, gives you access to comprehensive health education and services including 27,000 pages of in-depth information (in Spanish and English) on more than 19,000 clinical topics. The information is organized around health care decision points, rather than in encyclopedia format.
  4. Educational Audiotapes & Videotapes – Information and preparation are the key to taking an active role in the medical and surgical decisions that affect you. Health Dialog® can help you with both. For specific medical information, you can access audiotapes on more than 400 health care topics ranging from acne to weight management. These tapes contain the most up-to-date information available and are reviewed for accuracy by a panel of health care professionals. For more in-depth, comprehensive information on a health care problem facing you, the Health Dialog® Health Coach may send you a videotape and accompanying brochure. Video topics include: lower back pain; heart disease; breast cancer; prostate cancer; prostate enlargement; benign uterine conditions; hormone replacement therapy; and high blood pressure.
  5. Chronic Care Support – Should you have a chronic medical condition such as asthma, arthritis, Chronic Obstructive Pulmonary Disease (COPD), diabetes, depression, lower back pain, or heart disease, your Health Dialog® Health Coach may provide you with valuable information to help you reduce your medical risks and manage your illness more effectively. Improving your health habits helps you take charge of your life and can make a real difference in the way you feel.

For the sake of your good health, take advantage of this program offered to you through Blue Cross and Blue Shield of Florida by calling 1-877-789-2583 (TTY for hearing/speech impaired 1-877-900-4304), or you may also access the Dialog Center website through My Blue Service at [www.BCBSFL.com](http://www.BCBSFL.com).

## PREGNANCY SUPPORT

As soon as you or your dependent becomes pregnant, call the Healthy Addition® Pre-natal Program at 1-800-955-7635 (and press 6) in order to request a Maternity Wellness Profile. Fill out the Maternity Wellness Profile and send



it back to BCBSFL. A Health Coach may contact You depending on Your needs. A \$25 Deposit will be made to Your Health Reimbursement Account (HRA) for participation. If You do not have an HRA, a gift certificate will be provided.

## BLUE CROSS BLUE SHIELD OF FLORIDA'S WEBSITE

Visit [www.BCBSFL.com/MyBlueService](http://www.BCBSFL.com/MyBlueService) for a wide range of health-related information, interactive tools and services. As a Covered Person, You have access to health and wellness information, user-friendly services related to Your health care coverage, and valuable tools for managing Your own health and well-being on My BlueLink™ - Your personal website. Simply go to [www.BCBSFL.com](http://www.BCBSFL.com) and log onto MyBlueService<sup>SM</sup> where You can:

- Utilize online self-service capabilities.
- Access a variety of services related to Your Blue Cross Blue Shield of Florida coverage (e.g., find a Physician, review Claim Status, or order an ID Card or Claim form).
- Ask questions for Member Service by sending a secure message—just use Your BlueServiceMessage Center to send the message and check for a response from Member Service.
- Access WebMD Health and Wellness Content and Tools, including Care Consultants as well as **Personal Health Record**.
- Customize Your content to include the latest in breaking health news, diet and exercise tips, or articles specific to Your health-related interests.
- Access valuable online health resources: You can contact a Health Dialog® Health Coach, or look up any medical topic in the Healthwise Knowledgebase® and the illustrated Health Encyclopedia, which are two comprehensive health information resources.
- Find out just what to expect from a surgery or procedure in the illustrated Surgeries and Procedures Guide or track the progress of a pregnancy in the Pregnancy Center. You can also complete the **Personal Health Assessment** which helps You identify Your personal health risks and set goals to improve Your wellness. Once you complete the assessment, a \$25 deposit will be made to Your Health Reimbursement Account for Your participation. You can receive one deposit per Plan Year if You complete the Personal Health Assessment either between February 1 – April 30 or September 1 – November 30 of the applicable Plan Year. If You are a new Employee, You may receive this incentive if You complete the Personal Health Assessment within 30 days of Your eligibility date. You are also eligible if You complete a Personal Health Assessment at an Employer-sponsored health fair (Better You From Blue™). If You do not have a Health Reimbursement Account, You will be given a gift certificate.
- Stay on the track to wellness with interactive calculators, including body mass index, ideal weight, and nutritional needs.



- By logging onto My Blue Service, You can create a Personal Health Record which organizes Your health history including doctors visits and lab tests. You will also be given the opportunity to share Your claims with WebMD in order to update Your health record monthly. You can also save Your Personal Health Assessment data within Your Personal Health Record.
- You can improve Your health through personalized, convenient, and private on-line lifestyle improvement programs by HealthMedia®. It only takes a few minutes to get started. Here's how:
  1. Go to My Blue Service website at [www.BCBSFL.com/MyBlueService](http://www.BCBSFL.com/MyBlueService)
  2. Complete the login process by entering Your username and password.
  3. Scroll to the bottom of the page to "Personalized Health Tools from WebMD" then select "more".
  4. Choose the program in which You wish to enroll.
  5. Complete the program questionnaire to receive a customized guide for improving Your health.

The Health Management Centers provide helpful information resources and tools that can help you tackle your most important health challenges. Topics covered include:

- Alcohol Use
- Blood Pressure
- Blood Sugar
- Cholesterol
- Emotional Health
- Exercise
- Nutrition
- Safety
- Stress
- Substance Abuse



## ARTICLE FOUR

### SCHEDULE OF MEDICAL AND BEHAVIORAL HEALTH BENEFITS, INCLUDING EMPLOYEE ASSISTANCE PROGRAM

All Benefits below are subject to the Plan's terms and conditions, including Deductibles, Coinsurance, Network discounts and Reasonable and Customary charges. Benefit percentages payable by the Plan may change depending upon whether Covered Services are obtained from a Network Provider. The list of Network Providers may change from time to time. It is Your responsibility to verify that the Provider who is treating You is currently a Network Provider.

A list of Network Physicians, Hospitals and other health care professionals may be found on the BCBS website, <http://www.BCBS.com>, or by logging onto <http://www.BCBSFL.MyBlueService.com> or by calling 1-800-664-5295. Remember to always confirm with the Provider or facility that they are in the BCBSFL Preferred Patient Care PPO if You are enrolled in the Blue Choice Plan or Network Blue Network if You are enrolled in the Blue Options Plan.

A list of Network Behavioral Health and Substance Abuse and other mental health care professionals may be found on the MHNet Behavioral Health website, <http://www.mhnet.com> or by calling 1-877-398-5816.

If You are unable to locate a Participating Provider in Your area who can provide You with a service or supply that is covered under this Plan, You must call the number on the back of Your ID Card for medical: (1-800-664-5295); for behavioral health and substance abuse: (1-877-398-5816) to obtain authorization for non-Participating Provider coverage. If You obtain authorization for these services, the Benefits will be covered at the Network Participating Provider or Reasonable and Customary amount.

MHNet Behavioral Health is the provider of ICUBA's mental health, substance abuse, and Employee Assistance Program (EAP) Plan benefits. You **do not** access mental health or substance abuse services through Blue Cross Blue Shield of Florida. You are automatically enrolled in the mental health and substance abuse benefits when you enroll in an ICUBA Health Plan. All inpatient mental health and substance abuse treatments must be pre-certified by calling the 24-hour number 877-398-5816 and speaking with a licensed counselor. Claims and appeals can be filed to MHNet Behavioral Health, P.O. Box 7802, London, KY 40742.

### PPO PLAN GUIDELINES

1. Deductible and Coinsurance apply to all services except:
  - Network primary, Specialist office, Outpatient substance abuse, and Urgent Care visits in the PPO 70 plans
  - Network primary, Specialist office, Outpatient substance abuse, and Urgent Care visits in the Risk/Reward plans, where only the Coinsurance Percentage applies
  - Network short term rehabilitative therapy/spinal manipulation services in the PPO 70 plans
  - Network short term rehabilitative therapy/spinal manipulation services in the Risk/Reward plans, where only the Coinsurance Percentage applies



- Emergency room services
  - Network injectibles administered in a Physician's Office, except that the Coinsurance Percentage applies under the Risk/Reward plans
2. If there is a Participant Co-payment with a Deductible and Coinsurance Percentage, the Co-payment applies first, then the Deductible and Coinsurance.
  3. Deductibles, Medical Co-payments and Coinsurance apply toward the Out-of-Pocket Maximum.
  4. Out-of-Pocket Maximums and Deductibles are **not** combined for Network and Non-Network services and Out-of-Pocket Maximums are not available for use in another Plan should a Plan change occur during the Plan Year (4/1-3/31) (e.g., because You experience a Change in Status that allows for a Plan change between Open Enrollment periods). In addition, treatment or dollar maximums do not carry over to another Plan during the same Plan Year (4/1-3/31). Out-of-Pocket Maximums and Deductibles renew each Plan Year (4/1-3/31), effective April 1.
  5. Beneficiaries are financially responsible for all Non-Network bills in excess of Reasonable and Customary charges.
  6. Covered Services obtained from a Non-Network Provider will be covered at Network percentages and rates if the Covered Person was referred to a Non-Network Provider by the treating Network Provider and only if there are no viable Network Providers available. In such a case, the Covered Services are subject to receipt of a letter of Medical Necessity by the referring Network Provider. This may require advance approval from BCBSFL.
  7. Covered Services will also be considered at Network levels if an Accident, Injury, or Illness occurs and immediate services are required inside or outside the Network service area.
  8. Non-Network Providers of ancillary services such as assistant surgeons (paid at the assistant surgeon rate), lab, radiology, anesthesia, DME, and emergency room Physicians will be paid at the Network level when rendered at a Network facility, or if the services were performed outside the patient's control or election.
  9. Network and Non-Network services apply to the same treatment maximum, wherever such a limitation occurs. Treatment maximums do not carry over to another Plan during the Plan Year (4/1-3/31).
  10. Scalp Hair Prosthesis is covered for hair loss due to alopecia or cancer treatments.
  11. There is a \$10,000 per transplant Benefit for travel, meals, and lodging for recipient and travel companion. All expenses must be pre-approved by BCBSFL Care Management Services.



## **GUIDE TO BENEFITS CHART**

When reading the Benefit Plan designs offered by ICUBA, it will be important to understand the following terms (especially in reference to the following pages).

### **Deductible**

There is an annual (4/1-3/31) Plan Year Deductible per person enrolled in the Plan. Each Plan Year there is a new Deductible. The Family Deductible can be satisfied by combining Covered Expenses from each covered Family member. However, each Covered Person cannot contribute more than one Individual Deductible amount to the Family Deductible.

### **Coinsurance**

Coinsurance is the percentage of the covered charges paid by You for services rendered. For example, the Plan may pay 80% or 70%, and You pay the Coinsurance in the amount of 20% or 30%, respectively. Co-payments do not reduce the amount of eligible medical expenses subject to Coinsurance.

### **Out-of-Pocket Maximum**

The Medical Out-of-Pocket Maximum is comprised of the maximum amount of Deductible, Medical Co-payments and Coinsurance during any Plan Year (4/1-3/31) that a Covered Person or Family must pay before the Plan pays 100% of Covered Expenses for the Plan Year (4/1-3/31). Prescription Drug Co-payments accrue to the Prescription Drug Out-of-Pocket Maximum (See Article Six).

### **Co-payments**

The co-payment is always due when service is rendered. Medical co-payments accrue to the Medical Out-of-Pocket Maximum and Prescription Drug co-payments accrue to the Prescription Drug Out-of-Pocket Maximum.

### **Physician Office Visits**

This is a visit to a Physician who is a family, general practitioner, internist, OB/GYN, or pediatrician Physician. These Physicians provide a broad range of preventive medical services and recommend patients to Specialists, Hospitals, and other Providers as necessary.

### **Specialist Office Visits**

These are visits to Physicians whose practice is limited to treating a specific disease (*e.g.* oncologists), specific parts of the body (*e.g.*, ear, nose, and throat), a specific age group other than children (*e.g.*, gerontologist), or specific procedures (*e.g.*, oral surgery). You may obtain services directly from a Specialist and do not need to be referred by a Primary Care Physician.

## **OTHER TERMS YOU SHOULD KNOW**

**Allowable Charge (also called "Provider's Reasonable Charge")** – The dollar amount that Your PPO has determined is reasonable for Covered Services provided under Your program. This is an important term to know if You go outside the Network for care. The amount Your program pays for Non-Network care is based on the Allowable Charge—not the Provider's actual charge.

**Autism Spectrum Disorder** – MHNNet Behavioral Health offers access to Applied Behavioral Analysis for members (children who have yet to turn 26 years of age) diagnosed with Autism or other pervasive developmental disorders. The Autism benefit covers treatment of autism through speech therapy, occupational therapy, physical therapy, and



applied behavioral analysis. In concert with your child's physician or psychologist, MHNet's trained clinicians can help you sort through the available treatments and ensure your child receives the most appropriate care. If your child has been diagnosed with Autism, please contact MHNet at 1-877-398-5816 for more information on the services available and the steps necessary to receive authorization.

**Care Consultant** - A team of health experts comprised of nurses, plan benefit specialists and community resources professionals that can assist you in pricing services and resolving claims. Care Consultants are available Monday through Friday 8 AM to 9 PM by calling 1-888-476-2227.

**Claim** – There are three types of Claims You may make on the Plan: Pre-Service Claim, Urgent Care Claim, and Post-Service Claim. A Pre-Service Claim is a request for Precertification or prior approval of a Covered Service or for the payment or reimbursement of the charges or costs associated with a Covered Service. **All** Inpatient services at Hospital or other facility must be Precertified with a Pre-Service Claim. If You receive a Covered Service from a Network Provider they will submit the Claim on Your behalf.

- **Pre-Service Claim** – This is a request for Precertification or prior approval of a Covered Service, which under the terms of Your coverage, must be approved **before** You receive the Covered Service. All Inpatient Services at a Hospital or other facility must be Precertified. A Network Provider will take care of the Pre-Service Claim. If You use a Non-Network Provider, You are responsible to submit the Pre-Service Claim.

In order to ensure that the proposed elective treatment you are scheduling is a covered expense, your doctor can request a Voluntary Pre-Service Review in order to help you make better-informed decisions. These are non-life-threatening-non-emergency services that may not be covered under the ICUBA Plan. By asking your doctor to request a pre-service review, you'll know in advance the costs you may be responsible for. Together you and your doctor or health care provider can choose the best approach for your individual needs. Some of the procedures available for pre-service review include breast reduction mammoplasty, rhinoplasty, and TMJ surgery. Ask your doctor beforehand!

- **Urgent Care Claim** – This is a Pre-Service Claim that, if decided within the time periods established for making a non-Urgent Care Pre-Service Claim decision could seriously jeopardize Your life, health, or ability to regain maximum function or, in the opinion of a Physician with knowledge of Your medical condition, would subject You to severe pain that cannot be adequately managed without the service.
- **Post-Service Claim** – This is a request for payment or reimbursement of the charges or costs associated with a Covered Service that You have already received. These are typical Claims. If You use a Network Provider, Post-Service Claims will be taken care of by the Provider. If You use a Non-Network Provider, You will be responsible for submitting the Post-Service Claim.

**Experimental or Investigative** – The use of any Experimental or Investigative treatment, service, procedure, facility, equipment, drug, device, or supply (collectively, Intervention) that is determined by The Plan to not be medically effective for the condition being treated will not be covered. The Plan will consider an Intervention to be Experimental or Investigative if: (1) the Intervention does not have FDA approval to be marketed for the specific relevant indication(s); (2) available scientific evidence does not permit conclusions concerning the effect of the Intervention on health outcomes; (3) the Intervention is not proven to be as safe and as effective in achieving an outcome equal to or exceeding the outcome of alternative therapies; (4) the Intervention does not improve health outcomes; or (5) the Intervention is not proven to be applicable outside the research setting. **If an Intervention, as**



defined above, is determined to be Experimental or Investigative at the time of the service, it will not receive retroactive coverage, even if it is found to be in accordance with the above criteria at a later date.

The Plan recognizes that situations may occur when You elect to pursue Experimental or Investigative treatment. If You are to receive a service that The Plan may consider to be Experimental or Investigative, You or the Hospital and/or Provider may contact Blue Cross Blue Shield of Florida's Member Service (1-800-955-5692), Care Consultant Team (1-888-476-2227), MHNet Behavioral Health Services (1-877-398-5816) or Walgreens Health Initiatives Clinical Services (1-877-665-6609) to determine whether The Plan considers such service to be Experimental or Investigative. If The Plan determines the treatment is Experimental or Investigative, the treatment will **not** be covered.

**Health Dialog®** - A 24-hour health care assistance number for access to nurses who provide health education and support services is 1-877-789-2583.

**Medically Necessary and Appropriate** – Services or supplies provided by a Provider are Medically Necessary and Appropriate if The Plan determines they are: (1) appropriate for the symptoms and diagnosis or treatment of Your condition, illness, disease or Injury; (2) provided for the diagnosis or the direct care and treatment of Your condition, illness, disease or Injury; (3) provided in accordance with standards of good medical practice; (4) not primarily for Your or Your Provider's convenience; and (5) the most appropriate level of service or supply that can safely be provided to You. When applied to hospitalization, this further means that You require acute care as an Inpatient due to the nature of the services that must be rendered for Your condition, and You cannot receive safe or adequate care as an Outpatient. The Plan reserves the right to determine, in its sole judgment, whether a service is Medically Necessary and Appropriate. No Benefits will be provided unless The Plan determines that the service or supply is Medically Necessary and Appropriate.

**Precertification** – This is the process through which certain services are pre-approved by Blue Cross Blue Shield of Florida or MHNet Behavioral Health and the Covered Person is covered for services. **All Inpatient services at a Hospital or other facility must be Precertified** by calling the Blue Cross Blue Shield of Florida Admission Notification at 1-800-955-5692. **All Inpatient services at a Behavioral or Substance Abuse facility must be Precertified** by calling MHNet at 1-877-398-5816. In order to be Precertified for Inpatient Adult Rehabilitation for a substance-related disorder, demonstration of alternative levels of care such as partial hospitalization must have been attempted and relapse has occurred within 6 months of You or Your dependent's active participation in such a program. Some drugs may require prior authorization through Walgreens Health Initiatives (WHI). You can determine whether prior authorization is required by calling WHI at 1-800-207-2568.

**Preferred Provider Organization (PPO) Program** – This is a program that does not require the selection of a Primary Care Physician, but is based on a Provider Network made up of Physicians, Specialists, Hospitals and other health care facilities. Using this Provider Network helps ensure that Covered Persons receive maximum coverage for eligible services. All ICUBA medical plans are PPOs.



Benefit Period: April 1, 2011 – March 31, 2012

Benefits	PPO 70 Network	PPO 70 Non-Network	Risk/Reward PPO Network	Risk/Reward Non-Network
Deductible Individual Family	\$750 \$2250	\$1250 \$3750	\$1750 \$4000	\$3250 \$9750
Coinsurance	70/30% after Deductible	50/50% after Deductible	80/20% after Deductible	60/40% after Deductible
Lifetime Maximum	No maximum		No maximum	
Out-of-Pocket Maximums (includes deductible, coinsurance and medical copays) Individual Family	\$3,000 \$6,000	\$6,000 \$12,000	\$3,500 \$7,000	\$7,000 \$14,000
Physician Office Visits (General Practice, Internal Medicine, Family Practice, Pediatrician, OB/GYN) <sup>1</sup>	100% after \$20 Co-payment; Deductible does not apply	50/50% after Deductible	80/20%; Deductible does not apply	60/40% after Deductible
Specialist Office Visits	100% after \$30 Co-payment; Deductible does not apply	50/50% after Deductible	80/20%; Deductible does not apply	60/40% after Deductible
Independent Clinical Labs (free standing facilities and office visits)	100%; Not subject to deductible or copay	50/50% after Deductible	100%; Deductible does not apply	60/40% after Deductible
Urgent Care Facility <sup>2</sup>	100% after \$30 Co-payment; Deductible does not apply	100% after \$30 Co-payment; Deductible does not apply	80/20%; Deductible does not apply	80/20%; Deductible does not apply
Preventive Care Annual Physical and Gynecological Exam	100%; Not subject to deductible or copay	Not Covered	100%; Deductible does not apply	Not Covered
Preventive Care <sup>3</sup> Adult and Pediatric Approved Immunizations and Venipunctures	100%; Not subject to deductible or copay	Not Covered	100%; Deductible does not apply	Not Covered
Pap Tests	100%; Not subject to deductible or copay	Not Covered	100%; Deductible does not apply	Not Covered
Related Wellness Services (e.g. Colorectal Screenings, Colonoscopies, Sigmoidoscopies, Electrocardiograms, Echocardiograms and Bone Mineral Density Tests)	100%; Not subject to deductible or copay	Not Covered	100%; Deductible does not apply	Not Covered
Prostate Cancer Screenings (PSA)	100%; Not subject to deductible or copay	Not Covered	100%; Deductible does not apply	Not Covered
Mammograms	100%; Not subject to deductible or copay	Not Covered	100%; Deductible does not apply	Not Covered
Chlamydia and STD tests	100%; Not subject to deductible or copay	Not Covered	100%; Deductible does not apply	Not Covered
Allergy Injections	100%; Not subject to deductible or copay	50/50% after Deductible	100%; Deductible does not apply	60/40% after Deductible
General Health Blood Panel, Glucose Test, Lipids Panel, Cholesterol, and ALT/AST	100%; Not subject to deductible or copay	Not Covered	100%; Deductible does not apply	Not Covered



Benefits	PPO 70 Network	PPO 70 Non-Network	Risk/Reward PPO Network	Risk/Reward Non-Network
Venipunctures/ Conveyance Fee	100%; Not subject to deductible or copay	Not Covered	100%; Deductible does not apply	Not Covered
Urinalysis	100%; Not subject to deductible or copay	Not Covered	100%; Deductible does not apply	Not Covered
Emergency Room Services <sup>2</sup>	100% after \$100 Co-payment (waived if admitted); Deductible does not apply	100% after \$100 Co-payment (waived if admitted); Deductible does not apply	100% after \$100 Co-payment (waived if admitted); Deductible does not apply	100% after \$100 Co-payment (waived if admitted); Deductible does not apply
Ambulance Services	70/30% after In Network Deductible		80/20% after In Network Deductible	
Hospital Expenses Inpatient <sup>4</sup>	70% after \$250 per admission copayment (deductible applies)	50% after \$500 per admission copayment (deductible applies)	80/20% after Deductible	60/40% after Deductible
Outpatient	70/30% after Deductible	50/50% after Deductible	80/20% after Deductible	60/40% after Deductible
Outpatient Surgery Office Setting - Physician	100% after \$20 Co-payment; Deductible does not apply	50/50% after Deductible	80/20%; Deductible does not apply	60/40% after Deductible
Outpatient Surgery Office Setting - Specialist	100% after \$30 Co-payment; Deductible does not apply	50/50% after Deductible	80/20%; Deductible does not apply	60/40% after Deductible
Outpatient Facility	70% after \$100 copayment (deductible applies)	50/50% after Deductible	80/20% after Deductible	60/40% after Deductible
Related Professional Services	70/30% after Deductible	50/50% after Deductible	80/20% after Deductible	60/40% after Deductible
Infertility Services (counseling and testing to diagnose)	70/30% after Deductible	50/50% after Deductible	80/20% after Deductible	60/40% after Deductible
Assisted Fertilization Procedures	Not covered		Not covered	
Spinal Manipulations	100% after \$30 Co-payment; Deductible does not apply	50/50% after Deductible	80/20%; Deductible does not apply	60/40% after Deductible
	Limit: 60 visits / benefit period		Limit: 60 visits / benefit period	
Diagnostic Services Lab tests	100%; Deductible does not apply	50/50% after Deductible	100%; Deductible does not apply	60/40% after Deductible
	X-ray and other tests	70/30% after Deductible	80/20% after Deductible	60/40% after Deductible
Outpatient Diagnostic Imaging (MRI, MRA, CAT Scan, PET Scan)	70% after \$100 per service copayment (deductible applies)	50/50% after Deductible	80/20% after Deductible	60/40% after Deductible



Benefits	PPO 70 Network	PPO 70 Non-Network	Risk/Reward PPO Network	Risk/Reward Non-Network
Outpatient Physical Medicine	100% after \$30 Co-payment; Deductible does not apply	50/50% after Deductible	80/20%; Deductible does not apply	60/40% after Deductible
	Limit: 30 visits per benefit period		Limit: 30 visits per benefit period	
Outpatient Speech Therapy (restorative services only)	100% after \$30 Co-payment; Deductible does not apply	50/50% after Deductible	80/20%; Deductible does not apply	60/40% after Deductible
	Limit: 30 visits per benefit period		Limit: 30 visits per benefit period	
Outpatient Occupation Therapy	100% after \$30 Co-payment; Deductible does not apply	50/50% after Deductible	80/20%; Deductible does not apply	60/40% after Deductible
	Limit: 30 visits per benefit period		Limit: 30 visits per benefit period	
Applied Behavioral Analysis (for Autism Spectrum Disorder)	100% after \$30 Co-payment; Deductible does not apply	50/50% after Deductible	80/20%; Deductible does not apply	60/40% after Deductible
Cardiac Rehabilitation	70/30% after Deductible	50/50% after Deductible	80/20% after Deductible	60/40% after Deductible
Chemotherapy	70/30% after Deductible	50/50% after Deductible	80/20% after Deductible	60/40% after Deductible
Dialysis Treatment	70/30% after Deductible	50/50% after Deductible	80/20% after Deductible	60/40% after Deductible
Infusion Therapy	70/30% after Deductible	50/50% after Deductible	80/20% after Deductible	60/40% after Deductible
Radiation Therapy	70/30% after Deductible	50/50% after Deductible	80/20% after Deductible	60/40% after Deductible
Respiratory Therapy	70/30% after Deductible	50/50% after Deductible	80/20% after Deductible	60/40% after Deductible
Durable Medical Equipment (Medical Necessity Required)	70/30% after Deductible	50/50% after Deductible	80/20% after Deductible	60/40% after Deductible
Enteral Formulae	70/30% after Deductible	50/50% after Deductible	80/20% after Deductible	60/40% after Deductible
Prosthetic Appliances	70/30% after Deductible	50/50% after Deductible	80/20% after Deductible	60/40% after Deductible
Skilled Nursing Facility <sup>4</sup>	70/30% after Deductible	50/50% after Deductible	80/20% after Deductible	60/40% after Deductible
	Limit: 60 days / benefit period		Limit: 60 days / benefit period	



Benefits	PPO 70 Network	PPO 70 Non-Network	Risk/Reward PPO Network	Risk/Reward Non-Network
Inpatient Rehabilitation <sup>4</sup>	70/30% after Deductible; \$250 Per-Admission copay also applies	50/50% after Deductible; \$500 Per-Admission copay also applies	80/20% after Deductible	60/40% after Deductible
	Limit: 60 days / benefit period		Limit: 60 days / benefit period	
Home Health Care Medical Necessity Required (unlimited days per Plan Year (4/1-3/31); 16 hours per day maximum)	70/30% after Deductible	50/50% after Deductible	80/20% after Deductible	60/40% after Deductible
Private Duty Nursing	70/30% after Deductible	50/50% after Deductible	80/20% after Deductible	60/40% after Deductible
Hospice (Inpatient and Outpatient Care)	70/30% after Deductible	50/50% after Deductible	80/20% after Deductible	60/40% after Deductible
Transplant Services <sup>5</sup>	70/30% after Deductible	50/50% after Deductible	80/20% after Deductible	60/40% after Deductible
Hearing aid screening/exam	100% after office visit copayment	100% after office visit copayment	80/20% (not subject to deductible)	80/20% (not subject to deductible)
Hearing Aid	70/30% after in-network deductible	70/30% after in-network deductible	80/20% after in-network deductible	80/20% after in-network deductible
	Limit: \$1,500 / benefit period for exam and hearing aids		Limit: \$1,500 / benefit period for exam and hearing aids	
Temporomandibular Joint Disorder (TMJ) <i>(Medical necessity required; excludes appliances and orthodontic treatment)</i>	70/30% after Deductible	50/50% after Deductible	80/20% after Deductible	60/40% after Deductible
Mental Health Inpatient <sup>4</sup>	70% after \$250 per admission copayment (deductible applies)	50% after \$500 per admission copayment (deductible applies)	80/20% after Deductible	60/40% after Deductible
Mental Health Outpatient	100% after \$20 Co-payment	50/50% after Deductible	80/20%; Deductible does not apply	60/40% after Deductible
Substance Abuse Inpatient <sup>4,7</sup> Rehabilitation and Detoxification	70% after \$250 per admission copayment (deductible applies)	50% after \$500 per admission copayment (deductible applies)	80/20% after Deductible	60/40% after Deductible
Substance Abuse Outpatient	100% after \$20 Co-payment	50/50% after Deductible	80/20%; Deductible does not apply	60/40% after Deductible
Employee Assistance Program <sup>6</sup>	100%; Deductible does not apply 6 face to face visits per issue	Not covered	100%; Deductible does not apply 6 face to face visits per issue	Not covered

1. For maternity, if a Co-payment applies, it is charged for the first visit only.
2. The Office Visit Co-payment depends upon the setting. Urgent Care services received in a non-Hospital setting will be subject to the Specialist Co-payment or Coinsurance; Urgent Care services received in the emergency room setting will be subject to the Emergency Room Co-payment.



3. Eligible preventive Diagnostic Services include, but are not limited to, laboratory colorectal screenings, bone mineral density tests, sigmoidoscopies, colonoscopies, echocardiograms, electrocardiograms, general health blood panels, adult and pediatric immunizations, mammograms, PAP tests, PSA test, urinalyses, and venipuncture services. You will not be responsible for the office visit Co-pay or Coinsurance when receiving Preventive Care services and the services will be covered at 100%.
4. Precertification is required prior to all planned Inpatient admissions, skilled nursing facilities, Hospitals, and rehabilitation centers. For medical admissions, notification should be provided to Blue Cross Blue Shield of Florida within 48 hours of an Emergency or maternity-related admission. For behavioral health admissions, including mental health and substance abuse, notification should be provided to MHNet within 48 hours of admission. Please note that in most cases, Network Providers will obtain Precertification on behalf of the patient. However, You will be responsible for obtaining Precertification for Non-Network admissions. If this does not occur and it is later determined that all or part of the Inpatient stay was not Medically Necessary and Appropriate, the patient will be responsible for payment of any costs not covered.
5. Combined limit: \$10,000 per transplant for travel, meals and lodging for recipient and travel companion.
6. For Employee Assistance Program (EAP) Benefits, You do not have to be enrolled in a medical plan. All individuals who live in Your household are also eligible for EAP Benefits. MHNet is a recognized leader in the behavioral health industry for over 20 years and administers the Plan's mental health, substance abuse, and EAP benefits. Your medical card will provide MHNet's toll free number 877-398-5816 and website [www.mhnet.com](http://www.mhnet.com) on the back. All EAP and inpatient admissions require pre-certification. Each individual may receive up to six free in-person EAP counseling sessions per issue per plan year. You can find a listing of network providers by logging onto <http://www.mhnet.com> Username: ICUBA; Password: 8773985816. Members who are seeking EAP services may call 877 398-5816 24-hours a day and speak with a licensed counselor.
7. In order to be Precertified for Inpatient Adult Rehabilitation for a substance-related disorder, demonstration of alternative levels of care such as partial hospitalization must have been attempted and relapse has occurred within 6 months of You or Your dependent's active participation in such a program.



## ARTICLE FIVE

Precertification is required in order for Plan Benefits to be covered. This means that a Covered Person or Provider is required to call the Precertification Provider number on the Participant ID Card (1-800-955-5692 for Medical; 1-877-398-5816 for Behavioral Health). The purpose of a Precertification is to determine (1) that an Inpatient stay in the Hospital or other facility service is Medically Necessary and not Experimental or Investigative; (2) that the facility is the appropriate facility for the services; and (3) the standard length of stay allowed for the condition.

### CAUTION

Please remember that Precertification does not verify a Covered Person's eligibility for Benefits nor guarantee payment of Benefits under the Plan. It is in the Covered Person's best interest to go through the Precertification process in order to ensure Medical Necessity and appropriateness of care.

Precertification does not constitute a guarantee or warranty of the quality of the medical treatment that a Covered Person will receive. Actual payment of Benefits is governed by the Plan's terms, conditions, limitations, and exclusions.

The ICUBA Board of Directors has the final authority to determine whether the admission or treatment is covered under the Plan.

Please note that a Precertification Claim may be an Urgent Care Claim and will be handled as set forth in Article Thirteen - the Claims and Appeals Procedure Section.

### Utilization Review Process

To determine that care will be provided in the appropriate setting, BCBSFL, MHNet or its designated agent administers a care utilization review program comprised of prospective, concurrent, and/or retrospective reviews. In addition, BCBSFL, MHNet or its designated agent assists Hospitals with discharge planning. These activities are conducted via phone or on-site by a Care Coordinator working with a Physician advisor. Here is a brief description of these review procedures:

#### 5.01 PROSPECTIVE REVIEW

Prospective review, also known as Precertification or pre-service review, begins upon receipt of treatment information. After receiving the request for care, BCBSFL, MHNet or its designated agent:

- a. reviews available information regarding the Covered Person's eligibility for coverage and/or availability of Benefits;
- b. reviews the information provided, including patient demographics, diagnosis, and plan of treatment;
- c. assesses whether care is Medically Necessary and Appropriate;
- d. determines whether the proposed treatment is Experimental or Investigative;
- e. authorizes care or refers the request to a Physician advisor for determination; and



- f. assigns an appropriate length of stay for Inpatient admission.

## 5.02 CONCURRENT REVIEW

Concurrent review may occur during the course of on-going treatment and is used to assess the Medical Necessity and Appropriateness of the length of stay and level of care. BCBSFL, MHNet or its designated agent:

- a. reviews Your progress and ongoing treatment plan with the facility staff; and
- b. decides, when necessary, to either: extend Your care; offer an alternative level of care; or refer to the Physician advisor for a decision.

## 5.03 DISCHARGE PLANNING

Discharge planning is a process that begins prior to Your scheduled Hospital admission. Working with You, Your family, Your attending Physician(s) and Hospital staff, BCBSFL, MHNet or its designated agent will help plan for and coordinate Your discharge to ensure that You receive safe and uninterrupted care when needed at the time of Your discharge. In planning for discharge, BCBSFL, MHNet or its designated agent assesses Your:

- a. level of function pre- and post-admission;
- b. ability to perform self-care;
- c. primary caregiver and support system;
- d. living arrangements pre- and post-admission;
- e. special equipment, medication, dietary needs, and safety needs;
- f. obstacles to care;
- g. need for referral to Care Consultant or condition management; and
- h. psychological needs.

## 5.04 RETROSPECTIVE REVIEW

Retrospective review may occur when a service or procedure has been rendered without the required Precertification.

## 5.05 CARE CONSULTANT SERVICES

You are not alone when recovering from an Illness or Injury - Care Consultants can help. When You are recovering from a Hospital admission, experiencing multiple medical problems, or facing catastrophic needs, You want to be able to concentrate on dealing with Your health needs so that You can relax and recover. However, You have to schedule follow-up visits, fill Prescription Drugs, and perhaps arrange Therapy. Care Consultants can assist You in ensuring that the necessary steps are in place for Your treatment and recovery. Care Consultants work with You and Your family, caregivers, and health care Providers to help You recover to the fullest extent possible.

Care Consultants are professionals who can offer assistance if You are planning a hospitalization, are being discharged from a Hospital, or have been advised that You have a condition that will require additional treatment.



Care Consultants provide educational support and coordination of care (such as Home Health Care or Durable Medical Equipment) and can assist in the coordination and resolution of administrative issues, as well as assist You in determining the cost of a procedure across various settings.

Should You experience a serious Injury or Illness, or need hospitalization or assistance in coordinating Your care needs, the Care Coordination program will provide assistance. The Care Consultants will:

- a. work collaboratively with You, Your family or significant others, and all Your Providers to coordinate and implement a plan of care which meets Your holistic needs;
- b. help identify community-based support and educational services to assist with Your ongoing health care needs;
- c. assist in the Coordination of Benefits and alternative resources; and
- d. assist with discharge planning and care once You have been released from the Hospital.

The Care Consultants may be reached by calling 1-800-955-5692.

## **5.06 CARE COORDINATOR NURSE**

When You are scheduling an Inpatient Hospital admission or if You have had an Inpatient Hospital admission, You will be contacted by a Care Coordinator to (1) ensure that You have received and understand Your Discharge instructions and have obtained Your Prescription Drugs, (2) coordinate any additional services You may require, and (3) explain what to expect during Your recovery.

Care Coordinators can also be of assistance if You are in need of more complex care issues, are newly diagnosed with a debilitating Illness or Injury, or have multiple medical problems or end-of-life issues. Care Coordinators assist You in understanding Your Plan and can help You (1) with financial issues, (2) obtain a Home Health Care Provider, (3) get in touch with valuable community resources, or (4) coordinate a plan for Your care. The Care Coordinators will keep in touch with You on a regular basis to follow up on Your condition and answer any questions You may have about Claims or Plan Benefits.

Care Coordinators are available at **no cost** to Plan Participants. If You would benefit from Care Coordination, You will be contacted as part of the Plan's outreach program. The program is completely confidential and no information will be shared with Your Employer. You are also free to request Care Coordination assistance by calling 1-877-789-2583 for Medical or 1-877-398-5816 for Behavioral Health/Substance Abuse.

## **5.07 UTILIZATION REVIEW PROCESS INFORMATION**

### **a. Authorized Representatives**

You have the right to designate an authorized representative to file or pursue a request for Precertification or other Pre-Service Claim on Your behalf. The Plan reserves the right to establish reasonable procedures for determining whether an individual has been authorized to act on Your behalf. Procedures adopted by The Plan will, in the case of an Urgent Care Claim, permit a Physician or other Professional Provider with knowledge of Your medical condition to act as Your authorized representative. You will need to complete a HIPAA Authorization form in order to have information released to a third-party. This form can be accessed by logging onto <http://icubabenefits.org>



## **b. Decisions Involving Requests for Precertification and Other Non-Urgent Care Pre-Service Claims**

You will receive written notice of any decision on a request for Precertification or other Pre-Service Claim, whether the decision is adverse or not, within a reasonable period of time appropriate to the medical circumstances involved. Such period of time will not exceed 15 days from the date Blue Cross Blue Shield of Florida or MHNNet receives the Claim from You or Your Provider. However, this 15-day period of time may be extended one time by Blue Cross Blue Shield of Florida or MHNNet for an additional 15 days, provided that Blue Cross Blue Shield of Florida or MHNNet determines that the additional time is necessary due to matters outside its control, and notifies You of the extension prior to the expiration of the initial 15-day Pre-Service Claim determination period. If an extension of time is necessary because You failed to submit information necessary for Blue Cross Blue Shield of Florida or MHNNet to make a decision on Your Pre-Service Claim, the notice of extension that is sent to You will specifically describe the information that You must submit. In this event, You will have 45 days in which to submit the information before a decision is made on Your Pre-Service Claim.

## **c. Decisions Involving Urgent Care Claims**

1. If Your request involves an Urgent Care Claim, Blue Cross Blue Shield of Florida or MHNNet will make a decision on Your request as soon as possible, taking into account the medical exigencies involved. You will receive notice of the decision that has been made on Your Urgent Care Claim no later than 72 hours following receipt of the Claim from You or Your Provider.
2. If Blue Cross Blue Shield of Florida or MHNNet determines in connection with an Urgent Care Claim that You have not provided sufficient information to determine whether or to what extent Benefits are provided under Your coverage, You will be notified of the specific information needed to complete Your Claim within 24 hours following Blue Cross Blue Shield of Florida's or MHNNet's receipt of the Claim. You will then be given no less than 48 hours to provide the specific information to Blue Cross Blue Shield of Florida or MHNNet. Blue Cross Blue Shield of Florida or MHNNet will thereafter notify You of its determination on Your Claim as soon as possible but no later than 48 hours after the earlier of (A) its receipt of the additional specific information, or (B) the date Blue Cross Blue Shield of Florida or MHNNet informed You that it must receive the additional specific information.
3. In those cases where Your Urgent Care Claim request seeks to extend a previously approved course of treatment and is made at least 24 hours prior to the expiration of the previously approved course of treatment, the timeframe may be shortened. In such a situation, Blue Cross Blue Shield of Florida or MHNNet will notify You of its decision concerning Your Urgent Care Claim to extend the course of treatment not later than 24 hours following receipt of Your request.

## **d. Notices of Determination Involving Precertification Requests and Other Pre-Service Claims**

Any time Your request for Precertification or any other Pre-Service Claim is approved, You will be notified in writing that the request has been approved. If Your request for Precertification or approval of any other Pre-Service Claim has been denied, You will receive written notification of that denial which will include, among other items, the specific reason or reasons for the Adverse Benefit Decision and a statement describing Your right to file an appeal. You may only file an appeal once the Claim has been incurred.

For a description of Your right to file an appeal concerning an Adverse Benefit Decision involving a request for Precertification or any other Pre-Service Claim, see Article 13 (Appeals Procedures).



## ARTICLE SIX

### PRESCRIPTION DRUG BENEFITS

The Prescription Drug Benefits below are covered under each ICUBA Medical Plan through Walgreens Health Initiatives (WHI). For more specific details regarding excluded Prescription Drugs, please see Section 6.03. The Preferred Medication List (PML) and participating pharmacies are available on [www.walgreenshealth.com](http://www.walgreenshealth.com). The PML includes diabetic supplies. You may also call the WHI Customer Care Center 24-hours a day at 1-800-207-2568. All specialty drugs must be acquired through Walgreens specialty pharmacy at 1-866-823-2712 in order to be covered (see 6.01 (n) below).

If the actual cost is less than the Co-payment, the Covered Person will have to pay the actual cost. The prescribing Physician must obtain prior authorization from WHI prior to prescribing certain Prescription Drugs. To confirm whether you need clinical prior authorization and/or to request approval, call 1-877-665-6609.

Prescription Drug Co-payments are payable in full at the time a prescription is filled.

<i>Prescription Drug Co-payments/Coinsurance</i>						
	Retail		Mail		90 Days at Retail (Advantage 90 Retail Network)	
	Network	Non-Network	Network	Non-Network	Network	Non-Network
Generic	\$5.00	*	\$10.00	N/A	\$10.00	N/A
Brand Preferred	\$27.00	*	\$50.00	N/A	\$60.00	N/A
Brand Non Preferred	\$60.00	*	\$120.00	N/A	\$145.00	N/A
<b>Frequency</b>	<b>30-day supply</b>	*	<b>84 - 90-day supply</b>	N/A	<b>84 - 90-day supply</b>	N/A
<b>Out-of-Pocket Maximum</b>	<b>\$2,000/ \$4,000</b> (Individual/Family)					

\* Non-Network charges are covered 60% under the PPO Risk/Reward Plans, and 50% under the PPO 70 Plans.

#### 6.01 GENERAL PRESCRIPTION DRUG PROVISIONS

The Preferred Medication List is an extensive list of Food & Drug Administration (FDA) approved Prescription Drugs selected for their quality, safety and effectiveness. It includes products in every major therapeutic category. The PML was developed by the Pharmacy and Therapeutics Committee made up of clinical pharmacists and Physicians and may, from time to time, be revised by the committee. Your program includes coverage for both PML and non-PML drugs at the specific Co-payment or Coinsurance amounts listed above.

Prescription Drugs are covered when You purchase them through a Network Pharmacy Provider applicable to Your program. You can choose from more than 62,000 participating pharmacies. For convenience and choice, these Network pharmacies include both major chains and independent stores. Diabetic Supplies such as OneTouch®



meters, lancets, strips, and Novofine® needles are covered at 100% with a valid prescription at any Network pharmacy and through the mail service. To obtain more information about diabetic supplies, call the WHI Customer Care Center at 1-800-207-2568.

**a. Walgreens Health Initiatives (WHI) Customer Care Center:**

If You have a question about Your pharmacy Benefits (for example, Co-pay, eligibility, or location of a nearby participating pharmacy), call the WHI Customer Care Center toll-free, 24 hours a day, 7 days a week at 1-800-207-2568 TTY: 1-888-411-0767 or visit WHI on the website at [www.walgreenshealth.com](http://www.walgreenshealth.com)

**b. The Advantage90® Program :**

The Advantage90® Program is a convenient way to get a 90-day supply of Your Maintenance Medications at select retail locations. Have Your Physician write Your prescription for a 90-day supply of the medications. (Some medications may not be available in 90-day supplies under applicable law). Advantage90® is available at more than 45,000 pharmacies. But You can still get a 30-day supply of Your prescription at more than 62,000 Network pharmacies nationwide. If You prefer mail service, You can rely on WHI to deliver Your 90-day Maintenance Medications right to Your door. The following are some of the local participating Advantage90® pharmacies (check [www.walgreenshealth.com](http://www.walgreenshealth.com) for Advantage90® pharmacies in Your area):

- A & P
- Bashas
- Brooks Pharmacy
- City Market
- Cub Pharmacy
- CVS Pharmacy
- Dillons
- Discount Drug Mart
- Dominick's
- Duane Reade
- Food City
- Fred Meyer
- Fry's
- Giant Eagle
- Happy Harry's
- Harris Teeter
- Hy-Vee
- Kerr Drug Inc.
- King Soopers
- Kmart
- Kroger
- Longs\*
- Marsh Drug
- Medicine Shoppe
- Meijer
- Osco Drug
- Price Chopper
- Publix
- Ralphs
- Randalls
- Rite Aid
- Safeway
- Sam's Club
- Sav-on Pharmacy
- Schnucks
- ShopKo
- Shoppers Pharmacy
- Smith's Pharmacy
- Stop & Shop
- Target
- Tom Thumb
- TOPS Market
- Vons
- Walgreens
- Walmart
- Wegmans Pharmacy
- Winn-Dixie

\*Except Hawaii

**c. Participating Pharmacies:**

You can choose from more than 62,000 participating pharmacies. Below are just some of the many pharmacies participating in the WHI nationwide retail Network. For additional participating pharmacies, call the WHI Customer Care Center at 1-800-207-2568 or visit the website at [www.walgreenshealth.com](http://www.walgreenshealth.com).

- A & P
- Accredo Health Group
- Acme\*
- Harris Teeter\*
- H-E-B Pharmacy
- Hy-Vee\*
- Rite Aid\*
- Safeway\*
- Sam's Club\*



- Albertsons\*
- Aurora Pharmacy\*
- Bartell Drugs
- Bashas\*
- Bi-Lo Pharmacy\*
- Brooks Pharmacy\*
- Brookshire Brothers Pharmacy\*
- Brunos Food & Pharmacy
- City Market\*
- Costco
- CVS Pharmacy\*
- CVS ProCare Pharmacy\*
- Dillons\*
- Discount Drug Mart\*
- Dominick's\*
- Duane Reade\*
- Farm Fresh Pharmacy\*
- Food City\*
- Fred Meyer\*
- Fred's Pharmacy\*
- Fry's\*
- Giant Eagle\*
- Giant Pharmacy\*
- Hannaford
- Ingles Markets\*
- Kerr Drug Inc.\*
- King Soopers\*
- Kinney Drugs
- Kmart\*
- Kroger\*
- Longs\*\*
- Marc's Pharmacy
- Marsh Drug\*
- May's Drug Stores\*
- Medicap Pharmacy\*
- Medicine Shoppe\*
- Meijer\*
- Osco Drug\*
- Pamida Pharmacy
- Pathmark Pharmacy
- Price Chopper\*
- Publix\*
- QFC\*
- Raley's
- Ralphs\*
- Randalls\*
- Save Mart\*
- Sav-on Pharmacy\*
- Schnucks\*
- Shaw's/Osco Pharmacy\*
- ShopKo\*
- ShopRite
- Smith's Pharmacy\*
- Snyders Drug Stores
- Stop & Shop\*
- Super D\*
- Target\*
- Thrifty White\*
- Tom Thumb\*
- TOPS Market\*
- United Pharmacy\*
- Vons\*
- Walgreens\*
- Walmart\*
- Wegmans Pharmacy\*
- Weis Pharmacy
- Winn-Dixie\*

\*These pharmacies also participate in the WHI Advantage90® program. This program allows You to obtain a 90-day supply of maintenance medication at select retail locations.

\*\*Except Hawaii

#### d. Mail Service Pharmacy:

By using Walgreens' Mail Service Pharmacy or Advantage 90® Network Pharmacy, You will only have to order Your prescription four times per year. We recommend that if You have medications that You take every day, You utilize the 90-day supply to save money and decrease the likelihood of missed doses because You did not remember to go to the pharmacy.

By following these simple steps You can ensure that You will never run out of medication:

- Online: Setup Your secure WalgreensHealth.com account. Then enter the information required to complete Your mail service registration. If You already have a WalgreensHealth.com account, login and select any mail service tool to be prompted to complete your registration.
- By mail: Complete the Registration & Prescription Order form included with Your enrollment packet or available at WalgreensHealth.com, and mail it along with an original prescription to the address specified on the form.
- By phone: Call the Walgreens Mail Service at 1-888-265-1807 and have Your insurance, credit card, and health information handy.



- Have Your Physician write two prescriptions: one for a 90-day supply and one for a 30-day supply. Mail the 90-day prescription to Walgreens Mail Service and save the 30-day prescription to take to Your local pharmacy in case of emergencies. Your doctor may also fax Your 90-day prescription directly to the Walgreens Mail Service. Ask Your prescriber to fax or e-prescribe Your new medication.
  - Fax: Use the Prescriber Fax Form included with Your enrollment packet or log into Your online account to print a prescriber fax form. Give the form to Your prescriber to complete and fax to the number listed on the form.
  - E-prescribe: If Your prescriber has the technology to submit prescriptions electronically, request that he or she do so.
- Always allow two weeks for Your prescription to arrive.
- You may request refills online, review Your account, print registration and order forms, and view other important information.

**e. WalgreensHealth.com allows You to:**

- Create an online account to access Your personal information at Your convenience;
- Check eligibility for Yourself and Your family;
- Check Your benefit coverage and copays;
- Search, as well as download, Your plan's drug list;
- Find generic and formulary alternatives;
- Learn more about Your medication;
- Locate a nearby pharmacy in Your plan's Network;
- Review Your prescription history and refill information; and
- Print a temporary ID card.

**f. Clinical Appeals Program:**

The Walgreens Health Initiatives Clinical Appeal Review Program provides You with the option of having Adverse Benefit Decisions (denials) re-evaluated. The appeal process involves a review of the program criteria and basis for denial and Your medical and/or prescription history to determine appropriateness of the Benefit determination. Walgreens Health Initiatives offers a two-level appeal structure.

Following an Adverse Benefit Decision, You will receive a letter from Walgreens Health Initiatives informing You of the Benefit denial. The clinical appeal review process is initiated when You request, in writing, to appeal the Adverse Benefit Decision rendered by Walgreens Health Initiatives. You may file an appeal in writing to:

Walgreens Health Initiatives,  
 Attn: Appeals  
 PO BOX 269  
 Deerfield, IL 60015-0269  
 Fax: 847-964-8902

All pertinent medical and/or prescription information to evaluate the accuracy of the denied request will be objectively and thoroughly reviewed by clinical and/or vocational experts. After the review, You will be informed of the decision in writing.

Medical Care Management Corporation (MCMC) will conduct the appeal analysis for any external review program. An independent physician expert will review the case and make a recommendation. This recommendation will be



submitted to Walgreens Health Initiatives, and Walgreens Health Initiatives will then notify You and ICUBA of the recommended appeal outcome in writing and the final decision regarding the appeal. MCMC will review Your appeal to ensure the treatment is Medically Necessary and Appropriate, meets clinical guidelines, and is not Experimental or Investigative.

**g. Covered Drugs:**

Covered Drugs include:

1. those which, under Federal law, are required to bear the legend: "Caution: Federal law prohibits dispensing without a prescription";
2. legend drugs under applicable state law and dispensed by a licensed pharmacist;
3. Prescription Drugs listed in Your program's Prescription Drug Preferred Medication List (PML), including compounded medications consisting of a mixture of at least two ingredients other than water, one of which must be a legend drug;
4. prescribed injectible insulin;
5. diabetic supplies, including needles, syringes and diabetic pump supplies (OneTouch® meters, lancets, strips and Novofine® needles are covered at 100%);
6. iron supplementation for babies covered at 100%;
7. oral fluoride supplementation for children covered at 100%;
8. aspirin for adults covered at 100%;
9. generic prenatal vitamins or folic acid for women planning or capable of pregnancy covered at 100%; and
10. certain drugs that may require prior authorization from WHI.

**h. Preferred Medication List:**

Your Prescription Drug Program follows a select drug list which is referred to as a "Preferred Medication List." The PML is an extensive list of Food and Drug Administration (FDA) approved Prescription Drugs selected for their quality, safety, and effectiveness. It includes products in every major therapeutic category. Your program includes coverage for both PML and non-PML drugs.

1. To receive a copy of the Preferred Medication List, call 1-800-207-2568. You can also look up the PML at [www.walgreenshealth.com](http://www.walgreenshealth.com).
2. These listings are subject to periodic review and modification by Walgreens Health Initiatives or a designated committee of Physicians and pharmacists.

**i. Quantity Level Limits:**

Quantity level limits may be imposed on certain Prescription Drugs by Walgreens Health Initiatives. Such limits are based on the manufacturer's recommended daily dosage or as determined by Walgreens Health Initiatives. Quantity level limits control the quantity covered each time a new prescription order or refill is dispensed for



selected Prescription Drugs. Each time a prescription order or refill is dispensed, the pharmacy Provider may limit the amount dispensed. You may access information regarding quantity level limits by logging onto [www.walgreenshealth.com](http://www.walgreenshealth.com) or calling 1-800-207-2568.

#### **j. Managed Prescription Drug Coverage:**

A prescription order or refill that may exceed the manufacturer's recommended dosage over a specified period of time may be denied when presented to the pharmacy Provider. WHI may contact the prescribing Physician to determine if the Prescription Drug is Medically Necessary and Appropriate. If it is determined that the prescription is Medically Necessary and Appropriate, the Prescription Drug will be dispensed.

#### **k. Step-Care and Clinical Prior Authorization Program:**

Step-care and prior authorization programs help ensure appropriate drug treatment while managing overall prescription costs. These programs sometimes require extra steps when getting prescriptions filled. To avoid delays, check if Your prescription requires a prior authorization or a step-care plan before getting Your prescription filled on the Preferred Medication List (PML)

The categories/medications that require clinical prior authorization or step-care may include, but are not limited to:

- Acne
- Actiq®
- ADHD/Narcolepsy
- Anabolic Steroids
- Antidepressants (Step)
- Brand Proton Pump Inhibitors (Step)
- Byetta®
- Duragesic
- Fentora®
- Insomnia
- Long Acting Beta-Agonists (LABA)  
(e.g., Serevent®, Foradil®, Advair®)
- Migraine
- OxyContin®
- Ranexa®
- Statins (Step)
- Symlin®

Note: Drug names are the property of their respective owners.

You may also confirm whether You need clinical prior authorization or step-care and/or to request approval by calling the WHI Clinical Care Center at 1-877-665-6609. Please have available the name of Your medication, Your physician's name, phone (and fax number, if available), Your member ID number and Your group number (from Your ID Card).

#### **I. Quality Guidelines:**

The purpose of this program is to ensure that certain Prescription Drugs are administered according to Food and Drug Administration (FDA) requirements. FDA requirements can be found on the insert You receive with the drug. Sometimes a medical provider will prescribe the following drugs in a way other than described on the FDA required insert. The most common Prescription Drugs required to follow this guideline are:

- Migraine medications such as Amerge®, Axert®, Frova®, Imitrex®, Migranal®, Zomig®, Maxalt®, or Relpax®
- COXII inhibitors such as Celebrex®



- Proton Pump Inhibitors such as Nexium®, Prilosec®, Protonix®, Prevacid®, Zegerid®, Omeprazole®, or Aciphex®
- Oral antifungal agents such as Lamisil® or Sporanox®
- Singulair®, Accolate®, or Zflo®
- Strattera®
- Subutex® or Suboxone®

Note: Drug names are the property of their respective owners.

If this occurs Your retail or mail order pharmacist will receive an onscreen computer message requesting that Your medical Provider contact WHI clinical staff to determine if Your medical condition warrants that You receive the Prescription Drug. Otherwise, Your Prescription Drug will be filled according to FDA requirements. If You have any questions, You may contact WHI customer care center at 1-800-207-2568 for additional information.

#### **m. Generic Substitution:**

Many Brand-Name Drugs are available as Generic Drugs, which are just as effective, but less costly. If Your Physician prescribes a Brand-Name Drug that is available in generic form, and:

- Your Physician requires that only the Brand-Name Drug may be used, You will receive the 30-day supply of the Brand-Name Drug at retail for a Co-pay of \$27 or \$60, a 90-day supply of the Brand-Name Drug for a Co-pay of \$60 or \$145, or through mail order for a Co-pay of \$50 or \$120; or
- Your Physician approves a Generic Drug substitution to be allowed, You will receive the Generic Drug substitution at retail for a Co-pay of \$5, a 90-day supply of the Generic Drug at \$10 and through Mail Order at a Co-pay of \$10. If You still want to receive the Brand-Name Drug, You will be responsible for paying the Brand-Name Drug Co-payment plus the difference between the cost of the Brand-Name Drug and the Generic Drug, but in no case more than the cost of the Brand-Name Drug.

#### **n. Specialty Drugs**

Certain medications used for treating complex health conditions must be obtained through the Specialty Pharmacy Program. The following conditions may require drugs that fall under Specialty Pharmacy, which include, but are not limited to: Cystic Fibrosis, Enzyme Deficiency, Growth Hormone Deficiency, Multiple Sclerosis, Rheumatoid Arthritis, and Viral Hepatitis. Prescriptions for these types of drugs will be available through the Specialty Pharmacy Network. Please call Walgreens clinical services toll free 1-866-823-2712 for information. Walgreens Specialty Pharmacy Program is provided through Walgreens Specialty Pharmacy. Walgreens Specialty Pharmacy simplifies Your access to these medications, improves the consistency of Your quality pharmacy care, and helps control rising pharmaceutical costs.

This means that You will only be able to purchase these specialty medications through Walgreens Specialty Pharmacy as a retail days supply (which will not be dispensed in greater than a 30-day supply) at the retail cost-sharing amount. The delivery of Your medications will be coordinated and express-delivered to Your home or



Physician's office every month. The following list of medications is included in the program, and is subject to change based on new drugs being issued in the marketplace.

- Actimmune®
- Apokyn®
- Avonex®
- Baraclude®
- Betaseron®
- Cerezyme®
- Copaxone®
- Copegus®
- Depot®
- Eligard®
- Enbrel®
- Etoposide®
- Forteo®
- Fuzeon®
- Genotropin®
- Gleevec®
- Hepsera®
- Humatrope®
- Humira®
- Intrathecal®
- Intron A®
- Kineret®
- Leuprolide®
- Lioresal®
- Lupron®
- Nexavar®
- Norditropin®
- Nutropin®
- Pegasy®
- Peg-Intron®
- Pulmozyme®
- Raptiva®
- Rebetol®
- Rebif®
- Revatio®
- Revlimid®
- Ribasphere®
- Roferon A®
- Saizen®
- Sandostatin®
- Sensipar®
- Serostim®
- Sprycel®
- Sutent®
- Tarceva®
- Targretin®
- Temodar®
- Tev-Tropin®
- Thalomid®
- Tobi®
- VePesid®
- Viadur®
- Xeloda®
- Zoladex®
- Zorbitive®

Note: Drug names are the property of their respective owners.

In addition to providing access to these medications, Walgreens Specialty Pharmacy offers:

- A patient Care Coordinator dedicated to Your needs;
- Free overnight delivery of Your medications to Your home or Physician's office;
- Most specialty medication supplies at no charge;
- 24-hour pharmacist and nurse emergency on-call;
- 7-days per week pharmacy hours;
- 8AM - 9PM weekday customer service hours; and
- Monthly refill reminders and free educational items.

You can reach Walgreens Specialty Pharmacy at 1-866-823-2712.



**o. Participating/Non-Participating Pharmacies:**

You may purchase Prescription Drugs from either a Participating or Non-Participating Pharmacy. If You purchase Your Prescription Drugs at a Non-Participating Pharmacy You will pay the following Coinsurance:

- PPO 70: 50/50%
- PPO Risk/Reward: 60/40%

**p. Participating Network Pharmacy:**

The WHI network consists of more than 62,000 participating chain and independent pharmacies nationwide. Network pharmacies have an arrangement to provide Prescription Drugs to You at an agreed upon price. When You purchase covered drugs from a pharmacy in the Network applicable to Your program, present Your prescription and ID Card to the pharmacist. (Prescriptions that the pharmacy receives by phone from Your Physician or Dentist may also be covered.) You should request and retain a receipt for any amounts that You have paid in case You need the information for income tax or any other purpose. To get Your diabetic supplies such as OneTouch® meters, lancets, strips and Novofine® needles covered at 100% You must have a prescription from a provider and use a network pharmacy or mail order.

**q. ID Card:**

If You should forget Your ID Card when You go to a Network Pharmacy to have a prescription filled, the Pharmacy may ask You to pay in full for the prescription. If this happens, call the WHI Customer Care Center at 1-800-207-2568 to confirm eligibility. You may also call the Customer Care Center for ID card replacements.

**r. No Deductible:**

Prescription Drug Benefits, including Specialty Drugs obtained at Network Pharmacies, are not subject to the overall program Deductibles or Coinsurance.

**s. Out-of-Pocket Maximum:**

There is a \$2,000 Out-of-Pocket Maximum (individual) and a \$4,000 Out-of-Pocket Maximum (family) for prescription Drugs. Once You have spent \$2,000 (individual) or \$4,000 (family) in Co-payments in a Plan Year, Your Prescription Drugs will be covered at 100% in Network.

**t. Non-Participating Pharmacy:**

If You are at a Non-Network Pharmacy and are required to pay in full, simply complete a drug reimbursement Claim form. You can request a form online at WHI's website, [www.walgreenshealth.com](http://www.walgreenshealth.com), or by calling WHI Customer Care Center at 1-800-207-2568. Be sure to enclose a copy of Your receipt listing the name of the drug and amount You were charged. You will receive the appropriate reimbursement in three to five weeks.



## 6.02 NINETY (90) DAY PRESCRIPTION DRUG PROGRAM

A Covered Person can order long-term Maintenance Medication drugs by mail order as described in the Schedule of Medical Benefits. Specialty Drugs are not available through the Advantage90® or Walgreens Mail Service Prescription Drug program. Exclusions are noted below in Section 6.03

## 6.03 EXCLUSIONS

- a. Services of Your attending Physician, surgeon, or other medical attendant including medications taken by or administered to an individual, in whole or in part, while he or she is a patient in a licensed Hospital, Ambulatory Care Facility, Extended Care Facility, Skilled Nursing Facility, Substance Abuse Treatment Facility, Other Facility Provider, or similar institution which operates on its premises, or allows to be operated on its premises, a facility for dispensing pharmaceuticals and Network facilities such as those that include such charges as part of a global rate charged to the Plan.
- b. Prescription Drugs dispensed for treatment of an Illness or an Injury for which the group is required by law to furnish Hospital care in whole or in part including, but not limited to: state or federal workers' compensation laws, occupational disease laws and other employer liability laws.
- c. Cosmetic indications and anti-wrinkle agents (e.g., Botox®, Renova®).
- d. Prescription Drugs to which You are entitled, with or without charge, under a plan or program of any government or governmental body.
- e. Charges for therapeutic devices or appliances (e.g., support garments and other non-medicinal substances).
- f. Charges for administration of Prescription Drugs and/or injectible insulin, whether by a Physician or other person.
- g. Any charges by any pharmacy Provider or pharmacist except as provided herein.
- h. Any drug or medication except as provided herein.
- i. Any amounts You are required to pay directly to the pharmacy for each prescription or refill.
- j. Charges for a Prescription Drug when such drug or medication is used for unlabeled or unapproved indications and where the Food and Drug Administration (FDA) has not approved use of such drug or medication.
- k. Drugs and supplies that are not Medically Necessary and Appropriate or otherwise excluded herein.
- l. Any drug or medication which does not meet the definition of a covered maintenance Prescription Drug.
- m. Any charge for a fertility drug, even if such medication is a Prescription Drug.
- n. Pharmacological or hormonal treatment used in conjunction with assisted fertilization.



- o. Impotency treatment drugs.
- p. Oral impotency drugs.
- q. Hair growth stimulants.
- r. Food supplements.
- s. Biologicals.
- t. Any drugs used to abort a pregnancy.
- u. Blood products.
- v. Antihemophilic drugs.
- w. Smoking cessation products.
- x. Vitamins, except for prenatal vitamins prescribed as Medically Necessary vitamins.
- y. Anti-Obesity drugs.
- z. Any drugs which are Experimental or Investigative.
- aa. Any drugs and supplies which can be purchased without a prescription order, unless specifically described as provided herein.
- bb. Any selected diagnostic agents.
- cc. Fluoride products for adults.
- dd. Over-the-counter drugs that are not part of a generic substitution program unless aspirin filled with a prescription, which is covered at 100%.
- ee. Non-legend drugs.
- ff. Tretinoin topical (e.g., Retin-A®) for individuals 24years or older.
- gg. Syringes unless accompanied by a prescription order.

#### 6.04 YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

Your Prescription Drug coverage under the Plan is, on average for all Plan Participants, expected to pay out as much as the standard Medicare Prescription Drug coverage will pay and is considered Creditable Coverage. Because Your existing coverage is on average at least as good as standard Medicare Prescription Drug coverage, You can keep this coverage and not pay extra if You later decide to enroll in Medicare Prescription Drug coverage.



Individuals can enroll in a Medicare Prescription Drug plan when they first become eligible for Medicare and each year from November 15<sup>th</sup> through December 31<sup>st</sup>. Beneficiaries leaving Employer coverage may be eligible for a Special Enrollment period to sign up for a Medicare Prescription Drug program.

You should compare Your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare Prescription Drug coverage in Your area.

If You decide not to enroll in a Medicare Prescription Drug plan and drop Your coverage under the Plan, be aware that You and Your Dependents may not be able to get this coverage back.

You should also know that if You drop or lose coverage with the Plan and don't enroll in Medicare Prescription Drug coverage after Your current coverage ends, You may pay a penalty to enroll in Medicare Prescription Drug coverage later.

If You go 63 days or longer without Prescription Drug coverage that is at least as good as Medicare's Prescription Drug coverage, Your monthly premium for Medicare Prescription Drug coverage will go up at least 1% per month for every month that You go without such coverage. For example, if You go 19 months without coverage, Your Medicare Prescription Drug premium could be 19% higher than what many other people pay. You will have to pay this premium as long as You have Medicare Prescription Drug coverage.

For more information about Your options under Medicare Prescription Drug coverage visit [www.medicare.gov](http://www.medicare.gov) online, or call 1-800-Medicare (1-800-633-4227). TTY users should call 1-877-486-2048.

For people with limited income and resources, extra help paying for Medicare Prescription Drug coverage is available. Information about this extra help is available from the Social Security Administration (SSA) online, at [www.socialsecurity.gov](http://www.socialsecurity.gov), or You may call SSA at 1-800-772-1213 (TTY: 1-800-325-0778).

### **Important Notice from ICUBA About Your Prescription Drug Coverage and Medicare**

Please read this notice carefully. This notice has information about your current prescription drug coverage with ICUBA and prescription drug coverage available for people with Medicare. It also explains the options under Medicare prescription drug coverage and can help you decide whether or not you want to enroll. At the end of this notice is information about where you can get help to make decisions about your prescription drug coverage.

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare through Medicare prescription drug plans and Medicare Advantage Plans that offer prescription drug coverage. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. ICUBA has determined that the prescription drug coverage offered by the ICUBA Plan is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay and is considered Creditable Coverage.

**Because your existing coverage is on average at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay extra if you later decide to enroll in Medicare prescription drug coverage.**



Individuals can enroll in a Medicare prescription drug plan when they first become eligible for Medicare and each year from November 15<sup>th</sup> through December 31<sup>st</sup>. Beneficiaries leaving employer/union coverage may be eligible for a Special Enrollment Period to sign up for a Medicare prescription drug plan. You should compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. If you do decide to enroll in a Medicare prescription drug plan and drop your ICUBA prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back. Please contact us for more information about what happens to your coverage if you enroll in a Medicare prescription drug plan.

You should also know that if you drop or lose your coverage with ICUBA and do not enroll in Medicare prescription drug coverage after your current coverage ends, you may pay more (a penalty) to enroll in Medicare prescription drug coverage later. If you go 63 days or longer without prescription drug coverage that is at least as good as Medicare's prescription drug coverage, your monthly premium will go up at least 1% per month for every month that you did not have that coverage. For example, if you go nineteen months without coverage, your premium will always be at least 19% higher than what many other people pay. You will have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to enroll.

**For more information about this notice or your current prescription drug coverage....**

Contact your Division office for further information. You will receive this notice annually and at other times in the future such as before the next period you can enroll in Medicare prescription drug coverage, and if this coverage through ICUBA changes. You also may request a copy.

**For more information about your options under Medicare prescription drug coverage....**

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare and You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare prescription drug plans. For more information about Medicare prescription drug plans:

- Visit [www.medicare.gov](http://www.medicare.gov)
- Call your State Health Insurance Assistance Program (see your copy of the Medicare and You handbook for their telephone number) for personalized help.
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. For people with limited income and resources, extra help paying for Medicare prescription drug coverage is available. Information about this extra help is available from the Social Security Administration (SSA) online at [www.socialsecurity.gov](http://www.socialsecurity.gov) or you can call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: If you enroll in one of the plans approved by Medicare which offer prescription drug coverage, you may be required to provide a copy of this notice when you join to show that you are not required to pay a higher premium amount.



## ARTICLE SEVEN

### ENROLLMENT AND CONTRIBUTIONS

#### 7.01 PARTICIPANT ENROLLMENT AND ELIGIBILITY

- I. The “**Benefits Effective Date**” for an Employee shall be the Employee’s date of hire; provided that:
  - a. the Employee meets the requirements for Eligibility and enrolls in the Plan within 30 days of the date of eligibility; and
  - b. the Employer and Employee make any required contributions toward the cost of coverage for the Participant and any Covered Dependent(s). The formula used for allocating the required contributions shall be determined by such Employee’s Employer and the premium to be collected must be approved by the ICUBA Board of Directors. The amount of the respective contributions shall be set forth in notices from the Plan Administrator and may be changed at any time by the ICUBA Board of Directors.
  - c. If an Employee Terminates Employment and is rehired within 60 days of the date of Termination Of Employment, his or her Benefits shall be reinstated, effective as of the date of Termination of Employment and there shall be no break in coverage. The Employee shall be responsible for making any required contributions toward the cost of coverage for the Participant and any Covered Dependent(s) during the period beginning on the Employee’s date of Termination Of Employment and ending on the date that coverage is subsequently reinstated.
  
- II. **Covered Active Employees Age 65 or Over**

If You are age 65 or older and Actively At Work, You will remain covered under the Plan and be eligible for the same Benefits that are available to Employees under age 65. In such case, the following shall apply:

  - a. The Plan shall pay all eligible Benefits first.
  - b. Medicare will then pay for Medicare eligible expenses, if any, that were not paid by the Plan.
  - c. If You are age 65 or older and Actively At Work, You may elect not to be covered under the Plan. In such case, Medicare will be Your only coverage. If You choose this option, You will not be eligible for any Benefits under the Plan nor will You be offered retiree coverage if Your age and years of service would have otherwise made You eligible for retiree coverage unless You are a Participant in the Plan three months before You retire.
  - d. If You are Actively At Work, Your spouse has the same choices for Benefit coverage as indicated above for an Employee age 65 or older.
  - e. Regardless of the choice made by You or Your spouse, each one of You should apply for Medicare Part A coverage about three months prior to turning age 65. If You choose the Plan as primary, You may wait to enroll in Medicare Part B. You will be able to enroll in Medicare Part B later during special enrollment periods without penalty.



- III. The ICUBA Prescription Drug Benefit is Creditable Coverage, which means that You will receive credit towards Medicare Part D upon Your retirement if You choose to enroll in Medicare Part D. Creditable Coverage means that the amount the Plan expects to pay on average for Prescription Drugs for individuals covered under the Plan in the applicable year is the same or more than what standard Medicare Prescription Drug coverage would be expected to pay on average. This is important because the Medicare Modernization Act (MMA) imposes a late enrollment penalty on individuals who do not maintain Creditable Coverage for a period of 63 days or longer following their initial enrollment period for the Medicare Part D Prescription Drug benefit. MMA mandates that certain entities offering Prescription Drug coverage, including employer and union group health plan sponsors, disclose to all Medicare eligible individuals with Prescription Drug coverage under the plan whether such coverage is "creditable". This information is essential to an individual's decision whether to enroll in a Medicare Part D Prescription Drug plan. The Plan pays for other health expenses in addition to Prescription Drugs. If You or Your Dependent enroll in a Medicare Part D Prescription Drug plan, You and Your eligible Dependents will still be able to receive all of Your current health and Prescription Drug benefits under this Plan.

## 7.02 DEPENDENT ENROLLMENT AND ELIGIBILITY

- a. **Initial Enrollment.** If an Employee enrolls a Dependent within 30 days of his or her date of hire, the Dependent's Effective Date shall be the same day as the Participant's Effective Date. If You Terminate Employment and are rehired within 60 days of Your Date Of Termination, Your Dependent's Benefits shall be reinstated, effective as of Your date of Termination Of Employment and there shall be no break in coverage. You will be responsible for paying the required contributions toward the cost of coverage for Your Dependent(s) during the period beginning on Your date of Termination Of Employment and ending on the date that coverage is subsequently reinstated.
- b. **Participant or Dependent Contributions.** A Participant or Dependent may be required to make periodic contributions toward the cost of coverage under the Plan in an amount determined by the Employer or the Plan Administrator. The amount of the respective contributions shall be set forth in notices from the Plan Administrator, and may be changed from time to time by ICUBA.

## 7.03 SPECIAL ENROLLMENT

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) provides special enrollment opportunities for certain events. If an Employee or the Employee's Dependents are eligible to participate in the Plan, but are not already enrolled in the Plan, the Employee may request Special Enrollment mid-Plan Year (4/1 – 3/31) upon either (1) the loss of other group health plan coverage or (2) the addition of a new Dependent; **provided, however, that the Plan is notified of the Special Enrollment request within 30 days of the event.**

- a. **Loss of Other Group Health Plan Coverage.** An Employee or Dependent who is eligible to participate in the Plan, but not enrolled in the Plan, may enroll if all of the following conditions are met:
1. The Employee or Dependent was covered under another group health plan or had health insurance coverage at the time he or she first became eligible for coverage under this Plan.



2. The Employee selected other coverage as a reason for waiving coverage on the employment website or stated in writing at the time Plan coverage was initially offered that the other health coverage was the reason for declining enrollment in this Plan or the Employee provided sufficient documentation of coverage under another plan at the time the initial decision to decline coverage was made.
3. The other coverage of the Employee or Dependent ended because:
  - A. the other coverage was COBRA Continuation Coverage that was exhausted. COBRA Continuation Coverage is considered exhausted when it ceases for any reason other than the person's failure to pay premiums on a timely basis or for improper or illegal acts (such as making a fraudulent claim or an intentional misrepresentation).
  - B. the other health coverage was not COBRA Continuation Coverage and was terminated due to either a loss of eligibility for the coverage (*i.e.*, due to legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment) or because employer contributions for the other coverage were terminated or significant cost Increase or Decrease occur. An individual will not have Special Enrollment rights if the other coverage ended due to the individual's failure to pay premiums on a timely basis or for cause (*e.g.*, such as making fraudulent claims or intentional misrepresentations).
  - C. the Employee submits a request for Special Enrollment in writing to the Plan Administrator no later than 30 days after the date the other coverage terminates.

**b. Newly-Acquired Dependents**

1. An Employee's newly-acquired Dependents may enroll in the Plan if: (i) the Employee is a Participant in this Plan or, if not a Participant at the time, the Employee has met the waiting period applicable to becoming a Participant and is eligible to be enrolled under this Plan; and (ii) the person becomes a Dependent of the Employee through marriage, birth, adoption, or placement for adoption (this included foster children and/or other children in court-ordered custody of the Employee).
2. If the Employee is not yet a Participant, the Employee must enroll during the Special Enrollment Period in order for the newly acquired Dependent to be eligible for coverage. In the case of birth or adoption of a child, the spouse of the covered Employee may be enrolled as a Dependent of the covered Employee if the spouse is eligible for coverage. The Special Enrollment Period is a period of not more than 30 days that begins on the date of the marriage, birth, adoption, or placement for adoption. The time between the dates a Special Enrollee first becomes eligible for Special Enrollment under the Plan and the first day of coverage is not treated as a waiting period for purposes of the Plan's Pre-Existing Condition exclusion provisions.
3. The coverage of the Employee or Dependent enrolled during the Special Enrollment Period will be effective: (i) in the case of marriage, from the date of marriage; (ii) in the case of a Dependent's birth, as of the date of birth; (iii) in the case of a Dependent's adoption or placement for adoption, the date of the adoption or placement for adoption; (iv) in the case of foster children, as of the date of placement in the residence; and (v) in the case of children in court-ordered custody of the Employee, as of the date of the order; provided, however, that in each case, the individual is enrolled within 30 days of becoming eligible



for such enrollment and the Employee substantiates within that timeframe by providing the necessary documentation to the Plan Administrator or Employer.

4. If a Dependent is acquired other than at the time of birth, due to a court order, decree, or marriage, that Dependent will be considered a Dependent from the date of such court order, decree, or marriage, provided that this new Dependent is properly enrolled as a Dependent within 30 days of the court order, decree, or marriage and proof of the court order, decree, or marriage is provided to the Plan Administrator or Employer within that timeframe.

**In order to change benefits mid-Plan Year (4/1-3/31) due to a Special Enrollment event, You must complete, sign, and return an application to Your Employer or enroll online at <http://icubabenefits.org> within 30 days after the date of the event.** You must provide the Plan Administrator or Your Employer with documentation substantiating the event within the same 30-day period.

Once You have provided substantiation of the event, You and/or Your Dependents (as applicable) shall be enrolled in the Plan, effective as of the dates set forth above. If You do not enroll Yourself and/or Your Dependent upon becoming eligible for Special Enrollment, You and/or Your Dependent, as applicable (1) may be subject to Pre-Existing Condition limitations and (2) shall not be able to enroll in the Plan again until the following Open Enrollment or the occurrence of a subsequent Special Enrollment event (or Change in Status event).

Genetic Information shall not be treated as a Pre-Existing Condition in the absence of a diagnosis of the condition related to such information. If You or Your Dependent are diagnosed with a condition, even if the condition relates to Genetic Information, a Pre-Existing Condition exclusion with respect to the condition is subject to other limitations within the Plan.

If an individual enrolls as a Special Enrollee, he or she may not be treated as a Late Enrollee for purposes of applying any Pre-Existing Condition exclusion period. Therefore, the maximum Pre-Existing Condition exclusion period that may be applied is 12 months (rather than the 18 months for Late Enrollees), reduced by the individual's Creditable Coverage. Children up to the attainment of age 19 are not subject to Pre-Existing Condition limitations. In addition, a newborn, adopted child, child placed for adoption, foster child, or other child in court-ordered custody shall not be subject to a Pre-Existing Condition exclusion period if the child is enrolled within 30 days of such event and has no subsequent significant break in coverage or is age 19 or lower.

**VERY IMPORTANT NOTE: Actual enrollment is necessary for a newborn, adopted child, child placed for adoption, foster child, or other child in court-ordered custody to be covered under the Plan. This means that You must obtain, complete, sign, and return a new enrollment form or make Your election online to add a newborn, adopted child, foster child, or other child in court-ordered custody to the Plan and provide substantiation. *If you fail to complete, sign, and return an enrollment form within 30-days after the Special Enrollment event, the Dependent will not have coverage or be able to enroll in the Plan until the next Open Enrollment (unless a subsequent Special Enrollment event or Change in Status event occurs).* In such case, the Dependent may be subject to the Plan's Pre-Existing Condition limitations if they are older than 19 years of age. Accordingly, it is critical that the new Dependent be enrolled within 30 days after becoming a new Dependent. Claims for maternity expenses or maternity leave do not constitute notification or enrollment of a new Dependent for**



coverage. If you do not enroll Your Dependent within 30 days from the date of the Special Enrollment event, Your Dependent will not be covered under the Plan and will not have coverage for any conditions other than for the charges covered under the maternity coverage of a newborn's mother.

## 7.04 CHANGE IN STATUS

- I. Once enrollment elections are made, either during the initial or Special Enrollment periods or during the annual Open Enrollment period, those elections may not be changed and will remain in effect for the entire Plan Year. However, there are some important mid-Plan Year exceptions:
  - a. **Change in Status.** Employees may revoke or modify their enrollment elections mid-Plan Year only if they experience a Change in Status that affects their or their Dependent's eligibility under this Plan. An election change will be approved only if it is consistent with the Change in Status. An election change is "consistent with" a Change in Status if the change is both the result of, and corresponds with, the Change in Status. For example, if a child ceases to be eligible for coverage because of age, it would be consistent with the Change in Status to drop coverage for the child. However, it would not be consistent with the Change in Status to drop coverage for the Employee.
  - b. **Change in Cost or Coverage.** If the cost of Benefits increases or decreases during a Plan Year, the Plan Sponsor may automatically change Employee premium contributions. When the change in cost is significant, Employees will be given the opportunity to either increase their contributions or elect a less-costly option (if available). If there is a significant overall reduction in the Plan's coverage, Employees may elect another benefit option (if available). If a new Benefit option is added under the Plan, Employees will have the right to change their election to the new Benefit option.
  - c. **Qualified Medical Child Support Order ("QMCSO") or Qualified Domestic Relations Order ("QDRO").** A child may become eligible for coverage as set forth in a Qualified Medical Child Support Order or Qualified Domestic Relations Order. An Employee may change his or her Plan enrollment elections if the Employee becomes subject to a QMCSO or a QDRO that requires the Employee to provide (or cancel) health care coverage for the Dependent child; provided, however, that the Plan Administrator shall have sole discretion to determine whether a medical child support order and/or domestic relations order is qualified and for administering the provision of Benefits under the Plan pursuant to a QMCSO and/or QDRO. The Plan Administrator may seek clarification and modification of the order, up to and including, the right to seek a hearing before the court or agency, which issued the order. ERISA Section 206(d)(3)(B) defines the term Qualified Domestic Relations Order as a domestic relations order, which creates or recognizes the existence of an alternate payee's right to, or assigns to an alternate payee the right to, receive all or a portion of the Benefits payable with respect to a participant under a plan, and which meets the requirements of ERISA Section 206 (d)(3)(C) and (D). The term domestic relations order is defined in ERISA Section 206(d)(3)(B)(ii) as any judgment, decree, or order (including approval of a property settlement agreement), which relates to the provision of child support, alimony payments, or marital property rights to a spouse, former spouse, child or other Dependent of a participant, and is made pursuant to a



state domestic relations law (including a community property law). The term alternate payee is defined by ERISA Section 206(d)(3)(K) to mean any spouse, former spouse, child or other Dependent of a participant who is recognized by a domestic relations order as having a right to receive all, or a portion of, the Benefits payable under a plan with respect to such participant.

- d. **Entitlement to Medicare or Medicaid.** An Employee may change his or her elections for Plan coverage if the Employee or any Dependent becomes entitled to or loses Medicare or Medicaid coverage.
  - e. **Change in coverage under another employer plan.** An employee may make a prospective election change that is on account of and corresponds with a change made under another employer plan (including a plan of the Policyholder or of another employer) if:
    - 1. The other cafeteria plan or qualified benefits plan permits participants to make an election change that would be permitted under the applicable provisions of Section 125; or
    - 2. The cafeteria plan permits participants to make an election for a period of coverage that is different from the period of coverage under the other cafeteria plan or qualified benefits plan.
  - f. **Loss of coverage under other group health coverage.** An employee may make an election on a prospective basis to add coverage under the group policy/plan for the employee or employee's dependent if such employee or dependent loses coverage under any group health coverage sponsored by a governmental or educational institution, including a:
    - 1. State's children's health insurance program under Title XXI of the Social Security Act;
    - 2. Medical care program of an Indian Tribal government, the Indian Health Service, or a tribal organization;
    - 3. A State health benefits risk pool; or
    - 4. A foreign government group health plan.
- II. If an Employee experiences an event that allows the Employee to make a mid-Plan Year enrollment change, the Employee must enroll online at <http://icubabenefits.org> or submit a completed enrollment change form to the Plan Administrator or the Employer no later than 30 days after the event occurs. If the Employee does not request the coverage change within the specified time limit, the Employee will lose the right to make a change allowed by that event. If approved, the Employee's enrollment change(s) shall take effect on the date of the event.

**Consistency Rule:** In all cases, any election change as a result of any change in status must be on account of and correspond with a change in status that affects eligibility for coverage under the plan. For example, if the change in status is the employee's divorce, annulment or legal separation from a spouse, the death of a spouse or dependent child, or a dependent ceasing to satisfy the eligibility requirements for coverage, an employee's election to cancel health coverage will apply only to the spouse involved in the divorce, annulment or legal separation, the deceased spouse or dependent child, or the dependent that ceased to satisfy the eligibility requirements.



## 7.05 TERMINATION OF COVERAGE

A Participant's and/or covered Dependent's coverage under the Plan shall terminate on the earliest of the following dates:

- a. The date on which the Participant Terminates Employment with the Employer unless the Employer is obligated to continue to make contributions on behalf of the Participant by terms of an employment agreement;
- b. The date on which the Participant ceases to be eligible for the Plan due to a reduction in his or her number of hours of employment;
- c. The date on which the Participant loses his or her status as a Participant, or a Dependent loses his or her status as a Covered Dependent;
- d. The date on which the Participant ceases to be in a class eligible for coverage;
- e. The date on which this Plan is terminated (or in the case of any Benefit under this Plan, the date of termination of the specific benefit);
- f. The date following the date the Participant dies; provided, however, that any Covered Dependent may remain a Dependent for the applicable period of COBRA Continuation Coverage set forth in Article Eight, provided that the Covered Dependent complies with the conditions therein;
- g. The date the Participant, while on an Approved Leave of Absence or Approved Sabbatical, becomes employed full-time by another employer, or fails to return from such Approved Leave of Absence within 12 months of the date the Approved Leave of Absence commenced;
- h. The date the Participant fails to timely pay any required contributions; in such case, coverage shall terminate on the last date for which the required contributions were paid by the Employer and or Employee, as the case may be, and as determined by the Plan Administrator;
- i. The date that the Participant fails to return from a leave of absence under the Family and Medical Leave Act of 1993 after the maximum period allowed under the Act has expired;
- j. The date that the Participant fails to return from a Leave of Absence under the Uniformed Services Employment and Reemployment Rights Act (USERRA) of 1994 after the maximum period allowed under the Act has expired; or
- k. The date the Participant's request to revoke or modify coverage due to a Change in Status is approved. The Participant must notify the Plan Administrator or Employer of a Change in Status, either in writing or online, within 30 days of the Change in Status. Coverage is terminated on the last day of employment, or on the effective date of the Change in Status. If coverage is terminated during Open Enrollment, coverage terminates on the last day of the month of the Benefit Plan Year (4/1-3/31).



## 7.06 LATE ENROLLEES

Late Enrollees may enroll in the Plan only during Open Enrollment as set forth in the Open Enrollment Section. The Effective Date of the Late Enrollee's coverage is the first day of the Plan Year (4/1-3/31) following enrollment. Late Enrollees (over 19 years of age) will be subject to Pre-Existing Condition limitations unless proof of Continuous Coverage is provided.

## 7.07 PRE-EXISTING CONDITION LIMITATIONS

HIPAA defines a Pre-Existing Condition as one for which medical advice, diagnosis, care, or treatment was recommended or received during the 6-month period prior to an individual's Enrollment Date. Dependent Children up to the age of 19 are not subject to Pre-Existing Condition Limitations.

Group Medical Plans and issuers may not exclude an individual's Pre-Existing Condition(s) from coverage for more than 12 months (18 months for Late Enrollees) after an individual's Enrollment Date.

Under HIPAA, a Plan must give individuals credit for the length of time they had prior continuous medical coverage, without a break in coverage of 63 days or more, thereby reducing or eliminating the 12-month exclusion period (18 months for Late Enrollees).

Claims resulting from Pre-Existing Condition(s) shall be excluded from coverage under the Plan until the Covered Person has been covered under the Plan for a period of 12 consecutive months (18 months for Late Enrollees), reduced by the Covered Person's period of Creditable Coverage under a prior medical plan.

In no event, however, shall Pre-Existing Condition limitations of the Plan be applied to a Dependent of a Participant whose coverage under the Plan is terminated due to the failure of the Participant to pay premiums while said Participant is on leave qualified under the Family and Medical Leave Act (FMLA) of 1993 or the Uniformed Services Employment and Reemployment Rights Act (USERRA) of 1994, and who subsequently becomes eligible for coverage because of his or her return to Actively At Work status, provided that the Participant pays the required contributions following his or her return from leave.

In addition, if You lose eligibility for coverage as a result of Your Termination Of Employment, and then become eligible for coverage again due to Your re-employment, only the most recent period of eligibility may be considered for determining whether You failed to timely enroll Your Dependents.

## 7.08 THE GENETIC INFORMATION NON DISCRIMINATION ACT OF 2008 (GINA)

GINA prohibits discrimination in group health plan coverage based on genetic information. GINA expands the genetic protections included in HIPAA, which provides that Genetic Information shall not be treated as Pre-Existing Condition in the absence of a diagnosis of the condition related to such information. If You or Your Dependent are diagnosed with a condition, even if the condition relates to Genetic Information, a Pre-Existing Condition exclusion with respect to the condition is subject to other limitations within the Plan.



GINA provides that group health plans cannot base premiums for an employee or group of similarly situated individuals on genetic information.

GINA also prohibits plans from requesting or requiring an individual to undergo a genetic test. There is a research exception that permits a plan to request but not require that a participant or beneficiary undergo a genetic test.

GINA also restricts the Plan from collecting genetic information (including family medical history) prior to or in connection with enrollment. Under GINA, the Plan is generally prohibited from offering rewards in return for collection of genetic information, including family medical history collected as part of a Personal Health Assessment (PHA).

The Plan will not discriminate against participants or beneficiaries eligible to participate in the Plan's wellness programs and do not require individuals to meet any standards related to a health factor in order to obtain a reward, as specified in (29 CFR 2590. 702(f)(2)(iii)). Rewards for completion of a PHA are available whether or not the individual answers the questions regarding genetic information (e.g., family history).

If it is unreasonably difficult due to a medical condition for You to achieve the standards of the reward (attend a health fair or take the online assessment) under this program, call ICUBA at 866 377-5102 and we will work with You to develop another way to qualify for the reward.

## 7.09 OPEN ENROLLMENT

The Plan shall conduct an Open Enrollment each year. During Open Enrollment, Participants may make any of the following changes regarding participation in the Plan, subject to other governing provisions of this Plan Document.

- a. Enroll as a Late Enrollee;
- b. Add Dependents not able to enroll during the Plan Year of April 1 through March 31 as Special Enrollees; and
- c. Make such other changes as permitted by this Plan Document (including dropping coverage).

## 7.10 ELIGIBLE RETIREE'S PARTICIPATION

Retirees must meet a Member Institution's definition of Eligible Retiree in order to be covered under the ICUBA Retiree Plan. Retirees and their Dependents **MUST** enroll in medical coverage within 30 days of retirement unless the **Eligible Retiree** or Dependent chooses COBRA Continuation Coverage in lieu of the Retiree Plan. See Article Eight for COBRA Continuation Coverage enrollment rights.

An Eligible Retiree Dependent shall participate in the Plan as of the date of the Eligible Retiree's retirement from a Member Institution, subject to the following:

- a. If Your Dependent spouse is not a Covered Person at the time You become an Eligible Retiree, Your Dependent spouse may not thereafter become a Covered Person in the Plan unless You and Your spouse



acquire a new Dependent by adoption, placement for adoption, or birth (see Dependent Enrollment for further information);

- b. Upon Your death, any Covered Dependent may remain a Dependent for the applicable period of COBRA Continuation Coverage set forth in Article Eight, provided that the Covered Dependent complies with the conditions therein; and
- c. If You terminate participation in the Plan for any reason other than for death, Your eligible Dependents shall terminate participation in the Plan as of Your termination date.

## 7.11 ELIGIBLE RETIREE'S PREMIUM

An Eligible Retiree will be offered coverage at a premium rate, which is based upon attained age at the time of retirement. An Eligible Retiree who is under the age of 65 will be offered the Active Employee Plan at 100% cost. Upon attainment of age 65, the Eligible Retiree shall be offered a choice between the ICUBA Retiree Plan or the Monumental Life Medicare Supplement Plan.

Eligible Retirees who are age 65 and older shall be offered a choice between the ICUBA Retiree Plan or the Monumental Life Medicare Supplement Plan. Both plans pay secondary to Medicare and the Monumental Life Medicare Supplement Plan is age banded. Upon attainment of an age in a different age band, an Eligible Retiree's premium will change on the first day of the Plan Year following his or her attainment of an age in a new age band.



## ARTICLE EIGHT

### CONTINUATION OF COVERAGE

Coverage that would otherwise terminate may be continued due to eligibility for COBRA Continuation Coverage.

#### 8.01 COBRA CONTINUATION COVERAGE

COBRA Continuation Coverage shall be permitted in the following circumstances:

- a. **COBRA Continuation Coverage for Employees.** A Participant may elect COBRA Continuation Coverage, at the Participant's own expense at 102% of the total cost of the coverage elected under the Plan, if the Participant's participation under the Plan terminates as a result of Termination Of Employment or reduction of hours with a Member Institution. The COBRA Administrator will not offer COBRA Continuation Coverage where the COBRA Administrator determines that the Termination Of Employment was due to gross misconduct.
- b. **COBRA Continuation Coverage for Dependents.** A Dependent may elect COBRA Continuation Coverage, at the Dependent's own expense at 102% of the total cost of the coverage elected under the Plan, if the Dependent's participation under the Plan would terminate as a result of one of the following Qualifying Events:
  1. Death of a Participant;
  2. A reduction in hours of a Participant;
  3. Termination Of Employment of a Participant, except for a termination due to gross misconduct;
  4. The Participant becomes enrolled in Medicare benefits;
  5. Divorce or legal separation of the Participant (If an Employee cancels coverage for his or her spouse in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation will be considered a Qualifying Event even though the ex-spouse lost coverage prior to the date of divorce or legal separation. If the ex-spouse notifies the COBRA Administrator within 60 days after the divorce or legal separation and can establish that the Employee canceled the coverage earlier in anticipation of the divorce or legal separation, then COBRA coverage may be available for the period after the divorce or legal separation.);
  6. A Dependent child ceases to qualify as a Dependent under the Plan; or
  7. Bankruptcy. Sometimes, filing for bankruptcy under Title 11 of the United States Code can be a Qualifying Event. If a bankruptcy is filed by the sponsor of this Plan, and that bankruptcy results in the loss of coverage of any retired Participant under the Plan, the retired Participant is a Qualified Beneficiary with respect to the bankruptcy. The retired



Participant's spouse, surviving spouse, and Dependent children will also be Qualified Beneficiaries if bankruptcy results in the loss of their coverage under this Plan.

c. **Other individuals who may be Qualified Beneficiaries include:**

1. Recipients under Qualified Medical Child Support Orders. A child of the Participant who is receiving Benefits under the Plan pursuant to a Qualified Medical Child Support Order received by the COBRA Administrator during the Participant's period of employment with the Employer is entitled to the same rights under COBRA as a Dependent child of the Participant, regardless of whether that child would otherwise be considered a Dependent.
2. Children born to or placed for adoption with a Participant during COBRA period. Children born to, adopted by, or placed for adoption with a Participant during a period of COBRA Continuation Coverage is considered to be a Qualified Beneficiary provided that, if the Participant is a Qualified Beneficiary, the Participant has elected COBRA Continuation Coverage for himself or herself. The child's COBRA coverage begins when the child is enrolled in the Plan, whether through Special Enrollment or Open Enrollment, and it lasts for as long as COBRA Continuation Coverage lasts for other Family members of the Participant. To be enrolled in the Plan, the child must satisfy the otherwise applicable Plan requirements.

d. **Duty to Notify COBRA Administrator of Qualifying Events.** A Participant or Dependent must timely notify the COBRA Administrator in writing that a Qualifying Event has occurred in order to be eligible for COBRA Continuation Coverage.

1. Notice must be given by the Member Institution within thirty (30) days of the following events:

- A. Termination Of Employment of a Participant;
- B. Reduction of hours of employment of a Participant;
- C. Death of a Participant;
- D. Commencement of a bankruptcy by the Member Institution; or
- E. Enrollment of a Participant in Medicare.

2. Notice must be given by the Plan Participant or Qualified Beneficiary within sixty (60) days of the following events:

- A. Divorce or legal separation of a Participant;
- B. Dependent child loses Eligibility for coverage as a Dependent child.



If these procedures are not followed or if written notice is not provided to the COBRA Administrator within the requisite time period, any Spouse or Dependent who loses coverage will NOT BE OFFERED THE OPTION TO ELECT COBRA CONTINUATION COVERAGE.

Notice Procedures: Any notice that You provide must be in writing. Oral notice, including notice by telephone, is not accepted. You must mail Your notice to the COBRA Administrator at this address:

COBRA Administrator

P.O. Box 1517

Des Moines, IA 50305

877-547-6257

If mailed, Your notice must be postmarked no later than the last day of the required notice period. Any notice You provide must state the name of the Plan (Independent Colleges and Universities Benefits Association, Inc. Medical, Employee Assistance and Prescription Drug Plan), the name and address of the Employee covered under the Plan, and the name(s) and address(es) of the Qualified Beneficiary(ies). Your notice must also name the Qualifying Event and the date it occurred.

The Plan's "Notice of Qualifying Event" form should be used to notify the COBRA Administrator of a Qualifying Event. (A copy of this form can be obtained from the COBRA Administrator.) If the Qualifying Event is a divorce, Your notice must include a copy of the divorce decree.

Your notice of a second Qualifying Event also must name the event and the date it occurred. If the Qualifying Event is a divorce, Your notice must include a copy of the divorce decree.

Your notice of Disability must also include the name of the disabled Qualified Beneficiary, the date when the Qualified Beneficiary became Disabled and the date the Social Security Administration made its determination. Your notice of Disability must include a copy of the Social Security Administration's determination. Qualified Beneficiaries who wish to take advantage of the 11-month Disability extension must notify the COBRA Administrator of the disabled Qualified Beneficiary's Social Security determination. The notice must be provided within 60 days of the Disability determination and prior to the expiration of the initial 18-month period of COBRA coverage. You must also notify the Plan if the Qualified Beneficiary is determined by the Social Security Administration to no longer be Disabled.

The Plan's Notice by Qualified Beneficiary form should be used to notify the COBRA Administrator of a second Qualifying Event, a Disability determination, or a determination that a Qualified Beneficiary is no longer disabled. (A copy of this form can be obtained from the COBRA Administrator.)



- e. **Electing COBRA Continuation Coverage.** COBRA coverage is retroactive to the first day a Participant is no longer covered by the Plan if elected and paid for by the Qualified Beneficiary. The following rules apply to COBRA elections:
1. COBRA Continuation Coverage will begin on the date of the Qualifying Event for each Qualified Beneficiary who timely elects COBRA Continuation Coverage provided that full and timely premium payments are made.
  2. Each Qualified Beneficiary has an independent right to elect COBRA Continuation Coverage.
  3. A Qualified Beneficiary must elect coverage in writing within 60 days of being provided a COBRA election notice, using the Plan's "Election Form" and following the procedures specified on the Election Form. This period is measured from the later of the date that coverage was lost or the date the COBRA election notice was provided.
  4. Written notice of election must be provided to the COBRA Administrator at the address provided on the Plan's Election Form. If mailed, Your election must be postmarked no later than the last day of the 60-day election period.
  5. A Participant or Dependent may change a prior rejection of COBRA Continuation Coverage at any time during the 60-day period by providing the written notice of election described above.
  6. A Participant or Dependent who fails to elect COBRA Continuation Coverage within the 60-day election period will lose his or her right to elect COBRA Continuation Coverage.

**Note:** Regarding Affect of Failure to Elect. In considering whether to elect COBRA Continuation Coverage, You should take into account that a failure to continue Your group medical coverage will affect Your future rights under Federal law. First, You can lose the right to avoid having Pre-Existing Condition exclusions applied to You by other group health plans if You have more than a 63-day gap in health care coverage. Election of COBRA Continuation Coverage may help You avoid such a gap. Second, You will lose the guaranteed right to purchase individual health insurance policies that do not impose such Pre-Existing Condition exclusions if You do not get COBRA Continuation Coverage for the maximum time available to You. Finally, You should take into account that You have special enrollment rights under Federal law. You may have the right to request special enrollment in another group health plan for which You are otherwise eligible (such as a plan sponsored by Your spouse's employer) within 30 days after Your group health coverage ends because of a Qualifying Event described above. You may also have the same special enrollment right at the end of Your COBRA Continuation Coverage if You get COBRA Continuation Coverage for the maximum time available to You.



f. **Length of Continuation Coverage.**

1. **Period of Continuation Coverage for Participants.** A Participant who qualifies for COBRA Continuation Coverage as a result of Termination Of Employment or reduction in hours of employment as described above, may elect COBRA Continuation Coverage for up to 18 months measured from the date of the Qualifying Event.
2. **Coverage under this section may not continue beyond:**
  - A. The date on which the Member Institution ceases to maintain a group health plan;
  - B. The last day of the month for which full and timely premium payments have been made in accordance with subsection (f)(4) below;
  - C. The date the Participant becomes entitled to Medicare. However, if Medicare is obtained prior to the COBRA election, COBRA coverage may not be discontinued; or
  - D. The first day the Participant is covered under any other group health plan that is not maintained by ICUBA, provided the new group plan does not have a Pre-Existing Condition limitation that affects the Participant. However, if other group health coverage is obtained prior to the COBRA election, COBRA coverage may not be discontinued.
3. **Period of COBRA Continuation Coverage for Dependents.** If a Dependent elects COBRA Continuation Coverage under the Plan as a result of the Participant's Termination Of Employment or reduction in hours of employment as described above, Continuation Coverage may be continued for up to 18 months measured from the date of the Qualifying Event. COBRA Continuation Coverage for all other Qualifying Events may continue for up to 36 months.

In addition to maximum periods discussed immediately above, Continuation Coverage under this subsection may not continue beyond:

- A. The last day of the coverage period for which required contributions have been made, in accordance with subsection (4) below;
- B. The date the Dependent becomes entitled to Medicare. However, if Medicare is obtained prior to COBRA election, COBRA coverage may not be discontinued;
- C. The date on which the Member Institution ceases to maintain a group health plan;



- D. The first day after the COBRA Continuation Coverage election, when the Participant is covered under any other group health plan that is not maintained by ICUBA provided the new group plan does not have a Pre-Existing Condition limitation that affects the Dependent. However, if other group health coverage is obtained prior to the COBRA election, COBRA coverage may not be discontinued; or
  - E. If the Participant elects COBRA Continuation Coverage and, during the period of COBRA Continuation Coverage, a child is born or placed for adoption with the Participant, the Participant has the right to elect COBRA Continuation Coverage for the child, provided the child satisfies the otherwise applicable Plan Eligibility requirements and the Participant notifies the Plan of the birth or placement for adoption within 60 days of the birth or adoption. The period of COBRA Continuation Coverage shall be the same as that for the Participant, or as set forth below.
4. **Contribution Requirements for COBRA Continuation Coverage.** Participants and Dependents who elect COBRA Continuation Coverage as a result of one of the Qualifying Events specified above must make Continuation Coverage Payments.

The first Continuation Coverage Payment is due prior to the first day on which COBRA Continuation Coverage will take effect. However, a Participant or Dependent has 45 days from the date of the affirmative election to pay the Continuation Coverage Payment. This initial Continuation Coverage Payment shall apply to the period between the date coverage under the Plan would otherwise have terminated due to the Qualifying Event and the date the Participant and/or Dependent actually elects COBRA Continuation Coverage, and to the first months coverage. The Participant and/or Dependent shall have a 30-day grace period to make the Continuation Coverage Payments due thereafter. Continuation Coverage Payments must be postmarked on or before the completion of the 30-day grace period. If Continuation Coverage Payments are not made on a timely basis, COBRA Continuation Coverage will terminate as of the last day for which required contributions were made. The 30-day grace period shall not apply to the 45-day period for payment of initial COBRA premiums as set out in this subsection. If premiums are not paid by the first day of the period of coverage, the Plan has the option to cancel coverage until payment is received and then reinstate the coverage retroactively to the beginning of the period of coverage if the payment is received within the allowable 30 day grace period. If the amount of the payment made to the Plan is made in error, but is not significantly less than the amount due (the lesser of \$50 or 10% of the premium amount), the Plan is required to notify You of the deficiency and grant a reasonable period (for this purpose, 30 days is considered reasonable) to pay the difference. The Plan is not obligated to send monthly premium notices. COBRA Qualified Beneficiaries remain subject to the Plan's rules.



## 5. Limitation on Participant's Right to COBRA Continuation Coverage

- A. If a Dependent loses, or will lose coverage under the Plan as a result of a divorce or ceasing to be a Dependent, the Participant or Dependent is responsible for notifying the COBRA Administrator within 60 days of the divorce or loss of Dependent status. Failure to make timely notification will terminate the Dependent's rights to COBRA Continuation Coverage under this Article.
  - B. A Participant or Dependent must complete, sign and return the required enrollment materials within 60 days from the later of:
    - I. Loss of coverage, or
    - II. The date the COBRA Administrator or its authorized representative sends notice of eligibility for COBRA Continuation Coverage.
  - C. Failure to enroll for COBRA Continuation Coverage during this 60-day period will terminate all rights to COBRA Continuation Coverage under this Plan. An affirmative election of COBRA Continuation Coverage by a Participant or Participant's spouse shall be deemed to be an election for that Participant's Dependents who would otherwise lose coverage under the Plan.
6. **Multiple Qualifying Events.** If a second Qualifying Event which would entitle the Spouse and Dependents to 36 months of Continuation Coverage occurs during an 18-month extension explained above, coverage may be continued for a maximum of 36 months from the date of the first Qualifying Event provided that the Qualified Beneficiary notifies the Plan Administrator within 60 days of the second Qualifying Event. Such second Qualifying Events include the death of an Employee, divorce from an Employee, an Employee's enrollment in Medicare, or a Dependent child ceasing to be Eligible for coverage as a Dependent under the Plan. You must notify the Plan Administrator within 60 days after the second Qualifying Event using the Notice Procedures described in Section 8.01(d). Failure to provide timely notice will result in non-extension of COBRA Continuation Coverage.
7. **Medicare Entitlement.** If a spouse or Dependent loses coverage due to a Qualifying Event, and the Employee later becomes entitled to Medicare, the spouse or Dependent shall be eligible for up to 36 months of coverage measured from the date of the Qualifying Event, which caused the loss of coverage. However, if the Employee was entitled to Medicare within 18 months prior to the Qualifying Event, then spouse or Dependent shall have up to 36 months of coverage measured from the date of entitlement to Medicare.

8. **Extension of COBRA Continuation Period for Disabled Participants.** The period of continuation shall be extended to 29 months (measured from the date of the Qualifying Event) in the event:

- i. The Participant is Disabled (as determined by the Social Security Administration) within 60 days after the date of the Qualifying Event, and
- ii. The individual provides evidence to the COBRA Administrator or its authorized representative of such a determination by the Social Security Administration prior to the earlier of 60 days after the date of the Social Security determination, or the expiration of the initial 18 months of COBRA Continuation Coverage.

In such event, the Plan may charge the individual up to 150% of the cost of the coverage for all months after the 18th month of COBRA coverage. The Participant must notify the Plan Administrator if the Participant is deemed no longer disabled, in which case COBRA Continuation Coverage ends as of the first day of the coverage period that is more than 30 days after the Social Security Administration's determination.

9. **Extension of COBRA Continuation Coverage Period for Disabled Dependents.** The period of continuation shall be extended to 29 months (measured from the date of the Qualifying Event) in the event the Dependent is Disabled as determined by the Social Security Administration within 60 days after the date of the Qualifying Event and the individual provides written evidence to the Plan Administrator or its authorized representative of such Social Security determination 60 days after the date of such determination and prior to the expiration of the initial 18 months of COBRA Continuation Coverage. In such event, the Plan may charge the individual up to 150% of the cost of the coverage from all months after the 18 months of coverage.

g. **Cost of Continuation Coverage.** Generally, each Qualified Beneficiary is required to pay the entire cost of COBRA Continuation Coverage. The amount a Qualified Beneficiary may be required to pay may not exceed 102% of the cost to the group health plan (including both Employer and Employee contributions) for coverage of a similarly-situated Plan Participant or Beneficiary who is not receiving COBRA Continuation Coverage (or in the case of an extension of COBRA Continuation Coverage due to a Disability, 150%). COBRA premiums may be increased if the costs to the Plan increase but generally must be fixed in advance of each 12-month premium cycle.

**Notice Regarding Individual Policies.** The Health Insurance Portability and Accountability Act (HIPAA) requires that all health insurance carriers that offer coverage in the individual market accept any eligible individuals who apply for coverage without imposing a Pre-Existing Condition exclusion. To take advantage of this HIPAA right, You must elect COBRA Continuation Coverage under the Plan and pay the required contributions for the duration of Your 18-, 29-, or 36-month COBRA Continuation Coverage. You must then apply for coverage with an individual insurance carrier before You have a significant break in coverage.



#### h. Non-sufficient Funds.

1. If a Participant sends a check for a monthly COBRA premium that is returned for non-sufficient funds (NSF), the Participant is notified by letter and asked to resubmit the payment plus a bank fee of \$15. The Participant is advised that a NSF check is considered non-payment of premium, and is given 15 days from the date of the letter to send replacement payment. The payment is adjudicated by the postmark.
2. If a second check is also returned for Non-Sufficient Funds, the Participant is sent a second letter and asked to re-submit payment plus a fee of \$15 within 15 days of the date of the second letter. The Participant is advised that a Non-Sufficient Funds check is considered non-payment, and that their coverage has been cancelled until payment plus the bank fee is received and funds are verified. The Participant is notified that any further NSF checks will result in termination of COBRA coverage with **no reinstatement**. If there are any further Non-Sufficient Funds payments, coverage is terminated and there is no opportunity for reinstatement of coverage. This notice is sent certified mail/return receipt.

### 8.02 INITIAL NOTIFICATION OF YOUR COBRA CONTINUATION COVERAGE RIGHTS

You are receiving this Notice because You have recently become covered under the Independent Colleges and Universities Benefits Association, Inc. Medical, Employee Assistance, and Prescription Drug Plan (the "Plan"). This Notice contains important information about Your right to COBRA Continuation Coverage, which is a temporary extension of group health coverage under the Plan under certain circumstances when coverage would otherwise end. **This Notice generally explains COBRA Continuation Coverage, when it may become available to You and Your Family, and what You need to do to protect the right to receive it.** COBRA (and the description of COBRA Continuation Coverage contained in this Notice) applies only to the group health plan benefits offered under the Plan.

The right to COBRA Continuation Coverage was created by a Federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA Continuation Coverage can become available to You when You would otherwise lose Your group health coverage under the Plan. It can also become available to Your spouse and Dependent children, if they are covered under the Plan, when they would otherwise lose their group health coverage under the Plan. This Notice does not fully describe COBRA Continuation Coverage or other rights under the Plan. For additional information about Your rights and obligations under the Plan and under Federal law, You should review the Plan Document/Summary Plan Description or contact the Plan Administrator.

#### What is COBRA Continuation Coverage?

COBRA Continuation Coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event". Specific qualifying events are listed later in this Notice. After a qualifying event occurs and any required notice of that event is properly provided to Your Employer, COBRA Continuation Coverage must be offered to each person losing Plan coverage who is a "qualified beneficiary". You, Your spouse, and Your Dependent children could become qualified beneficiaries and would be entitled to elect COBRA if coverage under the Plan is lost because of the qualifying event. Certain newborns, newly adopted children, and alternate recipients under QMCSOs may also be qualified beneficiaries. This is discussed in more detail in the



separate paragraphs below. Under the Plan, qualified beneficiaries who elect COBRA must pay for COBRA Continuation Coverage.

### Who is Entitled to Elect COBRA?

If You are an Employee, You will be entitled to elect COBRA if you lose Your group health coverage under the Plan because either one of the following qualifying events happens:

1. Your hours of employment are reduced; or
2. Your employment ends for any reason other than Your gross misconduct.

If You are the spouse of an Employee (Participant) of ICUBA or a Member Institution, you will be entitled to elect COBRA if you lose group health coverage under the Plan because of any of the following qualifying events occurs:

1. your spouse dies;
2. your spouse's hours of employment are reduced;
3. your spouse's employment ends for reasons other than his or her gross misconduct; or
4. you become divorced or legally separated from your spouse. Also, if your spouse (the Employee) reduces or eliminates your group health coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a qualifying event for you even though your coverage was reduced or eliminated before the divorce or separation.

A person enrolled as the Employee's Dependent will be entitled to elect COBRA if he or she loses group health coverage under the Plan because any of the following qualifying events occurs:

1. the parent-Employee dies;
2. the parent-Employee's hours of employment are reduced;
3. the parent-Employee's employment ends for any reason other than his or her gross misconduct; or
4. the child stops being eligible for coverage under the Plan as a "Dependent child".

### When is COBRA Coverage Available?

When the qualifying event is the end of employment or reduction of hours of employment or death of the Employee, the Plan will offer COBRA coverage to qualified beneficiaries. You need not notify Your Employer or the Plan Administrator of any of these qualifying events.

### You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the Employee and spouse or a Dependent child's losing eligibility for coverage as a Dependent child), a COBRA election will be available to You only if You notify the Plan in writing **within 60 days** after the later of: (1) the date of the qualifying event; and (2) the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the qualifying event.



## Electing COBRA

Each qualified beneficiary will have an independent right to elect COBRA. Covered Employees and spouses (if the spouse is a qualified beneficiary) may elect COBRA on behalf of all of the qualified beneficiaries, and parents may elect COBRA on behalf of their children. **Any qualified beneficiary for whom COBRA is not elected within the 60-day election period specified in the Plan's COBRA election notice will lose his or her right to elect COBRA and his or her group health insurance coverage will end.**

## How Long Does COBRA Continuation Coverage Last?

COBRA Continuation Coverage is a temporary continuation of coverage. When the qualifying event is the death of the Employee, the covered Employee's divorce or legal separation, or a Dependent child's losing eligibility as a Dependent child, COBRA Continuation Coverage under the Plan can last for up to a total of 36 months.

When the qualifying event is the end of employment or reduction of the Employee's hours of employment, and the Employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA coverage under the Plan for qualified beneficiaries (other than the Employee) who lose coverage as a result of the qualifying event can last until up to 36 months after the date of Medicare entitlement. For example, if a covered Employee becomes entitled to Medicare 8 months before the date on which his Employment Terminates, COBRA Continuation Coverage for his spouse and children who lost coverage as a result of his termination can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). This COBRA coverage period is available only if the covered Employee becomes entitled to Medicare within 18 months before the termination or reduction of hours.

Otherwise, when the qualifying event is the end of employment or reduction of the Employee's hours of employment, COBRA Continuation Coverage under the Plan generally can last for only up to a total of 18 months.

The COBRA coverage periods described above are maximum coverage periods. COBRA Continuation Coverage can end before the end of the maximum coverage periods described in this Notice for any of the following five reasons:

1. Independent Colleges and Universities Benefits Association no longer provides group health coverage to any of its members;
2. The premium for COBRA Continuation Coverage is not paid on time;
3. The qualified beneficiary becomes covered — after the date he or she elects COBRA Continuation Coverage — under another group health plan that does not contain any exclusion or limitation with respect to any Pre-Existing Condition he or she may have;
4. The qualified beneficiary becomes entitled to Medicare after the date he or she elects COBRA coverage;
5. The qualified beneficiary extends coverage for up to 29 months due to disability and there has been a final determination that the individual is no longer disabled.

There are two ways in which the period of COBRA Continuation Coverage resulting from a Termination Of Employment or reduction of hours can be extended:



### Disability Extension of COBRA Continuation Coverage

If a qualified beneficiary is determined by the Social Security Administration to be disabled (for Social Security disability purposes) and You notify the Plan Administrator in a timely fashion, all of the qualified beneficiaries in Your family may be entitled to receive up to an additional 11 months of COBRA Continuation Coverage, for a total maximum of 29 months. This 11-month extension is available only for qualified beneficiaries who are receiving COBRA Continuation Coverage because of a qualifying event that was the covered Employee's Termination Of Employment or reduction of hours. The disability must have started at some time before the 61<sup>st</sup> day after the covered Employee's Termination Of Employment or reduction of hours and must last until the end of the period of COBRA Continuation Coverage that would be available without the disability extension (generally 18 months, as described above).

**The disability extension is available only if You notify the Plan Administrator in writing of the Social Security Administration's determination of disability within 60 days after the latest of:**

1. the date of the Social Security Administration's disability determination;
2. the date of the covered Employee's Termination Of Employment or reduction of hours; and
3. the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the covered Employee's Termination Of Employment or reduction of hours.

**You must also provide this notice within 18 months after the covered Employee's Termination Of Employment or reduction of hours in order to be entitled to a disability extension. If notice is not provided to the Plan Administrator during the 60-day notice period and within 18 months after the covered Employee's Termination Of Employment or reduction of hours, then there will be no disability extension of COBRA Continuation Coverage.**

### Second Qualifying Event Extension of COBRA Coverage

If Your family experiences another qualifying event while receiving COBRA Continuation Coverage because of the covered Employee's Termination Of Employment or reduction of hours (including COBRA coverage during a disability extension period as described above), the spouse and Dependent children receiving COBRA Continuation Coverage can get up to 18 additional months of COBRA Continuation Coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any Dependent children receiving COBRA Continuation Coverage if the Employee or former Employee dies or gets divorced or legally separated, or if the Dependent child stops being eligible under the Plan as a Dependent child, but only if the event would have caused the spouse or Dependent child to lose coverage under the Plan had the first qualifying event not occurred. (This extension is not available under the Plan when a covered Employee becomes entitled to Medicare after his or her Termination Of Employment or reduction of hours).

**This extension due to a second qualifying event is available only if You notify the Plan Administrator in writing of the second qualifying event within 60 days after the date of the second qualifying event. If the notice is not provided to the Plan Administrator during the 60-day notice period, then there will be no extension of COBRA Continuation Coverage due to a second qualifying event.**



## More Information About Individuals Who May Be Qualified Beneficiaries

### *Children Born to or Placed for Adoption with the Covered Employee during the COBRA Coverage Period*

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

### *Alternate Recipients under QMSCOs*

A child of the covered Employee who is receiving Benefits under the Plan pursuant to a qualified medical child support order (QMCSO) received by the Plan during the covered Employee's period of employment with the Employer is entitled to the same rights to elect COBRA as an eligible Dependent child of the covered Employee.

### If You Have Questions

If You have any questions about COBRA Continuation Coverage, You may call the COBRA Administrator toll free at 1-877-547-6257 or contact the COBRA Administrator via mail at P.O. Box 1517 Des Moines, IA 50305. Also, if Your marital status has changed, or You or Your spouse have changed addresses, please notify ICUBA at the above address.

For more information about Your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in Your area or visit the EBSA website at [www.dol.gov/ebsa](http://www.dol.gov/ebsa).

## **8.03 USERRA COVERAGE**

### **Your Rights Under COBRA and USERRA (Uniformed Services Employment and Reemployment Rights Act)**

Your rights under COBRA and USERRA are similar but not identical. Any election that You make pursuant to COBRA will also be an election under USERRA. COBRA and USERRA will both apply with respect to the continuation coverage elected. If COBRA or USERRA give You or Covered Dependents different rights or protections, the law that provides the greater benefit will apply. USERRA does not provide coverage for Dependents.

The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) established requirements that employers must meet for certain employees who are involved in the Uniformed Services (as defined below). In



addition to the rights that You have under COBRA, You are entitled under USERRA to continue the coverage You had under the Plan.

Uniformed Services means the U.S. Armed Services (including the Coast Guard), the Army National Guard and the Air National Guard (when engaged in active duty for training, inactive duty training, or full-time National Guard duty), and the commissioned corps of the Public Health Service. The President is authorized to expand the categories of Uniformed Services through the exercise of emergency or war powers.

Service in the Uniformed Services or Service means the performance of duty on a voluntary or involuntary basis in the Uniformed Services under competent authority, including active duty, active duty for training, initial active duty for training, inactive duty training, full time National Guard duty, and the time necessary for a person to be absent from employment for an examination to determine the fitness of the person to perform any of these duties.

- a. **Employee must give advance notice.** A Participant leaving for Service in the Uniformed Services must give the Member Institution/Employer advance notice of the absence from employment for Service. Notices can be written or oral. No such notice is required if the notice is precluded by military necessity or if the giving of notice is impossible or unreasonable under the circumstances.
- b. **Employee absence must not exceed 5 years.** The cumulative length of absence and all previous absences from the employment of the current Employer for periods of Service in the Uniformed Services must not exceed 5 years. The 5-year period does not include periods when an individual:
  - 1. is required to complete an initial period of obligated service;
  - 2. is unable to obtain release orders through no fault of his or her own;
  - 3. required to complete specific training requirements;
  - 4. is ordered to, or retained on, active duty because of war or national emergency declared by the President or by Congress;
  - 5. is ordered to active duty in support of an operational mission or in support of a critical mission; or
  - 6. is called into Service as a member of the National Guard.
- c. **Employee must report to work within specific timeframes after service ends.** Upon completion of Service in the military, the Employee must notify the Employer of the intention to return to work. The following chart identifies the notification requirements under USERRA:

Period of Absence	Return to Work Requirement
Less than 30 days	Report to work at the beginning of the first regularly scheduled work period following the end of service plus eight hours, or as soon as possible thereafter if satisfying the deadline is unreasonable or impossible through no fault of the Employee.
More than 30 days but less than 181 days	Submit an application for employment not later than 14 days



	after the completion of the service, or as soon as possible thereafter if satisfying the deadline is unreasonable or impossible through no fault of the Employee.
More than 180 days	Submit an application for employment not later than 90 days after the completion of the service.
Any period, if the absence was for purposes of an examination for fitness to perform service	Report to work at the beginning of the first regularly-scheduled work period following the end of service plus eight hours, or as soon as possible thereafter if satisfying the deadline is unreasonable or impossible through no fault of the Employee.
Person who is injured or ill as a result of (or Injury or Illness was aggravated by) military service	Apply for work or submit application as described above (depending on length of absence) when recovery is complete, provided that recovery time is limited to two years. The two-year period is extended by any minimum time required to accommodate circumstances beyond the Employee's control that make compliance with these deadlines unreasonable or impossible.

- d. **Employee's undesirable conduct.** Rights under USERRA will be terminated if service in the military ends under any of the following circumstances:
1. Separation from service with a dishonorable or bad conduct discharge;
  2. Certain less-than-honorable circumstances as characterized by the Department of Labor;
  3. For a commissioned officer, dismissal in connection with a court-martial; and
  4. The dropping of a commissioned officer from the rolls as a result of an unauthorized absence for at least three months or as a result of a sentence imposed after a court-martial or a conviction in another court.
- e. **USERRA coverage maximum twenty-four (24) months.** When a Participant takes a leave for Service, continued coverage under the Plan, as required by USERRA will begin the day after the Participant loses coverage under the Plan, and will continue for up to twenty-four (24) months. There are situations in which USERRA coverage will terminate before the maximum USERRA period expires.
- f. **COBRA and USERRA coverage are concurrent.** This means that both COBRA Continuation Coverage and USERRA coverage begin upon commencement of the Participant's leave, and continue for up to twenty-four (24) months. COBRA coverage (but not USERRA coverage) may continue for longer, as described in the COBRA section of this Article Nine.
- g. If You continue Your medical coverage pursuant to USERRA, You will be required to pay 102% of the full premium for the coverage elected (the same rate as COBRA). However, if Your Uniformed Service Leave of Absence is less than thirty (30) days, You are not required to pay more than the amount that You pay as an active Participant for that coverage.



- h. **USERRA leave time will count toward FMLA eligibility.** A Participant who was called to qualifying military service and is re-employed under USERRA's provisions is credited with the time he or she would have worked, but for his or her military service, when determining eligibility for leave under the Family and Medical Leave Act.
- i. If **coverage** is not continued during a USERRA Leave Of Absence, when the Employee returns to Actively At Work status no new Waiting Period will apply and Pre-Existing Conditions Limitations shall not apply.

#### 8.04 FAMILY AND MEDICAL LEAVE ACT

If an Employee is on a family or medical leave, the Employee may continue coverage in accordance with the Family and Medical Leave Act of 1993 and the Plan will continue coverage, as if the Employee were Actively At Work, if the following conditions are met:

1. The required contribution is paid; and
2. The Employee has written approval of leave from the Member Institution.

Coverage will be continued for up to the greater of:

1. The leave period required by the Family and Medical Leave Act of 1993, and any amendments thereto or regulations promulgated thereunder; or
2. The leave period required by applicable state law.

If coverage is not continued during a family or medical leave, when the Employee returns to Actively At Work status:

1. No new Waiting Period will apply; and
2. Pre-Existing Conditions limitations shall not apply.

#### 8.05 THE NATIONAL DEFENSE AUTHORIZATION ACT

The National Defense Authorization Act of 2008 adds two types of FMLA leave for the families of service members who are called to duty in the Armed Forces. The Servicemember Caregiver Leave provides up to 26 weeks of unpaid leave in a single 12-month period for any Eligible Employee who is the spouse, parent or next of kin of a covered service member who suffered a serious Injury or Illness in line of duty while on active duty that renders the service member medically unfit to perform the duties of his/her office, grade, rank, or rating.

An Eligible Employee can take up to 12 weeks of unpaid leave in a 12-month period as the result of any qualifying exigency because the Employee's spouse, son, daughter or parent is on active duty or has been notified of an impending call of duty in the Armed Forces in support of a "contingency operation."



If an Employee is on a leave provided for under the National Defense Authorization Act, the Employee may continue coverage under the Plan as if the Employee were Actively At Work if the following conditions are met:

The required contribution is paid; and

The Employee has written approval of the leave from the Member Institution.

Coverage will be continued for up to the greater of:

The leave period required by the Family and Medical Leave Act of 1993, and any amendments thereto or regulations promulgated thereunder; or

The leave period required by applicable state law.

If coverage is not continued during a family or medical leave, when the Employee returns to Actively At Work status:

No new Waiting Period will apply; and

Pre-Existing Conditions limitations shall not apply.



## ARTICLE NINE

### COVERED EXPENSES

#### 9.01 COVERED EXPENSES

The Plan provides coverage for a wide range of services called Covered Expenses. The services associated with these Benefits are covered to the extent that they are:

Medically Necessary;

Not considered Experimental or Investigative;

Prescribed by or given by a Physician;

Reasonable and Customary charges; and

Provided for care and treatment of a Covered Illness or Injury. Benefits are payable in accordance with the applicable Deductible, Co-payments, and Coinsurance listed in Article Four, the Schedule of Medical and Behavioral Health Benefits.

**If You receive Services from Network Providers, they have contracted with BCBSFL or MHNet to bill specified amounts and automatically meet the Reasonable and Customary charges requirement necessary to be considered a Covered Expense.** Covered Expenses are the services listed below, subject to Article Ten ("Limitations and Exclusions") and all other provisions of this Plan:

- a. **Ambulance Service.** Hospital or licensed ambulance or air Ambulance Service when Medically Necessary for transportation to a local Hospital or to the nearest Hospital. This service is treated as in Network and is subject to Deductible and Coinsurance. Also included is a transfer to the nearest facility equipped to treat the Emergency, as shown in the Schedule of Medical Benefits. Local transportation by a specially designed and equipped vehicle used only to transport the sick and injured by providing transportation from Your home, the scene of an Accident or medical Emergency to a Hospital; between Hospitals; or between a Hospital and a Skilled Nursing Facility; when such facility is the closest institution that can provide Covered Services appropriate to Your condition. If there is no facility in the local area that can provide Covered Services appropriate for Your condition, then You are covered for Ambulance Service to the closest facility outside Your local area that can provide the necessary service. Local transportation by a specially designed and equipped vehicle used only to transport the sick and injured: from a Hospital to Your home or from a Skilled Nursing Facility to Your home.
- b. **Aspirin.** Aspirin covered by the Plan at 100% when purchased with a prescription. You must use the Prescription Drug Plan at a Network Pharmacy or through the mail.
- c. **Autism.** Treatment for a Dependent Child diagnosed as Autism will be covered, including Applied Behavioral Analysis, Speech Therapy, Occupational Therapy and Physical Therapy.



- d. **Bariatric Surgery.** Services provided for surgical treatment for obesity from a BlueDistinctions™ Provider in Florida. Blue Distinction Centers for Bariatric Surgery provide a full range of bariatric surgery care services, including Inpatient care, post-operative care, Outpatient follow-up care and patient education. To see a list of the specific criteria for the Blue Distinction Centers for Bariatric Surgery, please visit [www.BCBS.com/bluedistinction](http://www.BCBS.com/bluedistinction). Some of the Blue Distinction Centers for Bariatric Surgery are:

Baptist Pensacola, Pensacola

Cleveland Clinic Hospital, Weston

Hialeah Hospital, Hialeah

Memorial Hospital of Jacksonville, Jacksonville

Memorial Regional Hospital, Hollywood

Northwest Medical Center, Margate

Ocala Regional Medical Center, Ocala

Palmetto General, Hialeah

Palms of Pasadena Hospital, St. Petersburg

Sacred Heart Hospital of Pensacola, Pensacola

South Miami Hospital, Miami

Tampa General Hospital, Tampa

- e. **Blood Plasma.** Services and supplies required for the administration of blood transfusions, including blood, blood plasma, and plasma expanders, when not available to the Covered Person without charge.

- d. **Breast Implants and Reconstructive Surgery.** Breast Implants and Reconstructive Surgery are covered following a Mastectomy as follows:

- o Reconstruction of the breast on which a mastectomy has been performed.
- o Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- o Prosthesis and treatment of physical complications including lymph edemas.



- o External breast prostheses and bras.

**Notice.** The Women's Health and Cancer Rights Act of 1998 requires group health plans to provide coverage for mastectomies and to also provide coverage for reconstructive surgery and prosthesis following mastectomies. The law mandates that a Participant or Eligible Beneficiary who is receiving Benefits on or after the law's effective date (January 1, 1999) for a mastectomy and who elects breast reconstruction in connection with the mastectomy, will also receive coverage for the following:

1. Reconstruction of the breast on which a mastectomy has been performed.
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance.
3. Prosthesis and treatment of physical complications of all stages of mastectomies, including lymph edemas.

This coverage will be provided in consultation with the patient and the patient's attending Physician and will be subject to the same annual Deductible, Coinsurance, and/or Co-payment provisions otherwise applicable under the Plan. If You have any questions about coverage for mastectomies and post-operative reconstructive surgery, please contact the Plan Administrator.

- e. **Cardiac Care.** Blue Distinction Centers for Cardiac Care provide a full range of cardiac care services, including Inpatient cardiac care, cardiac rehabilitation, cardiac catheterization and cardiac surgery (including coronary artery bypass graft surgery). Blue Distinctions Centers for Cardiac Care are as follows:

Baptist Hospital of Miami, Inc, Miami

Baptist Hospital, Inc, Pensacola

Bay Medical Center, Panama City

Blake Medical Center, Bradenton

Brandon Regional Hospital, Brandon

Central Florida Regional Hospital, Sanford

Columbia Regional Medical Center Oak Hill, Spring Hill

Delray Medical Center, Delray Beach

Florida Medical Center, Fort Lauderdale



Halifax Medical Center, Daytona Beach  
Holy Cross Hospital, Fort Lauderdale  
Indian River Memorial Hospital, Vero Beach  
JFK Medical Center, Atlantis  
Largo Medical Center, Largo  
Lawnwood Medical Center, Fort Pierce  
Martin Memorial Medical Center, Stuart  
Memorial Hospital, Jacksonville  
Morton Plant Hospital, Clearwater  
Munroe Regional Medical Center, Ocala  
Naples Community Hospital, Naples  
Northside Hospital, Saint Petersburg  
Osceola Regional Hospital, Kissimmee  
Palm Beach Gardens Medical Center, Palm Beach Gardens  
Sacred Heart Hospital, Pensacola  
Sarasota Memorial Hospital, Sarasota  
St Josephs Hospital, Tampa  
University Community Hospital, Tampa  
Venice Regional Community Hospital, Venice  
Winter Haven Hospital, Winter Haven

- f. **Complex Care and Rare Cancers.** Complex and rare cancers comprise approximately fifteen percent (15%) of new cancer cases each year. Blue Distinction Centers for Complex and Rare Cancers<sup>SM</sup> are the first in a line of Blue Distinction Centers<sup>®</sup> focused on cancer treatment. **This initial phase evaluates facilities on patient assessment, treatment planning, complex Inpatient Care, and major surgical treatments for adult, which are all delivered by teams with distinguished**



expertise and subspecialty training for complex and rare cancers. The program focuses on the following thirteen (13) cancers:

- Bladder cancer
- Brain cancer – primary
- Esophageal cancer
- Gastric cancer
- Liver cancer – primary
- Pancreatic cancer
- Rectal cancer
- Acute leukemia (inpatient, non-surgical)
- Bone cancer – primary
- Head and neck cancers
- Ocular melanoma
- Soft tissue sarcoma
- Thyroid cancer – medullary or anaplastic

Facilities designated as Blue Distinctions Centers for Complex and Rare Cancers offer comprehensive Inpatient cancer care programs for adults, delivered by multidisciplinary teams with subspecialty training and distinguished clinical expertise in treating complex and rare subtypes of cancer. This initial phase focuses on multi-disciplinary treatment planning and complex, major surgical treatments. Some of the Blue Distinction Facilities for Complex and Rare Cancer are as follows:

**Broward General Medical Center, Ft Lauderdale**  
**University of Miami Sylvester Comprehensive Cancer Center, Miami**  
**H. Lee Moffitt Cancer Center & Research Institute, Tampa**

- g. **Consumable Medical Supplies.** Ostomy supplies and urinary tract catheters.
- h. **Contact Lenses After Cataract Surgery.** Initial purchase of contact lenses, and/or eyeglasses if required as a result of cataract surgery.



- i. **Cosmetic or Reconstructive Surgery.** Cosmetic or Reconstructive Surgery, only if such surgery is to restore bodily function or correct deformity resulting from an Illness or Injury.
- j. **Dental Care Related to Accidental Injury.** Dental services rendered by a Physician or Dentist which are required as the result of accidental Injury to the jaw, sound natural teeth, mouth or face. Injury caused by chewing or biting will not be considered accidental Injury. Medical expenses for oral surgery:
- When necessitated as the direct result of an Injury to natural teeth or dental prosthesis if treatment begins within 6 months of the date of the Injury (chewing related expenses not covered);
  - Other Medically Necessary incision or excision procedures on the gums and tissues of the mouth when not performed in connection with extraction or repair of teeth;
  - Care of fractures or complete dislocation of the jaw; or
  - Surgical removal of tumors within the oral cavity. For the purpose of the dental work or oral surgery covered by the terms of this Benefit, Covered Expenses shall be deemed to include fees of a duly licensed Dentist. No other expenses for dental work are included as Covered Expenses. The Plan shall always pay secondary to any other dental coverage.
- k. **Diabetes Treatment.** Your program provides coverage for the following when required in connection with the treatment of diabetes and when prescribed by a Physician legally authorized to prescribe such items under the law:
- Equipment and supplies: Blood glucose monitors, monitor supplies, and insulin infusion devices. To obtain Your diabetic meters, strips, lancets, or needles covered by the Plan at 100%, You must use the Prescription Drug Plan at a Network Pharmacy or through the mail.
  - Outpatient Diabetes Education Program\*: When Your Physician certifies that You require diabetes education as an Outpatient, and coverage is provided through an Outpatient diabetes education program; and visits are Medically Necessary and Appropriate upon the diagnosis of diabetes; and subsequent visits under circumstances whereby Your Physician identifies or diagnoses a significant change in Your symptoms or conditions that necessitates changes in self-management, or identifies, as Medically Necessary and Appropriate, a new medication or therapeutic process relating to the treatment and/or management of diabetes.

\*Outpatient Diabetes Education Program – a program of self-management, training, and education, including medical nutrition therapy for the treatment of diabetes. Such program must be conducted under the supervision of a licensed health care professional with expertise in diabetes. Outpatient diabetes education services will be covered subject to Blue Cross Blue Shield of Florida's criteria. These criteria are based on the certification programs for Outpatient diabetes education developed by the American Diabetes Association (ADA).

- l. **Diagnostic Services.** This program covers the following services when ordered by a Professional Provider:



- Diagnostic x-ray consisting of radiology, magnetic resonance imaging (MRI), ultrasound and nuclear medicine;
  - Diagnostic pathology consisting of laboratory and pathology tests;
  - Diagnostic medical procedures consisting of electrocardiogram (ECG), electroencephalogram (EEG), and other electronic diagnostic medical procedures and physiological medical testing approved by Blue Cross Blue Shield of Florida; and
  - Allergy testing consisting of percutaneous, intracutaneous, and patch tests.
- m. **Durable Medical Equipment.** The rental or, at the option of Blue Cross Blue Shield of Florida, the purchase, adjustment, repair and replacement of Durable Medical Equipment when prescribed by a Professional Provider, within the scope of his/her license and required for therapeutic use. Rental costs cannot exceed the total cost of purchase.
- n. **Emergency Care.** Your Outpatient Emergency room visits may be subject to a Co-payment, which is waived if You are admitted as an Inpatient. You should use Emergency services only when appropriate. In some situations, such as strains or sprains, fevers and sore throats, it may make more sense to contact a Network Physician or Urgent Care Facility. Doing this puts You in touch with the person who truly knows Your health history. It can save You hours of waiting in a crowded Emergency room where more critical injuries are being treated. In true Emergency situations, where You must be treated immediately, go directly to Your nearest Hospital Emergency Provider or call "911" or Your area's Emergency number. Once the crisis has passed, call Your Physician to receive appropriate follow-up care.
- o. **Enteral Formulae.** Enteral Formulae is a liquid source of nutrition administered under the direction of a Physician that may contain some or all of the nutrients necessary to meet minimum daily nutritional requirements and is administered into the gastrointestinal tract either orally or through a tube. Coverage is provided for Enteral Formulae when administered on an Outpatient basis, either orally or through a tube, primarily for the therapeutic treatment of phenylketonuria, branched-chain ketonuria, galactosemia, and homocystinuria. This coverage does not include normal food products used in the dietary management of rare hereditary genetic metabolic disorders. Additional coverage for Enteral Formulae is provided when administered on an Outpatient basis, when Medically Necessary and Appropriate for Your medical condition, when considered to be the sole source of nutrition and:
- When provided through a feeding tube (nasogastric, gastrostomy, jejunostomy, etc.) and utilized instead of regular shelf food or regular infant formulae; or
  - When provided orally and identified as one of the following types of defined formulae:
    - With hydrolyzed (pre-digested) protein or amino acids;
    - With specialized content for special metabolic needs;

With modular components; or

With standardized nutrients.

Once it is determined that You meet the above criteria, coverage for Enteral Formulae will continue as long as it represents at least fifty percent (50%) of Your daily caloric requirement.

Additional coverage for Enteral Formulae excludes the following:

- Blended food, baby food, or regular shelf food when used with an enteral system;
  - Milk or soy-based infant formulae with intact proteins;
  - Any formulae, when used for the convenience of You or Your Family members;
  - Nutritional supplements or any other substance utilized for the sole purpose of weight loss or gain, or for caloric supplementation, limitation, or maintenance;
  - The following formulae when provided orally: semisynthetic intact protein/protein isolates, natural intact protein/protein isolates, and intact protein/protein isolates; and
  - Normal food products used in the dietary management of rare hereditary genetic metabolic disorders.
- p. **Hearing Care Services.** Benefits include coverage for diagnostic testing and the purchase of hearing aid devices, when prescribed by a Professional Provider. The hearing aid must be purchased from an eligible Provider. All eligible providers are considered in-network.
- q. **Home Health Care/ Hospice Care Services.** This program covers the following services You receive from a Home Health Care Agency, Hospice, or a Hospital program for Home Health Care and/or Hospice Care:
- Skilled nursing services of an RN or LPN, excluding private duty nursing services;
  - Physical medicine, Occupational Therapy, and speech therapy;
  - Medical and surgical supplies provided by the Home Health Care Agency or Hospital program for Home Health Care or Hospice care;
  - Oxygen and its administration;
  - Medical social service consultations;
  - Health aide services when You are also receiving covered nursing or therapy and rehabilitation services; and
  - Family counseling related to the Covered Person's terminal condition.



**No Home Health Care/ Hospice benefits will be provided for:**

- Dietitian services;
  - Homemaker services;
  - Maintenance therapy;
  - Dialysis treatment;
  - Custodial Care; and
  - Food or home-delivered meals.
- r. **Home Infusion Therapy Services.** Services provided by a home infusion therapy Provider in a home setting. This includes pharmaceuticals, pharmacy services, intravenous solutions, medical/surgical supplies and nursing services associated with home infusion therapy. Specific adjunct non-intravenous therapies are included when administered only in conjunction with home infusion therapy.
- s. **Hospice Care.** Hospice Care on either an Inpatient or Outpatient basis as an alternative to Hospitalization for a Terminally Ill person, as shown in the Schedule of Medical Benefits.

Covered Services must be rendered, furnished and billed by a Hospice Provider and included in a written Hospice Treatment Plan established and periodically reviewed by a Physician. The Hospice Treatment Plan must:

- Certify that the Covered Person is Terminally Ill and has less than a 6-month life expectancy;
- Certify that it is medically advisable for the Covered Person to live at home;
- Certify that Hospital confinement would be required in the absence of Hospice Care; and
- Describe the services and supplies for the palliative care and Medically Necessary treatment to be provided to the Covered Person by the Hospice.

Covered Expenses include:

- An assessment visit and initial testing;
- Room and board, services and supplies furnished by a Hospice while confined therein;
- Patient care provided by home health aides;
- Visits by speech therapists and psychotherapists;
- Intermittent care by a Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.);



- Drugs and medicines for the Terminal Illness that are legally obtainable only upon a Physician's written prescription and insulin while receiving Hospice Care on an Inpatient basis only;
- Medical supplies normally used for Hospital Inpatients, such as oxygen, catheters, needles, syringes, dressing, materials used in aseptic techniques, irrigation solutions, intravenous solutions, and other medical supplies including splints, trusses, braces, or crutches;
- Rental of Durable Medical Equipment;
- Family counseling of immediate family members;
- Respite care;
- Professional medical, psychological, social, and pastoral counseling services provided by salaried employees of Hospice; and
- Supportive services to the bereaved immediate family members for up to 3 months following the death of the Covered Person.

In addition to the Limitations and Exclusions below, Benefits will **NOT** be provided for any of the following:

- Homemaker or housekeeping services except by home health aides as ordered in the Hospice Treatment Plan;
- Supportive environmental materials such as handrails, ramps, air conditioners, and telephones;
- Services performed by family members or volunteer workers;
- "Meals on Wheels" or similar food services;
- Separate charges for records, reports or transportation;
- Expenses for the normal necessities of living, such as food, clothing and household supplies;
- Services rendered or supplies furnished to other than the Terminally Ill Covered Person except as listed above;
- Any services or supplies not included in the Hospice Treatment Plan or not specifically set forth as a Covered Expense;
- Legal and financial counseling services; and



- Services provided during any period of time in which the Covered Person is receiving Benefits under this Plan's Home Health Care Benefit.
- t. **Hospital Services.** This program covers the following services You receive in a Hospital or facility Provider. Benefits will be covered only when, and so long as, they are determined to be Medically Necessary and Appropriate for the proper treatment of the patient's condition.

Bed, Board and General Nursing Services for:

- A semi-private room;
  - A private room. Private room allowance is the average semi-private room charge;
  - A bed in a Special Care Unit where intensive care to the critically ill is provided;
  - Operating, delivery and treatment rooms and equipment;
  - Drugs and medicines provided to You while You are an Inpatient in a facility Provider;
  - Whole blood, administration of blood, blood processing, and blood derivatives;
  - Anesthesia, anesthesia supplies and services rendered in a facility Provider by an employee of the Hospital or other facility Provider. Administration of anesthesia ordered by the attending Professional Provider and rendered by a Professional Provider other than the surgeon or assistant at surgery;
  - Medical and surgical dressings, supplies, casts, and splints;
  - Diagnostic services;
  - Therapy and rehabilitation services;
  - Surgery; and
  - Hospital Services and supplies for Outpatient Surgery including removal of sutures, anesthesia, and anesthesia supplies and services rendered by an Employee of the facility Provider, other than the surgeon or assistant at surgery.
- u. **Inpatient Medical Services.** This program covers the following services You receive from a Professional Provider when You are an Inpatient for a condition not related to surgery, pregnancy, or mental illness:
- Care for a medical condition by a Professional Provider who is not Your surgeon while You are in the Hospital for surgery;



- Care by two or more Professional Providers during one Hospital stay when the nature or severity of Your condition requires the skills of separate Physicians;
  - Concurrent care;
  - Constant attendance and treatment by a Professional Provider when Your condition requires it for a prolonged period of time;
  - Consultation;
  - Consultation by another Professional Provider when requested by the attending Professional Provider;
  - Intensive Medical Care;
  - Inpatient Medical Care visits;
  - Professional Provider visits to examine a newborn infant while the mother is an Inpatient; and
  - Preventive newborn care.
- v. **Mastectomy and Breast Cancer Reconstruction.** This program covers a mastectomy performed on an Inpatient or Outpatient basis for the following:
- Surgery to re-establish symmetry or alleviate functional impairment. This includes, but is not limited to, augmentation, mammoplasty, reduction mammoplasty and mastopexy;
  - The use of initial and subsequent Prosthetic Devices to replace the removed breast or portions thereof;
  - Physical complications of all stages of mastectomy, including lymph edemas; and
  - This program covers one Home Health Care visit within forty-eight hours after discharge, as determined by Your Physician.
- w. **Maternity Care.** If You think You are pregnant, You may contact Your Physician or go to a Network obstetrician or nurse midwife. When Your pregnancy is confirmed, You may continue to receive follow-up care which includes prenatal visits, Medically Necessary and Appropriate sonograms, delivery, postpartum, and newborn care in the Hospital that is covered at the maximum level of Benefits. This program provides services for:
- Normal pregnancy;
  - Complications of pregnancy; and

- Nursery care.

Under Federal law, Your self-insured group health program generally may not restrict Benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery; or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable). In any case, under Federal law, Your self-insured program can only require that a Provider obtain authorization for prescribing an Inpatient Hospital stay that exceeds 48 hours (or 96 hours).

x. **Intrauterine Device (IUD).** IUD is covered when inserted in a Network Provider's office.

y. **Mental Health Care Services.** Your mental health is just as important as Your physical health. That is why Your MHNet program provides professional, confidential, mental health care that addresses Your individual needs. You have access to a wide range of mental health and substance abuse Professional Providers, so You can get the appropriate level of responsive, confidential care. See Article Six for more information.

You are covered for a full range of counseling and treatment services. The MHNet program covers the following services You receive from a Provider to treat mental illness:

- Inpatient facility services;
- Covered Inpatient Hospital Services provided by a Hospital or other facility Provider;
- Inpatient Medical Services;
- Covered Inpatient Medical Services provided by a Professional Provider;
- Individual psychotherapy;
- Group psychotherapy;
- Psychological testing;
- Counseling with family members to assist in Your diagnosis and treatment; and
- Electroshock treatment or convulsive drug therapy including anesthesia when administered concurrently with the treatment by the same Professional Provider.

z. **Newborn Expenses.** Newborn Expenses for a well baby shall be paid as part of the mother's delivery expenses, except for expenses related to circumcision.

If the baby has an illness, suffers injury, premature birth, congenital abnormality, or requires care other than Preventive Care, Benefits will be provided under the newborn's own Claim on the same basis as any other Covered Expense, provided, however, that coverage is in effect.



The newborn coverage shall include coverage for Injury or Illness, including the necessary care or treatment of medically diagnosed congenital defects, birth abnormalities or prematurity. Covered Expenses include transportation costs of the newborn to and from the nearest Hospital or Other Facility Provider appropriately staffed and equipped to treat the newborn's condition if the transportation is certified by the attending Physician as Medically Necessary to protect the health and safety of the newborn.

**aa. Nutritional Counseling.** Six sessions of Nutritional Counseling for Covered Persons with a diagnosis of Obesity.

**bb. Obesity.** Lap-Band and Gastric By-pass Surgery. A Covered Person must meet specific prior-authorization criteria in order to receive approval for this treatment.

**cc. Occupational Therapy.** Occupational Therapy rendered by a licensed occupational therapist or Certified Occupational Therapist Assistant (C.O.T.A.). This care must be prescribed by a Physician.

**dd. Oral surgery.** Benefits are provided for the following limited oral surgical procedures if determined to be Medically Necessary and Appropriate:

- Extraction of impacted third molars when partially or totally covered by bone;
- Extraction of teeth in preparation for radiation therapy;
- Mandibular staple implant when not done to prepare the mouth for dentures;
- Mandibular frenectomy;
- Facility Provider and anesthesia services rendered in conjunction with non-covered dental procedures when determined by the Plan to be Medically Necessary and Appropriate due to the age and/or medical condition of the Covered Person;
- Accidental Injury to the jaw or structures contiguous to the jaw;
- The correction of a non-dental physiological condition which has resulted in a severe functional impairment;
- Treatment for tumors and cysts requiring pathological examination of the jaw, cheeks, lips, tongue, roof, and floor of the mouth; and
- Orthodontic treatment of congenital cleft palates involving the maxillary arch, performed in conjunction with bone graft surgery to correct the bony deficits associated with extremely wide clefts affecting the alveolus.

**ee. Organ Transplant.** Medically Necessary organ or tissue transplant procedures for kidney, cornea, heart, heart/lung, liver, lung, pancreas, or bone marrow (including autologous bone marrow transplants) and all related Covered Expenses when incurred at designated facilities throughout the United States



as a BCBSFL transplant facility by a Covered Person who is the receipt of such transplant, provided such Organ Transplants are "human to human" and not Experimental Procedures. Blue Distinction Centers for Transplants have demonstrated their commitment to quality care, resulting in better overall outcomes for transplant patients. Each facility meets stringent clinical criteria, established in collaboration with expert Physicians' and medical organizations' recommendations, including the Center for International Blood and Marrow Transplant Research (CIBMTR), the Scientific Registry of Transplant Recipients (SRTR) and the Foundation for the Accreditation of Cellular Therapy (FACT), and is subject to periodic reevaluation as criteria continue to evolve.

Blue Distinction Centers for Transplants provide a range of services for transplant, including:

- heart
- lung (living and deceased)
- combination heart/lung
- liver (deceased and living donor)
- simultaneous pancreas kidney (SPK)
- pancreas (PAK/PTA)
- bone marrow/stem cell (autologous and allogeneic)

**Coverage is subject to the following conditions and limitations:**

- Coverage includes the recipient's medical, surgical and Hospital Services;
- Inpatient immunosuppressive medications; and
- Costs for organ procurement.

Organ procurement costs are limited to costs directly related to the procurement of an organ from a cadaver or live donor, and shall consist of the surgery necessary for organ removal, organ transportation, and the transportation, hospitalization and surgery of the live donor. Compatibility testing undertaken prior to procurement is covered if Medically Necessary. In addition, the Plan will pay, subject to limitations in the Schedule of Medical Benefits, the travel expenses incurred by the Participant or Dependent and one companion to accompany the recipient, for transportation, lodging and food associated with a pre-approved organ/tissue transplant during evaluation, candidacy, transplant event, or post-transplant care. The term companion includes spouse, domestic partner, family member, legal guardian of the Dependent recipient, or any person not related to the recipient but actively involved as a caregiver. The following conditions also apply:

- When both the recipient and donor are covered by this Plan, services will be covered for each patient;



- When only the recipient is covered by this Plan, Benefits are provided for services for both the recipient and donor, provided Benefits to the donor are not furnished under some other form of surgical/medical coverage; and
- When the recipient is not covered by this Plan and the donor is covered, expenses will be eligible for the donor to the extent that Benefits are not provided under the recipient's program of coverage.

Benefits will be provided for Covered Services furnished by a Hospital that are directly and specifically related to the transplantation of organs, bones, tissue, or blood stem cells.

If a human organ, bone, tissue, or blood stem cell transplant is provided from a living donor to a human transplant recipient when both the recipient and the donor are Covered Persons, each is entitled to the Benefits of this program:

- When only the recipient is a Covered Person, both the donor and the recipient are entitled to the Benefits of this program subject to the following additional limitations: (1) the donor Benefits are limited to only those not provided or available to the donor from any other source, including, but not limited to, other insurance coverage, other Blue Cross Blue Shield of Florida coverage or any government program; and (2) Benefits provided to the donor will be charged against the recipient's coverage under this program to the extent that Benefits remain and are available under this program after Benefits for the recipient's own expenses have been paid;
- When only the donor is a Covered Person, the donor is entitled to the Benefits of this program, subject to the following additional limitations: (1) the Benefits are limited to only those not provided or available to the donor from any other source in accordance with the terms of this program; and (2) no Benefits will be provided to the non-Covered Person transplant recipient; and
- If any organ, tissue or blood stem cell is sold rather than donated to the Covered Person recipient, no Benefits will be payable for the purchase price of such organ, tissue, or blood stem cell; however, other costs related to evaluation and procurement are covered up to the Covered Person recipient's program limit.

It is important to have Your Transplant at a Blue Distinction Center for Transplant. You can identify Blue Distinctions Transplant Centers by logging onto:

<http://www.bcbs.com/innovations/bluedistinction/bluedistinctiontransplants/bluedistinctiontransplants.pdf>

**ff. Orthotic Devices.** Purchase, fitting, necessary adjustment, repairs and replacement of a rigid or semi-rigid supportive device that restricts or eliminates motion of a weak or diseased body part. Your Provider will need to provide a prescription and may need to provide documentation for Medical Necessity.



gg. **Outpatient Medical Care Services including Physician Visits.** This program covers the following services:

- Medical Care rendered by a Professional Provider to You, as an Outpatient, for a condition not related to surgery, pregnancy, or mental illness, except as specifically provided herein; and
- Medical Care visits and consultations to examine, diagnose, and treat an Injury or Illness.
- Partial Hospitalization Mental Health Care Services. Partial hospitalization for Mental Health Care Services provided by a partial hospitalization program which has been approved by Blue Cross Blue Shield of Florida. Such programs are subject to periodic review by Blue Cross Blue Shield of Florida.
- Outpatient Mental Health Care Services. Inpatient facility service and Inpatient medical Benefits (except room and board) provided by a facility Provider or Professional Provider when You are an Outpatient.

hh. **Physical Therapy.** Physical therapy rendered by a licensed Physical Therapist or Physical Therapist Assistant, (P.T.A.) prescribed by a Physician.

ii. **Pre-Admission Testing.** Includes Outpatient tests and studies required in connection with an admission rendered or accepted by a Hospital on an Outpatient basis prior to a scheduled admission to the Hospital as an Inpatient.

jj. **Preventive Care.** Preventive “proactive” care today can help You avoid costly “reactive” care tomorrow. It can also help You establish a healthy lifestyle.

Maintaining Your good health is a major goal of the Independent Colleges and Universities Benefits Association, Inc. Medical, Employee Assistance and Prescription Drug Plan. As such, the Plan provides excellent Network coverage for Your Preventive Care. That is why You are encouraged to take advantage of our extensive Preventive Care Benefits, including periodic physical examinations, well child visits, immunizations, allergy extract/injections, and a full scope of diagnostic testing. This schedule is reviewed and updated periodically; therefore, the frequency and eligibility of services is subject to change.

- **Adult Care.** Examinations, including a complete medical history, height, and weight measurement, physical examinations (only when performed by a Network Provider), and selected Diagnostic Services based on age, sex, and other criteria (e.g., colonoscopies, bone mineral density test, etc).
- **Allergy Extract/Injections.** Allergy extract and allergy injections administered in a Network Physician’s office are covered at 100% by the Plan.
- **Bone Mineral Density Test and Colonoscopy or Sigmoidoscopy.** The Plan will cover bone mineral density tests and colonoscopies and sigmoidoscopies at 100%.



- **Echocardiograms and Electrocardiograms.** Echocardiograms and electrocardiograms are covered at 100% by the Plan.
- **Lab Work.** Lab In-Network are covered at 100% by the Plan.
- **Urinalysis.** Urinalyses are covered at 100% by the Plan.
- **Immunizations and Therapeutic Injections.** Immunizations for Covered Persons 18 years of age and older and therapeutic injections required in the diagnosis, prevention, and treatment of an Injury or Illness are covered at 100% by the Plan.
- **Preventive Gynecological Examination and Pap Test.** All female Covered Persons, regardless of age, are covered for preventive gynecological examination, including a pelvic and clinical breast examination. The preventive Papanicolaou smear (pap test) is covered at 100% by the Plan.
- **Venipunctures.** Venipunctures are covered at 100% by the Plan.
- **Blood Stool Tests.** Blood stool tests are covered at 100% by the Plan.
- **Prostate Screening.** PSAs are covered at 100% by the Plan.
- **Mammographic Screening.** Mammographies are covered 100% by the Plan.

Mammographic examinations are covered for all Covered Persons regardless of age when such services are prescribed by a Physician.

Benefits for mammographic screening are payable only if performed by a mammography service Provider who is properly certified.

**kk. Pediatric Care and Immunizations.** This program covers the following services:

Preventive physical examinations for Covered Persons who are 18 years of age or younger, but only when performed by a Network Provider. Selected Diagnostic Services, when appropriate. Benefits are provided for a medical history, height and weight measurement, physical examination and counseling, when appropriate.

Pediatric immunizations, when performed and billed by a Hospital, facility, Physician or Other Professional Provider, are covered. Benefits are provided to Covered Persons under 21 years of age and Dependent children for those pediatric immunizations, including the immunizing agents, which conform with the standards of the Advisory Committee on Immunization Practices of the Center for Disease Control and U.S. Department of Health and Human Services. Eligible Benefits are covered 100% by the Plan.

**Flu Shots** – Flu shots are covered by the Plan at 100%.



**ll. Private Duty Nursing Services.** Services of an actively practicing registered nurse (RN) or licensed practical nurse (LPN) when ordered by a Physician, provided that such nurse does not ordinarily reside in Your home and is not a member of Your immediate family.

For a Covered Person who is an Inpatient in a Hospital or Other Facility Provider, only when Blue Cross Blue Shield of Florida determines that the nursing services required are of a nature or degree of complexity or quantity that could not be provided by regular nursing staff.

For a Covered Person at home, only when Blue Cross Blue Shield of Florida determines that the nursing services require the skills of an RN or an LPN.

**mm. Prosthetic Appliances.** Purchase, fitting, necessary adjustments, repairs, and replacements of Prosthetic Devices and supplies that:

- Replace all or part of a missing body organ and its adjoining tissues; or
- Replace all or part of the function of a permanently inoperative or malfunctioning body organ.
- Initial and subsequent Prosthetic Devices to replace the removed breast(s) or a portion thereof, are also covered.
- Dental appliances and the replacement of cataract lenses are not covered.

**nn. Scalp Hair Prosthesis.** Purchase of a scalp hair Prosthesis when necessitated by hair loss due to the medical condition known as alopecia areata, or as the result of hair loss due to radiation or chemotherapy for diagnosed cancer will be payable as shown in the Schedule of Medical Benefits. Benefits may be provided for the purchase of wigs for hair loss due to alopecia or cancer treatments.

**oo. Skilled Nursing Facility Services.** Services rendered in a Skilled Nursing Facility to the same extent Benefits are available to an Inpatient of a Hospital.

No Benefits are payable:

- After You have reached the maximum level of recovery possible for Your particular condition and You no longer require definitive treatment other than preventive supportive care;
- When confinement is intended solely to assist You with the Activities Of Daily Living or to provide an institutional environment for Your convenience; and
- For treatment of substance abuse or mental illness.

**pp. Speech Therapy.** Speech Therapy provided by a speech therapist if all of the following conditions are met:



- The service of a speech therapist is required to restore a speech disability that the Covered Person lost as direct result of an Illness or Injury; and
- The services of the therapist are prescribed by a Physician who continues to control and direct the overall treatment of the case, as Medically Necessary to improve the specific defect.

qq. **Spinal Manipulation.** Spinal manipulations for the detection and correction by manual or mechanical means of structural imbalance or subluxation resulting from or related to distortion, misalignment, or subluxation of or in the vertebral column.

rr. **Sterilization.** Elective sterilization regardless of Medical Necessity.

ss. **Substance Abuse Services.** The program covers the following services You receive in a Hospital, Other Facility Provider, or from a Professional Provider.

**Inpatient Detoxification, Non-Hospital Residential and Rehabilitation Therapy.**

**Outpatient Rehabilitation.** Covered Services also include individual and group counseling, psychotherapy and psychological testing, and family counseling for the treatment of substance abuse.

**Inpatient Rehabilitation.** When You are admitted to a facility, You are responsible for contacting MHNNet for authorization for Your care.

tt. **Surgical Services.** This program covers the following services You receive from a Professional Provider. If an Inpatient Hospital admission is required, You must contact Blue Cross Blue Shield of Florida prior to Your admission.

**Anesthesia.** Administration of anesthesia ordered by the attending Professional Provider and rendered by a Professional Provider other than the surgeon or the assistant at surgery. Benefits will also be provided for the administration of anesthesia for oral surgical procedures in an Outpatient setting when ordered and administered by the attending Network Professional Provider.

**Assistant at Surgery.** Services of a Physician who actively assists the operating surgeon in performing covered surgery if a house staff member, intern, or resident is not available.

**Second Surgical Opinion.** A consulting Physician's opinion and related Diagnostic Services to confirm the need for recommended elective surgery.

- The second opinion must be from someone other than Your first Physician who recommended the elective surgery;
- Elective surgery means a covered surgery that may be deferred and is not an Emergency;



- Use of a second surgical opinion is Your option; and
- A third opinion and directly related Diagnostic Services are covered if the first and second opinions conflict.

**uu. Therapy and Rehabilitation Services.** This program covers the following services when such services are ordered by a Physician:

- Radiation therapy;
- Chemotherapy;
- Dialysis treatment;
- Physical medicine;
- Respiratory therapy;
- Occupational Therapy;
- Speech therapy;
- Infusion therapy; and
- Cardiac rehabilitation.

## 9.02 ELIGIBLE PROVIDERS

Eligible Network Providers include facilities, general practitioners, internists, obstetricians/gynecologists, and a wide range of Specialists.

### Facility Providers

- a. Hospital;
- b. Psychiatric Hospital; and
- c. Rehabilitation Hospital.

### Other Facility Providers

- d. Ambulance Service;



- e. Ambulatory surgical facility;
- f. Birthing Center;
- g. Day/night psychiatric facility;
- h. Freestanding dialysis facility;
- i. Freestanding nuclear magnetic resonance facility/magnetic resonance imaging facility;
- j. Home Health Care Agency;
- k. Home infusion therapy Provider;
- l. Hospice;
- m. Outpatient Substance Abuse Treatment Facility;
- n. Outpatient physical rehabilitation facility;
- o. Outpatient psychiatric facility;
- p. Pharmacy Provider;
- q. Skilled Nursing Facility; and
- r. Substance Abuse Treatment Facility.

#### Professional Providers

- s. Audiologist;
- t. Certified registered nurse;
- u. Chiropractor;
- v. Clinical laboratory;
- w. Dentist;
- x. Licensed practical nurse;
- y. Nurse-midwife;
- z. Occupational therapist;

- aa. Optometrist;
- bb. Physical therapist;
- cc. Physician;
- dd. Podiatrist;
- ee. Psychologist;
- ff. Registered nurse;
- gg. Respiratory therapist;
- hh. Speech-language pathologist; and
- ii. Teacher of hearing impaired.

## ARTICLE TEN

### LIMITATIONS AND EXCLUSIONS

#### 10.01 LIMITATIONS AND EXCLUSIONS

The Plan shall not pay for any service, procedure or supply incurred by a Covered Person, unless it is specifically listed as a Covered Expense under Article Nine, Covered Expenses. Services that are not Medically Necessary, except for those that are for Preventive Care, are not Covered Expenses under the Plan. For example, reports, evaluations, examinations, or hospitalizations not required for health reasons, such as employment, insurance, or government licenses and court ordered forensic or custodial evaluations are not Covered Expenses. The Plan will not provide Benefits for any services, supplies or charges that are:

1. Not Medically Necessary and Appropriate (as determined by Blue Cross Blue Shield of Florida or MHNNet or Walgreens Health Initiatives).
2. Not prescribed by, or performed by or upon the direction of, a Professional Provider.
3. Rendered by an entity or individual other than facility Providers, Professional Providers, or other professional Providers, or suppliers.
4. Experimental or Investigative in nature.
5. Rendered prior to Your Effective Date of coverage.
6. Incurred after the date of termination of Your coverage, except as otherwise provided in the Plan Document.
7. Artificial aids, including, but not limited to, orthopedic shoes, orthotics, arch supports, elastic stockings, dentures, and wigs.
8. Relating to a Pre-Existing Condition. This means coverage relating to a condition that was present before the date of enrollment for coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before such date. This does not include Pre-Existing Conditions for Dependent Children age 19 or younger. Genetic Information shall not be treated as a Pre-Existing Condition in the absence of a diagnosis of the condition related to such information. However, if an individual is diagnosed with a condition, even if the condition relates to Genetic Information, the Plan may impose a Pre-Existing Condition limitation with respect to the condition. Pregnancy is not a Pre-existing Condition.
9. For losses sustained or expenses incurred while on active duty as a member of the armed forces of any nation, or losses sustained or expenses incurred as a result of an act of war, whether declared or undeclared.
10. For which You would have no legal obligation to pay.



11. For services or supplies provided by a non-licensed provider.
12. For non-Prescription Drugs, medications and supplies, which do not require a Physician's prescription and are not otherwise specifically listed as a Covered Expense.
13. For non-professional care including Medical or surgical care that is not performed according to generally accepted professional standards.
14. For services or supplies that are not Medically Necessary for the diagnosis or treatment of an Illness or Injury, unless covered as a Preventive Benefit.
15. For non-medical ancillary services such as vocational rehabilitation, behavioral training, biofeedback, neurofeedback, hypnosis, hypnotic anesthesia, sleep therapy, employment counseling, back to school, work hardening, driving safety and services, training, and educational therapy.
16. Received from a dental or medical department maintained, in whole or in part, by or on behalf of an employer, a mutual benefit association, labor union, trust, or similar person or group.
17. Orthognathic surgery, which means any service or supply for correction of deformities of the jaw. This consists of surgical repositioning of portions of the upper or lower jaws or the bodily repositioning of the entire jaw, unless otherwise listed as a Covered Expense.
18. For Consumable Medical Supplies, other than ostomy supplies and urinary catheters. Excludable supplies include bandages and other disposable medical supplies, and skin preparations.
19. Paid under Medicare when Medicare is primary; however, this exclusion shall not apply when the Plan is obligated by law to offer You all the Benefits of this program and You elect this coverage as primary.
20. For any amounts You are required to pay under the Deductible and/or Coinsurance provisions of Medicare or any Medicare supplemental coverage.
21. For services or supplies for personal comfort or convenience, (e.g., private room, television, telephone, guest trays, etc.).
22. For certain internal or external prostheses due to wear and tear, loss, theft, or destruction.
23. For any Illness or bodily Injury which occurs in the course of employment if Benefits or compensation are available, in whole or in part, under the provisions of any federal, state, or local government's workers' compensation, occupational disease, or similar type legislation. This exclusion applies whether or not You Claim the Benefits or compensation.
24. Provided to Covered Persons of the armed forces or to patients in Veteran's Administration facilities for service-connected Illness or Injury, unless You have a legal obligation to pay.



25. For treatment or services for injuries resulting from the maintenance or use of a motor vehicle if such treatment or service is paid or payable under a plan or policy of motor vehicle insurance, including a certified or qualified plan of self-insurance, or any fund or program for the payment of extraordinary medical benefits established by law.
26. For Prescription Drugs which were paid or are payable under a freestanding Prescription Drug Program.
27. For nicotine cessation support programs and/or classes.
28. For methadone hydrochloride treatment for which no additional functional progress is expected to occur.
29. Submitted by a certified registered nurse and another Professional Provider or Other Professional Provider for the same services performed on the same date for the same Covered Person.
30. Rendered by a Provider who is a member of Your immediate family.
31. Performed by a Professional Provider or Other Professional Provider enrolled in an education or training program when such services are related to the education or training program.
32. For Ambulance Services, except as otherwise provided in the Plan Document.
33. For operations for cosmetic purposes done to improve the appearance of any portion of the body, and from which no improvement in physiological function can be expected, except as otherwise provided herein. Other exceptions to this exclusion are: (a) surgery to correct a condition resulting from an Accident; (b) surgery to correct a congenital birth defect; and (c) surgery to correct a functional impairment which results from a covered disease or Injury.
34. Charges for failure to keep a scheduled visit or charges for completion of a Claim form.
35. For personal hygiene and convenience items such as, but not limited to, air conditioners, humidifiers, or physical fitness equipment, stair glides, elevators/lifts, or "barrier free" home modifications, whether or not specifically recommended by a Professional Provider or Other Professional Provider.
36. For exercise programs and equipment such as, but not limited to, bicycles and treadmills.
37. For foreign travel for any routine non-Emergency services or procedures received outside the United States including foreign travel immunizations.
38. For Experimental Procedures.
39. For eyeglasses, services, or supplies for the purchase or fitting of eyeglasses or lenses except for the first pair of eye glasses and/or Contact Lenses provided within 1 year of Cataract Surgery.
40. For Inpatient admissions which are primarily for diagnostic studies.
41. For Inpatient admissions which are primarily for physical medicine services.



42. For Custodial Care, domiciliary care, residential care, protective and supportive care, including educational services, rest cures, and convalescent care.
43. For Outpatient therapy and rehabilitation services for which there is no expectation of restoring or improving a level of function or when no additional functional progress is expected to occur, unless Medically Necessary and Appropriate.
44. For respite care.
45. Directly related to the care, filling, removal, or replacement of teeth, the treatment of injuries to or diseases of the teeth, gums, or structures directly supporting or attached to the teeth. These include, but are not limited to, apicoectomy (dental root resection), root canal treatments, soft tissue impactions, alveolectomy and treatment of periodontal disease, except for dental expenses otherwise covered because of accidental bodily Injury to sound natural teeth and for orthodontic treatment for congenital cleft palates as provided herein.
46. For oral surgery procedures, except for the treatment of accidental Injury to the jaw, sound and natural teeth, mouth or face, except as provided herein.
47. For treatment of temporomandibular joint (jaw hinge) syndrome with intra-oral prosthetic devices, or any other method to alter vertical dimensions and/or restore or maintain the occlusion and treatment of temporomandibular joint dysfunction not caused by documented organic joint disease or physical trauma.
48. For palliative or cosmetic foot care including flat foot conditions, supportive devices for the foot, corrective shoes, the treatment of subluxations of the foot, care of corns, bunions, (except capsular or bone surgery), calluses, toe nails (except surgery for ingrown toe nails), fallen arches, weak feet, chronic foot strain, and symptomatic complaints of the feet, except when such devices or services are related to the treatment of diabetes.
49. For any treatment leading to or in connection with transsexual surgery, except for sickness or Injury resulting from such treatment or surgery.
50. For abortion.
51. For acupuncture or acupressure services or supplies.
52. For treatment provided specifically for the purpose of assisted fertilization, including pharmacological or hormonal treatments used in conjunction with assisted fertilization, unless mandated or required by law.
53. For reversal of sterilization.
54. For the treatment of infertility. This includes all forms of infertility treatment, including but not limited to artificial insemination, other artificial methods of conception, in vitro fertilization, in vivo fertilization, services for a surrogate mother, or treatment of sexual dysfunctions not related to organic disease. Cryopreservation of donor sperm and eggs are also excluded from coverage.

55. For eyeglasses or contact lenses and the vision examination for prescribing or fitting eyeglasses or contact lenses (except for the initial pair of contact lenses/glasses prescribed following cataract extraction in place of surgically implanted lenses, or sclera shells intended for use in the treatment of disease or Injury).
56. For the correction of myopia, hyperopia, or presbyopia, including but not limited to corneal microsurgery, such as keratomileusis, keratophakia, radial keratotomy, corneal ring implants, Laser-Assisted in Situ Keratomileusis (LASIK) and all related services.
57. For nutritional counseling, except as provided herein.
58. For weight reduction programs, including all diagnostic testing related to weight reduction programs, unless Medically Necessary and Appropriate.
59. For treatment of obesity, except for medical and surgical treatment of morbid obesity that Blue Cross Blue Shield of Florida, in its sole determination, determines to be Medically Necessary or as otherwise provided in the Plan Document.
60. For Covered Expenses in excess of the Maximum Benefit.
61. For Preventive Care services, wellness services or programs, except as otherwise provided in the Plan Document.
62. For well-baby care visits, except as otherwise provided in the Plan Document.
63. For allergy testing, except as otherwise provided in the Plan Document.
64. For preventive or periodic physical examinations, the completion of forms, and preparation of specialized reports solely for insurance, licensing, employment, or other non-preventive purposes, such as pre-marital examinations, physicals for school, camp, sports or travel, which are not Medically Necessary and Appropriate, except as otherwise provided in the Plan Document or as mandated by law.
65. For radial keratotomy, refractive keratoplasty, lasik, and other procedures performed solely for the correction of vision.
66. For preventive foot care.
67. For self-administered service.
68. For any expenses, treatment, or procedure related to sex change or designed to alter physical characteristics to those of the opposite sex, or any treatment, studies, or expenses related to a transsexual operation sex transformation.
69. For speech therapy unless restorative in nature or administered to a Dependent Child diagnosed with Autism Spectrum Disorder.



70. For charges of State, Federal, or local taxes.
71. For therapy to improve general condition.
72. For elective procedures such as erectile dysfunction, breast reduction (macromastia or gynecomastia) surgeries, varicose veins, abdominoplasty, and panniculectomy. Penile implants are covered when an established medical condition is the cause of erectile dysfunction.
73. Immunizations for employment.
74. For treatment of sexual dysfunction not related to organic disease or Injury.
75. For vocational testing, and educational services rendered primarily for training or education purposes.
76. For warning devices, stethoscopes, blood pressure cuffs or other types of apparatus used for self-diagnosis or monitoring.
77. For any care that is related to conditions such as autistic disease of childhood, hyperkinetic syndromes, learning disabilities, behavioral problems, or mental retardation, which extends beyond traditional medical management. Care which extends beyond traditional medical management includes the following:
  - Services that are primarily educational in nature, such as academic skills training or those for remedial education or those that may be delivered in a classroom-type setting;
  - Neuropsychological testing, educational testing (such as I.Q., mental ability, achievement and aptitude testing), except for specific evaluation purposes directly related to medical treatment;
  - Services provided for purposes of behavioral modification and/or training unless for a Dependent Child diagnosed with Autism Spectrum Disorder;
  - Services related to learning disorders or learning disabilities, unless for a Dependent Child diagnosed with Autism Spectrum Disorder;
  - Services provided primarily for social or environmental change unrelated to medical treatment;
  - Developmental or cognitive therapies that are not restorative in nature but used to facilitate or promote the development of skills which the Covered Person has not yet attained, unless for a Dependent Child diagnosed with Autism Spectrum Disorder; and
  - Services provided for which, based on medical standards, there is no established expectation of achieving measurable improvement in a reasonable and predictable period of time.
78. For any care, treatment, or service which has been disallowed under the provisions of Precertification, Utilization Review, or Care Coordination conducted by BCBSFL, MHNNet, WHI or its designated agents.



79. For otherwise Covered Services ordered by a court or other tribunal as part of a Participant's or Dependent's sentence.
80. For counseling such as Marriage, job, industrial or sex counseling and therapy, unless obtained through the Employee Assistance Program.
81. For any Illness or Injury suffered during the Covered Person's commission of a felony or any Illegal Activity.
82. For any other medical or dental service or treatment except as provided herein or as mandated by law.
83. For Late Submittal Claims, services or supplies for which a Claim is submitted 12 months or more after the Date of Service in which charges for such services were incurred.
84. For Music Therapy, remedial reading, recreational therapy, and other forms of special education.
85. For Cosmetic or Reconstructive Surgery services or supplies for cosmetic or reconstructive surgeries and related treatments, including but not limited to:

Surgical removal or reformation of sagging skin on any part of the body;

Enlargement, reduction or other changes in appearance of any part of the body, unless specifically covered under Covered Expenses;

Hair plants or removal of hair by electrolysis;

Chemical face peels or skin abrasions; and

Surgical treatments of scarring secondary to acne or chicken pox including, but not limited to, dermabrasion, chemical peel, salabrasion, and collagen injections.

This exclusion shall not apply to Cosmetic or Reconstructive Surgery specifically as listed as a Covered Expense, or as deemed Medically Necessary in connection with an Illness or Injury.

86. For IUD, Intrauterine Device, except if provided in the office of a Network Provider.

## 10.02 COVERED PERSON'S RIGHT TO CHOOSE

**The Plan does not limit a Covered Person's right to choose his or her own Medical Care.** If a medical expense is not a Covered Expense, or is subject to a Limitation or Exclusion, a Covered Person still has the right and privilege to receive such medical service or supply at the Covered Person's own personal expense. Similarly, if the Provider is Non-Network, the Covered Person still has the right and privilege to utilize such Provider at the Plan's reduced Coinsurance level with the Covered Person being responsible for a larger percentage of the total medical expense.



## ARTICLE ELEVEN

### COORDINATION OF BENEFITS

#### COORDINATION OF BENEFITS

Most health care plans, including Your PPO program, contain a Coordination of Benefits provision. This provision is used when You, Your spouse or Your covered Dependents are eligible for payment under more than one health care plan. The object of Coordination of Benefits is to ensure that Your Covered Expenses will be paid, while preventing duplicate benefit payments.

#### 11.01 COORDINATION OF BENEFITS PROVISION

- a. When Your other coverage does not mention "Coordination of Benefits," then that coverage pays first. Benefits paid or payable by the other coverage will be taken into account in determining if additional Benefit payments can be made under this Plan.
- b. When the person who received care is covered as an Employee under one contract and as a Dependent under another, then the Employee coverage pays first.
- c. When a Dependent child is covered under two contracts, the contract covering the parent whose birthday falls earlier in the calendar year pays first. However, if both parents have the same birthday, the plan which covered the parent longer will be the primary program. If the Dependent child's parents are separated or divorced, the following applies:
  - i. The parent with custody of the child pays first.
  - ii. The coverage of the parent with custody pays first, but the stepparent's coverage pays before the coverage of the parent who does not have custody.
  - iii. Regardless of which parent has custody, whenever a court decree specifies the parent who is financially responsible for the child's health care expenses, the coverage of that parent pays first.
  - iv. When none of the above circumstances apply, the coverage You have had for the longest time pays first; provided, however, that the benefits of a plan covering the person as an Employee (other than a laid-off or retired employee) or as the dependent of such person shall be determined before the benefits of a plan covering the person as a laid-off or retired employee or as a dependent of such person. If the other program does not have this provision regarding laid-off or retired employees, and, as a result, plans do not agree on the order of benefits, then this rule shall be disregarded.

Coordination of Benefits prevents duplication of Benefits and works to the advantage of all Covered Persons in the Plan. Coordination of Benefits applies when a Participant is covered under more than one group health benefits program. It requires that payment of Benefits be coordinated by all programs to eliminate over insurance or duplication of Benefits. If a Covered Person is covered under more than one group plan, benefits will be



coordinated. The Covered Person will be responsible for meeting the Plan's Co-payment, Deductible, and Coinsurance that would otherwise be the Covered Person's responsibility if the Plan were primary. The Benefits payable under this Plan for any Claim determination period will be either its regular Benefits or reduced Benefits which, when added to the benefits of the other plan, will equal 100% of the Allowable Expenses, as defined below. At no time is a Covered Person responsible for more than the applicable Co-payment, Deductible, or Coinsurance.

## 11.02 DEFINITIONS

The following terms have special meaning in Article Eleven - Coordination of Benefits:

1. **Allowable Expenses.** Any Medically Necessary, Reasonable and Customary expense incurred by a Covered Person, which is covered at least in part under this Plan.
2. **Claim Determination Period.** The portion of the Plan Year (4/1-3/31) during which a Covered Person who submitted a Claim, or for whom a Claim has been submitted, has been covered under the Plan.
3. **Other Plan.** Any plan under which medical or dental benefits or services are provided by:
  - a. Group, blanket, or franchise insurance coverage;
  - b. Any group Hospital service pre-payment, group medical service pre-payment, group practice or other group pre-payment coverage;
  - c. Group coverage under labor-management trustee plans, union welfare plans, employer organization plans or employee benefit plans; or
  - d. Coverage under governmental programs or coverage required or provided by any statute (including no-fault auto insurance), except Medicaid and Medicare. (Refer to the Coordination of Benefits with Medicare provision under Article Thirteen.)

## 11.03 EFFECT OF HEALTH MAINTENANCE ORGANIZATION (HMO) COVERAGE

This Plan will not consider, as an Allowable Expense, any charge (1) that would have been covered by an HMO had a Covered Person for whom the HMO would be primary payer used the services of an HMO participating provider or (2) in excess of what an HMO provider has agreed to accept.

## 11.04 RECOVERY

If the amount of the payment made by this Plan is more than it should have paid, the Plan has the right to recover the excess from one or more of the following:

- a. The person this Plan has paid or for whom it has paid;
- b. Insurance companies; and
- c. Other organizations.



## 11.05 PAYMENT TO OTHER CARRIERS

Whenever payments, which should have been made under this Plan in accordance with the above provisions, have been made under any Other Plans, this Plan will have the right, in its sole discretion, to pay any organization making those payments any amounts it determines to be warranted in order to satisfy the intent of the above provisions. Amounts paid in this manner will be considered to be Benefits paid under this Plan and, to the extent of these payments, this Plan will be fully discharged from liability.

## 11.06 REIMBURSEMENT, ASSIGNMENT, AND LIEN

If the Plan makes payments and a Participant later receives a settlement, or is otherwise compensated by a third-party as a result of the Participant's Injuries, the Participant must reimburse the Plan for payment the Plan made.

Each Covered Person also hereby grants the Plan a lien and assignment of any sums or proceeds recovered from any third-party (or his or her insurance carrier) whose negligent or intentional conduct was responsible in whole or in part for the Covered Person's need for Medical Care. The amount of such lien and assignment shall be equal to the sums paid by the Plan to, or on behalf of, the Covered Person for medical expenses arising out of such third-party's conduct, plus any attorney's fees incurred by the Plan in enforcing this lien and assignment.

## 11.07 SUBROGATION

Subrogation means that if You incur health care expenses for Injuries caused by another person or entity, the person or entity causing the Accident may be responsible for paying these expenses. For example, if You or one of Your Dependents receives Benefits under the Plan for Injuries or Illness caused by another person or organization, the Plan has the right, through subrogation, to seek repayment from the other person or entity or any applicable insurance company for Benefits already paid.

The Plan will provide eligible Benefits when needed, but You may be asked to show documents or take other necessary actions to support the Plan and Blue Cross Blue Shield of Florida in any subrogation efforts.

In the event of any payment of Covered Expenses under the Plan, the Plan may, to the extent of such payment, claim the right of subrogation to all the rights of recovery of the Covered Person, or any other party claiming through the Covered Person, arising out of any claim or cause of action that may accrue because of the alleged negligent conduct of a third-party. If the Covered Person brings a claim against a third-party, Benefits payable under the Plan must be included in such claim as well as in any recovery the Covered Person obtains, either by judgment, settlement, or otherwise, and the Covered Person must reimburse the Plan for the full amount of Benefits paid under the Plan, regardless of whether the Covered Person has been "made whole" as a result of such payments by such third-party. This means that the Plan's right of subrogation and reimbursement, as set forth herein, will not be affected, reduced, or eliminated by the "made whole doctrine" or any other equitable doctrine or law which requires an insured to be "made whole" before subrogation rights are allowed. Furthermore, it is prohibited for a Covered Person or beneficiaries to settle a claim against a third-party for certain elements of damages, but eliminating damages relating to medical expenses incurred.



The Plan's subrogation, reimbursement, and lien rights apply to any recoveries made by a Covered Person as a result of Injuries sustained or Illness suffered for which Benefit payments were made, including but not limited to, the following:

- a. Any award or settlement or benefits paid under any workers' compensation law or award.
- b. Any and all payments made directly by a third-party tortfeasor, person, entity, or any insurance company on behalf of the third-party tortfeasor or any payments or installments made to the Covered Person on behalf of the third-party tortfeasors, person, or entity responsible for indemnifying the third-party tortfeasors.
- c. Any arbitration awards, payments, settlements, structured settlements, or other benefits paid by an insurance company under an uninsured or underinsured motorist coverage policy, whether on behalf of the Covered Person, his employer, or any other person.
- d. Any other payments designated, delineated, earmarked, or intended to be paid to a Covered Person as compensation, restitution, or remuneration for Injuries sustained or Illnesses suffered as the result of the negligence, or liability, including contractual, of a third-party.

Subrogation does not apply to any individual insurance policy that You may have purchased for Yourself or Your Dependents or where subrogation is specifically prohibited by law.

The Plan will not be responsible for any expenses, fees, costs, or other monies incurred by the attorney for the Covered Person, commonly known as the "common fund doctrine". The Covered Person is specifically prohibited from incurring any expenses, costs, or fees on behalf of the Plan in pursuit of his or her rights of recovery against a third-party or the Plan's subrogation/reimbursement rights as set forth herein. No court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of a litigation nature may be deducted from the Plan's recovery without the prior written consent of the Plan.

In addition, the Plan's right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of the Covered Person, whether under the doctrines of imperative causation, comparative fault or contributory negligence, or any other similar doctrine in law. Accordingly, any so-called "lien reduction statutes" which attempt to apply such laws and reduce a subrogating Plan's recovery for any reason will not be applicable to the Plan and will not reduce the Plan's subrogation recovery. The Benefits provided under this Plan are secondary to any benefits or coverage provided under any no-fault laws or similar legislation or no-fault-type insurance.

Furthermore, as a Covered Person, You hereby agree to the following terms and conditions:

- a. Each Covered Person shall take such action, to furnish such information and assistance, and to execute and deliver all necessary instruments as the Plan Administrator may require to facilitate the enforcement of the Plan's rights hereunder.
- b. No Covered Person shall prejudice the Plan's right of subrogation or reimbursement.
- c. Each Covered Person shall do whatever is necessary to enable the Plan's right of subrogation to be exercised, including cooperate with the Plan and/or any and all representatives of the Plan, including subrogation counsel, in completing discovery, attending depositions, and/or attending or cooperating in trial in order to affect the Plan's subrogation rights. Furthermore, the Covered Person shall do nothing after loss to prejudice the Plan's subrogation rights.



- d. No covered person may assign any rights or causes of action that he or she might have against a third-party tortfeasor, person, or entity, which would grant the Covered Person the right to recover medical expenses or other damages, without the express, prior written consent of the Plan and the Plan Administrator. The Plan's subrogation and reimbursement rights apply even if the Covered Person has died as a result of his or her Injuries and is asserting a wrongful death or survivor claim against the third-party tortfeasor under the laws of any state. The Plan's right to recovery by subrogation or reimbursement shall thus apply to any settlements, recoveries, or causes of action owned or obtained by a decedent, minor, incompetent, or disabled person.

The Plan Administrator shall pay reasonable fees and costs associated with the enforcement of the Plan's rights. No Plan Benefits will be paid until liability has been established by the Plan Administrator.

Each Covered Person, and any other party to whom such payments have been assigned by such Covered Person, shall hold such payments in trust and reimburse the Plan for any payment the Plan made for which such person recovers payments, including attorneys' fees, regardless of the damages designation in any settlement document or court order.

Each Covered Person must cooperate at each stage under the Plan, including Claims investigation, recovery of overpayments, and subrogation. Failure to cooperate or prejudicing a right of the Plan may result in a loss of Benefits.

#### **11.08 RELEASE OF INFORMATION**

For the purpose of determining the applicability of, and implementing, the terms of the above provisions of this Plan or any similar provision of an Other Plan, BCBSFL, MHNet or WHI may, without the consent of, or notice to, any Covered Person, release to, or obtain from, any other insurance company or other organization or individuals, any information concerning any Covered Person that is necessary for those purposes. Any person receiving Benefits under this Plan must furnish to BCBSFL, MHNet or WHI information about other coverage, which may be involved in applying the Coordination of Benefits' provisions.



## ARTICLE TWELVE

### COORDINATION OF BENEFITS WITH MEDICARE

#### 12.01 ELIGIBILITY FOR MEDICARE

A Participant may have coverage under the Plan and under Medicare. Medicare means benefits offered under Title XVII of the Social Security Act, and includes all of the benefits provided by Parts A and B of Medicare. When a Participant has coverage under both the Plan and Medicare, the Plan will pay Benefits primary to Medicare for:

- a. An active Employee who is age 65 or over;
- b. An active Employee's covered spouse who is age 65 or over;
- c. An active Employee or covered spouse who is under age 65 and entitled to Medicare because of a Disability; or
- d. The first 30 months of treatment for end stage renal disease received by any Participant.

If a Participant does not fall into one or more of the categories above, the Plan will pay Benefits secondary to Medicare. When the Plan pays secondary to Medicare, the Participant must first submit a claim to Medicare. After Medicare makes payment, the Participant may submit the Claim to the Plan for payment.

When a Participant files for Social Security benefits, the Participant automatically becomes eligible for Medicare Part A Hospital coverage, which has no premium expense. A Participant must voluntarily enroll in Medicare Part B medical coverage and pay premiums.

#### 12.02 ELECTION BY PARTICIPANT

A Participant who is covered under Medicare and the Plan, and who falls into one of the categories above, may elect to waive coverage under the Plan. If coverage is waived under the Plan, the Plan will no longer provide coverage for that person. If a Participant waives coverage under the Plan, the Participant may later reapply for coverage under the Plan during Open Enrollment as a Late Enrollee. However, the rules governing Late Enrollees will apply. If a Participant elects Medicare as the primary coverage, the Participant will have no further coverage under this Plan.

#### 12.03 HCFA REGULATION

This Article is based on regulations issued by the Health Care Financing Administration (HCFA), now known as Centers for Medicare and Medicaid Services (CMS), and may be amended or changed at any time. It is the intent of the Plan to abide by the Medicare Secondary Payer rules. The Plan will coordinate with Medicare to the fullest extent permitted by applicable law. If the Plan in any way conflicts with regulations issued by CMS, the Plan will pay Benefits in accordance with CMS regulations.

**Note:** The Plan requires that all Covered Persons eligible for Medicare enroll in Medicare Part B, and pay the premium for Part B. The Plan will pay Benefits based on the premise that the Covered Person has elected Part B, regardless of whether the Covered Person has elected Part B or not.



## 12.04 COORDINATION OF MEDICARE WITH THE ICUBA MEDICAL PLAN

### Active Employees and Dependents

An Employee who is over the age of 65 and enrolled in Medicare will be Covered under the Plan as the primary payer if that Employee is still Actively At Work. Medicare is secondary to the Plan for these Actively At Work Employees. Medicare uses a Coordination of Benefits (COB) Contractor which consolidates the activities that support the collection, management, and reporting of other insurance coverage for Medicare beneficiaries. The purposes of the COB program are to identify the health benefits available to a Medicare beneficiary and to coordinate the payment process to prevent mistaken payment of Medicare benefits. The COB Contractor does not process claims, nor does it handle any mistaken payment recoveries or claims specific inquiries. The Medicare intermediaries and carriers are responsible for processing claims submitted for primary or secondary payment. Medicare's Coordination of Benefits Agreement Program establishes a nationally standard contract between the Center for Medicare and Medicaid Services (CMS) and other health insurance organizations that defines the criteria for transmitting enrollee eligibility data and Medicare adjudicated claim data. The CMS will transfer the claims crossover functions from individual Medicare contractors to a national claims crossover contractor, the Coordination of Benefits Contractor (COBC). This consolidation will allow for the establishment of unique identifiers (COBC IDs) to be associated with each contract and create a national repository for COB information. Employees over the age of 65 enrolled in Medicare, will be covered under the ICUBA Plan as the primary payer, if that Employee is still Actively At Work. Medicare is secondary to the ICUBA Plan for these Actively At Work Employees. You must supply the social security number of any dependent over the age of 45 at the time of enrollment.

### Retirees

**Note:** The Plan requires that all retired Covered Persons eligible for Medicare enroll in Medicare Parts A and B and pay any associated premiums. The Plan will pay Benefits based on the premise that the retired Covered Person has elected coverage under Medicare Parts A and B, regardless of whether the retired Covered Person actually has.

Plan coverage is available for Eligible Retirees. If You retire before the attaining age 65, You will be provided with the opportunity to remain covered under the Plan. Upon attaining age 65, You will be offered a choice to remain on the ICUBA Plan or switch to the Monumental Life Retiree Supplemental Plan and You have thirty (30) days to enroll in the Monumental Plan. The premium for the Monumental Plan is age banded and Your premium will change the first day of the plan year following Your birthday if Your birthday results in a change of Your age band.

Under the comprehensive benefits program, health care Benefits are provided under one integrated program. These Benefits include coverage for Hospital Services, Physician services, and many other Covered Services. Most Benefits are subject to Deductible and Coinsurance provisions which require You to share a portion of the medical costs. Below are the specific Benefit levels. These Benefits will be applied after Medicare Parts A and B have paid their portion for Covered Services.

As a Medicare Participant, You have a right to access and to review a fee schedule with a complete listing of fees used by Medicare to pay doctors or other providers/suppliers. This comprehensive listing of fee maximums is used to reimburse a Physician and/or other Providers on a fee-for-service basis. CMS develops fee schedules for



Physicians, Ambulance Services, clinical laboratory services, and Durable Medical Equipment, prosthetics, orthotics, and supplies. This fee schedule is available at <http://www.cms.hhs.gov/FeeScheduleGenInfo/>

The ICUBA Prescription Drug benefit is Creditable Coverage, so You will receive credit towards Medicare Part D upon Your retirement if You choose to elect Medicare Part D. Creditable Coverage means that the amount the Plan expects to pay on average for Prescription Drugs for individuals covered under the Plan in the applicable year is the same or more than what standard Medicare Prescription Drug coverage would be expected to pay on average. This is important because the Medicare Modernization Act (MMA) imposes a late enrollment penalty on individuals who do not maintain Creditable Coverage for a period of 63 days or longer following their initial enrollment period for the Medicare Prescription Drug benefit. MMA mandates that certain entities offering Prescription Drug coverage, including employer and union group health plan sponsors, disclose to all Medicare eligible individuals with Prescription Drug coverage under the plan whether such coverage is 'creditable.' This information is essential to an individual's decision whether to enroll in a Medicare Part D Prescription Drug plan. The Plan pays for other health expenses in addition to Prescription Drugs. If You or Your Dependent enroll in a Medicare Prescription Drug plan, You and Your eligible Dependents will still be able to receive all of Your current health and Prescription Drug Benefits.



**Benefit Period: April 1, 2011 – March 31, 2012**  
 General Provision: PPO 70 Plan, Risk/Reward Plan

BENEFITS	PPO 70 Plan	Risk/Reward Plan
Deductible Individual Family	\$750 \$2,250	\$1,750 \$4,000
Coinsurance	70/30% after Deductible	80/20% after Deductible
Lifetime Maximum	No maximum	No maximum
Out-of-Pocket Maximum (includes deductibles, coinsurance and medical copays) Individual Family	\$3,000 \$6,000	\$3,500 \$7,000
Physician Office Visits (General Practice, Internal Medicine, Family Practice, Pediatrician, OB/GYN) <sup>1</sup>	100% after \$20 co-payment; Deductible does not apply	80/20%; Deductible does not apply
Specialist Office Visits	100% after \$30 co-payment; Deductible does not apply	80/20%; Deductible does not apply
Urgent Care Facility <sup>2</sup>	100% after \$30 co-payment; Deductible does not apply	80/20%; Deductible does not apply
Preventive Care Annual Physical and Gynecological Exam	100%; Not subject to deductible or copay	100%; Deductible does not apply
Preventive Care <sup>3</sup> <i>Adult and Pediatric Approved Immunizations and Venipunctures</i>	100%; Not subject to deductible or copay	100%; Deductible does not apply
Pap Tests	100%; Not subject to deductible or copay	100%; Deductible does not apply
Related Wellness Services (e.g. Colorectal Screenings, Colonoscopies, Sigmoidoscopies, Electrocardiograms, Echocardiograms and Bone Mineral Density Tests)	100%; Not subject to deductible or copay	100%; Deductible does not apply
Prostate Cancer Screenings (PSA)	100%; Not subject to deductible or copay	100%; Deductible does not apply
Mammograms	100%; Not subject to deductible or copay	100%; Deductible does not apply
Chlamydia and STD tests	100%; Not subject to deductible or copay	100%; Deductible does not apply
Allergy Injections	100%; Not subject to deductible or copay	100%; Deductible does not apply
General Health Blood Panel, Glucose Test, Lipids Panel, Cholesterol, and ALT/AST	100%; Not subject to deductible or copay	100%; Deductible does not apply
Venipuncture/Conveyance Fee	100%; Not subject to deductible or copay	100%; Deductible does not apply
Urinalysis	100%; Not subject to deductible or copay	100%; Deductible does not apply
Emergency Room Services <sup>2</sup>	100% after \$100 Co-payment (waived if admitted); Deductible does not apply	100% after \$100 Co-payment (waived if admitted); Deductible does not apply



BENEFITS	PPO 70 Plan	Risk/Reward Plan
Ambulance Services	70/30% after in-network deductible	80/20% after in-network deductible
Hospital Expenses Inpatient <sup>4</sup>	70% after \$250 per admission Co-payment (deductible applies)	80/20% after Deductible
Outpatient	70/30% after Deductible	80/20% after Deductible
Outpatient Surgery Office Setting - Physician	100% after \$20 Co-payment; Deductible does not apply	80/20%; Deductible does not apply
Outpatient Surgery Office Setting - Specialist	100% after \$30 Co-payment; Deductible does not apply	80/20%; Deductible does not apply
Outpatient Facility	70% after \$100 Co-payment (deductible applies)	80/20% after Deductible
Related Professional Services	70/30% after Deductible	80/20% after Deductible
Infertility Services (counseling and test to diagnose)	70/30% after deductible	80/20% after deductible
Assisted Fertilization Procedures	Not covered	Not covered
Spinal Manipulations	100% after \$30 Co-payment; Deductible does not apply Limit: 60 visits / benefit period	80/20%; Deductible does not apply Limit: 60 visits / benefit period
Diagnostic Services Lab tests	100%; Deductible does not apply	100%; Deductible does not apply
X-ray and other tests	70/30% after Deductible	80/20% after Deductible
Outpatient Diagnostic Imaging (MRI, MRA, CAT Scan, PET Scan)	70% after \$100 per service copayment (deductible applies)	80/20% after Deductible
Outpatient Physical Medicine	100% after \$30 Co-payment; Deductible does not apply Limit: 30 visits / benefit period	80/20%; Deductible does not apply Limit: 30 visits / benefit period
Outpatient Speech Therapy (restorative services only)	100% after \$30 Co-payment; Deductible does not apply Limit: 30 visits / benefit period	80/20%; Deductible does not apply Limit: 30 visits / benefit period
Outpatient Occupational Therapy	100% after \$30 Co-payment; Deductible does not apply Limit: 30 visits / benefit period	80/20%; Deductible does not apply Limit: 30 visits / benefit period
Applied Behavioral Analysis (for Autism Spectrum Disorder)	100% after \$30 Co-payment; Deductible does not apply	80/20%; Deductible does not apply
Cardiac Rehabilitation	70/30% after Deductible	80/20% after Deductible
Chemotherapy	70/30% after Deductible	80/20% after Deductible
Dialysis Treatment	70/30% after Deductible	80/20% after Deductible
Infusion Therapy	70/30% after Deductible	80/20% after Deductible
Radiation Therapy	70/30% after Deductible	80/20% after Deductible



BENEFITS	PPO 70 Plan	Risk/Reward Plan
Respiratory Therapy	70/30% after Deductible	80/20% after Deductible
Durable Medical Equipment (Medical Necessity Required)	70/30% after Deductible	80/20% after Deductible
Enteral Formulae	70/30% after Deductible	80/20% after Deductible
Prosthetic Appliances	70/30% after Deductible	80/20% after Deductible
Skilled Nursing Facility <sup>4</sup>	70/30% after Deductible Limit: 60 days / benefit period	80/20% after Deductible Limit: 60 days / benefit period
Inpatient Rehabilitation <sup>4</sup>	70/30% after Deductible; \$250 per admission co-pay also applies	80/20% after Deductible
	Limit: 60 days / benefit period	Limit: 60 days / benefit period
Home Health Care Medical Necessity Required (unlimited days per Plan Year (4/1-3/31); 16 hours per day maximum)	70/30% after Deductible	80/20% after Deductible
Home Infusion Therapy Services	70/30% after Deductible	80/20% after Deductible
Private Duty Nursing	70/30% after Deductible	80/20% after Deductible
Hospice (Inpatient and Outpatient Care)	70/30% after Deductible	80/20% after Deductible
Transplant Services <sup>5</sup>	70/30% after Deductible	80/20% after Deductible
Hearing Aid screening/exam	100% after office visit copayment	80/20% (not subject to deductible)
Hearing Aids	70/30% after Deductible	80/20% after Deductible
	Limit: \$1,500 / benefit period for exam and hearing aids	Limit: \$1,500 / benefit period for exam and hearing aids
Temporomandibular Joint Disorder (TMJ) - (Medical Necessity required and excludes appliances and orthodontic treatment)	70/30% after Deductible	80/20% after Deductible
Mental Health Inpatient <sup>4</sup>	70% after \$250 per admission co-payment (deductible applies)	80/20% after Deductible
Mental Health Outpatient	100% after \$20 Co-payment	80/20%; Deductible does not apply
Substance Abuse Inpatient <sup>4,7</sup> Rehabilitation and Detoxification	70% after \$250 per admission co-payment (deductible applies)	80/20% after Deductible
Substance Abuse Outpatient	100% after \$20 Co-payment	80/20%; Deductible does not apply
Employee Assistance Program <sup>6</sup>	100%; Deductible does not apply 6 face to face visits per issue	100%; Deductible does not apply 6 face to face visits per issue



1. For maternity, if a Co-payment applies, it is charged for the first visit only.
2. The Office Visit Co-payment depends upon the setting. Urgent Care services received in a non-Hospital setting will be subject to the Specialist Co-payment or Coinsurance; Urgent Care services received in the emergency room setting will be subject to the Emergency Room Co-payment.
3. Eligible preventive Diagnostic Services include, but are not limited to laboratory colorectal screenings, bone mineral density tests, sigmoidoscopies, colonoscopies, echocardiograms, electrocardiograms, general health blood panels, adult and pediatric immunizations, mammograms, PAP tests, PSA test, urinalysis, and venipuncture services. You will not be responsible for the office visit Co-pay or Coinsurance when receiving Preventive Services and the services are covered at 100%.
4. Precertification is required prior to all planned Inpatient admissions, skilled nursing facilities, hospitals, and rehabilitation centers. For medical admissions, notification should be provided to Blue Cross Blue Shield of Florida within 48 hours of an Emergency or maternity-related admission. For behavioral health admissions, including mental health and substance abuse, notification should be provided to MHNet within 48 hours of admission. Please note that in most cases, Network Providers will obtain Precertification on behalf of the patient. However, You will be responsible for obtaining Precertification for Non-Network admissions. If this does not occur and it is later determined that all or part of the Inpatient stay was not Medically Necessary and Appropriate, the patient will be responsible for payment of any costs not covered.
5. Combined limit: \$10,000 per transplant for travel, meals and lodging for recipient and travel companion.
6. For Employee Assistance Program (EAP) Benefits, You do not have to be enrolled in a medical plan. All individuals who live in Your household are also eligible for EAP Benefits. MHNet is a recognized leader in the behavioral health industry for over 20 years and administers the Plan's mental health, substance abuse, and EAP benefits. Your medical card will provide MHNet's toll free number 877-398-5816 and website [www.mhnet.com](http://www.mhnet.com) on the back. All EAP and inpatient admissions require pre-certification. Each individual may receive up to six free in-person EAP counseling sessions per issue per plan year. You can find a listing of network providers by logging onto <http://www.mhnet.com> Username: ICUBA; Password: 8773985816. Members who are seeking EAP services may call 877 398-5816 24-hours a day and speak with a licensed counselor.
7. In order to be Precertified for Inpatient Adult Rehabilitation for a substance-related disorder, demonstration of alternative levels of care such as partial hospitalization must have been attempted and relapse has occurred within 6 months of You or Your dependent's active participation in such a program.



## ARTICLE THIRTEEN

### CLAIMS AND APPEALS PROCEDURES

#### 13.01 HOW TO FILE A CLAIM

If You receive services from a Network Provider, You will not have to file a Claim. If You receive services from a Non-Network Provider, You may be required to file the Claim Yourself. The procedure is simple. Just take the following steps:

- a. Know Your Benefits. Review this information to see if the services You received are Eligible under the Plan.
- b. Get an Itemized Bill. Itemized bills must include:
  - i) The name and address of the service Provider;
  - ii) The patient's full name;
  - iii) The Date of Service or supply;
  - iv) A description of the service/supply;
  - v) The amount charged;
  - vi) The diagnosis or nature of the Illness;
  - vii) For Durable Medical Equipment, the doctor's certification;
  - viii) For private duty nursing, the nurse's license number, charge per day, and shift worked; and
  - ix) For Ambulance Services, the total mileage.

**Please note:** If You have already made payment for the services You received, You must also submit proof of payment (receipt from the doctor) with Your Claim form. Cancelled checks, cash register receipts, or personal itemizations are not acceptable as itemized bills.

- c. Copy Itemized Bills. You must submit originals, so You should want to make copies for Your records. Once Your Claim is received, itemized bills cannot be returned.
- d. Complete a Claim Form. Make sure all information is completed properly then sign and date the form. Medical claim forms can be obtained by contacting BCBSFL Member Service at 1-800-664-5295. Behavioral Health and Substance Abuse Claim forms can be obtained by contacting MHNet at 1-877-398-5816. Prescription Drug Claim forms can be obtained by calling WHI at 1-800-207-2568.



- e. Attach Itemized Bills to the Claim Form and Mail. After You complete the above steps, attach all itemized bills to the Claim form and mail everything to the address on the form.
- f. Remember: Multiple services for the same Family member can be filed with one Claim form. However, a separate Claim form must be completed for each patient.
- g. Remember: Your Claims must be submitted within 12 (twelve) months from the Date of Service.

### 13.02 YOUR EXPLANATION OF BENEFITS STATEMENT (EOB)

Once Your Claim is processed, You will receive an Explanation of Benefits (EOB) statement. This statement lists: the Provider's charge; the allowable amount; the Co-payment, Deductible, and Coinsurance amounts, if any, You are required to pay; the total Benefits payable; and the total amount You owe.

### 13.03 ADDITIONAL INFORMATION ON HOW TO FILE A CLAIM

#### a. Covered Person Inquiries

- i) General inquiries regarding Your eligibility for coverage and Benefits that do not involve the filing of a Claim
- ii) should be made by directly contacting BCBS Member Service for Medical at 1-800-664-5295, MHNet for Behavioral Health at 1-877-398-5816 or WHI for Prescription Drugs at 1-800-207-2568.

#### b. Filing Benefit Claims

- i) Authorized Representatives: You have the right to designate an authorized representative to file or pursue a request for reimbursement or other Post-Service Claim on Your behalf. Blue Cross Blue Shield of Florida, MHNet or WHI reserves the right to establish reasonable procedures for determining whether an individual has been authorized to act on Your behalf.
- ii) Requests for Precertification and Other Pre-Service Claims: For a description of how to file a request for Precertification or other Pre-Service Claim, see the Utilization Review and Care Coordination Section in Article V. Please review the Covered Benefits as detailed in Section 9.01 prior to requesting Precertification or Pre-Service Claims to ensure that the procedure You are planning is a covered Benefit under the Plan. If the planned procedure is listed under the Limitations and Exclusions in Section 10.01, the procedure will not be covered except as otherwise explained herein. If the Plan does not require Precertification for the Claim for which the approval is being requested, it is not a "claim for benefits" governed by ERISA regulation.
- iii) Requests for Reimbursement and Other Post-Service Claims: When a participating Hospital, Physician, or other Provider submits its own reimbursement Claim, the amount paid to that Participating Provider will be determined in accordance with the Provider's agreement with Blue Cross Blue Shield of Florida, the local Blue Cross and Blue Shield Plan or MHNet serving Your area. Blue Cross Blue Shield of Florida or MHNet will notify You of the amount that was paid to the Provider. Any remaining amounts



that You are required to pay in the form of a Co-payment, Coinsurance, or program Deductible will also be identified in that Explanation of Benefits (EOB) or notice. If You believe that the Co-payment, Coinsurance, or Deductible amount identified in that EOB or notice is not correct, or that any portion of those amounts are covered under Your benefit program, You should contact BCBSFL Member Service at 1-800-664-5295 for Medical, MHNet at 1-877-398-5816 for Behavioral Health/Substance Abuse or WHI at 1-800-207-2568 for Prescription Drugs.

**c. Deadline**

To be Eligible for coverage, You must submit all requests for reimbursement and other Post-Service Claims within 12 (twelve) months from the Date of Service.

**d. Determinations on Benefit Claims**

For a description of the time frames in which requests for Precertification or other Pre-Service Claims will be determined by Blue Cross Blue Shield of Florida and the notice You will receive concerning its decision, whether adverse or not, see the Utilization Review and Care Coordination Section in Article V.

### 13.04 DEFINITIONS

1. **Claim.** A Claim is any request for a Plan Benefit or Benefits made in accordance with these Claims Procedures. A communication regarding Benefits that is not made in accordance with these Claims Procedures will not be treated as a Claim.
2. **Claimant.** A Claimant is an individual who makes a request for a Plan Benefit or Benefits in accordance with these Claims Procedures.
3. **Incorrectly Filed Claim.** Any request for Benefits that is not made in accordance with these Claims Procedures is called an Incorrectly-Filed Claim.
4. **Day.** When used in these Claims Procedures, the term Day means a calendar day.
5. **Authorized Representative.** An Authorized Representative may act on behalf of a Claimant with respect to a Claim or Appeal under these Claims Procedures. However, no person (including a treating health care professional, except as noted below) will be recognized as an Authorized Representative until the Plan receives an Appointment of Authorized Representative form signed by the Claimant, except for Urgent Care Claims. The Plan shall, even in the absence of a signed Appointment of Authorized Representative form, recognize a health care professional with knowledge of the Claimant's medical condition (*i.e.*, the treating Physician) as the Claimant's Authorized Representative unless the Claimant provides specific written direction otherwise.

An assignment for purposes of payment (*i.e.*, to a health care professional) does not constitute appointment of an Authorized Representative under these Claims Procedures.

Once an Authorized Representative is appointed, the Plan shall direct all information, notification, etc. regarding the Claim to the Authorized Representative. The Claimant shall be copied on all notifications regarding decisions, unless the Claimant provides specific written direction otherwise.



Any reference in these Claims Procedures to Claimant is intended to include the Authorized Representative of such Claimant appointed in compliance with the above Claims Procedures.

### 13.05 TYPES OF CLAIMS

1. **Different Rules Apply.** There are four categories of Claims, each with somewhat different Claim and appeal rules. The Department of Labor regulations set forth different requirements based on the type of Claim involved. The primary difference is the timeframe within which Claims and appeals must be determined.
2. **Pre-Service Claim.** A Claim is a Pre-Service Claim if the Plan Document specifically conditions receipt of the Benefit, in whole or in part, on receiving approval in advance of obtaining the Medical Care unless the Claim involves Urgent Care, as defined below. Benefits under this Plan that require approval in advance are specifically noted in this Plan Document as being subject to Precertification.
3. **Urgent Care Claim.** An Urgent Care Claim is a special type of Pre-Service Claim. A Claim involving Urgent Care is any Pre-Service Claim for Medical Care or treatment with respect to which the application of the time periods that otherwise apply to Pre-Service Claims could seriously jeopardize the Claimant's life or health or ability to regain maximum function or would, in the opinion of a Physician with knowledge of the Claimant's medical condition, subject the Claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the Claim. The prudent lay person standard applies to these determinations. If a treating Physician determines the Claim involves Urgent Care, the Claim shall be treated as an Urgent Care Claim. However, in order to file an Urgent Care Claim, You must be requesting to have a procedure which is a Covered Benefit as defined in Section 9.01 of this Plan Document. The procedure must not be a procedure that is a Limitation or Exclusion as defined in Section 10.01 of this Plan Document.

On receipt of a Pre-Service Claim, BCBSFL, MHNNet or WHI will make a determination of whether it involves Urgent Care; provided, however, that if a Physician with knowledge of the Claimant's medical condition determines that a Claim involves Urgent Care, the Claim shall be treated as an Urgent Care Claim.

4. **Post-Service Claim.** A Post-Service Claim is any Claim for a Benefit under this Plan that is not a Pre-Service Claim or an Urgent Care Claim. Post-Service Claims are Claims that involve only the payment or reimbursement of the cost for Medical Care that has already been provided.
5. **Concurrent Care Claim.** A Concurrent Care Claim occurs where the Plan approves an ongoing course of treatment to be provided over a period of time or for a specified number of treatments. There are two types of Concurrent Care Claims:

Where reconsideration of the approval results in a reduction or termination of the initially-approved period of time or number of treatments; and

Where an extension is requested beyond the initially-approved period of time or number of treatments.



6. **Change in Claim Type.** The Claim type is determined initially when the Claim is filed. However, if the nature of the Claim changes as it proceeds through these Claims Procedures, the Claim may be re-characterized. For example, a Claim may initially be an Urgent Care Claim. If the urgency subsides, it may be re-characterized as a Pre-Service Claim.
7. **Questions about Claim Type.** It is very important to follow the requirements that apply to the particular type of Claim. If You have any questions regarding what type of Claim and/or what Claims Procedure to follow, contact the Plan Administrator.

### 13.06 TIMEFRAME FOR DECIDING INITIAL BENEFIT CLAIMS

1. **Pre-Service Claims.** BCBSFL, MHNet or WHI shall decide an initial Pre-Service Claim within a reasonable time appropriate to the medical circumstances, but no later than 15 days after receipt of the Pre-Service request for authorization. If the Plan does not require Precertification for the Claim for which the approval is being requested, it is not a "claim for benefits" governed by ERISA and the Department of Labor regulations.
2. **Urgent Care Claims.** BCBSFL, MHNet or WHI shall decide an initial Urgent Care Claim as soon as possible, taking into account the medical exigencies, but no later than 72 hours after receipt of the Claim.
3. **Concurrent Care Extension Request.** If a Claim is a request to extend a Concurrent Care Claim (defined above) involving Urgent Care and if the Claim is made at least 24 hours prior to the end of the initially approved period of time or number of treatments, the Claim shall be decided within no more than 24 hours after receipt of the Claim. Any other request to extend a Concurrent Care Claim shall be decided in the otherwise applicable timeframes for Pre-Service, Urgent Care, or Post-Service Claims.
4. **Concurrent Care Early Termination.** A decision by BCBSFL, MHNet or WHI to reduce or terminate an initially approved course of treatment is an Adverse Benefit Decision that may be appealed by the Claimant under these Claims Procedures, as explained below. Notification to the Claimant of a decision to reduce or terminate an initially approved course of treatment shall be provided sufficiently in advance of the reduction or termination to allow the Claimant to appeal the Adverse Benefit Decision and receive a decision on review under these Claims Procedures prior to the reduction or termination.
5. **Post-Service Claim.** BCBSFL, MHNet or WHI shall decide an initial Post-Service Claim within a reasonable time but no later than 30 days after receipt of the Claim.
6. **When Extensions of Time Are Permitted.** Despite these specified timeframes, nothing prevents the Claimant from voluntarily agreeing to extend the above timeframes. In addition, if BCBSFL, MHNet or WHI, due to matters beyond its control, is not able to decide a Pre-Service Claim or a Post-Service Claim within the above timeframes, one 15-day extension of the applicable timeframe is permitted, provided that the Claimant is notified in writing prior to the expiration of the initial timeframe applicable to the Claim. The extension notice shall include a description of the matters beyond the Plan's control that justify the extension and the date by which a decision is expected. No extension is permitted for Urgent Care Claims.
7. **Incomplete Claims.** If any information needed to process a Claim is missing, the Claim shall be treated as an Incomplete Claim.



8. **How Incomplete Urgent Care Claims Are Treated.** If an Urgent Care Claim is incomplete, BCBSFL, MHNet or WHI shall notify the Claimant as soon as possible, but no later than 24 hours following receipt of the Incomplete Claim. The notification may be made orally to the Claimant, unless the Claimant requests written notice, and it shall describe the information necessary to complete the Claim and shall specify a reasonable time, no less than 48 hours, within which the Claim must be completed. The Plan shall decide the Claim as soon as possible, but no later than 48 hours after the earlier of:

Receipt of the specified information; or

The end of the period of time provided to submit the specified information.

9. **How Other Incomplete Claims Are Treated.** If a Pre-Service or Post-Service Claim is incomplete, BCBSFL, MHNet or WHI may deny the Claim or may take an extension of time, as described above. If BCBSFL, MHNet or WHI takes an extension of time, the extension notice shall include a description of the missing information and shall specify a timeframe, no less than 45 days, in which the necessary information must be provided. The timeframe for deciding the Claim shall be suspended from the date the extension notice is received by the Claimant until the date the missing necessary information is provided to BCBSFL, MHNet or WHI. If the requested information is provided, BCBSFL, MHNet or WHI shall decide the Claim within the extension period specified in the extension notice. If the requested information is not provided within the time specified, the Claim may be decided without that information.

### 13.07 NOTIFICATION OF INITIAL BENEFIT DECISION

1. **Pre-Service and Urgent Care.** Written notification of BCBSFL's, MHNet's or WHI's decision on a Pre-Service or Urgent Care Claim shall be provided to the Claimant whether or not the decision is Adverse.

2. **Definition of Adverse.** A decision on a Claim is "Adverse" if it is

A denial, reduction, or termination of; or

A failure to provide or make payment (in whole or in part) for a Benefit.

3. **Notification of Adverse Benefit Decision.** Written notification shall be provided to the Claimant of the Plan's Adverse Benefit Decision on a Claim and shall include the following, in a manner calculated to be understood by the Claimant:

A statement of the specific reason(s) for the decision;

Reference(s) to the specific Plan provision(s) on which the decision is based;

A description of any additional material or information necessary to perfect the Claim and why such information is necessary;



A description of the Claim Procedures and time limits for appeal of the decision, the right to obtain information about those Claim Procedures, and the right to sue in federal court;

A statement disclosing any internal rules, guidelines, protocol or similar criterion relied on in making the Adverse Decision (or a statement that such information will be provided free of charge upon request);

If the decision involves scientific or clinical judgment, disclose either:

An explanation of the scientific or clinical judgment applying the terms of the Plan to the Claimant's medical circumstance, or

A statement that such explanation will be provided at no charge upon request; and

In the case of an Urgent Care Claim, an explanation of the expedited review methods available for such Claim. Notification of the Plan's Adverse Benefit Decision on an Urgent Care Claim may be provided orally, but written notification shall be furnished no later than 3 days after the oral notice.

### 13.08 YOUR RIGHT TO APPEAL

A Claimant has a right to Appeal an Adverse Benefit Decision under these Claims Procedures. The Plan maintains an appeals process involving three levels of review with the exception of Urgent Care Claims (which are subject to one level of review): (1) the initial review; (2) the second level of review; and (3) the third level of review. For information regarding the Prescription Drug Clinical Appeals Program, see Article Six.

### 13.09 HOW TO APPEAL AN ADVERSE BENEFIT DECISION

**How to File Your Appeal.** Except for Urgent Care Claims, discussed below, an appeal of an Adverse Benefit Decision is filed when a Claimant (or Authorized Representative) submits a written request for review to BCBSFL, MHNNet or WHI at the address listed below:

Blue Cross Blue Shield of Florida	MHNNet Behavioral Health	Walgreens Health Initiatives
P.O. Box 1798 Jacksonville, FL 32231	P.O. Box 209010 Austin, TX 78720-9010	1411 Lake Cook Road Deerfield, IL 60015

In order to file an appeal, the request must pertain to a covered Benefit as detailed in Section 9.01 of the Plan and not listed as a Limitation or Exclusion as detailed in Section 10.01 of the Plan. A request for an appeal must be filed within 180 days of receipt of an Adverse Benefit Decision. The Claimant should state why the appeal should be approved and include any information supporting the appeal. The appeal will be reviewed and the decision made by a medical Claims reviewer not involved in the initial decision. Appeals involving Medical Necessity or clinical appropriateness will be considered by a health care professional. A decision in writing will be made within 15 days after BCBSFL, MHNNet or WHI receives a request for appeal of a Pre-Service Claim or Concurrent Care Claim and within 30 days of a Post-Service Claim determination. A request for expedition may be requested if the timeframes listed above would jeopardize the life, health, or ability to regain maximum functionality, or in the opinion of the Physician, would cause severe pain.



1. **Second Level of Review.** If the Claimant is dissatisfied with the appeal decision by BCBSFL, MHNet or WHI, a second review by BCBSFL, MHNet or WHI may be requested.
2. **Third Level of Review.** If You are dissatisfied with the second level of review, You have the right to voluntarily initiate an additional third level of review upon receipt of an Adverse Benefit Decision from BCBSFL, MHNet or WHI by sending all documentation along with a request for review to ICUBA's Board of Directors to the attention of ICUBA Appeals Department, P.O. Box 616927, Orlando, FL 32861. The third level of review will be reviewed by a Third Party Medical Review Company – IMC. Upon its determination, which will be presented at the next scheduled ICUBA Board of Directors' meeting, the Claimant will be notified in writing of the Board's decision within five business days after the Board of Directors' meeting. In cases of Medical Necessity or Experimental or Investigative denied appeals, You have a right to receive copies of any and all documentation that the Plan Administrator examined in making its determination.
3. **Important Appeal Deadline.** The appeal of an Adverse Benefit Decision must be filed within 180 days following the Claimant's receipt of the notification of Adverse Benefit Decision, except that the appeal of a decision by the Plan to reduce or terminate an initially-approved course of treatment (see the definition of Concurrent Care Claim) must be filed within 30 days of the Claimant's receipt of the notification of the Plan's decision to reduce or terminate. Failure to comply with these important deadlines may cause the Claimant to forfeit any right to any further review of an Adverse Benefit Decision under these Claims Procedures or in a court of law.
4. **Urgent Care Appeals.** In light of the expedited timeframes for decision of Urgent Care Claims, an appeal for an Urgent Care Claim may be submitted to Blue Cross Blue Shield of Florida Member Services at 1-800-664-5295 for Medical, to MHNet at 1-877-398-5816 for Behavioral Health or Walgreens Health Initiatives at 1-800-207-2568 for Prescription Drugs. The appeal should include at least the following information:
  - The identity of the Claimant;
  - A specific medical condition or symptom;
  - A specific treatment, service or product for which approval or payment is requested; and
  - Any reasons why the appeal should be processed on a more expedited basis.

#### 13.10 HOW YOUR APPEAL WILL BE DECIDED

The appeal of an Adverse Benefit Decision will be reviewed and decided first by the BCBSFL, MHNet or WHI appeals board, including a medical director or other Clinician. If the second level of appeal is denied by BCBSFL, MHNet or WHI, the Claimant may then request a third level of review by ICUBA's Board of Directors. The person(s) who reviews and decides an appeal will be a different individual than the person who made the initial Adverse Benefit Decision and will not be a subordinate of the person who made the initial Adverse Benefit Decision. The Board of Directors of ICUBA will follow these procedures when deciding any appeal:



1. **Consideration of Comments.** The review will take into account all information submitted by the Claimant, whether or not presented or available at the initial Adverse Benefit Decision. No deference will be given to the initial Adverse Benefit Decision.
2. **Consultation With Expert.** In the case of a Claim denied on the grounds of a Medical Necessity, there will be a consultation with a health professional with appropriate training and experience. The health care professional who is consulted on appeal will not be the same individual who was consulted, if any, regarding the initial Adverse Benefit Decision or a subordinate of that individual.
3. **Access to Relevant Information.** A Claimant shall, on request and free of charge, be given reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's Claim. If the advice of a medical or vocational expert was obtained in connection with the initial Benefit Decision, the names of each such expert shall be provided on request by the Claimant, regardless of whether the advice was relied upon by the Plan.
4. **Expedited Methods for Urgent Care.** All necessary information in connection with an Urgent Care Claim appeal shall be transmitted between the Plan and the Claimant by telephone, fax, or e-mail.

### 13.11 TIMEFRAMES FOR DECIDING BENEFIT CLAIM APPEALS

1. **Pre-Service Claims.** The Named Fiduciary shall decide the appeal of a Pre-Service Claim within a reasonable time appropriate to the medical circumstances but no later than 30 days after receipt by the Plan of the Request for Review Form.
2. **Urgent Care Claims.** The Named Fiduciary shall decide the appeal of an Urgent Care Claim as soon as possible, taking into account the medical exigencies, but no later than 72 hours after receipt by the Plan of the Request for Review Form.
3. **Post-Service Claims.** The Named Fiduciary shall decide the appeal of a Post-Service Claim within a reasonable period but no later than 60 days after receipt by the Plan of the Request for Review Form.
4. **Concurrent Care Claims.** The Named Fiduciary shall decide the appeal of a decision by the Plan to reduce or terminate an initially approved course of treatment (see the definition of Concurrent Care Claim) before the proposed reduction or termination takes place. The Named Fiduciary shall decide the appeal of a denied request to extend a Concurrent Care Claim in the appeal timeframe for Pre-Service, Urgent Care, or Post-Service Claims described above, as appropriate to the request.

### 13.12 NOTIFICATION OF DECISION ON APPEAL

Written notification of the decision on appeal shall be provided to the Claimant whether or not the decision is an Adverse Decision. Written notification shall be provided to the Claimant of an Adverse Benefit Decision on appeal by BCBSFL, MHNNet or WHI and shall include the following, written in a manner calculated to be understood by the Claimant:



The specific reason(s) for the appeal decision;

A reference to the specific Plan provision(s) on which the decision is based;

A statement disclosing any internal rules, guidelines, protocol or similar criterion relied upon in making the Adverse Benefit Decision (or a statement that such information will be provided free of charge upon request);

A statement of the right to sue in federal court;

A statement indicating entitlement to receive on request, and without charge, reasonable access to or copies of all documents, records, or other information relevant to the determination; and

Disclose either:

An explanation of the scientific or clinical judgment applying the terms of the Plan to the Claimant's medical circumstances; or

A statement that such explanation will be provided at no charge on request.

Notification of an Adverse Benefit Decision on appeal of an Urgent Care Claim may be provided orally, but written notification shall be furnished no later than 3 days after the oral notice.

### **13.13 FAILURE TO FILE A REQUEST FOR APPEAL**

If a Claimant fails to follow the Claims and Appeals Procedures as outlined herein, such Claimant shall have no right of review and shall have no right to bring an action in any court. The denial of the Claim shall become final and binding on all persons for all purposes.

### **13.14 ACTION FOR RECOVERY**

No action at law or in equity may be brought for recovery under this Plan after the period of time permitted by applicable state or federal statute has expired. Such period of time shall begin on the date the Claim is required to be sent to the Plan.

### **13.15 FILING SUIT**

Under ERISA, there are steps You can take to enforce Your rights. For instance, if You request materials from the Plan Administrator and do not receive them within 30 days, You may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials to You and pay You up to \$110 a day until You receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If You have a Claim for Benefits, which is denied or ignored, in whole or in part, You may file suit in a federal court.



If it should happen that Plan fiduciaries misuse the Plan's money, or if You are discriminated against for asserting Your rights, You may seek assistance from the U.S. Department of Labor, or You may file suit in a federal court. The court will decide who should pay court costs and legal fees. If You are successful, the court may order the person You have sued to pay these costs and fees. If You lose, the court may order You to pay these costs and fees, for example, if it finds Your Claim is frivolous.

For more information about Your right to file suit, please refer to the "Your Rights under ERISA" section in this Plan Document.

### 13.16 QUESTIONS

If You have any questions about this statement or Your rights under ERISA or if You need assistance or information regarding Your rights under HIPAA, You should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in Your telephone directory, or the Division of Technical Assistance and Inquiries, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.



## ARTICLE FOURTEEN

### 14.01 HIPAA PRIVACY NOTICE

#### INDEPENDENT COLLEGES AND UNIVERSITIES BENEFITS ASSOCIATION, INC. MEDICAL, BEHAVIORAL HEALTH, AND PRESCRIPTION DRUG PLAN NOTICE OF PRIVACY PRACTICES

Effective Date of Notice: April 2011

The Independent Colleges and Universities Benefits Association, Inc. Medical, Behavioral Health and Prescription Drug Plan (the "Plan") is required by law to take reasonable steps to ensure the privacy of Your personally identifiable health information and to inform You about:

the Plan's uses and disclosures of Protected Health Information (PHI);

Your privacy rights with respect to Your PHI;

Your right to file a complaint with the Plan and with the Secretary of the U.S. Department of Health and Human Services; and

the person or office to contact for further information about the Plan's privacy practices.

The term "Protected Health Information" (PHI) includes all individually identifiable health information transmitted or maintained by the Plan, regardless of form (oral, written, or electronic).

The American Recovery and Reinvestment Act of 2009, (the Act) requires that the Plan provide notice within 60 days to affected individuals if there is a breach involving unsecured protected health information that is PHI which is not secured through the use of a technology or methodology specified by the Secretary of Health and Human Services (HHS). The notice must contain:

a description of what happened;

the types of PHI involved;

the steps that You should take to protect Yourself;

the steps that the Plan is taking to investigate and mitigate harm; and

contact information for follow-up questions.

If You have any questions about this Notice, please address them to ICUBA Privacy Official:

ICUBA  
P.O. Box 616927



## WHO WILL FOLLOW THIS NOTICE?

This Notice describes the PHI practices of the Plan and that of any third-party that assists in the administration of Plan Claims.

## OUR PLEDGE REGARDING PHI

We understand that Your health information is personal, and we are committed to protecting Your health information. We create a record of the health care claims reimbursed under the Plan for Plan administration purposes. This Notice applies to all of the medical records we maintain. Your personal doctor or health care provider may have different policies or notices regarding the doctor's use and disclosure of Your health information created in the doctor's office or clinic.

This Notice will tell You about the ways in which we may use and disclose Your PHI. It also describes our obligations and Your rights regarding the use and disclosure of Your PHI.

We are required by law to:

Make sure that health information that identifies You is kept private;

Give You this Notice of our legal duties and privacy practices with respect to health information about You; and

Follow the terms of the Notice that is currently in effect.

## HOW WE MAY USE AND DISCLOSE YOUR PHI

The following categories describe different ways that we may use and disclose Your PHI. For each category of uses or disclosures we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

**For Treatment** (as described in applicable regulations). We may use or disclose Your PHI to facilitate medical treatment or services by providers. We may disclose Your PHI to providers, including doctors, nurses, technicians, medical students, or other hospital personnel who are involved in taking care of You. For example, we might disclose information about Your prior prescriptions to a pharmacist to determine if a pending prescription is contraindicated with prior prescriptions. Likewise, we might disclose information about Your prior treatment to Your campus wellness program or health center if medical history is necessary to determine a course of treatment.

**For Payment** (as described in applicable regulations). We may use and disclose Your PHI to determine Your eligibility for Plan benefits, to facilitate payment for the treatment and services You receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. For example, we may



tell Your health care provider about Your medical history to determine whether a particular treatment is experimental, investigational, or Medically Necessary or to determine whether the Plan will cover the treatment. We may also share Your PHI for utilization review, the adjudication or subrogation of health claims, or to another medical plan to coordinate benefit payments.

**For Health Care Operations** (as described in applicable regulations). We may use and disclose Your PHI for health care operations. These uses and disclosures are necessary to run the Plan and include, but are not limited to, quality assessment and improvement; reviewing competence or qualifications of health care professionals; underwriting, premium rating, and other insurance activities relating to creating or renewing insurance contracts; submitting claims for stop-loss (excess loss) coverage; conducting or arranging for medical review, legal services, and auditing functions, including fraud and abuse compliance programs; business planning and development such as cost management; and business management and general Plan administrative activities. For example, the Plan may use information about Your claims to refer You to a disease management program, project future benefit costs or audit the accuracy of its claims processing functions.

**As Required By Law.** We will disclose Your PHI when required to do so by federal, state, or local law. For example, we may disclose medical information when required by a court order in a litigation proceeding such as a malpractice action.

**To Avert a Serious Threat to Health or Safety.** We may use and disclose Your PHI when necessary to prevent a serious threat to the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat. For example, we may disclose medical information about You in a proceeding regarding the licensure of a physician.

## SPECIAL SITUATIONS

In certain cases, Your PHI can be disclosed without authorization to a family member, close friend, or other person You identify who is involved in Your care or payment for Your care. Information describing Your location, general condition, or death may be provided to a similar person (or to a public or private entity authorized to assist in disaster relief efforts). You will generally be given the chance to agree or object to these disclosures (although exceptions may be made, for example if You are not present or if You are incapacitated). In addition, Your PHI may be disclosed without authorization to Your legal representative.

The Plan is also allowed to use or disclose Your PHI without Your written authorization for uses and disclosures required by law, for public health activities, and other specified situations, including the following:

**Disclosure to Employer Member Institution.** There are few limited situations where information may be disclosed to any of the Member Institutions of ICUBA. First, information may be disclosed to another medical plan maintained by the Member Institution for purposes of facilitating claims under that plan. Second, information may be disclosed to a Member Institution's personnel solely for purposes of administering benefits under the Plan. Third, the Plan may disclose enrollment/disenrollment information to the Member Institution for enrollment and disenrollment purposes only.



Information will only be disclosed to a Member Institution if it has established certain safeguards and firewalls to limit the classes of employees who will have access to Your PHI and to limit the use of Your PHI to Plan purposes and not for non-permissible purposes.

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

**Military and Veterans.** If You are a member of the armed forces, we may release Your PHI as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority.

**Workers' Compensation.** We may release Your PHI for workers' compensation or similar programs. These programs provide benefits for work-related injuries and illness.

**Public Health Risks.** We may disclose Your PHI for public health activities. These activities generally include the following:

- a. To prevent and control disease, injury, or disability;
- b. To report births and deaths;
- c. To report child abuse or neglect;
- d. To report reactions to medications or problems with products;
- e. To notify people of recalls of products they may be using;
- f. To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and
- g. To notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if You agree or when required or authorized by law.

**Health Oversight Activities.** We may disclose Your PHI to a health oversight agency for activities authorized by law; these oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

**Lawsuits and Disputes.** If You are involved in a lawsuit or a dispute, we may disclose Your PHI in response to a court or administrative order. We may also disclose Your PHI in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell You about the request or to obtain an order protecting the requested information.



**Law Enforcement.** We may release PHI if asked to do so by a law enforcement official:

- a. In response to a court order, subpoena, warrant, summons, or similar process;
- b. To identify or locate a suspect, fugitive, material witness, or missing person;
- c. About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
- d. About a death we believe may be result of a criminal conduct;
- e. About criminal conduct at the hospital; and
- f. In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

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

**National Security and Intelligence Activities.** We may release Your PHI to authorized federal officials for intelligence, counterintelligence, and other national security activities as required by law.

**Inmates.** If You are an inmate of a correctional institution or under the custody of a law enforcement official, we may release Your PHI to the correctional institution or law enforcement official. This release would be necessary:

- a. For the institution to provide You with Medical Care;
- b. To protect Your health and safety or the health and safety of others; or
- c. For the safety and security of the correctional institution.

**Important Note.** Except as described in this Notice, other uses and disclosures will be made only with Your written authorization. For example, You may wish the Member Institution / Campus Human Resources office to assist You with a Claim. We have provided a form to each Human Resource office for this purpose. If You provide us permission to use or disclose Your PHI, You may revoke that permission, in writing, at any time. If You revoke Your permission, we will no longer use or disclose Your PHI for the reasons covered by Your written authorization. However, You cannot revoke Your authorization if the Plan has taken action relying on Your authorization. In other words, You cannot revoke Your authorization with respect to disclosures the Plan has already made.

## YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding the PHI we maintain about You:



**Right to Inspect and Copy.** You have a right to inspect and obtain a copy of Your PHI that may be used to make decisions about Your Plan benefits; provided, however, You submit Your request in writing to the Privacy Official. If You request a copy of the information, we may charge a fee for the costs of copying, mailing, or other supplies associated with Your request.

We may deny Your request to inspect and copy in certain very limited circumstances. If You are denied access to Your PHI, You may request that the denial be reviewed.

**Right to Amend.** If You feel the PHI we have about You is incorrect or incomplete, You may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by the Plan.

To request an amendment, Your request must be made in writing and submitted to the Privacy Official. In addition, You must provide a reason that supports Your request.

We may deny Your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny Your request if You ask us to amend information that:

- a. Is not part of the PHI kept by or for the Plan;
- b. Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- c. Is not part of the information which You would be permitted to inspect and copy; or
- d. Is accurate and complete.

**Right to Receive an Accounting of PHI Disclosures.** You have the right to request an “accounting of disclosures” by the Plan of Your PHI during the six (6) year period prior to the date of Your request. However, such accounting need not include PHI disclosures made to carry out treatment, payment, or health care operations to You about Your own PHI prior to April 14, 2003 or based on Your written authorization.

To request this list or accounting of disclosures, You must submit Your request in writing to the Privacy Official. Your request must state a time period, which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form You want the list (for example, paper or electronic). The first list You request within a 12-month period will be free. If You request more than one list within a 12-month period, we may charge You a reasonable cost-based fee for each subsequent list. We will notify You of the cost involved and You may choose to withdraw or modify Your request at that time before any costs are incurred.

**Right to Request Restrictions.** You have the right to request a restriction or limitation on the PHI we use or disclose about You for treatment, payment, or health care operations. You also have the right to request a limit on the PHI we disclose about You to someone who is involved in Your care or the payment for Your care, like a family member or friend. For example, You could ask that we not use or disclose information about a surgery that You had. We are not required to agree to Your request.



To request restrictions, You must make Your request in writing. In Your request, You must tell us:

- a. What information You want to limit;
- b. Whether You want to limit our use, disclosure, or both; and
- c. To whom You want the limits to apply (for example, disclosures to Your spouse).

**Right to Request Confidential Communications.** You have the right to request that we communicate with You about medical matters in a certain way or at a certain location. For example, You can ask that we only contact You at work or by mail. To request confidential communications, You must make Your request in writing to the Privacy Official and must specify how or where You wish to be contacted. We will not ask You the reason for Your request and will accommodate all reasonable requests.

**Right to a Paper Copy of This Notice.** You have the right to a paper copy of this Notice upon request. You may ask us to give You a copy of this Notice at any time. Even if You have agreed to receive this Notice electronically, You are still entitled to a paper copy of this Notice. You may obtain a copy of this Notice on the Internet. In order to obtain a paper copy of this Notice, please contact the Privacy Official for further information.

## CHANGES TO THIS NOTICE

The Plan must abide by the terms of the Notice currently in effect. This Notice took effect on April 14, 2006. However, the Plan reserves the right to change the terms of its privacy policies as described in this Notice at any time and to make new provisions effective for all PHI that the Plan maintains. This includes health information that was previously created or received, not just health information created or received after the policy is changed. If changes are made to the Plan's privacy policies described in this Notice, You will be provided with a revised Privacy Notice. We will post a copy of the current notice on the Plan website. The Notice will contain the effective date on the first page.

## COMPLAINTS

If You believe that Your privacy rights have been violated, You may complain to the Plan in care of the Privacy Official:

ICUBA  
P.O. Box 616927  
Orlando, FL 32861

In addition, You may file a complaint with the Secretary of the U.S. Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue, S.W., Washington, D.C. 20201.

The Plan will not retaliate against You for filing a complaint.

## WHOM TO CONTACT AT THE PLAN FOR MORE INFORMATION



If You have any questions regarding this Notice or the subjects addressed in it, You may address them to the Privacy Official:

ICUBA  
PO Box 616927  
Orlando, FL 32861

#### **OTHER USES OF PHI**

Other uses and disclosures of PHI not covered by this Notice or the laws that apply to us will be made only with Your written permission.

#### **CONCLUSION**

PHI use and disclosure by the Plan is regulated by a federal law known as HIPAA (the Health Insurance Portability and Accountability Act). You may find these rules at 45 Code of Federal Regulations Parts 160 and 164. This Notice attempts to summarize the regulations. The regulations will supersede any discrepancy between the information in this notice and the regulations.



## ARTICLE FIFTEEN

### YOUR RIGHTS UNDER ERISA

#### 15.01 STATEMENT OF PARTICIPANTS RIGHTS

As a Participant in the Plan, You are entitled to certain rights under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan Participants shall be entitled to:

- a. The right to receive information about Your Plan and Benefits including the right to examine, without charge, at the Plan Administrator's office and at other specified locations, all documents governing the Plan, including insurance contracts and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- b. The right to obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and copies of the latest annual report (Form 5500) as well as an updated Plan Document. The Plan Administrator has the right to charge You a reasonable amount for these materials.
- c. The right to receive a summary of the Plan's annual financial report.
- d. The right to continue group health plan coverage under COBRA should You or Your Dependent lose coverage as a result of a Qualifying Event.
- e. The right to reduction or elimination of exclusionary periods of coverage for Pre-existing Conditions under the Plan if You have Creditable Coverage from another plan. You will be provided with a certificate of Creditable Coverage, free of charge, from the Plan when You lose coverage under the Plan, when You become entitled to elect COBRA continuation coverage, when Your COBRA continuation coverage ceases, if You request it before losing coverage, or if You request it up to 24 months after losing coverage. Certificates of Creditable Coverage may be obtained by contacting COBRA Administrator at 1-877-547-6257. Without evidence of Creditable Coverage, You may be subject to a Pre-existing Condition exclusion for 12 months (18 months for Late Enrollees) after Your enrollment date in Your coverage.
- f. The right to prudent action by Plan fiduciaries. ERISA imposes duties upon the Plan fiduciaries, who are responsible for the operation of the Plan. The Fiduciaries have a duty to do so prudently, and in the sole interest of You and other Plan Participants and Beneficiaries. No one, including Your employer, can terminate You or otherwise discriminate against You in any way to prevent You from receiving Benefits under the Plan or exercising Your rights under ERISA.



## 15.02 HOW TO ENFORCE YOUR RIGHTS

- a. If Your Claim for a Benefit is denied or ignored, in whole or in part, You have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial as set forth within this Plan Document.
- b. Under ERISA, there are steps You can take to enforce Your above-listed rights. For instance, if You request materials from the Plan and do not receive them within 30 days, You may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay You up to \$110 a day until You receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.
- c. If You have a Claim for Benefits which is denied or ignored, in whole or in part, and if You have exhausted the Claims Procedures available to You under the Plan, You may file suit in a state or federal court. The court will decide who should pay court costs and legal fees. If You are successful the court may order the person You have sued to pay these costs and fees. If You lose, the court may order You to pay these costs and fees – for example, if it finds that Your Claim is frivolous. If You have any questions about Your Plan, You should contact the Plan Administrator.
- d. If it should happen that Plan fiduciaries misuse the Plan's money, or if You are discriminated against for asserting Your rights, You may seek assistance from the U.S. Department of Labor, or You may file suit in a federal court.
- e. If You have any questions about this statement or about Your rights under ERISA, or if You need assistance in obtaining documents from the Plan Administrator, You should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in Your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.



## ARTICLE SIXTEEN

### GENERAL PLAN PROVISIONS

#### 16.01 RIGHT OF RECOVERY

If the Plan has made an erroneous or excess payment to any Covered Person, the Plan Administrator shall be entitled to recover such excess from the Covered Person to whom such payments were made. The recovery of such overpayment may be made by offsetting the amount of any other Benefit or amount payable to the Covered Person by the amount of the overpayment under the Plan.

#### 16.02 VERIFICATION

The Plan Administrator shall be entitled to require reasonable information to verify any Claim or the status of any person as a Covered Person. If the Covered Person does not supply the requested information within the applicable time limits or provide a release for such information, such Covered Person shall not be entitled to Benefits under the Plan.

#### 16.03 LIMITATION OF RIGHTS

Nothing appearing in, or done pursuant to, the Plan shall be held or construed:

- a. To give any person any legal or equitable right against a Member Institution, ICUBA, the Board of Directors of ICUBA, or any of their employees, or person connected therewith, except as provided by law; or
- b. To give any person any legal or equitable right to any assets of the Plan or any related Trust, except as expressly provided herein or as provided by law.

#### 16.04 SEVERABILITY

If any provision of the Plan is held invalid or unenforceable, its validity or unenforceability shall not affect any other provision of the Plan, and the Plan shall be construed and enforced as if such provision had not been included herein.

#### 16.05 CAPTIONS

The captions contained herein are inserted only as a matter of convenience and for reference and in no way define, limit, enlarge or describe the scope or intent of the Plan nor in any way shall affect the Plan or the construction of any provision thereof.

#### 16.06 CONSTRUCTION

Any words herein used in the masculine shall also include the feminine and neutral where they would so apply. Words in the singular shall also include the plural and vice versa where they would so apply.



## 16.07 ENTIRE PLAN

This document constitutes the entire Plan and there are no oral items or conditions to the contrary. Any change, modification or amendment to the Plan must be in writing.

## 16.08 NON-GUARANTEE EMPLOYMENT

Nothing contained in the Plan shall be construed as a contract of employment between ICUBA or a Member Institution and any Participant, or as a right of any Participant to continue in the employment of ICUBA or a Member Institution, or as a limitation of the right of ICUBA or a Member Institution to discharge any Participant, with or without cause.



## ARTICLE SEVENTEEN

### PLAN ADMINISTRATOR DUTIES AND POWERS

#### 17.01 APPOINTMENT OF PLAN ADMINISTRATOR

ICUBA shall appoint a Plan Administrator to administer the Plan and keep records of proceedings and Claims. The Plan Administrator will serve until resignation or dismissal by ICUBA, and any vacancy or vacancies shall be filled in the same manner as the original appointments. ICUBA may dismiss any person or persons serving as Plan Administrator at any time with or without cause. In the event that ICUBA chooses to appoint more than one (1) person to act as Plan Administrator, a majority vote of such persons shall be necessary for the transaction of business. In the event only two (2) persons are named as Plan Administrator, the transaction of business shall require the unanimous vote of both parties.

#### 17.02 POWERS OF PLAN ADMINISTRATOR

Subject to the limitations of the Plan, the Plan Administrator will from time to time establish rules for the administration of the Plan and transaction of its business. The Plan Administrator will rely on the records of ICUBA or the Member Institutions, as applicable, with respect to any and all factual matters dealing with the employment and Eligibility of an Employee. The Plan Administrator will resolve any factual dispute, giving due weight to all evidence available to it. The Plan Administrator shall have such powers and duties as may be necessary to discharge its functions hereunder, including, but not limited to, the sole and absolute discretion to:

- a. Construe and interpret the Plan;
- b. Decide the questions of Eligibility to participate in the Plan; and
- c. Determine the amount, manner and time of payment of any Benefits to any Covered Person.

The Plan Administrator will have final discretionary authority to make such decisions and all such determinations shall be final, conclusive and binding.

#### 17.03 OUTSIDE ASSISTANCE

The Plan Administrator may employ such counsel, accountants, Claims Administrators, consultants, actuaries and other person or persons, as the Plan Administrator shall deem advisable. ICUBA shall pay the compensation of such counsel, accountants, and other person or persons and any other reasonable expenses incurred by the Plan Administrator in the administration of the Plan.

#### 17.04 DELEGATION OF POWERS

In accordance with the provisions hereof, the Plan Administrator has been delegated certain administrative functions relating to the Plan with all powers necessary to enable the Plan Administrator to properly carry out such duties. The Plan Administrator as such shall have no power in any way to modify, alter, add to, or subtract from any provisions of the Plan other than expressly provided in this Article.



## ARTICLE EIGHTEEN

### AMENDMENTS, TERMINATIONS AND MERGERS

#### 18.01 RIGHT TO AMEND, MERGE OR CONSOLIDATE

ICUBA reserves the right to merge or consolidate the Plan, and to make any amendment or amendments to the Plan periodically, including those, which are retroactive in effect. Such amendments may be applicable to any Covered Person.

#### 18.02 RIGHT TO TERMINATE

The Plan is intended to be permanent, but ICUBA may at any time terminate the Plan in whole or in part.



## GLOSSARY

### DEFINITIONS

The following terms, as used in the Plan, shall have the meaning specified in this Glossary, unless a different meaning is clearly required by the context in which it is used:

**Accident** shall mean an unforeseen event that may result in Injury or Illness.

**Accreditation** shall mean certification that an organization meets the reviewing organization's standards. Examples: Accreditation of HMOs by the National Committee on Quality Assurance (NCQA) or Accreditation of Hospitals by the Joint Commission of Accreditation of Healthcare Organizations.

**Actively At Work** shall mean performing the Employee's job at the location where the Employee generally reports to work. If such Employee is on vacation, Approved Leave of Absence, Approved Sabbatical, Approved Disability Leave, or is off due to a holiday or other reason approved by the Employer, the Employee will be deemed Actively At Work if the Employee was Actively At Work on the day immediately prior to such vacation, Approved Leave of Absence, Approved Sabbatical, Approved Disability, holiday, or other approved reason.

**Activities Of Daily Living** shall refer to the following, with or without assistance:

- a. Bathing, which is the cleansing of the body in either a tub or shower, or by sponge bath;
- b. Dressing, which is to put on, take off, and secure all necessary and appropriate items of clothing and any necessary braces or artificial limbs;
- c. Toileting, which is to get to and from the toilet, get on and off the toilet, and perform associated personal hygiene;
- d. Transferring, which is to move in and out of a bed, chair, wheelchair, tub, or shower;
- e. Mobility, which is to move from one place to another, with or without the assistance of equipment;
- f. Eating, which is getting nourishment into the body by any means other than intravenous; and
- g. Continence, which is voluntarily maintaining control of bowel and/or bladder function; in the event of incontinence, maintaining a reasonable level of personal hygiene.

**Adjudication** shall mean the administrative procedure used to process a Claim for a Covered Expense.

**Adverse Benefit Decision (or Determination)** shall mean a denial, reduction, termination, or failure to provide or make payment (in whole or in part) for a Benefit.

**Ambulance Services** shall mean services provided by a mobile unit designed to carry an ill or injured patient to a Hospital.



**Ambulatory Care** shall mean services provided in an Ambulatory Care Facility, which do not involve admission to an Inpatient Hospital bed. Visits to a Physician's office are a type of Ambulatory Care.

**Ambulatory Care Facility** shall mean a facility that provides Outpatient Care.

**Approved Disability Leave** shall mean an approved leave of absence due to Disability. For purposes of this definition, the term "Disability" shall mean that the Employee is unable to perform the duties of his or her regular occupation with the Member Institution, as determined in the sole discretion of the Plan Administrator. Coverage under an Approved Disability Leave shall terminate upon the earlier of: (1) the date the Employee completes 12-consecutive months of Approved Disability Leave or (2) the date the Employee becomes eligible for Medicare. If You are covered under Medicare prior to Your Approved Disability Leave, Your coverage will end on the date You complete 12-consecutive months of Approved Disability Leave.

**Approved Leave of Absence** shall mean an Approved Leave of Absence for a period not to exceed 12-consecutive months, with the stated intention of returning to full-time employment with the Member Institution. For purposes of this document the term Approved Leave of Absence shall not refer to leave under the Family and Medical Leave Act or the Uniformed Services Employment and Reemployment Rights Act. The service member caregiver leave provides up to 26 weeks of unpaid leave of absence in a single 12-month period for any Eligible Employee who is the spouse, parent, or next of kin of a covered service member who suffered a serious Injury or Illness incurred in the line of duty while on active duty that renders the service member medically unfit to perform the duties of his/her office, grade, rank, or rating. An Eligible Employee can take up to 12 weeks of unpaid Leave of Absence in a 12-month period as a result of any qualifying exigency because the Employee's spouse, son, daughter or parent is on active duty or has been notified of an impending call of duty in the Armed Forces in support of a "contingency operation."

**Approved Sabbatical** shall mean an approved paid sabbatical or fellowship for a period not to exceed 12 consecutive months. A Participant must be covered prior to the effective date of such Approved Sabbatical.

**Attained Age** shall mean the age in years of a Covered Person as of the last anniversary of his date of birth.

**Autism Spectrum Disorder** shall mean pervasive developmental disorders with origin specific to childhood that fall under the Autism diagnoses. The Autism benefit covers Autistic Disorder, Asperger's Syndrome, and Pervasive Developmental Disorder not otherwise defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association. You will see the diagnosis code on your physician's billing statement. Autism Spectrum Disorder Diagnosis to the 5<sup>th</sup> digit with Descriptors include:

- 299.00 Autistic Disorder Current of Active
- 299.01 Autistic Disorder Residual State
- 299.10 Childhood Disintegrative Disorder Current or Active
- 299.11 Childhood Disintegrative Disorder Residual State
- 299.80 Other Specified Pervasive Developmental Disorder
- 299.81 Other Specified Pervasive Developmental Disorder Residual State
- 299.90 Unspecified Pervasive Developmental Disorder Current or Active Status
- 299.91 Unspecified Pervasive Developmental Disorder Residual State



**Beneficiary** shall mean a person who is Eligible to receive Benefits under the Plan. Sometimes "Beneficiary" is used for Eligible Dependents enrolled under the Plan; "Beneficiary" can also be used to mean any person Eligible for Benefits, including Employees, retirees, and Eligible Dependents.

**Benefits** shall mean the portion of the costs of Covered Services paid by the Plan. For example, if the Plan pays the remainder of a Physician's bill after an office visit Co-payment has been made, the amount that the Plan pays is the "Benefit." Or, if the Plan pays 80% of the Reasonable and Customary cost of Covered Services, that 80% payment is the "Benefit."

**Benefits Effective Date** shall mean the first day of coverage under this Plan for Participants and Dependents as set forth in Article Seven, "Enrollment and Contributions".

**Birthing Center** shall mean a legally operated institution or facility which is licensed and equipped to provide immediate prenatal care, delivery, and postpartum care to a pregnant Individual under the direction and supervision of one or more Physicians specializing in obstetrics or gynecology or a certified nurse midwife. It must provide for 24-hour nursing care provided by registered nurses or certified nurse midwives.

**Blood Plasma** shall mean the liquid part of the blood and lymphatic fluid, which makes up about half of its volume. Plasma is devoid of cells and, unlike serum, has not clotted. Blood Plasma contains antibodies and other proteins. It is taken from donors and made into medications for a variety of blood-related conditions.

**Brand-Name Drug** shall mean a drug manufactured by a pharmaceutical company, which has chosen to patent the drug's formula and register its brand name.

**Breast Implant** shall mean an insertion of a silicone bag (prosthesis) under the breast (submammary) or under the breast and chest muscle (subpectoral) and then filling the bag with saline (salt water) or silicone.

**Care Consultant** is an expert at BCBSFL that is either a nurse, benefits specialist or community resource professional who can assist a member in deciding the best course of care based on quality and cost.

**Care Coordination** is coordinated by BCBSFL to provide assistance to a Participant who is at risk of developing medical complexities or for whom a health incident has precipitated a need for rehabilitation or additional health care support. The program strives to attain a balance between quality-and cost-effective care while maximizing the Participant's quality of life. It typically involves coordination of services to help meet a Participant's health care needs, usually when the Participant has a condition which requires multiple services from multiple Providers. This term is also used to refer to coordination of care during and after a Hospital stay.

**Change in Status** shall mean the ability to modify or revoke elections mid-Plan Year due to one of the following events:

- a. Change in legal marital status, including marriage, death of spouse, divorce, legal separation, or annulment;
- b. Change in number of Dependents, including birth, adoption, placement for adoption, and death of a spouse or other Dependent;



- c. A Dependent satisfying or ceasing to satisfy the requirements for coverage for unmarried Dependents due to age, student status, or any other circumstance;
- d. Change in employment status of the Employee, the Employee's spouse or other Dependent, including termination or commencement of employment, taking or returning from an unpaid leave of absence, change in work site, change in full-time or part-time status, change in hourly or salaried status; or
- e. Change in residence by the Employee, the spouse or Dependent.

**Claim** shall mean a request for payment under the terms of the Plan.

**Claims Administrator** shall mean the person or persons appointed by the Plan to determine Benefit eligibility and to adjudicate Claims under the Plan.

**Claims Appeal** shall mean the process used by a Participant or Provider to request re-consideration of an Adverse Benefit Decision.

**Claim Status** shall mean the state of a Claim. The various states are: paid, Pended, denied, and received-not-yet-processed.

**COBRA** shall mean the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

**COBRA Administrator** shall mean Businessolver at 1-877-547-6257.

**COBRA Continuation Coverage** shall mean the continuation of health care Benefits for Participants and Dependents on the occurrence of a Qualifying Event as defined by COBRA, and as further set forth in the Continuation of Coverage section.

**Code** shall mean the Internal Revenue Code of 1986, as amended.

**Coinsurance or Coinsurance Percentage** shall mean the percentage of a Covered Expense that You pay after the satisfaction of any applicable Deductible. It is a defined percentage of the covered charges for services rendered. For example, the Plan may pay 80% of Covered Services, and You pay 20%.

**Consumable Medical Supplies** shall mean supplies that are non-durable medical supplies and that are usually disposable in nature; cannot withstand repeated use by more than one individual; are primarily and customarily used to serve a medical purpose; generally are not useful to a person in the absence of Illness or Injury; and may be ordered and/or prescribed by a Physician.

**Contact Lenses after Cataract Surgery** shall mean contact lenses provided after a surgeon has removed a cataract, in which the surgeon must remove the entire lens of the eye. As a result, after surgery, without a lens, the eye cannot focus. There are four ways to provide an artificial form of focus: glasses, contact lenses, plastic lens implants inside the eye (intraocular lenses) or, less commonly, a procedure which uses donor corneas from



deceased individuals fashioned as a “human contact lens” which is permanently sewn onto the surface of the eye (epikeratophakia).

**Continuation Coverage Payments** shall mean the payments required for COBRA Continuation Coverage.

**Continuous Coverage** includes periods of coverage (under a plan eligible for Credible Coverage) that is followed by a break in coverage less than 63 days.

**Coordination of Benefits** shall mean a provision in a contract that applies when a person is covered under more than one group health benefits program. It requires that payment of Benefits be coordinated by all plans to eliminate over-insurance or duplication of Benefits.

**Co-payment (Co-pay)** shall mean the Covered Person's portion of the payment for Benefits indicated in the Schedule of Medical Benefits. It represents the fixed-dollar amount You are required to pay each time a particular service is used. This payment may be requested at the time of service. Co-payments do not count toward the satisfaction of Deductibles.

**Covered Expenses** shall mean those expenses listed as covered in Article Six and Article Nine of this Plan Document.

**Covered Person** shall mean a Participant or Dependent covered under the Plan.

**Covered Services** shall mean Hospital, medical, and other health care services incurred by a Covered Person that are entitled to a payment of Benefits under the Plan. The term defines the type and amount of expense that will be considered in the calculation of Benefits.

**Creditable Coverage** shall mean only those coverages required to be included as such under Section 2701(c) of the Public Health Services Act, and shall exclude those coverages that are permitted to be excluded under Section 2701(c). Solely for purposes of illustration and not in limitation of the foregoing, Creditable Coverage generally includes periods of coverage under an individual or group health plan that are not followed by a Significant Break (greater than 63 days) in coverage and excludes coverages for liability, limited scope dental or vision benefits, and specified disease and/or other supplemental type benefits. Creditable Coverage means coverage under the following:

- a. A group medical plan;
- b. Health insurance or Health Maintenance Organization coverage;
- c. Medicare;
- d. Medicaid;
- e. Military health care;
- f. A Medical Care program of the Indian health Services or of a tribal organization;



- g. A state health benefits risk pool;
- h. A health plan offered under the Federal Employee Health Benefits Program;
- i. A public health plan as defined under federal regulations; or
- j. A health benefit plan under Section 5(e) of the Peace Corps Act.

**Custodial Care** shall mean non-medical aid consisting of services and supplies, provided to an individual in or out of an institution, primarily to assist such person in Activities Of Daily Living, whether or not Disabled. The care is not meant to be curative or providing medical treatment

**Date of Service** shall mean the date a service or treatment was provided to a Participant as specified on the Claim and should be the date such service or treatment was received.

**Day Treatment Or Partial Hospitalization** shall mean an Outpatient treatment program that offers intensive, multidisciplinary services not otherwise offered in an Outpatient setting, 20 or more daytime hours or 12 or more evening hours per week. The program is designed to treat patients with serious mental, nervous and chemical dependency disorders and offers major diagnostic, psycho-social, and prevocational modalities. Such programs must be in a less restrictive, less expensive alternative to Inpatient treatment.

**Deductible** shall mean a flat amount a Covered Person must pay before the Plan will make any Benefit payments associated with specific plan provisions.

**Dentist** shall mean an individual licensed as a Dentist in the jurisdiction where services are provided.

**Dependent** shall mean a person Eligible for coverage because of that person's relationship to a Participant. For purposes of coverage under this Plan, if both parents are Participants, a Dependent shall only be covered as a Dependent under this Plan by one parent.

A Dependent may be one of the persons described below.

- a. The legally recognized spouse of a Participant. A spouse that is legally separated or divorced from the Participant shall not be a Dependent, except for purposes of COBRA Continuation Coverage;
- b. A child who is:
  - i. A natural child;
  - ii. A legally adopted child, which shall be defined as a child adopted or placed for adoption with the Participant before the child reaches age 18. A child is considered placed for adoption when the Participant provides Support and the child resides with the Participant (defined below) in anticipation of adoption. The child's placement for adoption ends upon the termination of the legal obligation;



- iii. A stepchild for whom the Participant provides Support (as defined herein) and who resides with the Participant;
  - iv. A child of a Participant required to be covered in accordance with applicable requirements of any Qualified Medical Child Support Order as defined by ERISA Section 609;
  - v. A child with proof of legal guardianship by the Participant where the Participant provides Support and the child resides with the Participant;
  - vi. A foster child or other child in court-ordered temporary or other custody of the Participant.
- c. A child shall be deemed a Dependent until the date in which such child:
- i. Reaches the end of the calendar year in which the age of 26 was attained;
  - ii. Becomes a Participant;
  - iii. Serves on extended active duty in the Armed Forces;
  - iv. Is over 26 years of age and is no longer continuously incapable of self-support because of a Disability;
- d. A child of a Participant shall be deemed a Dependent until the last day of calendar year in which such child turns 26 years of age. The child may be married, live outside the home, and/or be employed.

**Diabetes Treatment** shall mean treatment that is to provide insulin therapy in a manner that mimics the natural pancreas.

**Diagnostic Tests** shall mean tests and procedures ordered by a Physician to help diagnose or monitor a Participant's condition or disease. Diagnostic tools include radiology, ultrasound, nuclear medicine, laboratory, and pathology services or tests.

**Disability (or Disabled)** shall mean any congenital or acquired physical or mental illness, defect, or characteristic preventing or restricting an individual from participating in normal life, or limiting the individual's capacity to work. Such Disability must be certified by a Physician. The Participant must provide proof of such Disability within the 30-day period after the date the child would otherwise lose Dependent status.

**Diagnostic Services** shall mean services ordered by a Physician to help diagnose or monitor a patient's condition or disease. Diagnostic Services include radiology, ultrasound, nuclear medicine, laboratory, and pathology services or tests.

**Durable Medical Equipment** shall mean equipment prescribed by a Physician, which meets all of the following requirements:

- a. Is Medically Necessary;



- b. Is primarily and customarily used to serve a medical purpose;
- c. Is designed for prolonged and repeated use;
- d. Is for a specific therapeutic purpose in the treatment of an Illness or Injury;
- e. Would have been covered if provided in a Hospital; and
- f. Is appropriate for use in the home.

Hearing Aids shall not be treated as Durable Medical Equipment subject to the limits set forth in the Schedule of Medical Benefits, but will be subject to a separate limit set forth in the Schedule of Medical Benefits.

**Effective Date** shall mean the first day of coverage for Participants and Dependents under this Plan as set forth in the Enrollment and Contributions section.

**Eligible** shall mean an Employee, or Dependent who qualifies for coverage under the Plan.

**Eligible Retiree** shall mean each Employee who (1) is a Participant in the Plan during the 3-month period immediately prior to retirement from a Member Institution; (2) was Actively At Work on the day prior to retirement; and (3):

is at least 55 years of age and has 10 years of continuous service with a Member Institution;

is at least 56 years of age and has 9 years of continuous service with a Member Institution;

is at least 57 years of age and has 8 years of continuous service with a Member Institution;

is at least 58 years of age and has 7 years of continuous service with a Member Institution;

is at least 59 years of age and has 6 years of continuous service with a Member Institution; or

is at least 60 years of age and has at least 5 years of continuous service with a Member Institution.

**Eligibility** shall mean the provisions within the Plan that specify who qualifies for coverage under the Plan and when coverage becomes effective.

**Emergency** shall mean a serious medical condition, which arises suddenly and requires immediate care and treatment in order to avoid jeopardy to the life and health of the person. Emergencies are covered 24 hours a day, seven days a week, no matter where You are.

**Employee** shall mean:

- a. An Employee regularly scheduled to work at a position for a minimum of 75% of a workweek as defined by the Member Institution and shall not be less than 28 hours per week;



- b. A faculty member under an academic contract for a minimum of 18 undergraduate semester credit hours annualized, or equivalent, during the academic year with a Member Institution or equivalent;
- c. An Employee on an Approved Leave of Absence;
- d. An Employee on an Approved Sabbatical; or
- e. An Employee on an Approved Disability Leave.

The term Employee shall not include:

- a. Leased employees;
- b. Collectively bargained employees, unless an agreement between the Member Institution and the collectively bargained group specifies coverage for such individuals;
- c. Temporary employees;
- d. A member of the Member Institution's Board of Directors, unless engaged in the conduct of the business on a full-time basis;
- e. An independent contractor or consultant who is paid on other than a regular wage or salary by the Member Institution;
- f. A student employee; or
- g. Adjunct faculty.

**Employer or Member Institution** shall mean the independently governed and operated institutions of education in the State of Florida, who are members of ICUBA, and who are approved for membership as set forth in ICUBA's Articles of Incorporation and Bylaws. The term Member Institution shall also mean any affiliated foundation or other entity associated with such institutions, and any other entity adopting the Plan with the approval of its governing body and ICUBA as set forth in ICUBA's Articles of Incorporation and Bylaws. If a Member Institution merges or is otherwise consolidated with any affiliate, the successor shall, as to the group of Member Institutions covered by the Plan immediately before such merger or consolidation, be the Member Institution as defined hereunder, unless ICUBA specifies to the contrary. In the case of any other merger or consolidation, the successor shall not be the Member Institution except to the extent that it acts, with the approval of ICUBA, to adopt the Plan.

**Enrollment Date** shall mean the date a Participant first becomes covered under the Plan. It is the date of hire for new Employees, the Change in Status date for Special Enrollees, and the beginning of the Plan Year (4/1-3/31) for Employees who enroll during Open Enrollment.

**Enteral Formulae** shall mean food administered through a tube placed in the nose, the stomach, or the small intestine. A tube in the nose is called a nasogastric tube or nasoenteral tube. A tube that goes through the skin into



the stomach is called a gastrostomy or percutaneous endoscopic gastrostomy (PEG). A tube into the small intestine is called a jejunostomy or percutaneous endoscopic jejunostomy (PEJ) tube.

**ERISA** shall mean the Employee Retirement Income Security Act of 1974, as amended from time to time.

**Exclusions** shall mean specific conditions or services that are not covered under the Plan.

**Experimental or Investigative** shall have the meaning set forth in the Section entitled "Other Terms You Should Know" in Article Four.

**Experimental Procedure** shall mean any drug, device, procedure, service or treatment that is the subject of ongoing Phase I or II clinical trials to determine maximum tolerated dose, toxicity, safety, efficacy, or efficacy as compared to other treatments. A drug, device, procedure, service, or treatment will not be considered experimental if it is the subject of ongoing Phase III clinical trials and the Covered Person meets the Phase III protocol requirements to participate. A drug, device, procedure, service, or treatment will be considered to be the subject of ongoing Phase I or II clinical trials to determine maximum tolerated dose, toxicity, safety, efficacy, or efficacy as compared to other treatments unless all of the following criteria are met:

- a. The drug, device, procedure, service, or treatment must have approval from the appropriate government regulatory bodies.
- b. A drug, device, procedure, service, or treatment must have Food and Drug Administration ("FDA") approval for those specific indications and methods of use for which such drug, device, procedure, service, or treatment is sought to be provided.
- c. Any drugs, devices, procedures, services, or treatments, which at the time sought to be provided are not approved by the Center for Medicare and Medicaid Services for reimbursement under Medicare, are considered Experimental Procedures.
- d. Drugs are considered experimental if they are not commercially available for purchase and are not approved by FDA for general use. The phrase "approved by FDA for general use" refers to permission for commercial distribution. Any other approvals that are granted as an interim step in the FDA regulatory process, subject to the Phase III exception above, are considered Experimental Procedures.
- e. Drugs and tests approved by the FDA for a specific disease, Injury, Illness or condition, but which are sought to be provided for another disease, Injury, Illness, or condition, are considered Experimental Procedures.
- f. Drugs that are without at least one ingredient that constitutes a controlled substance as defined by the FDA are considered Experimental Procedures.
- g. The scientific evidence must permit conclusions concerning effect of the drug, device, procedure, service, or treatment on health outcomes.



- h. The evidence must consist of well-designed and well-conducted investigations published in peer-review journals. The quality of the body of studies and the consistency of the results are considered in evaluating the evidence.
- i. The evidence must demonstrate that the drug, device, procedure, service, or treatment can measure or alter the sought after changes related to the disease, Injury, Illness, or condition. In addition, there must be evidence or a convincing argument based on established medical facts that such measurement or alteration affects that health outcome.
- j. Opinions and evaluations by national medical associations, consensus panels or other technology evaluation bodies are evaluated according to the scientific quality of the supporting evidence and rationale.
- k. The drug, device, procedure, service, or treatment must improve or contribute to the improvement of the net health outcome.
- l. The drug, device, procedure, service, or treatment's beneficial effects on health outcomes must outweigh any harmful effects on health outcomes.
- m. The drug, device, procedure, service, or treatment must be as beneficial as any established alternatives.
- n. The technology must improve the net health outcome as much or more than established alternatives.
- o. The improvement must be attainable outside the investigational settings.
- p. When used under the usual conditions of medical practice, the drug, device, procedure, service or treatment must reasonably be expected to satisfy criteria (a) and (b).
- q. Notwithstanding any other provision contained herein, these criteria will be the sole means to construe and determine whether any drug, device, procedure, service, or treatment constitutes "Experimental Procedures."

**Explanation of Benefits (EOB)** shall mean a statement provided by the Claims Administrator that explains the Covered Expenses, the allowable reimbursement amounts, any Deductibles, Coinsurance, or other adjustments taken and the net amount paid. A Participant typically receives an Explanation of Benefits with a Claim reimbursement check or as confirmation that a Claim has been paid directly to the Provider.

**Extended Care Facility** shall mean an institution which:

- a. Is duly licensed as an Extended Care Facility, convalescent facility, or Skilled Nursing Facility and operates in accordance with governing laws and regulations;
- b. Regularly provides Inpatient Skilled Nursing Care for payment during the active or convalescent stage of an Injury or Illness;



- c. Is staffed with a Physician or registered nurse on duty 24 hours a day;
- d. Operates in accordance with medical policies, whereby such policies are supervised and established by a Physician other than the Participant's own Physician;
- e. Regularly maintains a daily medical record for each Participant;
- f. Is not, other than incidentally, a place for the aged, a place for individuals addicted to drugs or alcohol, or a place for Custodial Care; and
- g. Is recognized as an Extended Care Facility or a Skilled Nursing Facility under Medicare.

**Family** shall mean a Participant his or her Covered Dependents.

**Foreign Travel** shall mean travel outside of the United States. You are automatically covered for Emergency services outside the U.S. Preventive Care is not covered outside the United States.

**Generic Drug** shall mean a Prescription Drug that has the same active-ingredient formula as a Brand Name Drug. A Generic Drug is known only by its formula name and its formula is available to any pharmaceutical company. Generic Drugs are rated by the Food and Drug Administration (FDA) to be as safe and as effective as Brand Name Drugs and are typically less costly.

**Genetic Information** shall mean a condition that relates to genetics. The Plan shall not impose a pre-existing condition exclusion relating to a condition based solely on genetic information. However, if a participant is diagnosed with a condition, even if the condition relates to genetic information, The Plan may impose a pre-existing exclusion with respect to the condition subject to the other limitations of The Plan.

**Genetic Information Nondiscrimination Act of 2008 (GINA)** shall mean a federal law that outlines requirements that employer sponsored health plans may not require or discriminate due to Genetic Information.

**Health Insurance Portability and Accountability Act (HIPAA)** shall mean a federal law that outlines the requirements that employer-sponsored group insurance plans, insurance companies, and managed care organizations must satisfy in order to provide health insurance coverage in the individual and group healthcare markets.

**Hearing Care Services** shall mean services provided to assist in hearing.

**Home Health Care Agency** shall mean any of the following:

- a. A Home Health Care Agency licensed by the jurisdiction in which it is located;
- b. A Home Health Care Agency as defined by the Social Security Administration; or
- c. An organization licensed in the jurisdiction in which it is located which is an appropriate Provider of home health services, and which meets the following requirements:



- i. Has a full-time administrator;
- ii. Keeps written medical records; and
- iii. Has at least one Registered Nurse (R.N.) on staff, or the services of an R.N. available.

**Home Health Care or Home Health Care Services** shall mean the following care provided to a Covered Person at such Covered Person's home or a Home Health Care Agency on recommendation of a Physician:

- a. Intermittent care by a:
  - i. Registered Nurse (R.N.)
  - ii. Licensed Practical Nurse (L.P.N.)
  - iii. Home Health Aide
  - iv. Occupational and Physical Therapist
  - v. Licensed Vocational Nurse (L.V.N.)
  - vi. Physical Therapist Assistant (P.T.A.).
  - vii. Certified Occupational Therapist Assistant (C.O.T.A.)
- b. Private duty nursing services of a Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.);
- c. Social work; and
- d. Nutrition services, including special meals.

**Home Infusion Therapy Services** shall mean services that introduce a solution into the body through a vein. An infusion is the therapeutic introduction of a fluid other than blood into a vein.

**Hospice** shall mean a public agency or a private organization, which provides care and services for Terminally Ill persons and their families. Such agency or organization must be qualified to receive Medicare payments, or satisfy the following requirements:

- a. Provides and has available 24 hours per day:
  - i. Palliative and supportive care for Terminally Ill persons;
  - ii. Services which encompass the physical, psychological and spiritual needs of Terminally Ill persons and their families; and



- iii. Acute Inpatient Care, Outpatient Care, and Home Health Care. Care and counseling must be furnished directly by, or under the arrangement of, such agency or organization.
- b. Has a medical director who is a Physician;
- c. Has an interdisciplinary team to coordinate care and services, which includes at least one Physician, one R.N., and one social worker; and
- d. Is licensed or accredited as a Hospice, if the laws of the jurisdiction in which it is located allow for the licensing or accreditation of Hospices.

**Hospice Care** shall mean care rendered by a Hospice in response to the special physical, psychological, and spiritual needs of Terminally Ill Covered Persons and/or their family members.

**Hospital** shall mean an institution, which makes charges and is engaged primarily in providing Medical Care to sick and injured persons on an Inpatient basis at the Participant's expense which fully meets all the requirements set forth below:

- a. It is an institution operating in accordance with the law of the jurisdiction in which it is located pertaining to institutions identified as Hospitals. It is primarily engaged in providing Medical Care of injured and sick persons by or under the supervision of a staff of Physicians or surgeons for compensation from its patients on an Inpatient basis. It continuously provides 24 hour nursing services by Registered Nurses and maintains facilities on the premises for major operative surgery. It is not, other than incidentally, a nursing home, a place for rest, a place for the aged, a place for the mentally ill or emotionally disturbed, or a place for the treatment of substance abuse.
- b. It is accredited by the Joint Commission of Accreditation of Hospitals (JCAH) or is recognized by the American Hospital Association (AHA) and is qualified to receive payments under the Medicare program.
- c. It is a psychiatric Hospital, as defined by Medicare, which is qualified to participate in and is eligible to receive payments under and in accordance with the provisions of Medicare.

**Hospital Services** shall mean services provided in a Hospital.

**ID Card** shall mean an identification card provided to all Participants for proper identification under the Plan. ID Card information helps Providers verify Participant Eligibility for coverage.

**Illness** shall include disease, mental, emotional, or nervous disorders, and pregnancy.

**Injury** shall mean only bodily Injury.



**Inpatient** shall mean a registered bed Participant in a Hospital or Other Facility Provider and for whom a room and board charge is made. A person is not an Inpatient on any day on which he or she is on leave or otherwise gone from the Hospital, whether or not a room and board charge is made.

**Inpatient Care** shall mean Medical Care given to a Participant admitted to a Hospital, Extended Care Facility, nursing home, or other facility.

**Late Enrollee** shall mean a Participant or Dependent who (or a Dependent for whom the responsible Participant) fails to enroll during the periods set forth in the Enrollment and Contributions section of this Plan Document. A Special Enrollee shall not be considered a Late Enrollee.

**Maintenance Medication** shall mean medications that are prescribed for long-term treatment of chronic conditions, such as diabetes, high blood pressure, high cholesterol, or asthma. Maintenance Medications are available through WHI Mail Service or the 90-day retail program. Oral contraceptives are considered Maintenance Medications.

**Maximum Benefit** shall mean the maximum amount to be paid by the Plan on behalf of a Covered Person for Covered Expenses, which are incurred while such Covered Person is covered under the Plan.

**Medical Care** shall mean professional services rendered by a Physician or Other Professional Provider for the treatment of an Illness or Injury.

**Medically Necessary or Medical Necessity** refers to a course of treatment accepted as the most successful course for the medical symptoms You are experiencing. The course of treatment is determined jointly by You, Your health professional, and the Plan. A Medically Necessary course of treatment strives to provide You with the best care in the most appropriate setting. It shall mean the drug, device, procedure, service, treatment, or supplies which are required to identify or treat a Covered Person's Illness or Injury and which are:

- a. Commonly and customarily recognized by the medical profession as appropriate care consistent with the symptom or diagnosis and treatment of the Illness or Injury;
- b. Appropriate with regard to standards of sound medical practice;
- c. Not primarily Custodial Care;
- d. Services that could not have been omitted without adversely affecting the Participant's condition or the quality of Medical Care rendered;
- e. Not solely for the convenience of a Participant, Physician, Hospital, or Other Facility Provider;
- f. The most appropriate supply or level of service which can be safely provided to Participant, or for an Inpatient, as the Participant's medical symptoms or condition require, and that the services cannot be safely provided to the Participant as an Outpatient; and
- g. Not including unnecessary repeated tests.



**Medicare** shall mean Title XVII of the Social Security Act, as amended, and the regulations promulgated thereunder.

**Medicare Part A** shall mean Hospital insurance provided by Medicare that can help pay for Inpatient Hospital care, Medically Necessary Inpatient Care in a Skilled Nursing Facility, Home Health Care, Hospice Care, and end-stage renal disease treatment.

**Medicare Part B** shall mean Medicare-administered medical insurance that helps pay for certain Medically Necessary practitioner services and Outpatient Hospital Services and supplies not covered by Part A Hospital insurance of Medicare coverage. Physicians' services are covered under Part B even if they are provided to a Covered Person in an Inpatient setting.

**Medicare Part D** shall mean retail Prescription Drug benefits available to Medicare-eligible beneficiaries.

**Mental Health Care Services** shall mean services provided to treat a mental or nervous disorder such as neurosis, psychoneurosis, psychopathy, psychosis, or psychiatric-related disease, or disorder of any kind, including personality disorders. Note: Although a Physician or Other Professional Provider may have prescribed treatment, such treatment may not be considered Medically Necessary within this definition. Disorders, such as Autism, is a Covered Service so long as such condition has as its standard and accepted course of treatment the taking of Prescription Drugs. Learning disabilities, behavioral problems, or attention-deficit disorders are covered with a diagnosis of autism spectrum disorder. Psychiatric disorders resulting from specific external factors, such as grief, are classed as mental or nervous disorders. Dementia (presenile and arteriosclerotic) is not a covered benefit.

**Mental Health Parity** shall mean the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) which refers to a federal law that provides participants who already have benefits under mental health and substance use disorder (MH/SUD) coverage parity with benefits limitations under their medical/surgical coverage.

**Newborn Expenses** shall mean expenses incurred by a newborn child.

**Network** shall mean any Participating Provider or managed care network under contract with BCBSFL.

**Network Benefits** shall mean the services or supplies provided by a Participating Provider or authorized by any of ICUBA's contracted managed care networks.

**Network Preventive Care Benefits** shall mean mammograms, bone mineral density screenings, colorectal cancer screenings, colonoscopies, sigmoidoscopies, venipunctures, glucose testing, lipid panels, ALT/AST screenings, cholesterol screenings, electrocardiograms, urinalysis, echocardiograms, pap tests, prostate cancer screenings, Chlamydia and other sexually transmitted disease screenings, adult immunizations, well-Child exams, and flu shots.

**Non-Network Benefits** shall mean Benefits the Plan provides to Covered Persons for Covered Services obtained outside of the Network service area.

**Non-Network** shall mean the use of health care Providers not contracted with BCBSFL. This includes drugs, devices, procedures, services, treatments, or supplies, which are not provided by a BCBSFL Participating Provider.



**Non-Network Provider** shall mean the use of health care Providers not contracted with BCBSFL.

**Occupational Therapy** shall mean treatment to restore a physically Disabled person's ability to perform Activities Of Daily Living.

**Open Enrollment** shall mean the period when Eligible persons can enroll, terminate, or change coverage in the Plan. Open Enrollment occurs annually and is meant for enrollment in the new Plan Year (04/01 – 03/31).

**Organ Transplant** shall mean services that provide for Medically Necessary organ or tissue transplant procedures for kidney, cornea, heart, heart/lung, liver, lung, pancreas, or bone marrow.

**Orthotic Devices** shall include shoe inserts that can relieve stress and stretching of the plantar fascia while standing and walking.

**Other Facility Provider** shall mean any of the following: Ambulatory Care Facility, Substance Abuse Treatment Facility, free-standing dialysis facility, Outpatient psychiatric facility, psychiatric Day Treatment facility, psychiatric Hospital, Hospice, Extended Care Facility, or rehabilitation facility, which is licensed as such in the jurisdiction in which it is located.

**Other Professional Provider or Professional Provider** shall mean the following persons or practitioners, including Physicians, acting within the scope of such Provider's license, which is certified and licensed in the jurisdiction in which the services are provided:

- a. Audiologist
- b. Anesthesiologist
- c. Certified Nurse Practitioner
- d. Clinical Social Worker
- e. Dental Practitioner
- f. Emergency medical technician
- g. Independent laboratory technician
- h. Licensed Practical Nurse
- i. Nurse Midwife
- j. Occupational Nurse
- k. Pharmacist



- I. Physical Therapist
- m. Physician Assistants
- n. Registered Nurse
- o. Respiratory Therapist
- p. Speech - Language Pathologist or Audiologist

**Out-of-Pocket Expense** shall mean any amount of Deductible, Co-payment and Coinsurance that a Covered Person pays for any Covered Expense.

**Out-of-Pocket Limit or Out-of-Pocket Maximum** shall mean the maximum amount of Deductible, Co-payment and Coinsurance during any Plan Year (4/1-3/31) that a Covered Person or Family shall pay before the Plan shall pay 100% of Covered Expenses for that Plan Year (4/1-3/31). There are separate Out-of-Pocket limits for Network and Non-Network services. There is also a separate Out-of-Pocket Limit for Prescription Drugs. Each benefit plan option has its own Out-of-Pocket limits.

**Outpatient** shall mean a Covered Person who receives drugs, devices, procedures, services, treatments, or supplies while not confined as an Inpatient.

**Outpatient Care** shall mean any health care service provided to a Participant who is not admitted to an Inpatient facility. Outpatient Care may be provided in a Physician's office, clinic, a Participant's home, or Hospital outpatient department.

**Outpatient Surgery** shall mean surgical services provided to a Covered Person while such Covered Person is an Outpatient.

**Participant** shall mean an Employee or Eligible Retiree who meets the requirements for Eligibility, properly enrolls in the Plan, and continuously meets the requirements for Eligibility.

**Participating Physician** shall mean a duly licensed Physician under contract with BCBSFL or MHNNet.

**Participating Provider** shall mean any Hospital, Physician, pharmacy, Other Professional Provider, Other Facility Provider, or other entity under contract with BCBSFL, MHNNet or WHI. Refer to the Provider Directory for a listing of the Participating Providers. Contact BCBSFL (1-800-664-5295), or log onto the website at [www.BCBSFL.com](http://www.BCBSFL.com); contact MHNNet (1-877-398-5816), or log onto the website at [www.mhnet.com](http://www.mhnet.com); contact WHI (1-800-207-2568), or log onto the website at [www.walgreenshealth.com](http://www.walgreenshealth.com).

**Pended Claim** shall mean a Claim that requires additional information prior to completing the Adjudication process due to a specific reason.



**Personal Health Assessment (PHA)** is a health questionnaire used to provide individuals with an evaluation of their health risks and quality of life. The PHA incorporates an extended questionnaire (including biometric data), a risk calculation score, and feedback (often face-to-face with a health advisor).

**Personal Health Record** is a health record initiated and maintained by an individual that provides a complete and accurate summary of the health and medical history of an individual by gathering data from many sources and making this information accessible online to anyone who has the necessary electronic credentials to view the information.

**Physician** shall mean a properly licensed person holding the degree of Physician of Medicine (M.D.), Physician of Osteopathy (D.O.), Physician of Podiatry (D.P.M.), or Physician of Chiropractic (D.C.).

**Physical Therapy** shall mean rehabilitation concerned with restoration of function and prevention of physical Disability following disease, Injury, or loss of body part.

**Plan, The Plan, or This Plan** shall mean the Independent Colleges and Universities Benefits Association, Inc. Medical and Prescription Drug Plan.

**Plan Administrator** shall mean the Board of Directors of ICUBA.

**Plan Year** shall mean April 1 through March 31 of each year.

**Precertification** shall mean the pre-approval of a Covered Expense for all Inpatient and some Outpatient services, as illustrated in Article Five of this Plan Document.

**Pre-Existing Condition** shall mean any Illness, Injury, disease, or condition, regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the 6-month period immediately prior to such individual becoming a Covered Person. Pregnancy shall not be considered a Pre-Existing Condition hereunder. Genetic Information shall not be treated as a Pre-Existing Condition in the absence of a diagnosis of the condition related to the Genetic Information. Any Dependent Child age 19 or younger will not be subject to Pre-Existing Condition Limitations. If an individual is diagnosed with a condition, even if the condition relates to Genetic Information, the Plan may impose a Pre-Existing Condition limitation with respect to the condition.

**Preferred Medication List (PML)** shall mean a list of preferred, commonly prescribed Prescription Drugs.

**Prescription Drugs** shall mean drugs or medicines obtainable only upon a Physician's written prescription, including any medication compounded by the pharmacist that contains a prescription legend drug, insulin, and insulin needles and syringes.

**Preventive Care** shall mean medical services aimed at early detection and intervention.

**Primary Care** shall mean the basic, comprehensive, preventive level of health care typically provided by a person's general or family practitioner, internist, or pediatrician.



**Primary Care Physician (PCP)** shall mean a Physician, usually a family or general practitioner, internist or pediatrician, who provides a broad range of preventive medical services and recommends patients to Specialists, Hospitals, and other Providers as necessary. OB-GYN is considered a PCP.

**Private Duty Nursing Services** shall mean nursing services rendered at home by Registered Nurses (RNs) or Licensed Practical Nurses (LPNs), in accordance with Physician orders.

**Prosthetic Devices** shall mean a device that replaces all or a part of the human body because a part of the body is permanently damaged, is absent or is malfunctioning.

**Provider** shall mean a licensed health care facility, program, agency, Physician or health professional that delivers health care services.

**Provider Directories** shall mean listings of Providers who have contracted with BCBSFL, MHNet or WHI to provide care to its Participants. Participants may refer to the directories to select Network Providers. The Provider Directory for Medical is available at [www.BCBSFL.com](http://www.BCBSFL.com), for Behavioral Health at [www.mhnet.com](http://www.mhnet.com), for Prescription Drugs at [www.walgreenshealth.com](http://www.walgreenshealth.com).

**Provider Network** shall mean a panel of Providers contracted by BCBSFL, MHNet or WHI.

**Qualified Beneficiary** shall refer to an individual covered by a group health plan on the day before a Qualifying Event who is either an Employee, the Employee's spouse, or an Employee's Dependent child. In certain cases, a retired Employee, the retired Employee's spouse, and the retired Employee's Dependent children may be Qualified Beneficiaries. In addition, any child born to or placed for adoption with a covered Employee during the period of COBRA Continuation Coverage is considered a Qualified Beneficiary.

**Qualifying Event** shall refer to certain events that would cause an individual to lose health coverage. The type of Qualifying Event will determine who the Qualified Beneficiaries are and the amount of time that a plan must offer the health coverage to them under COBRA.

**Reasonable and Customary** shall mean those charges made for medical services and/or supplies essential to the care of a Covered Person which will be considered reasonable and customary if they are the amount normally charged by the Provider for similar services and supplies and do not exceed the amount ordinarily charged by most Providers for comparable services and supplies in the locality where the services or supplies are received. In determining whether charges are Reasonable and Customary, due consideration will be given to the nature or severity of the Illness or Injury being treated and any medical complications, degree of professional skill or unusual circumstances which require additional time, skill or experience. All Network Provider charges are deemed to be Reasonable and Customary.

**Rehire** shall mean an Employee who is terminated and then re-employed within 60 days from the date of Termination of Employment.

**Scalp Hair Prosthesis** shall mean an artificial substitute for scalp hair.

**Service Area** shall mean the geographical area covered by BCBSFL.



**Significant Break In Coverage** shall mean a period of 63 or more consecutive days without Creditable Coverage. Periods of no coverage during an HMO affiliation period or Waiting Period shall not be taken into account for purposes of determining whether a significant break in coverage has occurred. For this purpose, an HMO affiliation period means a period of time that must expire before health insurance coverage provided by an HMO becomes effective, and during which the HMO is not required to provide Benefits.

**Significant Cost Changes** consist of the following events:

- a. Automatic changes. If the cost of coverage increases or decreases and employees are required to make a corresponding change in their payments, the cafeteria plan may, on a reasonable and consistent basis, automatically make a prospective increase or decrease in the employee's contributions;
- b. Significant cost increases or decreases. If the cost charged to an employee for a Benefit Package Option significantly increases or decreases during a period of coverage, the employee may make a corresponding change in election under the cafeteria plan. Changes that may be made include starting participation in the plan for the option with a decrease in cost or revoking an election for the coverage with an increase in cost and, instead, either receiving on a prospective basis coverage under another Benefit Package Option providing similar coverage or dropping coverage if no other Benefit Package Option providing similar coverage is available.

A cost increase or decrease refers to an increase or decrease in the amount of the elective contributions under the cafeteria plan, whether that increase or decrease results from an action taken by the employee (such as switching between full-time and part-time status) or from an action taken by an employer (such as reducing the amount of employer contributions for a class of employees).

**Skilled Nursing Care** shall mean service provided by a Registered Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocational Nurse (L.V.N.), provided the care is Medically Necessary and the treating Physician has prescribed such care.

**Skilled Nursing Facility** shall mean an institution which:

- a. Is duly licensed as an Extended Care Facility or convalescent facility, and operates in accordance with governing laws and regulations;
- b. Regularly provides Inpatient Skilled Nursing Care for payment during the active or convalescent stage of an Injury or Illness;
- c. Is staffed with a Physician or Registered Nurse on duty 24 hours a day;
- d. Operates in accordance with medical policies supervised and established by a Physician other than the Participant's own Physician;
- e. Regularly maintains a daily medical record for each Participant;
- f. Is not, other than incidentally, a place for the aged, a Substance Abuse Treatment Facility, or a place for Custodial Care; and



- g. Is recognized as an Extended Care Facility or a Skilled Nursing Facility under Medicare.

**Special Enrollee** shall mean an Employee or Dependent who is entitled to and who requests Special Enrollment as described in the Enrollment Contributions section of this Plan Document.

**Specialists** shall mean Providers whose practices are limited to treating a specific disease (*e.g.*, oncologists), specific parts of the body (*e.g.*, ear, nose and throat), a specific age group: other than children (*e.g.*, gerontologist), or specific procedures (*e.g.*, oral surgery). A chiropractor (D.C.) is considered a Specialist.

**Speech Therapy** shall mean services provided by a speech therapist where all of the following conditions are met:

- a. The service of a speech therapist is required to restore a speech Disability that the patient lost as a direct result of an Illness or Injury, unless being treated under the diagnosis of autism spectrum disorder, in which the service of a speech therapist is covered.
- b. The services of the therapist are prescribed by a Physician who continues to direct the overall treatment of the case as Medically Necessary to improve the specific defect.

**Spinal Manipulation Treatment** shall mean office visits or treatment, which involve manipulation (with or without the application of treatment such as heat, water or cold therapy, diathermy or ultrasound) of the spinal skeletal system and surrounding tissues to allow free movement of joints, alignment of bones, or enhancement of nerve functions.

**Sterilization** shall mean a planned surgical procedure resulting in the inability to reproduce.

**Substance Abuse Treatment Facility** shall mean a facility, other than an acute care Hospital, established to care and treat those who need Inpatient Medical Care due to alcoholism or drug abuse. The institution must have permanent facilities on the premises for Inpatient Medical Care. The institution must be licensed, registered or approved by the appropriate authority of the jurisdiction in which it is located or it must be accredited by the American Hospital Association. It must keep daily medical records on all patients. A Substance Abuse Treatment Facility shall not include an institution, or part of one, used mainly for rest care, nursing care, care of the aged, or Custodial Care.

**Surgical Services** shall mean services received and performed by a professional Provider.

**Temporomandibular Joint Dysfunction Services (TMJ)** shall mean services rendered for the dysfunction of the temporal bone and mandible.

**Terminal Illness Or Terminally Ill** shall mean a life expectancy of six months or less.

**Termination Of Employment or Terminates Employment** shall mean the severance of an Employee's employment relationship with a Member Institution and all other affiliates, or the expiration of an Approved Leave of Absence, Approved Sabbatical, or leave mandated by the Family and Medical Leave Act or the Uniformed Services



Employment and Reemployment Rights Act from a Member Institution without the Employee returning to the employment of such Member Institution or any affiliate.

**Therapy and Rehabilitation Services** shall mean services ordered by a Physician in order to stimulate growth and development of the individuals enrolled.

**Transplant Services** shall mean services where the patient has new organs or body tissue transferred to replace the diseased or malfunctioning organs.

**Urgent Care** shall mean when prompt medical attention is needed.

**Urgent Care Claims** shall have the meaning set forth in the "Types of Claims" section of Article Fourteen.

**Waiting Period** shall mean the period that must pass under this Plan (or for purposes of determining Creditable Coverage, under any other group health plan) before an Employee or Dependent is eligible to enroll in the Plan (or other medical plan as the case may be). Notwithstanding the foregoing, if an Employee or Dependent enrolls as a Late Enrollee or Special Enrollee on a Special Enrollment Date, any period before such late or Special Enrollment is not a Waiting Period.

**You, Your, or Yourself** shall mean a Participant in the Plan.



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## RIDER # 1

### **RIDER TO INDEPENDENT COLLEGES AND UNIVERSITIES BENEFITS ASSOCIATION, INC. MEDICAL, BEHAVIORAL HEALTH, AND PRESCRIPTION DRUG PLAN DOCUMENT FOR BEACON COLLEGE, CENTRAL FLORIDA AHEC, EDWARD WATERS COLLEGE, EVERGLADES AHEC, FLORIDA INSTITUTE OF TECHNOLOGY, NOVA SOUTHEASTERN UNIVERSITY, THE POYNTER INSTITUTE, ROLLINS COLLEGE, SAINT EDWARD'S SCHOOL, TAMPA PREPARATORY SCHOOL, AND THE UNIVERSITY OF TAMPA**

PURPOSE OF RIDER: This Plan recognizes a limited number of issues are of a sensitive political, theological, or academic nature. The Plan allows individual Member Institutions to elect coverages with respect to these issues. Therefore, this Rider amends the coverages of the Plan for the Participants, Dependents, and Beneficiaries of Beacon College, Central Florida AHEC, Edward Waters College, Everglades AHEC, Florida Institute of Technology, Nova Southeastern University, The Poynter Institute, Rollins College, Saint Edward's School, Tampa Preparatory School, and The University of Tampa in the following manner.

#### **GLOSSARY, DEFINITION OF DEPENDENT (DOMESTIC PARTNERS)**

This Rider expands the definition of Dependent to include Domestic Partners who meet the following definition:

The Domestic Partner, along with the Participant, must complete, sign, and return to the Plan Administrator the Affidavit of Domestic Partnership supplied by the Plan Administrator, and certify that they:

Are each other's sole Domestic Partner with the intention to remain so indefinitely. Neither one is married to someone else;

Are in a relationship of mutual support, caring, and commitment, which each consider to be the functional equivalent of marriage;

Share joint responsibility for household and basic living expenses;

Are not related by blood;

Are at least 18 years of age; and

Have resided together for at least 6 consecutive months and intend to reside together indefinitely.

The Plan imposes a 12-month Waiting Period after termination of a Domestic Partner's coverage before a Participant can enroll a new Domestic Partner.



The Plan reserves the right to unilaterally change the terms or conditions for qualification or discontinue Eligibility for its Domestic Partner benefit at anytime without notice.

Domestic Partners shall be treated as spouses for purposes of determining Dependents of Domestic Partners.

At The University of Tampa only, a Domestic Partner must be of the same gender.

This Rider also expands the definition of Qualified Dependent for purposes of COBRA Continuation Coverage by amending Article Nine to add the following:

A Domestic Partner who has been covered as a Dependent and who no longer meets the definition of Domestic Partner, and any eligible Dependents of such Domestic Partner shall, be treated as qualified dependents for purposes of COBRA Continuation Coverage.



**RIDER # 2**

**RIDER TO INDEPENDENT COLLEGES AND UNIVERSITIES BENEFITS ASSOCIATION, INC. MEDICAL, BEHAVIORAL HEALTH, AND PRESCRIPTION DRUG PLAN DOCUMENT FOR BEACON COLLEGE, CENTRAL FLORIDA AHEC, EVERGLADES AHEC, FLORIDA INSTITUTE OF TECHNOLOGY, NOVA SOUTHEASTERN UNIVERSITY, THE POYNTER INSTITUTE, ROLLINS COLLEGE, TAMPA PREPARATORY SCHOOL, AND THE UNIVERSITY OF TAMPA**

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**ARTICLE TEN, LIMITATIONS AND EXCLUSIONS (ABORTION)**

This Rider allows the coverage of abortions which otherwise meet the definition of a Covered Expense by deleting Section 10.01 50.



RIDER # 3

RIDER TO INDEPENDENT COLLEGES AND UNIVERSITIES BENEFITS ASSOCIATION, INC. MEDICAL, BEHAVIORAL HEALTH, AND PRESCRIPTION DRUG PLAN DOCUMENT FOR BARRY UNIVERSITY, BEACON COLLEGE, THE BOLLES SCHOOL, CENTRAL FLORIDA AHEC, CLEARWATER CHRISTIAN COLLEGE, EDWARD WATERS COLLEGE, EVERGLADES AHEC, FLORIDA INSTITUTE OF TECHNOLOGY, FLORIDA MEMORIAL UNIVERSITY, NOVA SOUTHEASTERN UNIVERSITY, PALM BEACH ATLANTIC UNIVERSITY, THE POYNTER INSTITUTE, SAINT EDWARD'S SCHOOL, SAINT LEO UNIVERSITY, ST. MARK'S EPISCOPAL DAY SCHOOL, SAINT PAUL'S SCHOOL, SAN JOSE EPISCOPAL DAY SCHOOL, TAMPA PREPARATORY SCHOOL, AND THE UNIVERSITY OF TAMPA

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RIDER # 4

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RIDER # 7

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Rider # 8

RIDER TO INDEPENDENT COLLEGES AND UNIVERSITIES BENEFITS ASSOCIATION, INC. MEDICAL, BEHAVIORAL HEALTH, AND PRESCRIPTION DRUG PLAN DOCUMENT FOR THE BOLLES SCHOOL, CENTRAL FLORIDA AHEC, CLEARWATER CHRISTIAN COLLEGE, EVERGLADES AHEC, NOVA SOUTHEASTERN UNIVERSITY, THE POYNTER INSTITUTE, SAINT EDWARD'S SCHOOL, SAINT LEO UNIVERSITY, ST. MARK'S EPISCOPAL DAY SCHOOL, SAINT PAUL'S SCHOOL, SAN JOSE EPISCOPAL DAY SCHOOL, AND TAMPA PREPARATORY SCHOOL

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RIDER # 9

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**RIDER # 10**

**RIDER TO INDEPENDENT COLLEGES AND UNIVERSITIES BENEFITS ASSOCIATION, INC. MEDICAL, BEHAVIORAL HEALTH, AND PRESCRIPTION DRUG PLAN DOCUMENT FOR NOVA SOUTHEASTERN UNIVERSITY**

PURPOSE OF RIDER: This Rider amends the coverage of the Plan for Employees of Grand Oaks Country Club. Employees are eligible for the Plan if they are regularly scheduled to work at a position at the Country Club for a minimum of 32 hours per week and if such Employees also meet all other eligibility requirements.



RIDER # 11

RIDER TO INDEPENDENT COLLEGES AND UNIVERSITIES BENEFITS ASSOCIATION, INC. MEDICAL, BEHAVIORAL HEALTH, AND PRESCRIPTION DRUG PLAN DOCUMENT FOR BARRY UNIVERSITY, BEACON COLLEGE, THE BOLLES SCHOOL, CENTRAL FLORIDA AHEC, CLEARWATER CHRISTIAN COLLEGE, EDWARD WATERS COLLEGE, EVERGLADES AHEC, FLORIDA INSTITUTE OF TECHNOLOGY, FLORIDA MEMORIAL UNIVERSITY, NOVA SOUTHEASTERN UNIVERSITY, PALM BEACH ATLANTIC UNIVERSITY, THE POYNTER INSTITUTE, ROLLINS COLLEGE, SAINT LEO UNIVERSITY, ST. MARK'S EPISCOPAL DAY SCHOOL, SAINT PAUL'S SCHOOL, SAN JOSE EPISCOPAL DAY SCHOOL, TAMPA PREPARATORY SCHOOL, AND THE UNIVERSITY OF TAMPA

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RIDER # 12

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RIDER # 14

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RIDER # 16

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