

# **Lancesoft, Inc. PPO Platinum Plan**

**The Life Insurance and AD&D benefits described in this booklet are fully insured by  
Great-West Life & Annuity Insurance Company.**

## TABLE OF CONTENTS

### SECTION I - MEDICAL AND PRESCRIPTION DRUG BENEFITS

■ <b>INTRODUCTION</b>	
Notices.....	2
About This Plan.....	2
■ <b>PPO MEDICAL BENEFITS SUMMARY</b> .....	4
■ <b>PRESCRIPTION DRUG BENEFITS SUMMARY</b> .....	7
■ <b>ELIGIBILITY</b>	
Eligible Employees.....	8
Eligible Dependents.....	8
■ <b>WHEN COVERAGE BEGINS &amp; ENDS</b>	
When Will Coverage Begin?.....	10
What If I Don't Apply On Time?.....	10
What If I Was Covered for Health Benefits Under the Employer's Prior Plan?.....	11
Will My Coverage Change?.....	12
When Will My Coverage End?.....	12
Can I Continue My Coverage If I Become Ineligible?.....	12
Can Coverage Be Reinstated?.....	13
■ <b>PPO MEDICAL BENEFITS</b>	
How Does the Plan Work?.....	14
What's Covered?.....	20
Is There a Limit On My Expenses?.....	26
■ <b>PRESCRIPTION DRUG BENEFITS</b> .....	27
■ <b>BENEFIT LIMITATIONS</b> .....	29
■ <b>CLAIMS &amp; LEGAL ACTION</b>	
How To File Claims.....	33
If A Claim Is Denied.....	34
What If a Member Has Other Health Coverage?.....	35
How Will Benefits Be Affected By Medicare?.....	37
Provision for Subrogation and Right of Recovery.....	38
Other Information a Member Needs to Know.....	39
■ <b>GLOSSARY</b> .....	40
■ <b>USERRA RIGHTS AND RESPONSIBILITIES</b> .....	44
■ <b>CONTINUATION OF COVERAGE - FMLA</b> .....	45
■ <b>CONTINUATION OF COVERAGE - COBRA</b> .....	45

## TABLE OF CONTENTS

(cont'd)

### **SECTION II - LIFE INSURANCE AND ACCIDENTAL DEATH & DISMEMBERMENT BENEFITS**

#### **■ INTRODUCTION**

Notices.....	50
About This Plan .....	51

#### **■ LIFE INSURANCE AND ACCIDENTAL DEATH & DISMEMBERMENT BENEFITS SUMMARY..... 53**

#### **■ ELIGIBILITY**

Eligible Employees.....	54
-------------------------	----

#### **■ WHEN COVERAGE BEGINS & ENDS**

When Will Coverage Begin?.....	55
What If I Don't Apply On Time?.....	55
Will My Coverage Change?.....	55
When Will My Coverage End?.....	55
Can I Continue or Convert My Coverage If I Become Ineligible?.....	55
Can Coverage Be Reinstated?.....	56

#### **■ LIFE INSURANCE BENEFITS**

Standard Life Insurance .....	58
How Do I Name a Beneficiary?.....	58
How Will Benefits Be Paid? .....	58
What If I Become Disabled? (Waiver of Premium) .....	58
Is the Amount of My Insurance Reduced As I Grow Older?.....	59
Other Information About Life Insurance .....	59

#### **■ AD&D BENEFITS..... 60**

#### **■ AD&D BENEFIT LIMITATIONS..... 61**

#### **■ CLAIMS & LEGAL ACTION**

How To File Claims.....	62
If A Claim Is Denied.....	63
Other Information a Member Needs to Know.....	64

#### **■ GLOSSARY..... 66**

#### **■ USERRA RIGHTS AND RESPONSIBILITIES..... 68**

#### **■ CONTINUATION OF COVERAGE - FMLA..... 68**

### **SECTION III - ERISA**

#### **■ ERISA GENERAL INFORMATION..... 70**

TABLE OF CONTENTS

*(cont'd)*

■ STATEMENT OF ERISA RIGHTS..... 70

**SECTION I - MEDICAL AND PRESCRIPTION DRUG BENEFITS**

## **INTRODUCTION**

### **■ Notices**

#### **Women's Health and Cancer Rights Act**

This Notice is required by the Women's Health and Cancer Rights Act of 1998 (WHCRA) to inform you, as a member of the Plan, of your rights relating to coverage provided through the Plan in connection with a mastectomy. As a Plan Member, you have rights to coverage provided in a manner determined in consultation with your attending Physician for:

- all stages of reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

This coverage may be subject to deductible and copayment provisions, if your Plan includes such provisions. Additional details regarding this coverage are provided in the Plan. Keep this notice for your records and call your Plan Administrator for more information.

#### **Statement of Rights Under the Newborns' and Mothers' Health Protection Act**

Under the federal law, group health plans and health insurance issuers offering group health insurance coverage 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 delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification, contact your plan administrator.

### **■ About This Plan**

Great-West Life & Annuity Insurance Company (Great-West) processes the benefits for this Plan under the name of **Great-West Healthcare**.

LanceSoft, Inc. (the Employer) has established an Employee Welfare Benefit Plan within the meaning of the Employee Retirement Income Security Act of 1974 (ERISA). As of June 1, 2008, the medical and drug benefits described in this booklet form a part of the Employee Welfare Benefit Plan and are referred to collectively in this booklet section as the Plan. The Employee Welfare Benefit Plan will be maintained pursuant to the medical and drug benefit terms described in this booklet. The Plan may be amended from time to time.

If a booklet was issued to you under the Employer's prior plan, this is your new booklet. This new booklet replaces your old booklet in its entirety. If you were covered under the replaced booklet on the day before the effective date of the Plan, you will be covered under this booklet as of the date shown above.

The medical and drug benefits described in this booklet are self-funded by the Employer. The Employer is fully responsible for the self-funded benefits. Great-West processes claims and provides other services to the Employer related to the self-funded benefits. Great-West does not insure or guarantee the self-funded benefits.

Under the terms of a Group Stop Loss Contract between the Employer and Great-West Life & Annuity, Great-West agrees to reimburse the Employer when claims for benefits reach a specified level.

Defined terms are capitalized and have specific meaning with respect to medical and drug benefits, see GLOSSARY.

## **INTRODUCTION - Continued**

### **Discretionary Authority**

The Plan Administrator has the discretionary authority to control and manage the operation and administration of the Employer's self-funded medical and drug benefit Plan. The Plan Administrator in his or her discretionary authority, will determine benefit eligibility under such self-funded Plan, construe the terms of the self-funded Plan and resolve any disputes which may arise with regard to the rights of any person under the terms of the self-funded Plan, including but not limited to eligibility for participation and claims for benefits.

For initial claim determination, the Plan Administrator has the discretionary authority to determine eligibility and to interpret the Plan. For claim appeals, the Plan Administrator has designated Great-West Life & Annuity Insurance Company, 8505 E. Orchard Road, Greenwood Village, CO 80111 as the appeals fiduciary. Great-West will have the discretionary authority to determine whether a claim should be paid or denied on appeal and according to the Plan provisions.

### **Plan Modification/Termination**

The Employer may:

- change the contributions a Member must pay for benefits; or
- amend or terminate the benefits provided to you in the Plan.

If the Plan is amended or terminated it will not affect coverage for services provided prior to the effective date of the change.

## PPO MEDICAL BENEFITS SUMMARY

This summary provides a general description of your medical benefits. It does not list all benefits. The Plan contains limitations and restrictions that could reduce the benefits payable under the Plan. Please read the entire booklet for details about your benefits.

### Copay Amount for Network Services

Outpatient Mental Health Conditions and Chemical Dependency Treatment	\$35.00
Other Office Visits	\$20.00

### Emergency Room Visit Copay

If admitted to a Hospital as an inpatient	None
If not admitted to a Hospital as an inpatient	\$100.00

### Deductible

The calendar year deductible applies to all covered expenses except:

- expenses subject to a copay
- facility expenses that are subject to the per confinement deductible
- expenses for outpatient x-rays and lab tests
- expenses for services, including surgery, provided in a Network Doctor's office

### Individual Calendar Year Deductible

Network	\$250.00
Non-network and outside the PPO Network Area	\$250.00

### Family Deductible

Network	\$500.00
Non-network and outside the PPO Network Area	\$500.00

### Per Confinement Deductible

The Per Confinement Deductible applies to facility charges for each inpatient confinement in a Hospital, Skilled Nursing Facility, Hospice facility or Mental Health and Chemical Dependency Treatment facility and to outpatient surgery in a Hospital or an Ambulatory Surgical Center.

Network Facility	None
Non-network Facility	\$250.00

### Medical Management Program

Non-compliance Penalty	50% reduction per claim
------------------------	-------------------------

### Percentage Payable after any applicable Deductible, Copay or Contracted Rate Reduction

Outpatient Surgery, including surgery performed in a Doctor's Office	
- Network	100%
- Services outside the PPO Network Area	80%
- Non-network	70%
Hospital	
- Network	100%
- Services outside the PPO Network Area	80%
- Non-network	70%

## PPO MEDICAL BENEFITS SUMMARY - Continued

Physician charges for Hospital care and Surgery	
- Network	100%
- Services outside the PPO Network Area	80%
- Non-network	70%
X-rays and Lab Tests	
- ordered as part of Emergency Room Care in a	
* Network Hospital	100%
* Hospital outside the PPO Network Area	80%
* Non-network Hospital	100%
- ordered as part of Hospital care in a	
* Network Hospital	100%
* Hospital outside the PPO Network Area	80%
* Non-network Hospital	70%
- ordered as part of an Office Visit (including Preventive Care Office Visits) and performed in a	
* Network provider's office or Network x-ray or lab facility	100%
* Provider outside the PPO Network Area	80%
* Non-network provider's office or Non-network x-ray or lab facility	70%
Durable Medical Equipment	
- Network	100%
- Services outside the PPO Network Area	80%
- Non-network	70%
Office Visits	
- Network	100%
- Services outside the PPO Network Area	80%
- Non-network	70%
Outpatient Mental Health Conditions and Chemical Dependency Treatment	
- Network	100%
- Services outside the PPO Network Area	80%
- Non-network	70%
Emergency Room Care	
- Network	100%
- Services outside the PPO Network Area	100%
- Non-network	100%
Spinal Adjustment Therapy	
- Network	100%
- Services outside the PPO Network Area	80%
- Non-network	70%
Outpatient Speech, Hearing and Occupational Therapy	
- Network	100%
- Services outside the PPO Network Area	80%
- Non-network	70%
Outpatient Physical Therapy	

## PPO MEDICAL BENEFITS SUMMARY - Continued

- Network	100%
- Services outside the PPO Network Area	80%
- Non-network	70%
Ambulance Expenses	
- Network	100%
- Services outside the PPO Network Area	100%
- Non-network	100%
Transplant Expenses	
- Travel Expenses to and from a Great-West Healthcare Transplant Network facility	100%
- Other Transplant Expenses	
* Great-West Healthcare Transplant Network facility	100%
* Other Network facilities	Not Covered
* Services outside the PPO Network Area	Not Covered
* Non-network	Not Covered
Other Covered Expenses	
- Network	100%
- Services outside the PPO Network Area	80%
- Non-network	70%
<b>Individual Breakpoint</b>	\$10,000.00
<b>Family Breakpoint</b>	\$20,000.00
<b>Calendar Year Benefit Maximum</b>	
Home Health Care	1 visit per day up to 100 visits
Skilled Nursing Facility	100 days
Inpatient Treatment of Mental Health Conditions and Chemical Dependency	10 days
Outpatient Treatment of Mental Health Conditions and Chemical Dependency	20 visits
Outpatient Occupational, Speech and Hearing Therapy	\$2,000.00
Outpatient Physical Therapy	\$2,000.00
Spinal Adjustment Treatment	\$500.00
<b>Lifetime Benefit Maximum</b>	
Inpatient Treatment of Mental Health Conditions and Chemical Dependency	20 days
Durable Medical Equipment	\$10,000.00
Transplant Travel Expenses to and from a Great-West Healthcare Transplant Network facility. Certain travel expenses are limited to a daily maximum. See the "Transplants" benefit provision for more details.	\$10,000.00
<b>Maximum Benefit for all Covered Expenses</b>	
Lifetime benefit per Member	\$2,000,000.00

## **PRESCRIPTION DRUG BENEFITS SUMMARY**

This summary provides a general description of your prescription drug benefits. It does not list all benefits. The Plan contains limitations and restrictions that could reduce the benefits payable under the Plan. Please read the entire booklet for details about your benefits.

### **Retail Network Pharmacy - up to a 30-day supply**

Tier 1 - Generic Drug copay	100% after \$10.00 copay
Tier 2 - Lowest Brand Name Drug copay	100% after \$20.00 copay
Tier 3 - Highest Brand Name Drug copay	100% after \$40.00 copay

### **Non-network Pharmacy - up to a 30-day supply**

Member must pay 100% of drug cost at time of purchase and submit a claim for reimbursement. Reimbursement will be 50% of the network pharmacy cost after the copay.

### **Ninety-day Retail Network Pharmacy Program - 80 to 90-day supply**

Tier 1 - Generic Drug copay	100% after \$30.00 copay
Tier 2 - Lowest Brand Name Drug copay	100% after \$60.00 copay
Tier 3 - Highest Brand Name Drug copay	100% after \$120.00 copay

### **Mail Order Drug Program - up to a 90-day supply**

Tier 1 - Generic Drug copay	100% after \$20.00 copay
Tier 2 - Lowest Brand Name Drug copay	100% after \$40.00 copay
Tier 3 - Highest Brand Name Drug copay	100% after \$80.00 copay

### **Specialty Pharmacy Program - for certain high-cost drugs**

The copay for Specialty drugs will mirror either the Retail Network Pharmacy or Mail Order Drug Program copays. The way the prescription is written by the physician (*i.e., 30-day supply or 90-day supply*) will dictate the copay. A 30-day supply will require a Retail Network Pharmacy copay. A 90-day supply will require a Mail Order Drug Program copay.

## **ELIGIBILITY**

### **■ Eligible Employees**

For the purpose of medical and drug benefits, an eligible Employee is a person who is in the Service of the Employer and is a resident of the United States.

#### **Service**

“Service” means work with the Employer on an active, full-time and full pay basis for at least 40.00 hours per week.

### **■ Eligible Dependents**

*It is your responsibility to notify the Employer when a covered Dependent is no longer eligible for coverage.*

Your Dependents must live in the United States to be eligible for coverage.

A spouse or child who is covered under this Plan as an Employee may not be covered as a Dependent.

Eligible Dependents are:

- your legal spouse.
- an unmarried child, as defined below.

#### **Child**

“Child” means:

- your natural child.
- your stepchild.
- a natural child of your covered minor Dependent.
- your adopted child. This includes a child placed with you for adoption.

“Placed for adoption” means the assumption and retention of a legal obligation for the total or partial support of a child in anticipation of the adoption of such child. The child’s placement is considered terminated upon the termination of such legal obligation.

- a child who is recognized under a medical child support order as having a right to enrollment under the Plan.
- a foster child.

The child must meet the age requirements described below and depend on you for financial support. The support requirement does not apply to a child who is recognized under a medical child support order as having a right to enrollment under the Plan.

#### ***Dependent Child Age Requirements***

The child is:

- under age 19.
- over the age limit and under age 23, if a full-time student in an accredited school. Proof of the child’s student status must be provided upon request, and may be required before paying a claim.

#### ***Handicapped/Disabled Child***

The age limits do not apply to a child who becomes disabled, or became disabled, before reaching the age limits and who cannot hold a self-supporting job due to a permanent physical handicap or mental retardation.

“Physical handicap/mental retardation” means permanent physical or mental impairment that is a result of either a congenital or acquired illness or injury leading to the individual being incapable of independent living.

“Permanent physical or mental impairment” means:

## **ELIGIBILITY - Continued**

- a physiological condition, skeletal or motor deficit; or
- mental retardation or organic brain syndrome.

A non-permanent total disability where medical improvement is possible is not considered to be a “handicap” for the purpose of this provision. This includes substance abuse and non-permanent mental impairments.

At reasonable intervals, but not more often than annually, the Plan may require a Doctor’s certificate as proof of the child’s disability.

### ***Medical Child Support Order***

A medical child support order is a *qualified* medical child support order (QMCSO) or a *qualified* national medical support notice issued by a state court or administrative agency that requires the Plan to cover a child of an Employee, if the Employee is eligible for benefits under the Plan.

When the Employer receives a medical support order, the Employer will determine whether the order is “qualified”.

If the order is determined to be qualified, and if you are eligible to receive benefits under this Plan, then your Dependent child will be covered, subject to any applicable contribution requirements. Your Employer will provide your Dependent child with necessary information which includes, but is not limited to, a description of coverages and ID cards, if any. Upon request, your Employer will provide at no charge, a description of procedures governing medical child support orders.

## WHEN COVERAGE BEGINS & ENDS

### ■ When Will Coverage Begin?

The definition of Employee or Dependent in ELIGIBILITY will determine who is eligible for coverage under the Plan.

Coverage will begin on the date you satisfy any eligibility waiting periods required by the Employer.

Before coverage can start, you must:

- Submit an application within 31 days after becoming eligible;
- Pay any required contribution.

Coverage for a newly acquired Dependent will begin on the date you acquire the Dependent if you are covered and if you apply for coverage within 31 days after acquiring the new Dependent.

If the Dependent is an adoptive child, coverage will start:

- For an adoptive newborn, from the moment of birth if the child's date of placement is within 31 days after the birth; and
- For any other adoptive child, from the date of placement.

### ■ What If I Don't Apply On Time?

You are a late applicant under the Plan if you don't apply for coverage within 31 days of the date you become eligible for coverage. Your Dependent is a late applicant if you elect not to cover a Dependent and then later want coverage for that Dependent.

#### Medical and Prescription Drug Benefits

A late applicant may apply for coverage only during an open enrollment period. The Plan Administrator can tell you when the open enrollment period begins and ends. Coverage for a late applicant who applies during the open enrollment period will begin on the first day of the month following the close of the open enrollment period.

You may waive coverage for all benefits described in this section. Proof of Good Health is not required if you apply for coverage at a later date.

For medical and drug benefits, a Member is *not* a late applicant if:

- You did not apply for coverage within 31 days of the eligible date because the Member was covered under another health insurance plan or arrangement and coverage under the other plan was lost as a result of:
  - Exhausting the maximum period of COBRA coverage; or
  - Loss of eligibility for the other plan's coverage due to legal separation, divorce, cessation of dependent status, death of a spouse, termination of employment or reduction in the number of hours of employment; or
  - Loss of eligibility for the other plan's coverage because the Member no longer lives or resides in the service area; or
  - Loss of eligibility for the other plan's coverage because the Member incurs a claim that meets or exceeds the lifetime maximum for that plan; or
  - Termination of benefits for a class of individuals and the Member is included in that class; or
  - Termination of the employer's contribution for the other plan's coverage.

You must have stated in writing that the other health coverage was the reason you declined coverage under this Plan, but only if the Employer required such a statement and notified you of the consequences of the requirement when you declined coverage.

- You did not apply to cover your spouse or a Dependent child within 31 days of the date you became eligible to do so and later are required by a qualified court order to provide coverage under this Plan for that person.
- You did not apply to cover yourself or an eligible Dependent within 31 days of the date you became eligible to do so and later experience a change in family status because you acquire a Dependent through marriage, birth or adoption. In this case, you may apply for coverage for yourself, your spouse and any newly acquired Dependents.

If you apply within 31 days of the date:

## **WHEN COVERAGE BEGINS & ENDS - Continued**

- Coverage is lost under the other plan, as described above, coverage will start on the day after coverage is lost under the other plan.
- A court order was issued, coverage will start on the court ordered date.
- You acquire a new Dependent, coverage will start:
  - In the case of marriage, on the date of marriage.
  - In the case of birth or adoption, on the date of birth, adoption or placement for adoption.

### **■ What If I Was Covered for Health Benefits Under the Employer's Prior Plan?**

A Member who had similar coverage for health benefits under the Employer's prior plan on the date of its termination will be covered under this Plan on the Plan effective date.

Any waiting period under this Plan will be reduced by the part of the waiting period that had been satisfied under the prior plan.

Any calendar year or lifetime maximum under this Plan will be reduced by the amount paid under Employer's prior plan that was in effect immediately prior to the transferring of claims processing to Great-West.

"Health benefits" mean medical and prescription drug benefits.

*If a Member was on COBRA or any other continuation coverage or extension of benefits under the prior plan and that plan terminated, coverage will be provided for that Member until the earlier of:*

- The date on which coverage would end under the terms of the Plan; or
- The last day of the period for which coverage would have been provided had the prior plan not terminated.

*If a Member was covered under any extension of benefits under the prior plan, the benefits provided under this Plan will be the same as those provided by the prior plan, less any amount paid under the prior plan.*

*If you were on Family and Medical Leave on the effective date of this Plan and you were covered under the Employer's prior plan on the date of its termination, then you will become covered for the benefits provided under this Plan as of its effective date.*

### **Medical Deductible and Breakpoint Credits**

Any amount a Member has already paid toward the calendar year medical deductible for Network services under the prior medical plan will be applied to this Plan's calendar year deductible for Network services. The amount a Member has already paid toward the calendar year medical deductible for Non-network services under the prior medical plan will be applied to this Plan's calendar year deductible for Non-network services. If the prior medical plan applied one calendar year deductible to all services, then the amount a Member has already paid toward such calendar year medical deductible will be applied to this Plan's calendar year deductible for Network services.

Any amount of covered expenses a Member has already used to satisfy any calendar year breakpoint for Network expenses under the prior medical plan will be applied to this Plan's calendar year breakpoint. The amount a Member has already paid toward the calendar year breakpoint for Non-network services under the prior medical plan will not be applied to this Plan's calendar year breakpoint. If the prior medical plan had one calendar year breakpoint that applied to all expenses, then the amount a Member has had applied toward such calendar year breakpoint will be applied to this Plan's calendar year breakpoint.

## **WHEN COVERAGE BEGINS & ENDS - Continued**

### **Special Benefits for Pre-Existing Conditions**

These benefits apply if a Member would not be eligible for coverage under the Plan because of the pre-existing conditions limitation and is not eligible for benefits under the prior plan because expenses were incurred after termination of that plan.

The amount of benefits will be the lesser of the amount that would have been paid under the prior plan if it had stayed in force and the amount that would have been paid under this medical Plan if it did not have a pre-existing conditions limitation.

Any length of time a Member has already satisfied toward the pre-existing conditions limitation waiting period of the prior plan will be carried over to this medical Plan.

### **■ Will My Coverage Change?**

If the Employer amends the benefits or amounts provided under the Plan, a Member's coverage will change on the effective date of the amendment. If a Member changes classes, coverage will begin under the new class on the date that the Member's class status changes.

All claims will be based on the benefits in effect on the date the claim was incurred.

### **■ When Will My Coverage End?**

Your coverage will end on the earliest of the following dates:

- The date the Employer terminates the benefits described in this booklet.
- The date you are no longer eligible or your Service ends.
- The due date of the first contribution toward your coverage that you or the Employer fails to make.
- The date Loss of Residence occurs.

Your Dependent coverage will end on the earliest of the following dates:

- The date your coverage ends; or
- The date Loss of Residence occurs; or
- The date your Dependent is no longer eligible for benefits; or
- The due date of the first contribution toward Dependent coverage that you or the Employer fails to make.

A Certificate of Creditable Coverage (CCC) will be sent when coverage for a Member ends. In addition, a CCC may be requested from the Plan Administrator at any time while a Member is covered under the Plan and up to 24 months after coverage ends.

### **■ Can I Continue My Coverage If I Become Ineligible?**

If you become ineligible for coverage under the Plan, you may be able to continue coverage for certain benefits.

#### **Continuation of Coverage under Federal Laws and Regulations**

If coverage would otherwise terminate under this Plan, you and your Dependents may be eligible to continue coverage under certain federal laws and regulations. See USERRA RIGHTS AND RESPONSIBILITIES, CONTINUATION OF COVERAGE - FMLA and CONTINUATION OF COVERAGE - COBRA.

#### **Extension of Medical and Prescription Drug Benefits**

A Member who is Totally Disabled on the date he or she becomes ineligible for continuation coverage or coverage under COBRA, including a Member who declines COBRA, may still be eligible for extended benefits for the disabling condition only. These benefits are extended:

- During the course of that Total Disability.
- Under the same benefit provisions as if coverage had not ended.
- Upon termination of the Member's coverage under this Plan, for 90 days, as long as this Plan is still in force.

## **WHEN COVERAGE BEGINS & ENDS - Continued**

Benefits for prescription drugs will be payable under the Medical Benefit and not the Prescription Drug Benefit.

You do not have to pay for extended benefits.

### **■ Can Coverage Be Reinstated?**

If your coverage ended because of termination of your Service, it will be reinstated on the date you return to work with the Employer. You must return within 3 month(s) to be reinstated.

On the date you return to work, coverage for you and your eligible Dependents will be on the same basis as that provided for any other active Employee and his or her Dependents as of that date. However, any restrictions on your coverage that were in effect before your reinstatement will still apply.

See USERRA RIGHTS AND RESPONSIBILITIES for information about reinstatement of coverage upon return from leave for military service.

### **Reinstatement When Coverage Ends Due to Loss of Residence**

Coverage for a Member whose coverage ended due to Loss of Residence will be reinstated:

- for an Employee, on the day after completing 30 consecutive days of Work in the United States;
- for a Dependent, on the day after completing 30 consecutive days residence in the United States.

The Member must return to the United States within three months of the date the Loss of Residence occurred to be reinstated. Coverage will be on the same basis as that being provided for any other active Employee and his or her Dependents on the date coverage is reinstated. However, any restrictions on the coverage that were in effect before reinstatement will continue to apply.

## **PPO MEDICAL BENEFITS**

### **■ How Does the Plan Work?**

The PPO plan includes a nationwide network of Hospitals and Doctors and a Medical Management Program. For the names of network providers, contact Member Services at the phone number or access the on-line directory at the website address shown on the Member ID card.

Benefits received from network providers are payable at a higher level than benefits received from non-network providers. Members are responsible for confirming that a provider is a network provider.

If a Member is traveling and needs care for a non-Emergency Medical Condition, contact Member Services for help in locating a network provider. Since the network is nationwide, the Member may be able to see a network provider and receive a higher level of benefits. If a Member is outside the network area, benefits will be payable as shown in PPO MEDICAL BENEFITS SUMMARY.

Network providers will submit Members' claims and take care of getting Medical Management approval when necessary. When a non-network provider is used, the Member will need to file their own claim and make sure treatment is approved by Medical Management. See "Medical Management (MM) Program" for information about pretreatment authorization.

### **Special Services**

Certain services are payable at the network level even when not performed by a network provider. These services include:

- Services (other than surgical assistance and Emergency Room Care) of a non-network provider such as, but not limited to: inpatient consultations, neonatology, x-rays and lab tests, radiology, anesthesiology and other specialists over whom the Member has no control in selecting after admission, when the Member is admitted for inpatient or outpatient care in:
  - a network facility, if the admission and the provider's services are approved by Medical Management.
  - a non-network facility, if the admission and the provider's services are approved by Medical Management, and the authorization indicates that the services are payable at the network level.
- Services of a non-network assistant surgeon, surgical assistant or any other non-network provider who is qualified to assist during surgery (other than surgery performed as part of Emergency Room Care), if the surgery is performed by a network Doctor in a network facility. The use of an assistant during surgery must be appropriate for the type of surgery rendered.
- Inpatient care provided in a non-network Hospital or by a non-network Doctor immediately following Emergency Room Care through stabilization if the services are approved by Medical Management.
- Ambulance services.

### **Supplemental Network**

Members who use a non-network provider may reduce their out-of-pocket expenses by choosing a provider participating in a supplemental network. This supplemental network is available to Members who choose a provider outside the primary network. Call Member Services for the names of providers who are participating in the program. Certain claims from non-network providers who are not in the supplemental network may, however, qualify for negotiation. Providers that participate in the supplemental network or agree to negotiate are considered non-network providers under the Plan. The Member is responsible for pretreatment authorization for all services and supplies that require pretreatment authorization.

### **Transitional Care for Members upon Termination of a Provider from the Network**

If a Member's provider ceases to be a network provider for reasons other than quality-related reasons, fraud, or failure to adhere to Great-West's policies and procedures, coverage may continue for a specified period of time for treatment in progress for a Member who is:

- in her third trimester of pregnancy; or
- receiving care for end-stage renal disease and dialysis; or
- receiving outpatient mental health treatment; or
- terminally ill, with anticipated life expectancy of six months or less; or

## **PPO MEDICAL BENEFITS - Continued**

- undergoing an active course of treatment for which changing to a different provider would be likely to cause significant risk of harm to the Member's health; or
- undergoing chemotherapy or radiation therapy for treatment of cancer; or
- a candidate for a solid organ or bone marrow transplant.

Contact Member Services to obtain a Transition of Care Request Form. The Transition of Care Request Form must be received by Great-West within 60 days of the provider's termination date. If your request is approved, care provided will be subject to the same copays, deductibles, coinsurance and limitations as care given by a network provider.

### **Medical Management (MM) Program**

Medical Management will review and make an authorization determination for urgent, concurrent and prospective medical services, and prescription drugs for Members covered under the Plan. Medical Management will also review the medical necessity of services that have already been provided.

Medical Management will determine the medical necessity of the care, the appropriate location for the care to be provided, and if admitted to a Hospital, the appropriate length of stay.

If a pretreatment request does not follow the Medical Management procedures, the provider will be notified of the established procedures no later than 5 days after receipt of the request.

Your Doctor must call Medical Management (MM) for pretreatment authorization. If a Member uses a non-network Doctor, the Member must make sure that treatment is approved by Medical Management.

Network Doctors are responsible for contacting the MM Program for pretreatment authorization. If a non-network Doctor does not get pretreatment authorization or if a Member does not follow the recommended care plan, covered expenses will be reduced by a 50% non-compliance penalty. The non-compliance penalty cannot be applied toward the calendar year deductible or breakpoint.

Certain services and supplies require pretreatment authorization, including, but not limited to:

- Air ambulance, when used for non-Emergency Medical Conditions.
- Durable medical equipment charges over \$500.
- Genetic testing.
- Home health care (including IV therapy).
- Hospital admissions, including partial hospitalization programs for mental health treatment.
- Outpatient high technology radiology (examples include: CAT scans, PET scans and MRIs).
- Outpatient surgery, except for surgery performed in a Doctor's office.
- Prescription drugs that need to be reviewed for Medical Necessity. This includes, but is not limited to:
  - certain drugs that are used for specialized medical treatment, to ensure that the drugs are used appropriately. Examples of medical conditions that may require specialized drugs include: arthritis, growth deficiencies and immune disorders; and
  - certain drugs that have multiple uses, to ensure that the drug is used according to acceptable medical practice and FDA guidelines.
- Renal dialysis.
- Skilled nursing facilities.
- Transplant evaluations.

For more information about services and supplies that require pretreatment authorization, contact Member Services at the phone number on the ID card.

Medical Management will review and render an authorization determination as described below.

- Urgent Care Requests

## **PPO MEDICAL BENEFITS - Continued**

For an urgent care request, MM will notify the Member and the provider of the authorization decision:

- no later than 24 hours after receipt of a request involving concurrent care, if the request is made at least 24 hours prior to the expiration of the previously approved care; and
- no later than 72 hours after receipt of any other urgent care request.

If MM does not have all the information needed to process an urgent care request, MM will notify the Member or provider within 24 hours after receipt of the request and give details as to what additional information is required. The requested information should be provided within 48 hours or the authorization request may be denied. MM will notify the Member and provider of the authorization decision within 48 hours after the requested information has been received.

MM will provide either verbal or written notice of the decision. When verbal notice is provided, a written notice will be sent within 3 days.

- **Non-urgent Care Requests**

For a non-urgent care request, MM will notify the Member and provider of an authorization decision no later than 15 days after receipt of the request. If an authorization decision cannot be made within the 15-day period, an extension of up to 15 days may be requested. If additional information is needed, the Member or provider will be notified within the initial 15-day period and given details as to what information is required. The requested information should be provided within 45 days after receipt of the request or the authorization request may be denied.

An authorization decision will be made no later than 15 days after MM receives the requested information, unless the Member or provider agrees to a voluntary extension of time.

Medical Management will send the Member and the provider written notice of all authorization determinations.

If previously authorized benefits are reduced or terminated, MM will send notice of this decision *prior* to any reduction or termination of benefits.

If a Member receives notice of an adverse determination, in whole or in part, the Member or the Member's Authorized Representative can appeal the decision.

An "Authorized Representative" means a person authorized in writing by the Member or a court of law to represent the Member's interests for claim submission, pretreatment and appeal requests. The Member's spouse, parent (if Member is a minor) and health care provider will be automatically recognized as the Member's Authorized Representative for pretreatment requests, claim submissions and appeals. For requests involving urgent care, any health care professional with knowledge of a Member's medical condition will be automatically recognized as the Member's Authorized Representative for pretreatment requests and appeals.

"Adverse determination" means a determination of non-approval, in whole or in part, of a pretreatment or claim payment request.

If the MM decision is an adverse determination, the Member will be sent written notice that will include the reason(s) for the denial, reference to the Plan provision(s) on which the denial is based, whether additional information is needed to process the request and why the information is needed, the appeal procedures and time limits, including procedures and time limits for urgent care appeals, and the Member's right to bring civil action under ERISA Section 502(a) after required Plan appeals have been exhausted.

The adverse determination notice will also specify:

- whether an internal rule, guideline, protocol or other criterion was relied upon in making the adverse decision and that this information is available to the Member upon request and at no charge; and
- that an explanation of the scientific or clinical judgment for a decision based on medical necessity, experimental treatment or a similar limitation is available to the Member upon request and at no charge.

## **PPO MEDICAL BENEFITS - Continued**

### **Appeal of Medical Management Decision**

Appeal of a Medical Management decision should be requested within 180 days after receipt of an adverse determination. You have the right to review and/or request copies of relevant documents, free of charge, and to submit written comments, documents and issues.

One level of appeal must be completed for appeals involving urgent care and two levels of appeal must be completed for all other appeals involving a MM adverse determination, before a Member may bring civil action under ERISA for an adverse determination. (See STATEMENT OF ERISA RIGHTS.) The appeal review will consider written comments, documents and any other information submitted by the Member, Authorized Representative or Doctor, regardless of whether the documentation was reviewed as part of the initial determination.

#### **• Level I Appeal**

The first appeal level is an internal review by MM. Upon receipt of an initial appeal of a denied request for medical services, MM will assign the review to a board certified Physician Reviewer who is in the same or similar specialty that typically manages the service under review and *who was not involved in the prior adverse determination and is not a subordinate of the individual who made the prior determination.*

The Member and the provider or other Authorized Representative will be sent written notice of an appeal determination:

- no later than 72 hours after receipt of an appeal involving urgent care; and
- no later than 15 days after receipt of an appeal involving non-urgent care; and
- no later than 30 days after receipt of an appeal involving services that have already been provided.

If the appeal decision upholds an adverse determination, and you decide to appeal the decision, you may proceed to Level II. For appeals involving urgent care, Level II is voluntary.

#### **• Level II Appeal**

If the first level internal review denies authorization, in whole or in part, a second level appeal review may be requested. The second level appeal is an external review by an independent review entity and is binding on the Plan. The written request for external review must be submitted to Medical Management within 60 days after receipt of the first level appeal determination. An external review will be provided at no cost to the Member.

A Doctor or a group of Doctors in the same or similar specialty that typically manage the service under review and who is not affiliated with Medical Management will conduct the external review.

The Member and the provider will be sent a written notice of the external review determination:

- no later than 15 days after receipt of the second level appeal request for preauthorization of services; and
- no later than 30 days after receipt of the second level appeal request for authorization of services that have already been provided.

If the external review results in a denial of the requested service, the Member has the right to bring civil action under ERISA Section 502(a) after required Plan appeals have been exhausted.

Members will be sent written notice of an adverse determination upon completion of a Level I appeal and upon completion of a Level II appeal. The notice will include:

- the reason(s) for the determination;
- reference to the Plan provision(s) on which the determination is based;
- the Member's right to review and request copies of all relevant documents, free of charge;
- whether an internal rule, guideline, protocol or other criterion was relied upon in making the adverse decision and that this information is available to the Member upon request and at no charge;

## **PPO MEDICAL BENEFITS - Continued**

- that an explanation of the scientific or clinical judgment for a decision based on medical necessity, experimental treatment or a similar limitation is available to the Member upon request and at no charge.

The notice will also include the Member's right to bring civil action under ERISA Section 502(a) after required Plan appeals have been exhausted.

*Appeal of an adverse determination involving urgent care may be submitted either orally or in writing and will be expedited.*

### **Medical Outreach Program**

The Medical Outreach Program includes various initiatives to assist Members to manage their health concerns and to stay healthy. The Medical Outreach Program includes:

- A Disease Management Program;
- A Care Management Program; and
- A Health Management Program.

A Member may call the toll-free Member services telephone number or access the website shown on his or her ID card for more information about these Programs.

### ***Disease Management Program***

If this Plan participates in the Disease Management (DM) Program, Members have access to educational materials and individualized care plans designed to help a Member manage a chronic medical condition such as pain, asthma, diabetes, coronary disease and chronic lung disease. The DM Program also provides services and support for Members with conditions classified as Oncology, End Stage Renal Disease (ESRD) and Neonatology. The DM Program is staffed by specially trained nurses who are available 24 hours a day, 7 days a week.

Members who may benefit from the DM Program are identified through a variety of means, such as medical and/or pharmacy claims, health risk assessments, preauthorization, physician referrals and self referrals. Each enrolled Member will receive tailored educational material depending on the Member's condition. The care managers in the DM Program will assist in setting clinical goals and monitor adherence to goals. Based on the severity of the condition, the care managers will schedule ongoing telephonic contact or home care visits by trained professionals. The Member's Doctor will be able to access the information provided to Members.

A Member may call the toll-free Member services telephone number or access the website shown on his or her ID card to confirm that this Plan participates in the DM Program and to access the DM Program.

There are no additional out-of-pocket expenses for these services obtained through the DM Program. If this Plan includes a Lifetime Maximum, then any costs associated with the Member's participation in the DM Program will be applied to the Maximum Benefit for All Covered Expenses.

### ***Care Management Program***

The Care Management (CM) Program manages the care of Members with serious Illnesses. Under the CM Program, if a Member requires inpatient care, such as surgery followed by long term medical care, a case manager who will work on behalf of the Member is assigned to the Member.

The case manager will help to coordinate and provide the most appropriate care in the most cost-effective manner. This includes handling the pretreatment authorization process, providing concurrent review for continued stay as an inpatient in a Hospital, discharge planning and post-discharge follow-up by the clinical staff to ensure that the Member is receiving proper care and support outside of a Hospital setting.

## **PPO MEDICAL BENEFITS - Continued**

Members who may benefit from the CM Program are identified through a variety of means, such as the pretreatment authorization process and medical claims. Generally, Members may choose to participate in the CM Program.

If a Member chooses to participate in the CM Program and if a Member and the Member's Physician decide that the recommended alternative treatment plan is right for the Member, it will be covered on the same basis as the care and treatment for which it is substituted.

Members with certain serious Illnesses must participate in the CM Program.

A Member may call the toll-free Member Services telephone number or access the website shown on his or her ID card to find out more about participation in the CM Program.

### ***Health Management Program***

The Health Management (HM) Program offers online health and wellness services, programs and other resources that enable Members to more easily and effectively obtain information about health-related topics. This includes the latest medical advances and a variety of information about eating a healthy diet and exercise support and smoking cessation.

### **Calendar Year Deductible and Copay**

A calendar year deductible is the amount of covered medical expenses that must be satisfied before the Plan begins to pay benefits.

Network expenses will not apply to a non-network deductible and non-network expenses will not apply to a network deductible. Any expenses incurred for Special Services will always apply to network deductible even when not performed by a network provider.

Any expenses that were incurred in the last three months of a calendar year and used to satisfy the deductible for that year will also be applied to the deductible for the next calendar year.

A copay is an amount a Member pays for care at the time of service.

### **Allowable Covered Expenses**

All medical benefits are subject to allowable covered expense guidelines.

Network providers have agreed to a set fee schedule. Members are not responsible for expenses over the scheduled amount for covered services. Members are responsible for any applicable copays, deductibles and coinsurance.

For services provided by a non-network provider, the allowable covered expense is based upon the average contracted rates (ACR) for network providers in the area where the care is provided. The covered amount for each service or supply will be the lesser of the fee usually charged by a provider and the ACR for that service or supply. The Member is fully responsible for any amount over the ACR, in addition to any applicable copays, deductibles and coinsurance. However, for the following services, the allowable covered expense is determined by usual and customary charge guidelines:

- Services provided by out-of-area providers.
- Services by an assistant surgeon when the surgery is performed by a network Doctor in a network Hospital.
- Services by an anesthesiologist when the surgery is performed in a network Hospital.
- Services of a radiologist or pathologist in a network Hospital.
- Services received in an emergency room or as an inpatient in a Hospital following Emergency Room Care until the Member's Emergency Medical condition is stabilized.
- Ambulance services.

The usual and customary charge for each service or supply received will be the lesser of the fee usually charged by a provider and the fee usually charged by other providers in the same geographical area for these services and supplies.

## **PPO MEDICAL BENEFITS - Continued**

### **■ What's Covered?**

PPO MEDICAL BENEFITS SUMMARY shows the payment percentage, deductible and copay amounts applicable to various covered expenses. Any benefit maximums applied to specific covered expenses and calendar and lifetime benefit maximums for *all* covered expenses are also shown in PPO MEDICAL BENEFITS SUMMARY.

If the Plan pays benefits at less than 100%, you must pay the remaining percentage of covered services. This amount is in addition to any deductible or copay amounts. You are also responsible for any amount over the allowable covered expense limit described in the Plan provision "Allowable Covered Expenses".

Services must be Medically Necessary as defined in the GLOSSARY. Unless otherwise noted for a particular service, services must be required as a result of symptoms of Illness. Expenses are covered only if incurred while the Member is covered for these medical benefits.

### **Emergency Care**

#### ***Emergency Room Care***

If you need care for an Emergency Medical Condition, go to the nearest medical facility. Coverage for an Emergency Medical Condition is available 7 days a week, 24 hours a day. This includes care received outside of the United States, required to stabilize the Member's condition for return to the United States. Pretreatment authorization is not required prior to receiving care in an emergency room.

X-rays and lab tests are not included as part of the Emergency Room Care copay. A separate coinsurance percentage applies to these services.

#### ***Inpatient Hospital Care immediately following Emergency Room Care***

Inpatient care for an Emergency Medical Condition includes both Hospital and Doctor's charges for initial medical screening examination as well as Medically Necessary treatment which is immediately required to stabilize the Member's condition. After care is provided for an Emergency Medical Condition, Medical Management must be contacted within 48 hours.

When care is provided in a non-network Hospital or by a non-network Doctor, the inpatient services and supplies received in the Hospital and the Doctor's charges are paid at the network level through stabilization if the services are approved by Medical Management.

When care is provided in an out-of-area Hospital, the inpatient services and supplies received in the Hospital and the Doctor's charges will be covered at the Services Outside the PPO Network Area level shown in PPO MEDICAL BENEFITS SUMMARY.

After the Member's condition is stabilized, the Member or his/her Authorized Representative will be presented with the options described below. The inpatient Hospital and Doctor's charges incurred after the Member's condition is stabilized, are determined based on the *network status of the provider*. If:

- the Member elects to be transferred to a network Hospital after stabilization in a non-network Hospital or in an out-of-area Hospital, then the benefits will be paid at the network Hospital and Physician payment percentage shown in PPO MEDICAL BENEFITS SUMMARY. Any transportation costs associated with this transfer will be paid at the network level.
- the Member elects to continue to stay in a non-network Hospital and:
  - receives treatment from a non-network Doctor after stabilization of the Emergency Medical Condition, then the benefits will be payable at the non-network Hospital and Physician payment percentage shown in PPO MEDICAL BENEFITS SUMMARY.
  - receives treatment from a network Doctor after stabilization of the Emergency Medical Condition, then the benefits will be payable at the non-network Hospital and network Physician payment percentage shown in PPO MEDICAL BENEFITS SUMMARY.
- the Member elects to continue to stay in an out-of-area Hospital, then benefits will be payable at the Services Outside the PPO Network Area level shown in PPO MEDICAL BENEFITS SUMMARY.

## **PPO MEDICAL BENEFITS - Continued**

- the Member is admitted to a network Hospital and is under the treatment of a non-network Doctor, and if:
  - the Member elects to transfer care to a network Doctor associated with the network Hospital, then the benefits will be payable at the network Physician payment percentage shown in PPO MEDICAL BENEFITS SUMMARY.
  - the Member elects to continue to receive care from a non-network Doctor associated with a network Hospital, then the benefits will be payable at the non-network Physician payment percentage shown in PPO MEDICAL BENEFITS SUMMARY.

### **Hospital Care and Surgery**

The Plan covers semi-private room and board and ICU expenses as well as other inpatient and outpatient services, supplies and Doctor's charges. Hospital and Doctor charges for infant care through the first seven days of life are covered if you have elected Dependent coverage.

X-rays and lab tests ordered as part of Hospital Care or as part of care received in an ambulatory surgical center are payable at the X-rays and Lab Tests coinsurance percentage shown in PPO MEDICAL BENEFITS SUMMARY.

### **Skilled Nursing Facility**

The Plan covers semi-private care, including room and board, in a licensed skilled nursing facility. Care must be such that it requires the skills of technical or professional personnel, is needed on a daily basis and cannot be provided in the patient's home or on an outpatient basis. Care must be required for a medical condition which is expected to improve significantly in a reasonable period of time and the Member must continue to show functional improvement.

### **Office Visits**

The Plan covers most services and supplies in a Doctor's office, including the cost and fitting of FDA-approved contraceptive devices.

X-rays and lab tests ordered during an Office Visit are payable at the X-rays and Lab Tests payment percentage shown in PPO MEDICAL BENEFITS SUMMARY. The payment percentage is determined by the network status of the provider or facility that performs the x-rays or lab tests.

Certain procedures, such as surgery in a Doctor's office, are considered separate from the office visit. These expenses are subject to the calendar year deductible and payment percentage shown in PPO MEDICAL BENEFITS SUMMARY.

### **Preventive Care**

The Plan covers periodic physical exams by a Doctor for a Member who is at least eight days of age. This includes x-ray and lab services if part of the annual physical exam, necessary immunizations and booster shots. For a Member over the age of two, benefits are payable for one exam per year.

The Plan covers an annual pelvic exam, Pap smear and mammogram. Colorectal cancer screening and prostate specific antigen (PSA) screening are also covered.

Preventive care x-rays and lab tests ordered as part of an Office Visit and performed in a Hospital are subject to the X-rays and Lab Tests "Hospital care" payment percentage shown in PPO MEDICAL BENEFITS SUMMARY.

Preventive care x-rays and lab tests ordered as part of an Office Visit and performed in a provider's office or independent x-ray and lab facility, are subject to the X-rays and Lab Test "Office Visit" payment percentage shown in PPO MEDICAL BENEFITS SUMMARY.

The Preventive Care x-rays and lab tests payment percentage is determined by the network status of the provider or facility that performs the x-rays and lab tests.

## **PPO MEDICAL BENEFITS - Continued**

### **Post-Mastectomy Coverage**

The Plan covers reconstruction of the breast on which a mastectomy has been performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and physical complications related to all stages of mastectomy, including lymphedemas.

Treatment is to be determined by the attending Doctor, in consultation with the patient. Benefits will be payable on the same basis as for similar treatment covered under the Plan.

### **Reconstructive Services and Surgery**

The Plan covers reconstructive services and surgery, including but not limited to treatment of covered newborn children's congenital defects and birth abnormalities, when the reconstruction meets **one** of the following primary purposes:

- When the primary purpose is to restore large skin defects due to a port wine stain.
- When the primary purpose is to relieve severe physical pain caused by an abnormal body structure.
- When the primary purpose is reconstruction following a mastectomy. See "Post-Mastectomy Coverage".
- When the primary purpose is to:
  - treat a functional impairment caused by an abnormal body structure; or
  - restore the Member's normal appearance, regardless of whether a functional impairment exists;

when the abnormality results from a documented Illness that occurred within the preceding 12 months.

Subsequent procedures integral or linked to the covered reconstruction that cannot be performed within the 12-month period due to medical considerations, may be covered after the 12-month period if documented planning for these procedures takes place within 12 months of the Illness.

"Functional impairment" means an impairment that interferes with normal bodily function. For the purpose of this provision, interference with psychological function or well-being is not considered to be a functional impairment.

Certain types of reconstructive services and surgeries may not be covered under the Plan. See BENEFIT LIMITATIONS.

### **Maternity Coverage**

The Plan includes Great Beginnings which is a Maternity Support Program (the GB Program) that will assist Members to identify the care they need during their pregnancy and avoid risks related to their pregnancy. Members who may benefit from the GB Program are identified through a variety of means, such as review of medical claims, preauthorization requests, physician referrals and self referrals. An enrolled Member will receive educational materials and a medical assessment. The care managers in the GB Program will work with the Member and the attending Doctor and provide the care and education necessary during the Member's pregnancy. If it is determined that there are complications and that the pregnancy will qualify as high risk, then the progress of the Member's pregnancy will be followed more intensely and care will be coordinated with the attending obstetrician and perinatologist. All information is confidential and will only be shared with those directly involved in your medical care.

There are no additional out-of-pocket expenses for these services obtained through the GB Program. If this Plan includes a Lifetime Maximum, then any costs associated with the Member's participation in the GB Program will be applied to the Maximum Benefit for All Covered Expenses.

The Plan covers prenatal, childbirth and postnatal care. Coverage for you and your baby, if dependent coverage is elected, includes a Hospital stay of 48 hours following a normal vaginal delivery and 96 hours following a C-section. The 48/96 hours begin following delivery of the last newborn in case of multiple-births. When delivery takes place outside a hospital, the 48/96 hours begin at the time of inpatient admission. The Hospital stay may be less than the 48-hour or 96-hour minimum if a decision for early discharge is made by the attending Doctor in consultation with the mother.

## **PPO MEDICAL BENEFITS - Continued**

*Pre-authorization is not required for the 48/96-hour Hospital stay. However, authorization is needed for a longer stay than as described above.*

### **Family Planning**

The Plan covers tubal ligations, vasectomies, elective abortions and infertility testing.

### **Treatment of Mental Health Conditions and Chemical Dependency**

The Plan covers inpatient and outpatient treatment of mental health conditions, alcoholism, drug addiction and other chemical dependency.

### **Spinal Adjustment and Treatment**

The Plan covers expenses for services related to spinal adjustment.

### **Home Health Care**

The Plan covers home health care visits when services are provided by a licensed home health care agency. Services must be prescribed as an alternative or a follow-up to inpatient Hospital care. The Member must be restricted from leaving home due to a medical condition.

Care must be such that it cannot be learned or performed by the average, non-medically trained person. Care must be provided by technical or professional personnel or by home health aides working along with technical or professional personnel. Care must be required for a medical condition which is expected to improve significantly in a reasonable period of time.

### **Hospice Care**

The Plan covers hospice care if prescribed by a Doctor and the Member's life expectancy is six months or less.

### **Durable Medical Equipment**

The Plan covers durable medical equipment, including orthopedic and prosthetic devices, that are not useful in the absence of an Illness or Injury, not disposable, able to withstand repeated use and appropriate for use in a Member's home.

Coverage includes repair or replacement of covered equipment only when repair or replacement is required as a result of normal usage. Coverage for equipment rental will not exceed the equipment's purchase price.

### **Physical Therapy**

The Plan covers physical therapy rehabilitation that is performed to restore function and prevent disability following acute disease, Injury or loss of body part with the expectation of significant improvement within two months.

Covered therapy includes exercise, heat, cold, electricity, ultrasound and massage to improve circulation, strengthen muscles, encourage return of motion and train Members to perform the activities of daily living.

Massage is covered only when it is part of a covered course of physical therapy and is provided by or under the direct supervision of a physical therapist.

## **PPO MEDICAL BENEFITS - Continued**

### **Occupational, Speech and Hearing Therapy**

The Plan covers outpatient occupational, speech and hearing therapy.

Occupational therapy means rehabilitation to attain the maximum level of physical and psycho-social independence following acute disease, Injury or loss of body part with the expectation of significant improvement within two months. This includes fine motor coordination, perceptual-motor skills, sensory testing, adaptive/assistive equipment, activities of daily living and specialized upper extremity and hand therapies.

Speech therapy means restoration of speech due to impairment following a recent physiological disturbance or Injury, such as CVA, tracheostomy, swallowing disorders, laryngectomy and neuromuscular disease, with the expectation of significant improvement within two months.

### **Transplants**

The Plan covers transplants that have been preauthorized by Medical Management.

Medical Management will direct the patient to the appropriate facility for the patient's specific type of transplant.

Certain types of transplants must be performed in a Great-West Healthcare Transplant Network facility to be covered under the Plan. For more information, contact Member Services at the phone number or website address shown on the Member's ID card.

As used in this Transplant provision, the term "donor" means a person who furnishes an organ or tissue for transplantation. If a human organ or tissue transplant is provided from a donor to a transplant recipient, the following will apply:

- When the donor and recipient are both covered under this Plan - This Plan covers, under the recipient's coverage, eligible transplant expenses incurred by both patients.
- When only the recipient is covered under this Plan - This Plan covers eligible transplant expenses incurred by the recipient. Coverage may also be provided under this Plan for certain donor expenses, but only if such donor expenses are not eligible for coverage under any other coverage available to the donor.
- When only the donor is covered under this Plan - When the donor is covered under this Plan, but the recipient is not, this Plan does not cover transplant expenses of either person.

Any amounts paid under this Plan on behalf of a donor or a recipient will count toward the recipient's Plan lifetime maximum.

### ***Travel Expenses***

The Plan covers the following:

- Transportation costs and miscellaneous expenses such as lodging, meals and parking incurred for travel to and from a Great-West Healthcare Transplant Network facility, if the site is outside a 50-mile radius from the Member's home. Travel expenses must be preauthorized by Medical Management to be covered under the Plan.

Travel expense coverage will be for the Member (the transplant recipient) and one other individual, or two other individuals if the transplant recipient is a minor, accompanying the Member. While there is no maximum limit to the number of days per trip, miscellaneous expenses such as lodging, meals and parking are limited to \$100 per person, per day. Transportation expenses do not have a daily limit.

Travel coverage, including transportation and miscellaneous expenses, is limited to the Transplant Travel Expenses Lifetime Maximum shown in PPO MEDICAL BENEFITS SUMMARY, not to exceed \$100 total per person, per day.

- If a living donor is used, reimbursement for the donor's Travel Expenses to and from a Great-West Healthcare Transplant Network facility is limited to one trip and \$100 per day for travel and lodging. All living donor travel and lodging charges apply to the Member's Transplant Travel Expenses Lifetime Maximum shown in PPO MEDICAL BENEFITS SUMMARY.

Travel expenses are not covered if the Member utilizes a facility other than a Great-West Healthcare Transplant Network facility.

## **PPO MEDICAL BENEFITS - Continued**

### **Enteral Nutrition**

Enteral nutrition means medical foods that are specially formulated for enteral feedings or oral consumption. Coverage includes medically approved formulas prescribed by a Physician for the treatment of phenylketonuria (PKU).

The Plan covers enteral nutrition and supplies required for enteral feedings when *all* of the following conditions are met:

- It is necessary to sustain life or health;
- It is used in the treatment of, or in association with, a demonstrable disease, condition or disorder;
- It requires ongoing evaluation and management by a Physician; and
- It is the sole source of nutrition or a significant percentage of the daily caloric intake.

Coverage *does not* include:

- Regular grocery products that meet the nutritional needs of the patient (e.g., over-the-counter infant formulas such as Similac, Nutramigen and Enfamil); or
- Medical food products:
  - Prescribed without a diagnosis requiring such foods;
  - Used for convenience purposes;
  - That have no proven therapeutic benefit without an underlying disease, condition or disorder;
  - Used as a substitute for acceptable standard dietary intervention; or
  - Used exclusively for nutritional supplementation.

### **Clinical Trials**

Services and supplies, such as medications, provided as part of clinical trials are generally not covered under the Plan because they are Experimental, Investigational or Unproven.

However, the Plan covers clinical services, as defined in this provision, when a Member participates in a phase III or IV clinical trial that has been preauthorized by Medical Management for treatment of cancer or other life-threatening illness, if all of the following criteria are met:

- the Member has a current diagnosis that will likely be terminal in less than two years under generally accepted treatment options in the absence of the clinical trial; and
- standard therapies have not been effective in significantly improving the condition or standard therapies are not medically appropriate; and
- the Member must be enrolled in the clinical trial and not be treated off protocol; and
- treatment is provided in a clinical trial that meets certain criteria established by Great-West Healthcare. For more information, contact Member Services at the phone number or website address shown on the Member's ID card.

All Plan provisions, including but not limited to pretreatment authorization and Medical Management review, apply to a Member's participation in a clinical trial.

For the purpose of this provision, "clinical services" mean services and supplies that are:

- necessary to administer the service or supply that is the focus of the clinical trial.
- necessary for management of the patient's health within the clinical trial.
- required for the clinically appropriate monitoring of the effects of the focus of the clinical trial (example: blood tests to measure tumor markers).
- required for the prevention, diagnosis or treatment of complications that result from the clinical trial treatment.

Clinical services do not include:

## **PPO MEDICAL BENEFITS - Continued**

- services and supplies that:
  - are excluded from coverage under the Plan in absence of an approved clinical trial.
  - are customarily provided by the trial sponsor at no cost to the patient.
  - are provided solely to determine trial eligibility.
  - are provided solely to satisfy the trial's data collection needs (examples: monthly CT scans for a condition that usually requires a single scan, protocol induced costs).
- costs that are funded by other agencies or research sponsors.
- expenses such as travel, housing, companion expenses that may result from a Member's participation in a clinical trial.
- administrative services (example: statistical analysis).
- charges related to covered services or supplies that have not or cannot be separated from costs related to non-covered services or supplies.

### **Miscellaneous Medical Services and Supplies**

- Nursing services.
- Air or ground ambulance when used to transport a Member:
  - from place of Illness or Injury to the nearest Hospital where appropriate treatment can be provided; and
  - from one Hospital to another, when approved by Medical Management.
- General anesthesia and associated facility charges for dental procedures when determined to be Medically Necessary.
- Custom-designed orthotics when prescribed by a Doctor and required for all normal, daily activities.
- Treatment of Injury to sound/natural teeth within six months after the accident. "Sound/natural" means teeth that are free from defect or disease, and are not artificial. A chewing injury is not considered to be an Injury.
- Services required for the treatment of diabetes and diabetes self-management education programs.

### **■ Is There a Limit On My Expenses?**

The breakpoint maximums are shown in PPO MEDICAL BENEFITS SUMMARY.

#### **Calendar Year Breakpoint**

If in any one calendar year a Member's covered expenses reach the individual breakpoint, all other covered expenses for that Member during the rest of that calendar year, subject to the Member's payment of copays and satisfaction of deductibles, will be payable at 100%. No more than the individual breakpoint per Member will be applied to the family breakpoint.

Covered expenses for outpatient care of mental health conditions and chemical dependency treatment will *not* be payable at 100%, even if a Member has reached the breakpoint.

#### **Expenses Excluded from the Breakpoint**

Expenses that are not applied toward the breakpoint include expenses:

- for services and supplies not covered under this Plan.
- used to satisfy any deductible or copay amounts.
- for outpatient care of mental health conditions and chemical dependency.
- that are payable at 100%.

## **PRESCRIPTION DRUG BENEFITS**

The prescription drug benefits are provided through several programs. The Choice Pharmacy Program uses a nationwide network of participating retail pharmacies. The Ninety-day Retail Network Pharmacy Program offers the convenience of obtaining a three-month supply of medication at designated retail pharmacies. The Mail Order Drug Program offers one mail order pharmacy that can dispense a multiple-month supply of medication and lowers a member's out-of-pocket costs. The Specialty Drug Program uses a small pharmacy network referred to as the Specialty Pharmacy Network (SPN). The SPN covers certain drugs commonly referred to as *high-cost specialty drugs*.

The Tier 2 and Tier 3 drugs are subject to change. Contact Member Services or go to [www.mygreatwest.com](http://www.mygreatwest.com) for additional information.

Covered drugs and contraceptive devices require the written prescription of a Doctor and approval by the Food and Drug Administration (FDA). Drugs and contraceptive devices must be purchased from a licensed pharmacist or Doctor. Benefits are payable only for drugs required for the treatment of illness or birth control, when received as an outpatient and while covered for these benefits.

New FDA approved drugs are evaluated by the Pharmacy and Therapeutics Committee of your Plan's pharmacy benefit management company. Oversight and final decisions are made by the Great-West Healthcare Pharmacy Committee.

Some drugs may have dispensing limits that are primarily based on FDA recommendations. Additionally, some drugs are subject to prior authorization. Coverage for these drugs is dependent upon satisfying Medically Necessary requirements.

### **The Choice Pharmacy Program**

The Choice Pharmacy Program covers charges for prescription drugs, insulin and diabetic supplies, except as specifically excluded under the Plan. Refer to Prescription Drug Benefit Limitations.

Benefits are also payable for contraceptive drugs and devices prescribed for the purpose of birth control.

The Choice Pharmacy Program covers a 30-day supply received in any one purchase.

Covered expenses will be limited to the cost of a generic drug if a generic drug is available. If the Member requests a brand name drug when a generic drug is available, then, in addition to the brand name drug copay, the Member must pay the difference between the cost of the generic drug and the brand name drug.

When a Member shows his/her ID card at a participating pharmacy, the pharmacist will collect the appropriate copay and the Member won't have to file a claim.

If a Member buys drugs at a pharmacy that is not a participating pharmacy, the Member must pay the pharmacist the full price of the drug and file a claim for reimbursement. Reimbursement will be 50% of the network pharmacy cost of the drug, minus the copay amount.

### **Ninety-day Retail Network Pharmacy Program**

For convenience, a Member may elect to have a 90-day supply of maintenance medication filled at a designated retail pharmacy. This option is available **only after the Member has filled a 30-day prescription for the same medication**. To locate a retail network pharmacy that is equipped to fill a 90-day supply of medication, you may contact Member Services or access the website at [www.mygreatwest.com](http://www.mygreatwest.com). The minimum supply available under this benefit is an 80-day supply.

## **PRESCRIPTION DRUG BENEFITS - Continued**

### **Mail Order Drug Program**

The Mail Order Drug Program covers costs for home delivery and expenses for prescription maintenance drugs required for treatment of illness. Prescription maintenance drugs are drugs prescribed by the Doctor on an ongoing basis. This includes expenses for diabetic supplies and insulin.

Benefits are also payable for contraceptive drugs and devices prescribed for the purpose of birth control.

With this program, a Member may buy through the mail up to 90-day supplies of insulin and covered maintenance prescription drugs. Ask the Employer for a mail order drug brochure.

Ask the Doctor to prescribe needed medications for a 90-day supply, plus refills. If a Member is presently taking medications, the Member should ask the Doctor for a new prescription.

Covered expenses will be limited to the cost of a generic drug if a generic drug is available. If a Member's prescription is for a brand name drug but a generic equivalent is available, then in addition to the brand name drug copay, the Member must pay the difference between the cost of the generic drug and the brand name drug.

**If medication is needed immediately**, the Member should ask the Doctor for two prescriptions. The first should be for a 14-day supply that the Member can have filled at a local participating pharmacy. The second prescription should be mailed to the Mail Order Drug Program with the copay.

### **The Specialty Pharmacy Program**

The Specialty Pharmacy Program covers certain drugs commonly referred to as *high-cost specialty drugs*. To receive the network discount for these medications, and lower out-of-pocket costs, these drugs must be obtained by mail through a select group of pharmacies. These pharmacies comprise the Specialty Pharmacy Network (SPN). The SPN specializes in dispensing and delivering drugs that require special handling. Specialty Pharmacies provide additional helpful services, including free courier delivery, Medically Necessary ancillary supplies such as syringes and alcohol swabs, and education programs focused on the disease for which the medication is dispensed. Common conditions that involve treatment with one of the specialty drugs include multiple sclerosis, hepatitis C and rheumatoid arthritis.

With a new Specialty Pharmacy prescription, the Member may contact Member Services, or access [www.mygreatwest.com](http://www.mygreatwest.com), to identify the drugs contained on the Specialty Pharmacy list. Members may also access the website or contact Member Services for assistance in locating the Specialty Pharmacy that can be used to obtain medication.

### **Managed Drug Limit (MDL) Program**

The MDL Program helps promote safe, clinically appropriate prescription drug use. With this program there is a limit on the dose amount and days' supply of certain medications. The limits for prescription drugs were developed based on recommendations by the Food and Drug Administration (FDA) and the manufacturer of the prescription drug. If a Doctor prescribes an additional supply of a prescription drug that is on the MDL list, the Pharmacy Prior Authorization (PPA) unit will review the request for Medical Necessity. If a Member has exceeded the limit, the Member must contact the Doctor or Member Services to initiate the authorization process with the PPA unit for additional supply of the prescription drug.

### **The Prior Authorization (PA) Program**

The PA program helps to control the cost of prescription drug benefits by requiring certain high-cost drugs to be reviewed for Medical Necessity. This list is reviewed and updated periodically. The Member must make sure to contact their Doctor or Member Services to initiate the authorization process with the PPA unit for the high-cost drugs. To avoid any delay when filling prescriptions, a Member can call Member Services or access the Prior Authorization prescription drug list available at [www.mygreatwest.com](http://www.mygreatwest.com).

## **BENEFIT LIMITATIONS**

### **Pre-Existing Conditions Limitation for Medical Benefits**

This provision will *not* apply to a child placed with you for adoption.

A pre-existing condition is an illness or any related condition for which a Member received services, supplies or medication during the 3 months before the enrollment date of the Member under this medical Plan.

A pre-existing condition is not:

- A pregnancy existing on the enrollment date.
- Genetic information.

Benefits are payable for services, supplies and medication received for a pre-existing condition if they are received 12 months after the enrollment date for the Member.

For a late applicant as described in “What If I Don’t Apply On Time?”, benefits will be payable for services, supplies and medication for a pre-existing condition only if they are received on or after the date which is 18 months after the person’s enrollment date.

“Enrollment date” means:

- the first day of coverage; or
- the first day of the eligibility waiting period, if an eligibility waiting period is required by the Employer.

You must apply for coverage for yourself and/or your eligible Dependents within the 31-day period when you are first eligible.

### **Portability of Coverage**

A person will receive credit toward this Plan’s Pre-Existing Condition Limitation periods for the time covered under another health plan, but only if the person was covered, under another health plan that meets the definition of “Creditable Coverage”, within the 63-day period just before his or her enrollment date under this Plan. Any eligibility waiting period that the person must satisfy under this Plan will not be considered in determining the 63-day period. Creditable Coverage information is given to Great-West by the Employer. For questions regarding the amount of prior Creditable Coverage, contact the Plan Administrator.

If the person was covered:

- For a period of time under Creditable Coverage that is greater than the time periods referred to in the Pre-Existing Conditions Limitation, then the Pre-Existing Conditions Limitation periods will not apply to the person.
- For a period of time under Creditable Coverage that is less than the time periods referred to in the Pre-Existing Conditions Limitation, then the Pre-Existing Conditions Limitation periods will be reduced by the number of consecutive days that the person was covered under Creditable Coverage.

However, for a child who became covered under Creditable Coverage within 31 days of birth, the Pre-Existing Conditions Limitation periods will not apply regardless of how long the child was covered under Creditable Coverage.

If a Member resides in Colorado and:

- The Member’s coverage under this medical Plan has been in force for at least six months; and
- The Member has a pre-existing condition that will not be covered under this Plan because he has not satisfied the periods referred to in this provision;

Then, subject to payment of the required premium, the Member may be eligible for coverage under the Colorado High Risk Health Insurance Act, under the CoverColorado program.

For further information regarding CoverColorado, please contact:

**CoverColorado**  
**425 So. Cherry Street, Suite 160**

## **BENEFIT LIMITATIONS - Continued**

**Glendale, Colorado 80246  
303-863-1960 or 1-877-461-3811**

### **Medical Benefit Limitations**

#### *No amount will be payable for:*

- Services and supplies that are not Medically Necessary.
- Custodial care of a Member whose health is stabilized and whose current condition is not expected to significantly or objectively improve or progress over a specified period of time. Custodial care does not seek a cure, can be provided in any setting and may be provided between periods of acute or intercurrent health care needs.

Custodial care includes any skilled or non-skilled health services or personal comfort and convenience services which provide general maintenance, supportive, preventive and/or protective care. This includes assistance with, performance of, or supervision of:

- walking, transferring or positioning in bed and range of motion exercises;
- self-administered medications;
- meal preparation and feeding, by utensil, tube or gastronomy;
- oral hygiene, skin and nail care, toilet use, routine enemas;
- nasal oxygen applications, dressing changes, maintenance of indwelling bladder catheters, general maintenance of colostomy, ileostomy, gastronomy, tracheostomy and casts.
- Special nursing services if those same services could be provided by the regular nursing staff of any Hospital in which the Member is confined.
- Charges by a Doctor for any phone call or interview during which the Member is not examined.
- Confinement, treatment, services or materials for educational or training problems or learning disorders.
- Outpatient physical, occupational or speech therapy for non-acute injuries, diseases or conditions that are not reasonably expected to result in significant clinical improvement within two months. This includes developmental progress in skills such as sitting, walking, talking and learning that compare unfavorably to measured results from standardized tests of others of the same age.
- Services or supplies which are primarily for the Member's education, training or development of skills needed to cope with an injury or sickness, except as specifically provided in the Plan.
- Any expense or charge, including any membership dues, associated with exercise equipment, health clubs, weight loss clinics or similar programs.
- Travel or transportation expenses, except as specifically provided in the Plan.
- Cosmetic, plastic or reconstructive services or surgery, except reconstructive services and surgery described in "What's Covered?".
- Gene manipulation therapy.
- The reversal of any sterilization procedure.
- Massage, except when it is part of a covered course of physical therapy and is provided by or under the direct supervision of a physical therapist.
- Services for a surgical procedure to correct refraction errors of the eye, including any confinement, treatment, services or supplies provided in connection with or related to the surgery.
- Eyeglasses, contact lenses, eye exams to assess visual acuity or the fitting of glasses and lenses.
- Care of or treatment to the teeth, gums or supporting structures such as, but not limited to, periodontal treatment, endodontic services, extractions, implants, or any treatment to improve the ability to chew or speak, unless otherwise covered under this Plan.
- Non-prescription/over-the-counter drugs or medicines, except as specifically provided under the Plan.
- Drugs or medicines that are not approved by the Food and Drug Administration (FDA).

## **BENEFIT LIMITATIONS - Continued**

- Programs related to smoking cessation.
- Osteotomy, orthognathic surgery, maxillofacial orthopedics or related treatment for deformities caused by anything other than cancer or trauma.
- Treatment for the purpose of weight loss, unless the Member is morbidly obese.
- Hearing aids or the fitting of hearing aids, including surgically implanted hearing aids.
- Treatment of temporomandibular disorders and craniofacial muscle disorders.
- Counseling, except as covered under the Plan's mental health and chemical dependency provisions.
- Drugs, medicines or insulin which are received as an outpatient.
- Any family planning procedure that requires surgical or drug assisted reproductive technology, such as, but not limited to, artificial insemination, in-vitro fertilization, GIFT or ZIFT, except necessary care and supplies needed to diagnose infertility.
- Infertility treatment.
- Chelation therapy, except to treat heavy metal poisoning.
- Examinations or treatment ordered by a court in connection with legal proceedings when such treatment or examinations are not included as a covered expense under the Plan.
- Sex transformation procedures, services and supplies.
- Charges made by a Doctor for his or her time on "stand-by" status if he or she performs no actual services except for interventional cardiology procedures (such as angioplasty) and C-sections.
- Purchase or rental of luxury medical equipment when standard equipment is appropriate for the patient's condition (e.g., motorized wheelchairs or other vehicles, bionic or computerized artificial limbs).
- Computerized speech devices or other adaptive equipment that is not primarily restorative in nature.
- Any charge not included as a covered expense under the Plan.
- Transplants, except as provided in the Transplant benefit provision. Non-human organs and Experimental, Investigational or Unproven transplant services and supplies, and any transplant expenses which are eligible to be paid under any private or public research fund, government program or other funding program, are not covered.
- Home delivery. Pre and postnatal care are covered expenses, but obstetrical services and medical expenses related to home delivery are not covered.
- Emergency Room Care charges for non-Emergency Medical Conditions.
- Transcutaneous Electrical Nerve Stimulation (TENS) units.
- Enteral feedings, supplies and specially formulated medical foods that are prescribed and non-prescribed, except as specifically provided in the Enteral Nutrition benefits provision.
- Clinical trials, except as provided in the Clinical Trials benefit provision.

### **Prescription Drug Benefit Limitations**

#### ***No amount will be payable for:***

- Therapeutic devices and appliances, except as specifically provided under the Plan.
- Non-prescription/over-the-counter drugs and supplies, except as specifically provided under the Plan.
- Drugs or medicines that are not approved by the Food and Drug Administration (FDA).
- The administration of drugs.
- More than one purchase of a drug or insulin during the dosage period recommended by the prescribing Doctor.
- Allergy serums.
- Drugs for treatment of infertility.

### **General Benefit Limitations**

#### ***No amount will be payable for:***

## **BENEFIT LIMITATIONS - Continued**

- Experimental, Investigational or Unproven services and supplies. Any service or supply that is integral or linked to an Experimental, Investigational or Unproven service or supply that, in the absence of the Experimental, Investigational or Unproven service or supply, would not be Medically Necessary, is also not covered.
- Vision therapy or orthoptic treatment.
- Anti-obesity drugs and formulas.
- Broken appointments.
- Care provided by a government health plan or for which there would be no cost if the Member did not have coverage. If the Member is entitled to benefits under a state-sponsored medical assistance program, benefits under the Plan will be paid to the state.
- Expenses incurred for care provided by your or your spouse's immediate or extended family.
- Care received for an illness that is a result of war or engaging in a riot or insurrection.
- An Injury that occurs while working for pay or profit.
- An illness for which the Member can receive benefits under any Workers' Compensation or similar law.

## **CLAIMS & LEGAL ACTION**

### **■ How To File Claims**

A claim for benefits and services that have been provided may be filed by a Member, beneficiary or Authorized Representative. An *Authorized Representative* means a person authorized in writing by the Member or a court of law to represent the Member's interests for claim submission, pretreatment requests and appeals.

The Member's spouse, parent (if Member is a minor) and health care provider will be automatically recognized as the Member's Authorized Representative for pretreatment requests, claim submissions and appeals. For requests involving urgent care, any health care professional with knowledge of a Member's condition will also be automatically recognized as the Member's Authorized Representative for pretreatment requests and appeals.

All claim forms include instructions on how to complete and submit a claim. Members can request a claim form from the Plan Administrator or go to [www.mygreatwest.com](http://www.mygreatwest.com) to print a copy of a claim form. Complete and accurate claim information is necessary to avoid claim processing delays. Claim decisions will not exceed the time frames described below, unless the Member, beneficiary or Authorized Representative agrees to a longer period of time.

#### **Health Benefits**

##### ***Medical Benefits***

Members who present their ID card when using a network provider will not have to file a claim. The ID card contains all the information network providers need to directly bill the Company for the balance.

For other services, Members must file a claim. Sign the completed form, attach the itemized bill and mail both to the address on the Member ID card.

An Explanation of Benefits (EOB) will be sent to the Member showing how the claim was paid.

For expenses incurred outside the United States, the Member must pay the bill and file a claim.

##### ***Prescription Drug Benefits***

A prescription given to a pharmacist is not a claim for benefits under the Plan. A Member may submit a claim for prescription drugs if:

- a copay amount was charged that the Member believes to be incorrect; or
- all or a portion of the cost of a prescription drug or supply is paid by the Member at the time the drug or supply is dispensed and the Member wants to request reimbursement for the amount paid; or
- prescription drugs or supplies are purchased at a pharmacy that is *not* a participating pharmacy.

Claim forms are available from Member Services and from the Employer. If a Member decides to pay full price to purchase a drug or supply, the Member should submit a claim to the prescription drug benefits manager for processing. Benefits will be processed subject to the provisions of the Plan. This includes any deductible, copayment percentage, coverage limitations and benefit maximums.

With the first Mail Order drug order, the Member should complete the member profile form found in the Mail Service brochure. Ask the Employer for a copy of this brochure.

##### ***Claim Decisions***

Claims for health benefits and services provided to a Member will be processed within 30 days of the date the claim is received by Great-West. If a decision cannot be made within this time period for reasons beyond the control of the Plan, the Member will be notified of:

- the reasons for the delay;
- any information needed to perfect the claim; and

## **CLAIMS & LEGAL ACTION - Continued**

- the date by which a decision is expected.

The Member will have 45 days from the date the notice is received to provide the requested information. If the information is received within this time period, a decision will be made within 15 days of the date the information is received, unless the Member agrees to a longer period of time. If the requested information is not provided within this time period, the Member should consider the claim to be denied. The claim will be reconsidered if the information is subsequently received.

### **■ If A Claim Is Denied**

If benefits are denied, in whole or in part, Great-West will send the Member a written or electronic notice within the established time periods described in "How to File Claims". The Member or Authorized Representative may appeal the denial as described below. The adverse determination notice will include the reason(s) for the denial, reference to the Plan provision(s) on which the denial is based, whether additional information is needed to process the claim and why the information is needed, the claim appeal procedures and time limits, and the Member's right to bring civil action under ERISA Section 502(a) after required Plan appeals have been exhausted.

The notice will also specify:

- whether an internal rule, guideline, protocol or other criterion was relied upon in making the claim decision and that this information is available to the Member upon request and at no charge.
- that an explanation of the scientific or clinical judgment for a decision based on medical necessity, experimental treatment or a similar limitation is available to the Member upon request and at no charge.

### **Appeal of a Health Benefit Claim Denial**

After receiving notice of a claim denial, in whole or in part, the Member, the Member's beneficiary, provider or other Authorized Representative can appeal a claim denial by submitting a written request within:

- 180 days of the date the notice of denial of the initial claim is received; or
- 60 days of the date the notice of the initial appeal decision is received.

The appeal request must be submitted to Health Claim Appeal at the address on the adverse determination notice. The appeal request should include the Member's and the Employee's name and identification number, the date of service, address and telephone number of the Member and the provider, and a description of the appeal.

The appeal will be reviewed by an individual who was not involved in the prior adverse determination and who is not a subordinate of the individual who made the prior determination. If the prior determination was based on medical judgment, a health care professional with appropriate training in the field of medicine that is the subject of the claim will be consulted and identified.

In connection with the review, the Member has the right to:

- review and request copies of relevant documents, free of charge; and
- submit issues and comments in writing; and
- have a representative act on his or her behalf in the appeal.

The decision on the appeal will be made within 30 days of the date the appeal is received.

In the case of an adverse decision of an appeal, the notice of the decision will include the information described above for a claim denial.

Two appeals are required before the Member may bring civil action under ERISA Section 502(a) as described in the Statement of ERISA Rights.

Once the required appeals have been exhausted, additional appeals are allowed on a voluntary basis upon request when new and substantial information is provided. Voluntary reviews must be requested within 60 days of the date the notice of the appeal decision is received.

## **CLAIMS & LEGAL ACTION - Continued**

There are no voluntary appeal rights following the required appeal process when the denial was based on medical judgment.

The Member has a right to request information regarding voluntary appeal procedures. Any statute of limitations or other defense based on timeliness is suspended during the time that a voluntary appeal is pending. Voluntary appeals do not need to be exhausted in order to bring civil action under ERISA Section 502(a).

For the purposes of health benefits, "medical judgment" includes but is not limited to Medically Necessity, and Experimental, Investigational or Unproven determinations.

Please see "How Does the Plan Work?" in MEDICAL BENEFITS for information about pretreatment authorization, urgent care and non-urgent care denials and appeals.

### **■ What If a Member Has Other Health Coverage?**

A Member may be covered under more than one health plan. For example, coverage may be under this Plan and also under a group health plan sponsored by the Employee's spouse's employer. If this type of duplicate coverage occurs, this Plan uses a method called Coordination of Benefits (COB) to determine which plan pays benefits first on a claim (is primary) and which plan pays second (is secondary). Under COB, total payments from both plans will never be more than the expenses actually incurred.

This COB provision does not apply to your Prescription Drug Benefits.

The benefits provided by the plans listed below are considered in coordinating benefits:

- This Plan;
- Any other group health plan, including automobile fault or no-fault insurance; Health Maintenance Organizations (HMOs); Blue Cross/Blue Shield;
- Any labor-management trusteed plan, union welfare plan, employer organization plan or employee benefit organization plan;
- Any government plan or statute providing benefits for which COB is not prohibited by law;
- Any individual automobile no-fault insurance plan.

### **Which Plan Is Primary?**

Certain rules are used to determine which of the plans will be primary. This is done by using the first of the following rules that applies:

- A plan with no COB provision will determine its benefits before a plan with a COB provision.
- A plan that covers a person other than as a Dependent will determine its benefits before a plan that covers the person as a Dependent.
- When a claim is made for a Dependent child who is covered by more than one plan, in most cases the birthday rule will be used to determine the order of benefits. Under the birthday rule:
  - the plan of the parent whose birthday falls earlier in a year will be primary; but
  - if both parents have the same birthday, the plan that covered the parent longer will be primary.

However:

- If the other plan does not have the birthday rule, then the plan that covers the child as a Dependent of the male parent will be primary.
- If the parents are legally separated or divorced, benefits for the child will be determined in this order:
  - \* first, the plan of the parent with custody of the child will pay its benefits;
  - \* then, the plan of the spouse of the parent with custody of the child will pay its benefits; and
  - \* finally, the plan of the parent not having custody of the child will pay its benefits.

## **CLAIMS & LEGAL ACTION - Continued**

However, if there is a court decree stating which parent is responsible for the health care expenses of the child, then a plan covering the child as a Dependent of that parent will be primary.

If a court decree states that the parents have joint custody of the child, but does not specify which parent has responsibility for the child's health care expenses, benefits will be determined on the same basis as for a child whose parents are not separated or divorced.

- A plan that covers a person as:
  - a laid-off or retired employee; or
  - a Dependent of such an employee; or
  - a continuee under a state or Federal law;

will determine its benefits after the benefits of any other plan covering that person as an employee.

If one of the plans does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule will not apply.

- When a claim is made for an Employee's Dependent who is also covered under Medicare and as a retiree under his employer's plan:
  - the plan covering the person as a Dependent will determine its benefits prior to Medicare; and
  - the plan covering the person as a retiree will determine its benefits after Medicare.
- If none of the above rules establishes the order of payment, the plan covering the person for a longer period of time will be primary.

### **What If This Plan Is Primary?**

If this Plan is primary, it will determine its benefits without considering other coverage. The Member should submit the claim first to the Benefit Payment Office listed on the claim form. When the explanation of benefits is received from this Plan, send it, along with the claim and itemized bills, to the secondary plan.

### **What If This Plan Is Secondary?**

Submit the Member's claim first to the primary plan. After the other plan has determined its benefits, send the explanation of benefits from the other plan, along with the Member's claim, to the Benefit Payment Office listed on the claim form.

If this Plan is secondary, it pays the lesser of:

- the allowable expenses that were not reimbursed under the other plan; and
- the amount this Plan would have paid if there were no other coverage.

The COB provision is applied throughout the calendar year.

When the COB provision reduces the benefits payable under this Plan:

- each benefit will be reduced proportionately; and
- only the reduced amount will be charged against any benefit limits under this Plan.

A credit savings may be established if this Plan is secondary. A credit savings is the difference between the benefits this Plan would pay if there were no other coverage and the benefits this Plan actually paid. Credit savings may be used to provide 100% rather than partial payment of allowable expenses that are incurred by the same person within the same calendar year.

Allowable expenses for a Member are any necessary, usual and customary items of expense, at least part of which is covered under at least one of the plans covering the person.

Allowable expenses will not include the difference between the cost of a private Hospital room and a semi-private Hospital room unless the patient's stay in a private Hospital room is Medically Necessary.

## CLAIMS & LEGAL ACTION - Continued

When the benefits of a government plan are taken into consideration, the allowable expense is limited to the benefits provided by that plan.

### ■ How Will Benefits Be Affected By Medicare?

The following applies to you if you are an active Employee and you or your spouse becomes eligible for Medicare **due to age**. You and your Dependents will continue to be eligible for the benefits provided under this medical Plan. This Plan will coordinate benefits with Medicare. If:

- Your Employer employed at least 20 full-time or part-time employees during at least 20 calendar weeks of the preceding or current calendar year, then this medical Plan will be considered the Member's primary coverage, and Medicare will be considered the Member's secondary coverage. This means that benefits under this medical Plan will be payable first, and then Medicare will determine the remaining expenses it will pay.
- Your Employer employed fewer than 20 full-time or part-time employees during at least 20 calendar weeks of the preceding or current calendar year, then Medicare will be considered primary, and this medical Plan will be considered secondary.

The following applies to you if you are an active Employee and you or your Dependents become eligible for Medicare **due to disability**. You and your covered Dependents will continue to be eligible for the benefits provided under this medical Plan. This Plan will coordinate benefits with Medicare. If:

- Your Employer employed at least 100 full-time or part-time employees during 50% or more of the Employer's business days during the previous calendar year, then coverage under this medical Plan will be considered the primary coverage, and Medicare will be considered the secondary coverage. This means that the benefits payable under this medical Plan will be payable first, and then Medicare will determine the remaining expenses it will pay.
- Your Employer employed fewer than 100 full-time or part-time employees during 50% or more of the Employer's business days during the previous calendar year, Medicare will be considered the primary coverage, and coverage under this Plan will be considered the secondary coverage.

### If A Member Becomes Eligible for Medicare Due to End-Stage Renal Disease (ESRD)

Under Medicare law, a Member must complete a waiting period, typically three months, before becoming eligible for Medicare solely because of ESRD. During this waiting period, this Plan will pay benefits and Medicare will not pay any benefits.

After the waiting period, for the first 30 months of eligibility for Medicare Part A benefits solely due to ESRD, this Plan will pay its benefits first (primary payer) and Medicare will pay its benefits second (secondary payer). After that, if the Member is still eligible for Medicare due to ESRD, Medicare will be the primary payer and this Plan will be the secondary payer.

In certain circumstances, such as a kidney transplant, the 30-month time frame that this Plan will be the primary payer may be less as defined by the Medicare guidelines for determining primary payer.

If the Member becomes eligible for Medicare due to ESRD after Medicare became the primary payer under any other provision of Medicare law or this Plan, Medicare will be the primary payer and this Plan will be the secondary payer.

Treatment must be rendered in a Medicare-approved facility in order to be covered under this Plan.

A Member is eligible for Medicare when:

- the Member is covered under Medicare; or
- the Member is not covered under Medicare due to:
  - the Member's refusal of Medicare coverage;
  - the Member's voluntary termination of Medicare coverage; or
  - the Member's failure to apply for Medicare coverage.

## **CLAIMS & LEGAL ACTION - Continued**

### **■ Provision for Subrogation and Right of Recovery**

An Other Party may be liable or legally responsible to pay expenses, compensation and/or damages in relation to an Illness incurred by a Member (i.e. a Covered Person). A Covered Person is defined to also include the Member's legal representative.

An Other Party is defined to include, but is not limited to, any of the following:

- the party or parties who caused the Illness;
- the insurer or other indemnifier or guarantor or indemnifier of the party or parties who caused the Illness;
- the Covered Person's own insurer (for example, in the case of uninsured, underinsured, medical payments or no-fault coverage);
- a Workers' Compensation insurer;
- any other person, entity, policy or plan that is liable or legally responsible in relation to the Illness.

Benefits may also be payable under the Plan in relation to the Illness. When this happens, Great-West may, at its option:

- subrogate, that is, take over the Covered Person's right to receive payments from the Other Party. The Covered Person will transfer to Great-West any rights he or she may have to take legal action arising from the Illness to recover any sums paid under the Plan on behalf of the Covered Person;
- recover from the Covered Person any benefits paid under the Plan from any payment the Covered Person is entitled to receive from the Other Party.

The Covered Person must cooperate fully with Great-West in asserting its subrogation and recovery rights. The Covered Person will, upon request from Great-West, provide all information and sign and return all documents necessary to exercise Great-West's rights under this provision.

Great-West will have a first lien upon any recovery, whether by settlement, judgment, mediation or arbitration, that the Covered Person receives or is entitled to receive from any of the sources listed above. This lien will not exceed:

- the amount of benefits paid by Great-West for the Illness, plus the amount of all future benefits which may become payable under the Plan which result from the Illness. Great-West will have the right to offset or recover such future benefits from the amount received from the Other Party; or
- the amount recovered from the Other Party.

No Covered Person shall make any settlement which specifically reduces or excludes, or attempts to exclude, the benefits provided by the Plan.

If the Covered Person:

- makes any recovery from any of the sources described above; and
- fails to reimburse Great-West for any benefits which arise from the Illness;

then:

- the Covered Person will be personally liable to Great-West for the amount of the benefits paid under this Plan; and
- Great-West may reduce future benefits payable under this Plan for any Illness by the payment that the Covered Person has received from the Other Party.

**Great-West's first lien rights will not be reduced due to the Covered Person's own negligence; or due to the Covered Person not being made whole; or due to attorney's fees and costs.**

For clarification, this provision for subrogation and right of recovery applies to any funds recovered from the Other Party by or on behalf of:

- an Employee's minor covered Dependent;
- the estate of any Covered Person; or

## **CLAIMS & LEGAL ACTION - Continued**

- on behalf of any incapacitated person.

### **■ Other Information a Member Needs to Know**

#### **Proof of Claim**

Send written claim to Great-West as soon as reasonably possible. A Member must submit a written claim no later than 15 months from the date the claim is incurred, unless legally incapable of doing so.

#### **Complaint Process**

For concerns or complaints, contact Member Services at the phone number shown on the ID card. Whether the issue involves health care or the administration of coverage, Great-West's representatives will do what they can to make sure it's addressed. No retaliatory action will be taken by Great-West against the Member because of a complaint. Great-West's goal is for the Member to be completely satisfied with the measures taken to resolve the issue. However, if a Member is not satisfied, Great-West's representatives can help the Member begin the formal complaint process. If the issue is not resolved to the Member's satisfaction, the Member may appeal.

For complaints involving timely claim payment or a denial of a claim see "How To File Claims". For complaints involving a preauthorization determination, see "Medical Management (MM) Program" in MEDICAL BENEFITS.

For all other complaints, including those related to availability, delivery or quality of a health care service, contact Member Services for an explanation of the complaint process.

#### **Legal Actions**

A Member may bring a legal action to recover under the Plan. Such legal action may be brought no sooner than 60 days, and no later than 3 years, after the time written proof of loss is required to be given under the terms of the Plan.

#### **Physical Examinations**

The Company, at its own expense, has the right to have the person for whom a claim is pending examined as often as reasonably necessary.

#### **Benefit Payments**

Benefits will be paid to the Member, if living. If not, benefits will be paid to the Member's estate. If any benefit is payable to the Member's estate or to a person who cannot give a valid release, then Great-West can pay up to \$1,000.00 to any relative it considers to be entitled to such payment. The Member may request in writing that payments under the Plan be made directly to the person providing the services.

#### **Benefit Payments to a Representative of a Minor**

In the case of a minor child who qualifies as a Dependent under the Plan, if the child has a representative who is not covered under the Plan, then the Plan must pay benefits on behalf of that child to the representative. The person must submit proof that he or she is the child's representative and that he or she qualifies to be paid the benefits.

#### **Relationship Between Great-West and Network Providers**

Providers under contract with Great-West are independent contractors. Network providers are neither agents nor employees of Great-West, nor is Great-West, or any employee of Great-West, an agent or employee of Network providers. Great-West will not be responsible for any claim or demand on account of damages arising out of, or in any way connected with, any injuries suffered by the Member while receiving care from any Network provider or in any Network provider's facilities.

## **GLOSSARY**

### **Creditable Coverage**

Coverage under a group health plan, individual health insurance coverage, Medicare, Medicaid or other public health plans, TRICARE coverage (formerly known as CHAMPUS) for military personnel and their families, a medical program of the Indian Health Service or of a tribal organization or the Peace Corps, state health benefit risk pools, the Federal Employee Health Benefit Plan (FEHBP) or a State Children's Health Insurance Program (S-CHIP).

### **Dentist**

A person licensed to practice dentistry.

### **Dependent**

See ELIGIBILITY.

### **Doctor/Physician**

A person licensed to practice medicine or osteopathy. This also includes any other practitioner of the healing arts if:

- He or she performs a service within the scope of his or her license and for which this Plan provides coverage; and
- State law requires such practitioner to be covered.

### **Emergency Medical Condition**

The sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, that would lead a prudent layperson who possesses an average knowledge of health and medicine to believe that immediate medical care is required and that lack of such care could reasonably be expected to result in:

- placing the patient's life in serious jeopardy;
- serious Injury or impairment of bodily functions; or
- serious or permanent dysfunction of any bodily organ or part;
- with respect to a pregnant woman, placing the woman's health, or that of her unborn child, in serious jeopardy.

### **Employee**

See ELIGIBILITY.

### **Employer**

- LanceSoft, Inc.; and
- Any affiliated companies listed in the application of the Employer. The Employer may add an affiliated company after the effective date of the Plan. For that company only, the effective date of the Plan will be considered to be the effective date of the amendment that adds that company.

### **Experimental, Investigational or Unproven**

A service or supply, such as medication, that meets any of the following criteria:

- For a service or supply that is subject to Food and Drug Administration (FDA) approval:
  - it does not have FDA approval; or
  - it has FDA approval, but is being used for an indication or at a dosage that is not an accepted off-label use.

An accepted off-label use is a use that is:

- established based on reliable evidence as defined in this provision; or
- is included and favorably recognized for treatment of the indication in at least one of the following publications: DrugDex, Drug Facts and Comparisons, Clinical Pharmacology or other established reference compendia as designated by Medical Management, and the data are sufficiently conclusive as to efficacy to allow recognition of the off-label use; or
- Is being provided pursuant to phase I, II, III or IV clinical trials, unless in the case of phase III or phase IV clinical trials is provided in accordance with the clinical trials coverage described in the Plan; or

## **GLOSSARY - Continued**

- Is being provided pursuant to a written protocol that describes among its primary objectives determination of maximum tolerated dosage, safety, toxicity, effectiveness, or effectiveness compared to conventional alternatives; or
- Is being provided pursuant to a written informed consent used by the treating provider that refers to the service or supply as experimental, investigational, unproven or for research; or
- Is being delivered or should be delivered subject to the approval and supervision of an Institutional Review Board (IRB) as required and defined by federal regulations, particularly those of the Department of Health & Human Services (HHS) and the FDA; or
- Based upon review and analysis of the published peer-reviewed medical literature, the weight of the evidence demonstrates that it is the predominant opinion of independent experts that the service or supply:
  - is substantially confined to use in research settings; or
  - is subject to further research studies or clinical trials, in order to determine maximum tolerated dosage, safety, toxicity, effectiveness, or effectiveness compared to conventional alternatives; or
  - is experimental, investigational, unproven; or
- Is not a covered service or supply as defined under Medicare because it is considered investigational or experimental as determined by HHS/Centers for Medicare & Medicaid Services (CMS); or
- Is not currently the subject of active investigation because prior investigations and/or studies have failed to establish proven efficacy and/or safety.

In making the determination whether a service or supply is Experimental, Investigational or Unproven, Medical Management reserves the right to certify coverage of a service or supply, notwithstanding that the service or supply meets one of the above criteria, if there is reliable evidence as defined in this provision, that would support use of the service or supply as efficacious in the unique circumstances present in a particular case.

For these purposes, “reliable evidence” means evidence of all of the following:

- There are at least two articles in peer-reviewed U.S. scientific medical or pharmaceutical publications supporting use of the service or supply outside the investigational setting; and
- The published articles evidence a well-designed investigation that has been reproduced by non-affiliated authoritative sources with measurable, clinically meaningful results; and
- The investigation evidences that the probable benefits of using the service or supply in the unique circumstances in the particular case in question outweigh the risks associated with such use in situations where conventional alternatives have not or would not be efficacious.

### **Hospital**

An institution licensed as a Hospital by the proper authority of the state in which it is located. An institution recognized as a Hospital by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). This does not include any institution that is used primarily as a place for treatment of alcoholism or substance abuse, a clinic, convalescent home, rest home, home for the aged, nursing home, custodial care facility, or training center.

### **Illness**

An Injury, a sickness, a disease, a bodily or mental disorder, a pregnancy, or any birth defect of a newborn child. Conditions that exist and are treated at the same time or are due to the same or related causes are considered to be one Illness.

### **Injury**

A sudden and unforeseen event from an external agent or trauma, resulting in injuries to the physical structure of the body. It is definite as to time and place and it happens involuntarily or, if the result of a voluntary act, entails unforeseen consequences. It does not include harm resulting from disease.

## **GLOSSARY - Continued**

### **Loss of Residence**

Being outside the United States for more than 60 days. However, a Member will continue to be eligible for the benefits provided under this Plan if he or she is temporarily outside of the United States:

- On vacation;
- To study; or
- To conduct business for your Employer;

For a period of up to, but not exceeding, 60 continuous days.

### **Medically Necessary/Medical Necessity**

Health care services and supplies, such as medication, that a Physician, exercising prudent clinical judgment, provides to a Member for the purpose of preventing, evaluating, diagnosing or treating an Illness, Injury, disease or its symptoms, and are:

- In accordance with generally accepted standards of medical practice; and
- Clinically appropriate, in terms of type, frequency, level, extent, site and duration, and considered effective for the Member's Illness, Injury or disease; and
- Not deemed to be cosmetic or Experimental, Investigational or Unproven as defined in the Plan; and
- Specifically allowed by the licensing statutes which apply to the Physician who provides the service or supply; and
- At least as medically effective as any standard care and treatment; and
- Not primarily for the convenience, psychological support, education or vocational training of the Member, Physician or other health care provider; and
- Not more costly than an alternative service, supply or sequence of services or supplies, and at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the Member's Illness, Injury or disease.

For these purposes, "generally accepted standards of medical practice" mean the:

- Standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community;
- Recommendations of an American Medical Association-recognized Physician specialty society;
- Prevalent practices of Physicians in the relevant clinical area; or
- Any other relevant factors.

Medical Management may require satisfactory proof in writing that any type of service or supply received is Medically Necessary. Medical Necessity will be determined solely by Medical Management, in accordance with the definition above.

### **Medicare**

Title 18 of the United States Social Security Act of 1965 as amended from time to time and the coverage provided under it. This includes coverage provided under Medicare Advantage plans.

### **Member**

An Employee and any covered Dependent.

### **Plan**

The medical and drug benefits described in this booklet.

### **Service**

See ELIGIBILITY.

## **GLOSSARY - Continued**

### **Totally Disabled and Total Disability**

#### *Active Employees*

Being under the care of a Doctor and prevented by Illness from performing your regular work.

#### *Dependents*

Being under the care of a Doctor and prevented by Illness from engaging in substantially all of the normal activities of a person of the same age and sex who is in good health.

### **You and Your**

An Employee.

## **USERRA RIGHTS AND RESPONSIBILITIES**

The federal Uniformed Services Employment and Reemployment Rights Act (USERRA), establishes requirements for Employers and certain Employees who terminate Service with the Employer for the purpose of Uniformed Service. This includes the right to continue the medical and prescription drug coverage that you (the Employee) had in effect for yourself and your Dependents.

“Uniformed Service” means the performance of active duty in the Uniformed Services under competent authority which includes 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 the assigned duties.

You must notify your Employer verbally or in writing of your intent to leave employment and terminate your Service with the Employer for the purpose of Uniformed Service. The notice must be provided at least 30 days prior to the start of your leave, unless it is unreasonable or impossible for you to provide advance notice due to reasons such as military necessity.

### **Continued Medical and Prescription Drug Coverage**

Under USERRA, you are eligible to elect continued medical and prescription drug coverage for yourself and your Dependents when you terminate Service with the Employer for the purpose of Uniformed Service.

The Employer should establish reasonable procedures for electing continued medical and prescription drug coverage and for payment of contributions. See the Plan Administrator for details.

#### ***If you do not provide advance notice of your leave and you do not elect continued coverage prior to your leave***

Coverage for you and your Dependents will terminate on the date that coverage would otherwise terminate due to termination of your Service.

However, if you are excused from giving advance notice because it was unreasonable or impossible for you to provide advance notice due to reasons such as military necessity, then coverage will be retroactively reinstated if you elect coverage for yourself and your Dependents and pay all unpaid contributions within the period specified in the Employer’s reasonable procedures.

#### ***If you provide advance notice of your leave but you do not elect continued coverage prior to your leave***

Coverage for you and your Dependents will terminate on the date that coverage would otherwise terminate due to termination of your Service, when the duration of Uniformed Service is at least 30 days.

However, coverage will be retroactively reinstated if the Employer has established reasonable procedures for election of continued coverage after the period of Uniformed Service begins, and you elect coverage for yourself and your Dependents and pay all unpaid contributions within the time period specified in the procedures.

If the Employer has not established reasonable procedures, then the Employer must permit you to elect continued coverage for yourself and your Dependents and pay all required contributions at any time during the period of continued coverage, and the Employer must retroactively reinstate coverage.

#### ***If you elect continued coverage but do not make timely payments for the cost of coverage***

If the Employer has established reasonable payment procedures and you do not make payments according to the procedures, then coverage for you and your covered Dependents will terminate as described in the procedures.

### ***Period of Continued Coverage***

During a leave for Uniformed Service, the period of continued coverage begins immediately following the date you and your covered Dependents lose coverage under the Plan, and it continues for a maximum period of up to 24 months.

### ***Cost of Continued Coverage***

If the period of Uniformed Service is less than 31 days, you are not required to pay more than the amount that you paid as an active Employee for that coverage for continued coverage.

## **USERRA RIGHTS AND RESPONSIBILITIES - Continued**

If the period of Uniformed Service is 31 days or longer, then you will be required to pay up to 102% of the applicable group rate for continued coverage.

### *COBRA Coverage*

If you are entitled to COBRA continuation coverage, then the COBRA coverage period runs concurrently with the USERRA coverage period. In some instances, COBRA coverage may continue longer than USERRA coverage.

### Reinstatement of Coverage

Coverage for an Employee who returns to Service with the Employer following Uniformed Service will be reinstated upon request from the Employee and in accordance with USERRA.

Reinstated coverage will not be subject to any exclusion or waiting period, if such exclusion and/or waiting period would not have been imposed had coverage not terminated as a result of Uniformed Service.

For medical coverage, a pre-existing condition limitation may be imposed on an Illness that is determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, Uniformed Service. See the Plan Administrator for details.

## **CONTINUATION OF COVERAGE - FMLA**

If the Employer approves your FMLA leave pursuant to the Family and Medical Leave Act of 1993 (as amended) (FMLA), coverage under the Plan will continue during your leave. Contributions must be paid by you and/or the Employer. If contributions are not paid, your coverage will cease. However, a COBRA qualifying event does not occur unless you do not return to work on the date you are scheduled to return from your FMLA leave. If you return to work on your scheduled date, coverage will be on the same basis as that provided for any active Member on that date. If you have questions about FMLA leave, see the Plan Administrator.

## **CONTINUATION OF COVERAGE - COBRA**

This provision generally explains COBRA continuation coverage, when it may become available to a Member and what a Member needs to do to protect the right to receive it. COBRA continuation coverage, is a temporary extension of coverage under the Plan, and was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

In some circumstances, COBRA requires that Members who lose group Medical and Prescription Drug plan coverage to be given an opportunity to continue that coverage when there is a "qualifying event" that would result in a loss of coverage under the Plan. A "qualified beneficiary" is a person who will lose coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, qualified beneficiaries can include the Employee and/or the Employee's spouse or Dependent children. COBRA continuation coverage must be offered to each qualified beneficiary and the coverage is the same coverage that other Members under the Plan who have not had a qualifying event have. Each qualified beneficiary will have the same rights under the Plan as other Members, including open enrollment and special enrollment rights.

### Right to COBRA Continuation Coverage

- As an Employee, you have a right to choose COBRA continuation coverage, if you lose your coverage due to a reduction in your hours of employment, or due to voluntary or involuntary termination of your employment, for any reason except gross misconduct.
- As a Dependent spouse, you have the right to choose COBRA continuation coverage, if you lose your coverage due to the Employee's death, or the Employee's termination of employment or reduction in hours of employment, as stated above, or due to your divorce or legal separation. If the Employee cancels your coverage in anticipation of your 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 you have lost coverage earlier.
- Your Dependent Child, including alternate recipients under a medical child support order have the right to choose COBRA continuation coverage if the Dependent Child loses coverage due to the reasons stated above or ceases to be an eligible Dependent under the terms of the Plan.

## **CONTINUATION OF COVERAGE - COBRA - Continued**

### **Length of COBRA Continuation Coverage**

Generally:

- In the case of loss of coverage due to termination of employment or reduction in hours of Service, coverage may be continued for those who elect continuation coverage, for up to 18 months from the date of the qualifying event.
- In the case of loss of coverage due to your death, divorce or legal separation, or a Dependent Child ceasing to be a Dependent under the terms of the Plan, coverage may be continued for those who elect continuation coverage, for up to 36 months from the date of such event.
- If an Employee becomes entitled to Medicare and later has a qualifying event, which is a termination of employment or reduction of hours, within 18 months of entitlement to Medicare, then the maximum coverage period for the Dependent spouse and children will be 36 months which begins from the date the Employee becomes entitled to Medicare.
- If, after the occurrence of any event described in the Right to COBRA Continuation Coverage above, the Member is allowed to continue coverage under the Plan (whether or not contributions are required) beyond the Plan's termination of coverage provision for any reason other than to comply with the federal law (i.e. state laws mandating continuation coverage or the Plan's special provisions), such continuation period(s) will be used to reduce the maximum length of COBRA continuation coverage period otherwise available to such person under this provision.

### **Extension of COBRA Continuation Coverage**

- ***Disability Extension*** - If you lose coverage because of termination of your employment or reduction in your hours of employment, and if anyone in your family unit is determined under Title II or XVI of the Social Security Act to have been Totally Disabled at any time during the first 60 days of COBRA continuation coverage, then the Totally Disabled Member and other qualified beneficiaries who are entitled to COBRA continuation coverage may extend the continuation for 11 additional months.
- ***Second Qualifying Event*** - If your Dependent:
  - is covered under COBRA because of termination of your employment or reduction in your hours of employment; and
  - while covered under COBRA experiences a second qualifying event, such as a divorce or legal separation or ceasing to be an eligible Dependent;

then such qualified beneficiaries are entitled to up to a maximum of 36 months of COBRA coverage from the date of the first qualifying event.

### **Health FSA**

The maximum COBRA coverage period for a health flexible spending arrangement (Health FSA), if maintained by your Employer, ends on the last day of the Flexible Benefits Plan Year in which the qualifying event occurred.

### **Notice Requirements**

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator of the Employer or the representative of the Employer has been timely notified that a qualifying event has occurred.

When the qualifying event is termination of employment, reduction of hours of employment or death of the Employee, the Plan Administrator will notify the Employee within 44 days of the later of the date of the qualifying event or the date coverage ends.

***Dependents*** - If your spouse or Dependent children become eligible for COBRA continuation coverage due to divorce or legal separation or end of dependency status, or upon occurrence of a second qualifying event, the Plan Administrator or the representative of the Employer must be notified within 60 days of the first or the second qualifying event. The notice must be provided following Reasonable Notice Procedures, as described below.

If the notice is not provided within 60 days of the qualifying event, your spouse or Dependent children will lose the right to such coverage.

## **CONTINUATION OF COVERAGE - COBRA - Continued**

If you have a child or adopt a child while covered under COBRA, and you decide to add the child to your COBRA continuation coverage, then you must notify the Plan Administrator or the representative of the Employer of the birth or adoption within the 30 days of birth, adoption or placement for adoption in order for the child to be considered a COBRA qualified beneficiary. The notice must be provided following Reasonable Notice Procedures, as described below.

***Disability Extension*** - A Member who wishes to continue COBRA continuation coverage under the Disability Extension must notify the Plan Administrator or the representative of the Employer of the Social Security Administration's disability determination within 60 days of such determination and before the end of the initial 18-month COBRA coverage period. If the notice is not provided within the specified timeframe, the qualified beneficiary and the members of the family unit will lose the right to extend COBRA coverage under the Disability Extension.

If the Social Security Administration determines that the qualified beneficiary's disability ceases to exist, then the qualified beneficiary must notify the Plan Administrator or the representative of the Employer of this information within 30 days of such determination.

The notice must be provided following the Reasonable Notice Procedures, as described below.

### **Reasonable Notice Procedures**

Any notice that needs to be provided must be in writing. Oral notice, including notice by telephone, is not acceptable. The qualified beneficiary must mail the notice to the contact person at the address specified below:

Manisha Shivaprasad  
2325 Dulles Corner Blvd  
Suite 910  
Herndon, VA  
20171

The notice must be postmarked no later than the last day of the required notice period. Any notice provided must state the name and address of the Employee covered under the Plan and the names and addresses of the qualified beneficiaries, the qualifying event and the date of the qualifying event. If a qualifying event is a divorce, the notice must include a copy of the divorce decree. In case of a disability, the notice must include the name of the disabled qualified beneficiary, the date of disability and a copy of the Social Security Administration's letter of determination of disability or determination that the qualified beneficiary is no longer disabled. The notice must be provided by the qualified beneficiary, spouse or parent, if applicable, or by an authorized representative of the qualified beneficiary.

### **Election of COBRA Continuation Coverage**

When a qualifying event occurs, the Employer or a representative of the Employer must give the qualified beneficiary the necessary COBRA election form. The qualified beneficiary must elect coverage in writing within 60 days of being provided a COBRA election notice or the date the qualified beneficiary would lose coverage, whichever is later. To elect coverage, the qualified beneficiary must follow the procedures specified in the Election Form. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered Employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children. If the qualified beneficiary does not elect coverage within the 60-day election period, the qualified beneficiary will lose the right to elect COBRA continuation coverage. The qualified beneficiary has the right to change a prior rejection of COBRA continuation coverage anytime within the 60-day election period by following the procedures specified in the Election Form. Failure to continue this coverage will affect future rights under federal law, such as the right to purchase individual health insurance policies that do not impose a pre-existing condition exclusion.

### **Cost of Coverage**

Generally, each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount a qualified beneficiary may be required to pay may not exceed 102% of the applicable group rate.

## **CONTINUATION OF COVERAGE - COBRA - Continued**

If a qualified beneficiary elects to continue coverage, the qualified beneficiary must make the first payment for continuation within 45 days of the election. The qualified beneficiary is responsible for making sure that the amount of the first payment is enough to cover the entire initial period from the date coverage would have otherwise terminated, up to the date the qualified beneficiary makes the first payment. If the qualified beneficiary fails to make the first payment, they will lose the continuation coverage rights under the Plan. Claims incurred during the period covered by the initial payment period will not be processed until the payment is made.

After the qualified beneficiary makes the first payment for continuation coverage, they will be required to pay for continuing the coverage for each subsequent month of coverage; they will be given a grace period of 30 days to make each periodic payment. The coverage will be continued as long as payment for that period is made before the end of the grace period.

The Plan may require payments of up to 150% of the applicable group rate if coverage is extended under the *Disability Extension*.

If you are a resident of Tennessee, you may be entitled to have the State of Tennessee pay the contribution for your on-going health coverage. For more information, contact your local Tennessee Department of Human Services.

### **Termination of COBRA Continuation Coverage**

The COBRA continuation coverage may terminate before the maximum period of continuation runs out if:

- The required contribution is not paid; or
- After the date of election of COBRA continuation coverage, the qualified beneficiary becomes entitled to Medicare benefits (except for a person whose continuation coverage right derives from the Employer's filing for reorganization under Chapter 11 of the Bankruptcy Code); or
- After the date of election of COBRA continuation coverage, the qualified beneficiary becomes covered under another group health plan that does not impose a pre-existing condition limitation for a pre-existing condition of a qualified beneficiary; or
- After the date the qualified beneficiary qualifies under the *Disability Extension*, the beneficiary is no longer disabled; or
- All of Employer's group health plans are terminated.

The qualified beneficiary must notify the Employer or its representative of the beneficiary's entitlement to Medicare coverage under another group health plan or that the beneficiary is no longer disabled within 30 days of the event. The notice must comply with the Reasonable Notice Procedures, described above. The Employer or its representative will notify the qualified beneficiary of the termination of coverage if it happens prior to the maximum period of COBRA continuation coverage.

For more information about COBRA continuation of coverage, a Member may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at [www.dol.gov/ebsa](http://www.dol.gov/ebsa).

In order to protect your rights and your Dependent's rights, you should keep the Plan Administrator informed of any changes in the address of family members.

### **The Trade Act of 2002**

The Trade Act of 2002 created special second COBRA election period for certain displaced workers receiving Trade Adjustment Assistance (TAA) under the Trade Act of 1974. A Member who did not elect COBRA continuation coverage during the initial 60-day election period that was a direct consequence of the TAA-related loss of coverage, may elect COBRA continuation coverage during a second 60-day period that begins on the first day of the month in which the Member is determined to be "TAA-Eligible". The election must be made within 6 months after the date of the TAA-related loss of coverage.

Under the new tax provisions eligible individuals can either take a tax credit or get advance payment of 65% of contributions paid for qualified health insurance, including COBRA continuation coverage. If you have questions about these new tax provisions you may call the Health Care Tax Credit Customer Contact Center toll free at 1-866-628-4282. TTD/TTY callers may call toll free at 1-866-626-4282.

**SECTION II - LIFE INSURANCE AND ACCIDENTAL DEATH & DISMEMBERMENT BENEFITS**

## INTRODUCTION

### ■ Notices

#### Notice Required for Residents of Texas/Aviso Para Residentes Del Estado De Texas

**GREAT-WEST LIFE & ANNUITY  
INSURANCE COMPANY**  
EXECUTIVE OFFICES -  
8505 EAST ORCHARD ROAD  
GREENWOOD VILLAGE, COLORADO 80111

#### **IMPORTANT NOTICE**

To obtain information or make a complaint  
You may call Great-West's toll-free telephone number  
for information or to make a complaint at

**1-800-537-2033**

You may contact the Texas Department of Insurance to  
obtain information on companies, coverages, rights or  
complaints at

**1-800-252-3439**

You may write the Texas Department of Insurance P.O.  
BOX 149104 Austin, TX 78714-9104 FAX # (512)  
475-1771

#### **PREMIUM OR CLAIM DISPUTES:**

Should you have a dispute concerning your premium or  
about a claim you should contact Great-West first. If the  
dispute is not resolved, you may contact the Texas  
Department of Insurance.

#### **ATTACH THIS NOTICE TO YOUR PLAN**

This notice is for information only and does not become  
a part or condition of the attached document.

#### Notice Required by Virginia Law

*Virginia Residents - Important information regarding your coverage* - If you have any questions or concerns regarding  
your coverage, please contact Member services at the following address and telephone number: Great-West Life & Annuity Insurance  
Company, Executive Office, 8505 East Orchard Road, Greenwood Village, Colorado 80111, Telephone 1-800-537-2033.

We recommend that you familiarize yourself with our Complaint procedure and make use of it before taking any other action. If  
you have been unable to contact or obtain satisfaction from Great-West, you may contact the Virginia State Corporation  
Commission's Bureau of Insurance at: Virginia State Corporation Commission, Bureau of Insurance, P.O. Box 1157, Richmond, VA  
23218, Telephone 1-800-552-7945 and outside Virginia 1-804-371-9741.

Written correspondence is preferable so that a record of your inquiry is maintained. When contacting Great-West or the Bureau of  
Insurance, please have your Plan number available.

#### Notice Required by Virginia Law - Beneficiary Designation May Not Apply in the Event of Annulment or Divorce

Under Virginia law, a revocable beneficiary designation in a policy owned by one spouse that names the other spouse as beneficiary  
becomes void upon the entry of a decree of annulment or divorce, and the death benefit prevented from passing to a former spouse  
will be paid as if the former spouse had predeceased the decedent. In the event of annulment or divorce proceedings, and if it is the  
intent of the parties that the beneficiary designation of the former spouse is to continue, you are advised to make certain that one of  
the following courses of action is taken prior to the entry of a decree of annulment or divorce:

#### **AVISO IMPORTANTE**

Para obtener informacion o para someter una queja  
Usted puede llamar al numero de telefono gratis de  
Great-West's para informacion o para someter una queja al

**1-800-537-2033**

Puede comunicarse con el Departamento de Seguros de  
Texas para obtener informacion acerca de companias,  
coberturas, derechos o quejas al

**1-800-252-3439**

Puede escribir al Departamento de Seguros de Texas P.O.  
BOX 149104 Austin, TX 78714-9104 FAX # (512) 475-1771

#### **DISPUTAS SOBRE PRIMAS O RECLAMOS:**

Si tiene una disputa concerniente a su prima o a un reclamo,  
debe comunicarse con el Great-West primero. Si no se  
resuelve la disputa, puede entonces comunicarse con el  
Departamento de Seguros de Texas.

#### **UNA ESTA AVISO A SU POLIZA**

Este aviso es solo para proposito de informacion y no se  
convierte en parte o condicion del documento adjunto.

## **INTRODUCTION - Continued**

- change the beneficiary designation to make it irrevocable;
- change the ownership of the policy or contract;
- execute a separate written agreement stating the intention of both parties that the beneficiary designation is to remain in effect beyond the date of the entry of the decree of annulment or divorce; or
- make certain that the decree of annulment or divorce contains a provision stating that the beneficiary designation is not to be revoked pursuant to Section 20-111.1 of the Code of Virginia.

### **Notice Required by Wisconsin Law**

#### *Wisconsin Residents -*

- **KEEP THIS NOTICE WITH YOUR INSURANCE PAPERS**
- **PROBLEMS WITH YOUR INSURANCE?** If you are having problems with your insurance company or agent, do not hesitate to contact the insurance company or agent to resolve your problem. GREAT-WEST LIFE & ANNUITY INSURANCE COMPANY, P.O. BOX 1080, DENVER CO 80201, (303) 737-3000.

You can also contact the **OFFICE OF THE COMMISSIONER OF INSURANCE**, a state agency which enforces Wisconsin's insurance laws, and file a complaint. You can contact the **OFFICE OF THE COMMISSIONER OF INSURANCE** by writing to: Office of the Commissioner of Insurance, Complaints Department, P.O. BOX 7873, Madison, WI 53707-7873. You can call 1-800-236-8517 outside Madison or 266-0103 in Madison, and request a complaint form.

### **Coverage for Residents of Certain Other States**

If you are a resident of a state other than Virginia and the life insurance and accidental death & dismemberment insurance laws of the state in which you reside require the Plan to provide coverage in excess of what is described in this booklet, the Plan will be administered to comply with such law(s).

#### **■ About This Plan**

LanceSoft, Inc. (the Employer) has established an Employee Welfare Benefit Plan within the meaning of the Employee Retirement Income Security Act of 1974 (ERISA). As of June 1, 2008, the Life Insurance and Accidental Death & Dismemberment (AD&D) benefits described in this booklet form a part of the Employee Welfare Benefit Plan and are referred to collectively in this booklet section as the Plan. The Employee Welfare Benefit Plan will be maintained pursuant to the Life Insurance and AD&D benefit terms described in this booklet. The Plan may be amended from time to time.

If a booklet was issued to you under the Employer's prior plan, this is your new booklet. This new booklet replaces your old booklet in its entirety. If you were covered under the replaced booklet on the day before the effective date of the Plan, you will be covered under this booklet as of the date shown above.

If on the date shown above you are not Actively at Work, see "Will My Coverage Change?" in WHEN COVERAGE BEGINS & ENDS for details as to when a change in coverage will become effective.

The Life Insurance and AD&D benefits described in this booklet are fully insured by Great-West Life & Annuity Insurance Company (referred to as Great-West or Company in this booklet), 8505 E. Orchard Road, Greenwood Village, CO 80111.

This booklet becomes your certificate of insurance for Life Insurance and AD&D benefits only if you complete the appropriate application forms and are approved for coverage by Great-West.

Defined terms are capitalized and have specific meaning with respect to Life Insurance and AD&D benefits, see GLOSSARY.

### **Discretionary Authority**

Great-West, as the claims administrator for Life Insurance and AD&D benefits, has the discretionary authority, subject to review by state insurance regulatory agencies and courts of competent jurisdiction, to determine benefit eligibility, construe the terms of the Plan and resolve any disputes which may arise with regard to the rights of any person under the terms of the Plan, including but not

## **INTRODUCTION - Continued**

limited to eligibility for participation and claims for benefits.

### **Plan Modification/Termination**

The Employer may:

- change the contributions a Member must pay for benefits; or
- amend or terminate the benefits provided to you in the Plan.

If the Plan is amended or terminated it will not affect coverage for services provided prior to the effective date of the change.

## **LIFE INSURANCE AND ACCIDENTAL DEATH & DISMEMBERMENT BENEFITS SUMMARY**

This summary provides a general description of your Life Insurance and Accidental Death & Dismemberment benefits. It does not list all benefits. The Plan contains limitations and restrictions that could reduce the benefits payable under the Plan. Please read the entire booklet for details about your benefits.

### **LIFE INSURANCE BENEFITS**

All Employees \$50,000.00

### **ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) BENEFITS**

The amount of AD&D Benefit that an Employee may receive is based on a Principal Sum. The amount of the Principal Sum is equal to the amount of Standard Life Insurance.

<b>AD&amp;D Benefit for the Loss of:</b>	<b>Amount Payable</b>
Life	Principal Sum
Both hands or both feet or sight of both eyes	Principal Sum
One hand and one foot	Principal Sum
One hand or one foot and sight of one eye	Principal Sum
One hand or one foot	1/2 of Principal Sum
Sight of one eye	1/2 of Principal Sum

Loss of hands and feet means permanent dismemberment by severance through or above the wrist or ankle joints. Loss of sight means total and permanent loss of sight beyond remedy by surgical or other means.

### **REDUCTIONS IN LIFE INSURANCE AND AD&D BENEFIT**

The amount of an Employee's Life Insurance and AD&D Benefit in effect at the time the Employee reaches age 65 will reduce by 35% at age 65, 55% at age 70, 70% at age 75, 80% at age 80 and 85% at age 85.

## **ELIGIBILITY**

### **■ Eligible Employees**

For the purpose of Life Insurance and Accidental Death & Dismemberment benefits, an eligible Employee is a person who is in the Service of the Employer and is a resident of the United States.

#### **Service**

“Service” means work with the Employer on an active, full-time and full pay basis for at least 40.00 hours per week.

## **WHEN COVERAGE BEGINS & ENDS**

### **■ When Will Coverage Begin?**

The definition of Employee in ELIGIBILITY will determine who is eligible for coverage under the Plan.

Coverage will begin on the date you satisfy any eligibility waiting periods required by the Employer.

Before coverage can start, you must:

- Submit an application within 31 days after becoming eligible;
- Pay any required contribution; and
- Be Actively at Work on the eligibility date.

### **■ What If I Don't Apply On Time?**

You are a late applicant under the Plan if you don't apply for coverage within 31 days of the date you become eligible for coverage.

Late applicants must provide the Company with Proof of Good Health at their own expense. Coverage for a late applicant will begin on the date the Company approves Proof of Good Health.

### **■ Will My Coverage Change?**

If the Employer amends the benefits or amounts provided under the Plan, a Member's coverage will change on the effective date of the amendment. If a Member changes classes, coverage will begin under the new class on the date that the Member's class status changes.

If you are an active Employee and you are not Actively at Work when either of these changes occurs, the change in your coverage will not take place until you return to work with the Employer for one full day.

All claims will be based on the benefits in effect on the date the claim was incurred.

### **■ When Will My Coverage End?**

Your coverage will end on the earliest of the following dates:

- The date the Employer terminates the benefits described in this booklet.
- The date you are no longer eligible or your Service ends.
- The due date of the first contribution toward your coverage that the Employer fails to make.
- The date Loss of Residence occurs.

### **■ Can I Continue or Convert My Coverage If I Become Ineligible?**

If you become ineligible for coverage under the Plan, you may be able to continue coverage for certain benefits.

#### **Continuation of Life Insurance during an Illness, Approved Leave of Absence or Temporary Layoff**

If your Service ends due to Illness, Life Insurance will continue for 12 months after your Service ends.

If you are continuously covered under this provision and this group life policy terminates before you are eligible to qualify for coverage under the provision "What If I Become Disabled? (Waiver of Premium)", you must convert to an individual life insurance policy within 31 days in order to continue your life insurance.

If your Service ends due to approved leave of absence or temporary layoff, Life Insurance will continue for 31 days after the date your Service terminates.

Your coverage will end sooner than stated above if you and/or your Employer fails to pay for this continuation coverage.

There is no continuation for AD&D benefits.

## **WHEN COVERAGE BEGINS & ENDS - Continued**

### **Continuation of Coverage under Federal Laws and Regulations**

If coverage would otherwise terminate under this Plan, you may be eligible to continue coverage under certain federal laws and regulations. See USERRA RIGHTS AND RESPONSIBILITIES and CONTINUATION OF COVERAGE - FMLA.

### **Conversion of Life Insurance Benefits**

If all or part of your group term life insurance ends, you may apply for an individual life insurance policy.

Proof of Good Health is not required. You must apply for the life conversion coverage within 31 days after your life insurance coverage ends.

The policy will be one of Great-West's standard conversion policies and will not contain a disability benefit or an accidental death benefit. The amount of coverage chosen can never be more than your current amount of insurance. The amount of the premium will depend on your age and class of risk.

You are allowed 31 days to apply for the individual policy. If you die within this period, your beneficiary will receive a death benefit. The amount of this benefit will be the maximum amount of group term life insurance which you would have been eligible to convert under this provision.

However, if the amount of your insurance had been reduced during this 31-day period because of age or retirement, the death benefit will be the amount of your group term life insurance before the reduction. This death benefit is payable even if you had not applied for an individual policy.

### ***Employee Conversion of Life Insurance Benefits***

If the group policy is still in force, you may convert all or part of your insurance to an individual policy if your coverage ends. If your coverage reduces due to age or retirement you may convert up to the amount of the reduction.

If the group policy is terminated or amended you may convert your life insurance if all or part of your coverage ends. However:

- You must have been insured under the group policy for at least five consecutive years; and
- The amount of the individual policy will be the lesser of \$10,000.00 and the current amount of your group term life insurance.

If your insurance is being continued under the disability benefit, you may convert your coverage if your coverage ends or reduces due to age or retirement. You may convert this coverage even if the group policy is not in force.

### ***Conversion of AD&D Benefits***

Conversion coverage is not available for AD&D benefits.

### **■ Can Coverage Be Reinstated?**

If your coverage ended because of termination of your Service, it will be reinstated on the date you return to work with the Employer. You must return within 3 month(s) to be reinstated.

On the date you return to work, coverage will be on the same basis as that provided for any other active Employee as of that date. However, any restrictions on your coverage that were in effect before your reinstatement will still apply.

See USERRA RIGHTS AND RESPONSIBILITIES for information about reinstatement of coverage upon return from leave for military service.

## **WHEN COVERAGE BEGINS & ENDS - Continued**

### **Reinstatement When Coverage Ends Due to Loss of Residence**

Coverage for an Employee whose coverage ended due to Loss of Residence will be reinstated on the day after completing 30 consecutive days of Work in the United States. You must return to the United States within three months of the date the Loss of Residence occurred to be reinstated. Coverage will be on the same basis as that being provided for any other active Employee on the date coverage is reinstated. However, any restrictions on the coverage that were in effect before reinstatement will continue to apply.

## **LIFE INSURANCE BENEFITS**

### **■ Standard Life Insurance**

If you die from any cause while covered under the life insurance Plan, your amount of standard life insurance will be paid to your beneficiary. The amount is shown in the LIFE INSURANCE AND ACCIDENTAL DEATH & DISMEMBERMENT BENEFITS SUMMARY.

### **■ How Do I Name a Beneficiary?**

A beneficiary is the person who will receive payment of the life insurance amount if you die. You should name a beneficiary when you first apply for insurance. Unless legally restricted, you can change the beneficiary at any time by giving written notice. The beneficiary's consent is not required unless the designation of the beneficiary is irrevocable.

Naming or changing a beneficiary must be in writing, signed by you and filed with your Employer.

If a named beneficiary dies before you, the amount of the life insurance that beneficiary would have received will be paid to any remaining named beneficiaries who survive you, unless you have specified otherwise on your application or state law does not allow this.

When there are two or more named beneficiaries the life insurance will be divided in equal shares, unless you have specified otherwise.

Subject to state law, if no named beneficiary survives you or if you have not named a beneficiary, the amount of insurance will be paid to your surviving spouse; if none, then to your surviving child or children; if none, then to your surviving parent or parents; if none, then to your surviving brothers or sisters; if none, then to your estate.

### **■ How Will Benefits Be Paid?**

Proof of death must be sent to Great-West. Great-West will pay the amount of insurance (the death benefit) to the beneficiary.

- If any person has incurred expenses related to your last illness or death, Great-West can deduct up to \$2000.00 from the death benefit to pay the person who incurred these expenses.
- The life insurance will be paid to the beneficiary. Prior to your death, you may elect to have your life insurance paid to your beneficiary in any manner to which Great-West agrees.
- If you do not elect an optional payment method prior to your death, then after your death the beneficiary may elect to have the life insurance paid to him or her in any manner to which Great-West agrees.

Payments will not be made more than once a year unless each payment is at least \$25.00.

### **■ What If I Become Disabled? (Waiver of Premium)**

After you have been Totally Disabled for 9 consecutive months, insurance for yourself may be continued without further premium payment. To qualify for this benefit:

- You must become Totally Disabled while insured under this life insurance Plan;
- Your Total Disability must continue without interruption for at least 9 months;
- You must be under age 60 when you become Totally Disabled;
- You must send proof of your Total Disability to Great-West within 12 months of the start of the disability.

If you were continuously covered under the provision "Continuation of Life Insurance During an Illness, Approved Leave of Absence or Temporary Layoff" when you qualified for this disability waiver of premium benefit, you will be notified of the date when you will no longer be required to pay life insurance premium.

## **LIFE INSURANCE BENEFITS - Continued**

If you have converted to an individual policy because this group life policy terminated or the continuation benefit ended during your qualifying period, you must surrender it. See the provision "Conversion of Life Insurance Benefits" in WHEN COVERAGE BEGINS & ENDS. All premiums paid for the individual policy after you have been Totally Disabled for 9 months will be returned. If you die during this 9 month period, the amount of insurance will be paid under either this life insurance Plan or the individual policy but *not* under both.

If you qualify for this disability waiver of premium benefit, you must send proof of the continuance of your Total Disability to Great-West when requested.

The amount of life insurance continued will be the amount in effect under this Plan on the date you became disabled. However, the amount of insurance may reduce or terminate due to age or retirement according to the provisions of the Plan that were in effect on the date you became Totally Disabled.

This life insurance Plan does not have to be in force at the time of death for life insurance to be paid.

Your disability waiver of premium benefit will terminate:

- On the date you recover from your Total Disability; or
- If you do not send Great-West proof of the continuance of your Total Disability when requested.

### **■ Is the Amount of My Insurance Reduced As I Grow Older?**

Your amount of standard life insurance will be reduced according to the LIFE INSURANCE AND ACCIDENTAL DEATH & DISMEMBERMENT BENEFITS SUMMARY - REDUCTIONS IN LIFE INSURANCE AND AD&D BENEFIT.

### **■ Other Information About Life Insurance**

#### **Absolute Assignment**

You can transfer all your rights of ownership in your life insurance. This is known as absolute assignment. Great-West is not responsible for the validity or effect of any assignment.

To assign your life insurance, notify your Employer, who will contact Great-West for an assignment form. Great-West will not recognize an assignment until the original assignment form has been noted at its Executive Offices.

#### **Collateral Assignment**

You cannot assign your insurance as collateral for a loan.

#### **Proof of Age**

Before benefits are paid, Great-West may request proof of age. An adjustment may be made if:

- The Member's age was misstated; and
- A different premium rate would have been charged for the person's true age.

The difference between the premiums actually paid, and those that should have been paid, will be calculated. Any difference will be paid:

- By your Employer to Great-West, if the age was understated; and
- By Great-West to your Employer, if the age was overstated.

## **AD&D BENEFITS**

Your AD&D benefits are payable if you are Injured while covered under this AD&D Plan and suffer a loss:

- Within 90 days of the Injury; and
- As a result of the Injury.

The amount of AD&D benefits that you may receive is based on a Principal Sum. The amount of your Principal Sum is equal to the amount of your Standard Life Insurance. (See "Standard Life Insurance" in LIFE INSURANCE BENEFITS.) Great-West will pay all or part of the Principal Sum according to the AD&D Benefit shown in the LIFE INSURANCE AND ACCIDENTAL DEATH & DISMEMBERMENT BENEFITS SUMMARY.

Only one of the amounts, the largest, will be paid for all Injuries that result from any one accident.

Loss of hands and feet means permanent dismemberment by severance through or above the wrist or ankle joints. Loss of sight means total and permanent loss of sight beyond remedy by surgical or other means.

If you die, the benefit will be paid to the beneficiary you name for life insurance. If you suffer any other loss, the benefit will be paid to you.

To claim AD&D benefits, written proof of loss must be sent to Great-West as soon as reasonably possible. In any case, the proof required must be given no later than 15 months from the date of loss unless the claimant was legally incapable of doing so.

Your amount of AD&D Principal Sum is subject to the same age-based reductions as your life insurance.

## **AD&D BENEFIT LIMITATIONS**

*No amount will be payable for any loss caused by or in connection with:*

- Intentionally self-inflicted Injury.
- War or any act relating to war.
- Any form of disease.
- Physical or mental infirmity.
- The medical or surgical treatment of a disease or infirmity.
- Suicide.
- Potomac poisoning.
- Bacterial infections.
- Commission of a felony.

## **CLAIMS & LEGAL ACTION**

### **■ How To File Claims**

A claim for benefits may be filed by a Member, beneficiary or Authorized Representative. An *Authorized Representative* means a person authorized in writing by the Member or a court of law to represent the Member's interests for claim submission and appeals.

All claim forms include instructions on how to complete and submit a claim. Claim forms may be requested from the Plan Administrator. Complete and accurate claim information is necessary to avoid claim processing delays. Claim decisions will not exceed the time frames described below, unless the Member, beneficiary or Authorized Representative agrees to a longer period of time.

#### **Disability Waiver of Premium Benefits**

To apply for disability waiver of premium benefits, the Plan Administrator, Member and the Member's Doctor must complete the Waiver of Premium Disability Claim Report. The Plan Administrator will submit the report to Great-West for processing.

Claims for which determination of disability is involved will be processed within 45 days of the date received by Great-West. If a decision cannot be made within this time period for reasons beyond the control of the Plan, the Member will be notified of:

- the reasons for the delay;
- any information needed to perfect the claim; and
- the date by which a decision is expected.

The Member will have 45 days from the date the notice is received to provide the requested information. If the requested information is not provided within this time period, the Member should consider the claim to be denied.

This denial will be reconsidered if the information is subsequently received. If the necessary information is received within the 45-day period, a decision will be made within 30 days of the date the information is received, unless a decision still cannot be made. If this is the case, the above notification process will be repeated within the 30-day decision period.

The Member will again have 45 days from receipt of the notice to provide the requested information. If the information is received within the 45-day period, a decision will be made within 30 days of the date the information is received, unless the Member agrees to a longer period of time.

#### **Life Insurance and Accidental Death & Dismemberment Benefits**

For life insurance and accidental death claims, the beneficiary must request a claim form from the Plan Administrator, complete the form and return it with the certified proof of death to the Plan Administrator, who will submit to Great-West for processing.

For accidental dismemberment and loss of sight claims, the Member must request a claim form from the Plan Administrator, complete the form and return it with the accident or police report to the Plan Administrator, who will submit to Great-West for processing.

Life insurance and accidental death & dismemberment claims will be processed within 90 days of the date received by Great-West. If a claim decision cannot be made within the initial 90-day period because of special circumstances, Great-West may request an extension of up to 90 days. Before the end of the initial 90-day period, Great-West will notify the Member or beneficiary in writing of the reason(s) for the extension, whether additional information is required and why this information is needed, and the date that Great-West expects to make a claim decision. Claim decisions will not exceed the above time frames unless the beneficiary agrees to a longer period of time. Once the decision is made, Great-West will either pay the allowable amount of insurance to the beneficiary(ies) or send written notice of benefits denied.

## **CLAIMS & LEGAL ACTION - Continued**

### **■ If A Claim Is Denied**

If benefits are denied, in whole or in part, Great-West will send the Member or beneficiary a written or electronic notice within the established time periods described in "How To File Claims". The denial may be appealed as described below. The adverse determination notice will include the reason(s) for the denial, reference to the Plan provision(s) on which the denial is based, whether additional information is needed to process the claim and why the information is needed, the claim appeal procedures and time limits, and the right to bring civil action by the Member or beneficiary under ERISA Section 502(a) after required Plan appeals have been exhausted.

If the denial involves a disability claim, the notice will also specify:

- whether an internal rule, guideline, protocol or other criterion was relied upon in making the claim decision and that this information is available upon request and at no charge.
- that an explanation of the scientific or clinical judgment for a decision based on medical necessity, experimental treatment or a similar limitation is available upon request and at no charge.

### **Appeal of a Disability Waiver of Premium Claim Denial**

After receiving notice of a claim denial, in whole or in part, the Member, the Member's beneficiary, provider or other Authorized Representative can appeal by submitting a written request to the address shown on the adverse determination letter within:

- 180 days of the date the notice of denial of the initial claim is received; or
- 60 days of the date the notice of the initial appeal decision is received.

In connection with the review, the Member has the right to:

- review and request copies of relevant documents, free of charge; and
- submit issues and comments in writing; and
- have a representative act on his or her behalf in the appeal.

The appeal will be reviewed by an individual who was not involved in the prior adverse determination and who is not a subordinate of the individual who made the prior determination. If the prior determination was based on medical judgment, a health care professional with appropriate training in the field of medicine that is the subject of the claim will be consulted and identified.

The decision on the appeal will be made within 45 days of the date the appeal is received. If special circumstances require it, the time period may be extended up to an additional 45 days provided that within the initial 45-day review period the Member is informed of the special circumstances and the date a decision is expected. If the special circumstances include the need for additional information from the Member in order for a decision to be made, the necessary information will be requested. The Member will have 45 days from the date the request is received to provide the information. If the requested information is not provided within this time period, the appeal may be denied. If the additional information is received within the 45-day period, a decision on the appeal will be made within 45 days of the date the information is received, unless the Member agrees to a longer period of time.

In the case of an adverse decision of an appeal, the notice of the decision will include the information described above for a claim denial.

Two appeals are required before the Member may bring civil action under ERISA Section 502(a) as described in the STATEMENT OF ERISA RIGHTS.

Once the required appeals have been exhausted, additional appeals are allowed on a voluntary basis upon request when new and substantial information is provided. Voluntary reviews must be requested within 60 days of the date the notice of the appeal decision is received.

There are no voluntary appeal rights following the required appeal process when the denial was based on medical judgment.

## **CLAIMS & LEGAL ACTION - Continued**

The Member has a right to request information regarding voluntary appeal procedures. Any statute of limitations or other defense based on timeliness is suspended during the time that a voluntary appeal is pending. Voluntary appeals do not need to be exhausted in order to bring civil action under ERISA Section 502(a).

### **Appeal of a Life Insurance or Accidental Death & Dismemberment Claim Denial**

After receiving notice of a claim denial, in whole or in part, the Member, beneficiary, or Authorized Representative can appeal a claim denial by submitting a written request to the address shown on the adverse determination letter within 60 days of the date the denial notice is received.

An appeal includes the right to review and request copies of relevant documents, free of charge, and to submit issues and comments in writing.

The appeal request should include the following information:

- The name of the Member, Employee and the deceased; and
- The Member's group plan number and claim number, as shown on the adverse determination letter; and
- Any relevant information in support of the appeal.

The appeal will be reviewed by an individual who was not involved in the prior adverse determination and who is not a subordinate of the individual who made the prior determination. If the prior determination was based on medical judgment, a health care professional with appropriate training in the field of medicine that is the subject of the claim will be consulted and identified.

The decision on the appeal will be made within 60 days of the date the appeal is received. If special circumstances require it, the decision may be extended up to an additional 60 days provided the Member or beneficiary is informed of the special circumstances within the initial 60-day review period.

Two appeals are required before the Member or beneficiary may bring civil action under ERISA Section 502(a) as described in the STATEMENT OF ERISA RIGHTS.

Once the required appeals have been exhausted, additional appeals are allowed on a voluntary basis upon request when new and substantial information is provided. Voluntary reviews must be requested within 60 days of the date the notice of the appeal decision is received.

There are no voluntary appeal rights following the required appeal process when the denial was based on medical judgment.

The Member or beneficiary has a right to request information regarding voluntary appeal procedures. Any statute of limitations or other defense based on timeliness is suspended during the time that a voluntary appeal is pending. Voluntary appeals do not need to be exhausted in order to bring civil action under ERISA Section 502(a).

### **■ Other Information a Member Needs to Know**

#### **Incontestability**

After the Plan has been in force for 2 years, its validity can only be contested due to non-payment of premiums. During the first 2 years a Member is covered under this Plan, only a written statement signed by the Member can be used to contest the validity of the coverage. After the Member's coverage has been in force for 2 years during the Member's lifetime, no statement by the Member can be used to contest the validity of the Member's coverage.

#### **Proof of Claim**

Send written claim to Great-West as soon as reasonably possible. A written claim must be submitted no later than 15 months from the date the claim is incurred, unless the claim can not be filed for legal reasons.

#### **Benefit Payments**

The death benefit will be paid to the beneficiary(ies).

## **CLAIMS & LEGAL ACTION - Continued**

### **Legal Actions**

A Member may bring a legal action to recover under the Plan. Such legal action may be brought no sooner than 60 days, and no later than 3 years, after the time written proof of loss is required to be given under the terms of the Plan.

### **Physical Examinations**

The Company, at its own expense, has the right to have the person for whom a claim is pending examined as often as reasonably necessary.

### **Autopsy**

The Company may have an autopsy performed unless prohibited by law.

### **Notice to Arkansas Residents**

Arkansas law requires that the following information be provided to all Arkansas residents:

REGIONAL SALES OFFICE - 622 Emerson Road, Suite #250, St. Louis, MO 63141-6708, Telephone (800) 234-2636.

LOCAL INSURANCE DEPARTMENT - Arkansas Insurance Department, Consumer Service Division, 1200 West 3rd Street, Little Rock, Arkansas 72201-1904, Telephone (501) 371-2600 or (800) 282-9134.

## **GLOSSARY**

### **Actively at Work**

Employment on an active and full-time basis at the Employer's usual place of business.

### **Doctor/Physician**

A person licensed to practice medicine or osteopathy. This also includes any other practitioner of the healing arts if:

- He or she performs a service within the scope of his or her license; and
- State law requires such practitioner to be covered.

### **Employee**

See ELIGIBILITY.

### **Employer**

- LanceSoft, Inc.; and
- Any affiliated companies listed in the application of the Employer. The Employer may add an affiliated company after the effective date of the Plan. For that company only, the effective date of the Plan will be considered to be the effective date of the amendment that adds that company.

### **Hospital**

An institution licensed as a Hospital by the proper authority of the state in which it is located. An institution recognized as a Hospital by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). This does not include any institution that is used primarily as a place for treatment of alcoholism or substance abuse, unless required by state law, a clinic, convalescent home, rest home, home for the aged, nursing home, custodial care facility, or training center.

### **Illness**

An Injury, a sickness, a disease, a bodily or mental disorder or pregnancy. Conditions that exist and are treated at the same time or are due to the same or related causes are considered to be one Illness.

### **Injury**

A sudden and unforeseen event from an external agent or trauma, resulting in injuries to the physical structure of the body. It is definite as to time and place and it happens involuntarily or, if the result of a voluntary act, entails unforeseen consequences. It does not include harm resulting from disease.

### **Loss of Residence**

Being outside the United States for more than 60 days. However, a Member will continue to be eligible for the benefits provided under this Plan if he or she is temporarily outside of the United States:

- On vacation;
- To study; or
- To conduct business for your Employer;

For a period of up to, but not exceeding, 60 continuous days.

### **Member**

An Employee.

### **Plan**

The Life Insurance and AD&D benefits described in this booklet.

### **Proof of Good Health**

Written evidence that the person meets Great-West's general underwriting standards. Such evidence includes but is not limited to medical evidence.

## **GLOSSARY - Continued**

### **Service**

See ELIGIBILITY.

### **Totally Disabled and Total Disability**

Being under the care of a Doctor and prevented by Illness from working for pay or profit in any job for which you are or may become suited by reason of education, training or experience.

### **You and Your**

An Employee.

## **USERRA RIGHTS AND RESPONSIBILITIES**

The federal Uniformed Services Employment and Reemployment Rights Act (USERRA), establishes requirements for Employers and certain Employees who terminate Service with the Employer for the purpose of Uniformed Service.

“Uniformed Service” means the performance of active duty in the Uniformed Services under competent authority which includes 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 the assigned duties.

You must notify your Employer verbally or in writing of your intent to leave employment and terminate your Service with the Employer for the purpose of Uniformed Service. The notice must be provided at least 30 days prior to the start of your leave, unless it is unreasonable or impossible for you to provide advance notice due to reasons such as military necessity.

### **Continued Life Insurance Benefits**

If you are covered under the Employer’s Plan for life insurance and the Plan includes continuation of life insurance benefits for an approved leave of absence, then you are eligible for this continuation when you take a leave for Uniformed Service. Continuation of such coverage is subject to the same conditions, limitations and payment provisions that apply to continuation of life insurance benefits for any other approved leave of absence. No continuation is available for AD&D benefits.

### **Reinstatement of Coverage**

Coverage for an Employee who returns to Service with the Employer following Uniformed Service will be reinstated upon request from the Employee and in accordance with USERRA.

Reinstated coverage will not be subject to any exclusion or waiting period, if such exclusion and/or waiting period would not have been imposed had coverage not terminated as a result of Uniformed Service.

## **CONTINUATION OF COVERAGE - FMLA**

If the Employer approves your FMLA leave pursuant to the Family and Medical Leave Act of 1993 (as amended) (FMLA), coverage under the Plan will continue during your leave. Contributions must be paid by you and/or the Employer. If contributions are not paid, your coverage will cease. If you return to work on your scheduled date, coverage will be on the same basis as that provided for any active Member on that date. If you have questions about FMLA leave, see the Plan Administrator.

## **SECTION III - ERISA**

## **ERISA GENERAL INFORMATION**

The following information is required by the Employee Retirement Income Security Act of 1974 (ERISA).

The Plan Sponsor/Employer is LanceSoft, Inc..

The address of the Plan Sponsor/Employer is 2325 Dulles Corner Blvd Suite 910, Herdon, VA 20171. The telephone number is 703-674-4507.

The Employer Identification Number (EIN) is 54-1974095. The Plan Number assigned by the Plan Sponsor is 501.

The Plan Administrator is Manisha Shivaprasad, HR Director.

The Agent for Service of Legal Process is Ram Karuppusamy, Chairman & CEO.

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

The Plan provides Life and AD&D Insurance, Medical and Prescription Drug Benefits.

The medical and drug benefits described in this booklet are self-funded by the Employer. The Employer is fully responsible for the self-funded benefits. Great-West processes claims and provides other services to the Employer related to the self-funded benefits. Great-West does not insure or guarantee the self-funded benefits.

The Life Insurance and AD&D benefits described in this booklet are fully insured by Great-West.

Great-West Life & Annuity Insurance Company provides Contract Administration.

The eligibility requirements, termination provisions and a description of the circumstances that may result in disqualification, ineligibility, or denial or loss of any benefits are described in this booklet.

Contributions are determined by the Employer. Employee contributions, if any, for a time period for which the Employee is not covered under the Plan may be refunded by the Employer. Please see your Plan Administrator for details.

The fiscal records of the Plan are maintained on the basis of Plan years ending December 31.

Procedures to be followed in presenting claims for medical and drug benefits and what to do when claims are denied in whole or in part are described in "How To File Claims" under the MEDICAL AND PRESCRIPTION DRUG BENEFITS SECTION of this booklet.

Procedures to be followed in presenting claims for Life Insurance and Accidental Death & Dismemberment benefits and what to do when claims are denied in whole or in part are described in "How To File Claims" under the LIFE INSURANCE AND ACCIDENTAL DEATH & DISMEMBERMENT BENEFITS SECTION of this booklet.

## **STATEMENT OF ERISA RIGHTS**

As a participant in this Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

- Receive Information About Your Plan and Benefits.

You may examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest Annual Report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

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

## STATEMENT OF ERISA RIGHTS - Continued

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

**However, Employers with fewer than 100 Participants at the beginning of the Plan Year are not required to:**

- **furnish statements of the plan's assets and liabilities and receipts and disbursements or allow examination of the Annual Report; or**
  - **furnish copies of the Annual Report or any Terminal Report.**
- Continue Group Health Plan Coverage.

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

There may be a reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, or when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it within 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for up to 12 months (up to 18 months if you are a late enrollee) after your enrollment date in your coverage.

- Prudent Actions by Plan Fiduciaries.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your Employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

- Enforce Your Rights.

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

- Assistance With Your Questions.

## **STATEMENT OF ERISA RIGHTS - Continued**

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