
**PLAN DOCUMENT AND
SUMMARY PLAN DESCRIPTION
FOR**

THE UNIVERSITY OF CENTRAL ARKANSAS MEDICAL PLAN

Benefits effective January 1, 2023

- High Deductible Health Plan
- Preferred Provider Organization Plan

TABLE OF CONTENTS

INTRODUCTION.....	1
ELIGIBILITY, FUNDING, EFFECTIVE DATE AND TERMINATION PROVISIONS	3
OPEN ENROLLMENT	11
SCHEDULE OF BENEFITS- HIGH DEDUCTIBLE HEALTH PLAN.....	12
SCHEDULE OF BENEFITS- PPO PLAN	18
PROVIDER NETWORK PROVISIONS AND COST SHARING PROCEDURES	25
CORONAVIRUS PANDEMIC, TEMPORARY BENEFITS	28
MEDICAL BENEFITS	29
COST MANAGEMENT SERVICES	42
DEFINED TERMS	45
PLAN EXCLUSIONS.....	53
HOW TO SUBMIT A CLAIM	59
COORDINATION OF BENEFITS.....	71
THIRD PARTY RECOVERY PROVISION.....	74
CONTINUATION COVERAGE RIGHTS UNDER COBRA	76
RESPONSIBILITIES FOR PLAN ADMINISTRATION	83
GENERAL PLAN INFORMATION.....	87
APPENDIX I- IMPORTANT NOTICES	89

INTRODUCTION

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

Para obtener asistencia en Español, llame al 1-800-370-5852.

At all times this Plan will comply with all applicable laws and regulations.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

ELIGIBILITY, FUNDING, EFFECTIVE DATE AND TERMINATION PROVISIONS

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

ELIGIBILITY

Eligible Classes of Employees. All Active and Retired Employees, who qualify under one of the classes below.

New Hires:

- **Regular Full-Time Employees:** Employees designated by the Employer as Regular Full-Time Employees who are scheduled to work at least 30 hours per week. Coverage for Regular Full-Time Employees becomes effective on the date the Employee is employed as a Regular Full-Time Employee, subject to completion of enrollment requirements.
- **Qualifying Employee:** A Qualifying Employee is an Employee who is not a Regular Full-Time Employee but who averages at least 30 Hours of Service per week over the Employee's Initial Measurement Period. Coverage will be effective on the first day of the Qualifying Employee's New Employee Stability Period, subject to completion of enrollment requirements. A Qualifying Employee will remain eligible throughout the New Employee Stability Period to the extent that the employee remains employed, subject to the Plan's Break in Service rules.

Note: if there is a gap between the end of the Qualifying Employee's New Employee Stability Period and the start of the Qualifying Employee's first Ongoing Employee Stability Period (see below), the Qualifying Employee will remain eligible under the Plan until the day preceding the start of the Ongoing Employee Stability Period (to the extent the employee remains employed, and subject to the Plan's Break in Service rules.)

If a Qualifying Employee transfers to a Regular Full-Time Employee position prior to the start of the Qualifying Employee's New Employee Stability Period, the Employee will become eligible for coverage. Coverage for the new Regular Full-Time Employee will become effective on the first day, subject to completion of the enrollment requirements.

Retirees:

- An eligible Retired Employee is an Active Employee who retires from active service while enrolled as an active participant in the University Central Arkansas Group Health Plan and who is under the age of 65 with at least 10 years of employment.

Ongoing Employees:

Once an Employee has completed the Plan's Initial Measurement Period, eligibility will be based solely on the Employee's Hours of Service during the Plan's Standard Measurement Period. Any Employee who averages 30 Hours of Service per week during the Plan's Standard Measurement Period ("Ongoing Employees") will be eligible for coverage under the Plan during the Plan's next Ongoing Employee Stability Period, provided that the Ongoing Employee remains employed, and subject to the Plan's Break in Service rules. Coverage will be effective on the first day of the Ongoing Employee Stability Period, subject to completion of the enrollment requirements.

Impact of Breaks in Service:

If the Employee has a Break in Service and then returns to work, they will be treated as a New Hire, and eligibility for coverage under the Plan upon return will be determined in accordance with the New Hire rules above. However, if the Employee is not actively at work for a period and returns to work or are otherwise credited with Hours of Service before they incur a Break in Service, they will be treated as a continuous Employee and will be eligible for coverage

under the Plan upon return if they were enrolled in coverage prior to the start of the period during which they had no Hours of Service. Coverage will be effective on the first day of the month that coincides with or follows the date the Covered Employee resumes Hours of Service, subject to completion of enrollment requirements.

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

- (1) A covered Employee's Spouse.

The term "Spouse" shall mean the person with whom covered Employee has established a valid marriage under applicable State law but does not include common law marriages. The term "Spouse" shall include an individual of the same sex as the covered employee if they were legally married under the laws of a State or other foreign or domestic jurisdiction. The Plan Administrator may require documentation proving a legal marital relationship.

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

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

The phrase "placed for adoption" refers to a child whom a person intends to adopt, whether or not the adoption has become final, who has not attained the age of 26 as of the date of such placement for adoption. The term "placed" means the assumption and retention by such person of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child must be available for adoption and the legal process must have commenced.

- (3) A covered Employee's Qualified Dependents.

The term "Qualified Dependents" shall include individuals who do not qualify as a Child as defined above, but who are children for whom the Employee is a Legal Guardian.

To be eligible for Dependent coverage under the Plan, a Qualified Dependent must be under the limiting age of 26 years and primarily dependent upon the covered Employee for support and maintenance. Coverage will end on the last day of the month in which the Qualified Dependent ceases to meet the applicable eligibility requirements.

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

- (4) A covered Dependent Child or Qualified Dependent who reaches the limiting age and is Totally Disabled, unmarried, incapable of self-support because of intellectual or developmental disability, primarily dependent upon the covered Employee for support and maintenance. The Plan Administrator may require, at reasonable intervals, continuing proof of the Total Disability and dependency. The parent of the Totally Disabled Dependent who reaches the age 26 must provide the University of Central Arkansas proof the child's incapacity and dependency within 60 days of the date coverage would have otherwise ended.

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

These persons are excluded as Dependents: other individuals living in the covered Employee's or Retiree's home, but who are not eligible as defined; the legally separated or divorced former Spouse of the Employee or Retiree; any

person who is on active duty in any military service of any country; or any person who is covered under the Plan as an Employee or Retiree.

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

If both parents are Employees, their eligible Dependent will be covered as the Dependent of one or the other, but not of both.

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

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

FUNDING

Cost of the Plan. University of Central Arkansas shares the cost of Employee and Dependent coverage under this Plan with the covered Employees. The enrollment application for coverage will include a payroll deduction authorization. This authorization must be completed in a manner set forth by the Plan Administrator.

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

ENROLLMENT

Enrollment Requirements. An Employee must enroll for coverage by completing the electronic enrollment process. If an eligible Employee wishes to add Dependents to their coverage, the covered Employee is required to enroll each Dependent.

Enrollment Requirements for Newborn Children. A newborn child of a covered Employee who has Dependent coverage is not automatically enrolled in this Plan. If the newborn child is not enrolled in this Plan on a timely basis, as defined in the section "Timely Enrollments" following this section, there will be no payment from the Plan and the covered parent will be responsible for all costs.

If the child is not enrolled within 90 days of birth, the enrollment will be considered a Late Enrollment.

TIMELY OR LATE ENROLLMENT

- (1) **Timely Enrollment** - The enrollment will be "timely" if the completed form is received by the Plan Administrator no later than 31 days after the person initially becomes eligible for coverage. In addition, in the case of a birth, marriage, adoption or placement for adoption, there may be a right to enroll in this Plan. However, a request for enrollment must be made within 90 days of the date of birth, 31 days of the date of marriage or a loss of coverage, or within 90 days of an adoption or placement for adoption.

If two Employees who are covered under the Plan are the parents of children who are covered under the Plan, and the Employee who is covering the Dependent children terminates coverage, the Dependent coverage may be continued by the other covered Employee as long as coverage has been continuous.

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

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

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

SPECIAL ENROLLMENT RIGHTS

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

In addition, in the case of a birth, marriage, adoption or placement for adoption, there may be a right to enroll in this Plan. However, a request for enrollment must be made within 90 days of the date of birth, 31 days of the date of marriage or a loss of coverage, or within 90 days of an adoption or placement for adoption.

The Special Enrollment rules are described in more detail below. To request Special Enrollment or obtain more detailed information of these portability provisions, contact the Plan Administrator, University of Central Arkansas, 201 Donaghey Ave., 106 Wingo Hall Conway, Arkansas 72035 or by phone at 501-450-5052.

SPECIAL ENROLLMENT PERIODS

The events described below may create a right to enroll in the Plan under a Special Enrollment Period.

- (1) **Losing other coverage may create a Special Enrollment right.** An Employee or Dependent who is eligible, but not enrolled in this Plan, may enroll if the individual loses eligibility for other coverage and loss of eligibility for coverage meets all of the following conditions:
- (a) The Employee or Dependent was covered under a group health plan or had health insurance coverage at the time coverage under this Plan was previously offered to the individual.
 - (b) If required by the Plan Administrator, the Employee stated in writing at the time that coverage was offered that the other health coverage was the reason for declining enrollment.
 - (c) Either (i) the other coverage was COBRA coverage, and the COBRA coverage was exhausted, or (ii) the other coverage was not COBRA coverage, and the coverage was terminated as a result of loss of eligibility for the coverage or because employer contributions towards the coverage were terminated. Coverage will begin no later than the first day of the first calendar month following the date the completed enrollment form is received.
 - (d) The Employee or Dependent requests enrollment in this Plan not later than 30 days after the date of exhaustion of COBRA coverage or the termination of non-COBRA coverage due to loss of eligibility or termination of employer contributions, described above. Coverage will begin no

later than the first day of the first calendar month following the date the completed enrollment form is received.

- (2) For purposes of these rules, a loss of eligibility occurs if one of the following occurs:
- (a) The Employee or Dependent has a loss of eligibility due to the plan no longer offering any benefits to a class of similarly situated individuals (for example: part-time employees).
 - (b) The Employee or Dependent has a loss of eligibility as a result of legal separation, divorce, cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan), death, termination of employment, or reduction in the number of hours of employment or contributions towards the coverage were terminated.
 - (c) The Employee or Dependent has a loss of eligibility when coverage is offered through an HMO, or other arrangement, in the individual market that does not provide benefits to individuals who no longer reside, live or work in a service area, (whether or not within the choice of the individual).
 - (d) The Employee or Dependent has a loss of eligibility when coverage is offered through an HMO, or other arrangement, in the group market that does not provide benefits to individuals who no longer reside, live or work in a service area, (whether or not within the choice of the individual), and no other benefit package is available to the individual.

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

(3) **Acquiring a newly eligible Dependent may create a Special Enrollment right. If:**

- (a) The Employee is a participant under this Plan (or is eligible to be enrolled under this Plan but for a failure to enroll during a previous enrollment period), and
- (b) A person becomes a Dependent of the Employee through marriage, birth, adoption or placement for adoption,

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

The Special Enrollment Period for newly eligible Dependents that begins after the date of the marriage, birth, adoption, or placement for adoption. To be eligible for this Special Enrollment, the Dependent and/or Employee must request enrollment within 90 days of the date of birth, 31 days of the date of marriage, or 90 days of the date of adoption or placement for adoption.

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

- (a) in the case of marriage, the date of marriage;
- (b) in the case of a Dependent's birth, as of the date of birth; or
- (c) in the case of a Dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.

(4) **Eligibility changes in Medicaid or State Child Health Insurance Programs may create a Special Enrollment right.** An Employee or Dependent who is eligible, but not enrolled in this Plan, may enroll if:

- (a) The Employee or Dependent is covered under a Medicaid plan under Title XIX of the Social Security Act or a State child health plan (CHIP) under Title XXI of such Act, and coverage of the Employee or Dependent is terminated due to loss of eligibility for such coverage, and the Employee or Dependent requests enrollment in this Plan within 60 days after such Medicaid or CHIP coverage is terminated.
- (b) The Employee or Dependent becomes eligible for assistance with payment of Employee contributions to this Plan through a Medicaid or CHIP plan (including any waiver or demonstration project conducted with respect to such plan), and the Employee or Dependent requests enrollment in this Plan within 60 days after the date the Employee or Dependent is determined to be eligible for such assistance.

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

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

EFFECTIVE DATE

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

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

TERMINATION OF COVERAGE

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

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

- (1) The date the Plan is terminated.
- (2) The date the covered Employee's Eligible Class is eliminated.

- (3) The last day of the calendar month in which the covered Employee ceases to be in one of the Eligible Classes. This includes death or termination of Active Employment of the covered Employee. (See the section entitled Continuation Coverage Rights under COBRA.) It also includes an Employee on disability, leave of absence or other leave of absence, unless the Plan specifically provides for continuation during these periods.
- (4) The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due.
- (5) If an Employee commits fraud, makes an intentional misrepresentation of material fact in applying for or obtaining coverage, or obtaining benefits under the Plan, or fails to notify the Plan Administrator that he or she has become ineligible for coverage, then the Employer or Plan may either void coverage for the Employee and covered Dependents for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage. If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the Plan will provide at least 30 days' advance written notice of such action.

Continuation During Periods of Employer-Certified Disability or Leave of Absence. A person may remain eligible for a limited time if Active, full-time work ceases due to disability. This continuance will end as follows:

For disability leave: the end of the 180 days that runs concurrently with FMLA, following the month in which the person last worked as an Active Employee.

For leave of Absence: the amount of time is determined by the Employer and will run concurrently with FMLA, following the month in which the person last worked as an Active Employee.

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

Continuation During Family and Medical Leave. Regardless of the established leave policies mentioned above, this Plan shall at all times comply with the Family and Medical Leave Act, as amended, and as promulgated in regulations issued by the Department of Labor.

During any leave taken under the Family and Medical Leave Act, the Employer will maintain coverage under this Plan on the same conditions as coverage would have been provided if the covered Employee had been continuously employed during the entire leave period.

If Plan coverage terminates during the FMLA leave, coverage will be reinstated for the Employee and his or her covered Dependents if the Employee returns to work in accordance with the terms of the FMLA leave. Coverage will be reinstated only if the person(s) had coverage under this Plan when the FMLA leave started and will be reinstated to the same extent that it was in force when that coverage terminated. For example, Waiting Periods will not be imposed unless they were in effect for the Employee and/or his or her Dependents when Plan coverage terminated.

Rehiring a Terminated Employee. A terminated Employee who is rehired will be treated as a new hire and be required to satisfy all Eligibility and Enrollment requirements to the extent permitted by the terms of the Plan and applicable law.

Employees on Military Leave. Employees going into or returning from military service may elect to continue Plan coverage as mandated by the Uniformed Services Employment and Reemployment Rights Act (USERRA) under the following circumstances. These rights apply only to Employees and their Dependents covered under the Plan immediately before leaving for military service.

- (1) The maximum period of coverage of a person and the person's covered Dependents under such an election shall be the lesser of:
 - (a) The 24-month period beginning on the date on which the person's absence begins; or
 - (b) The day after the date on which the person was required to apply for or return to a position of employment and fails to do so.
- (2) A person who elects to continue health plan coverage must pay up to 102% of the full contribution under the Plan, except a person on active duty for 30 days or less cannot be required to pay more than the Employee's share, if any, for the coverage.
- (3) An exclusion or Waiting Period may not be imposed in connection with the reinstatement of coverage upon reemployment if one would not have been imposed had coverage not been terminated because of service. However, an exclusion or Waiting Period may be imposed for coverage of any Illness or Injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of uniformed service.

If the Employee wishes to elect this coverage or obtain more detailed information, contact the Plan Administrator. The Employee may also have continuation rights under USERRA. In general, the Employee must meet the same requirements for electing USERRA coverage as are required under COBRA continuation coverage requirements. Coverage elected under these circumstances is concurrent, not cumulative. The Employee may elect USERRA continuation coverage for the Employee and their Dependents. Only the Employee has election rights. Dependents do not have any independent right to elect USERRA health plan continuation.

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

- (1) The date the Plan or Dependent coverage under the Plan is terminated.
- (2) The date that the Employee's coverage under the Plan terminates for any reason including death. (See the section entitled Continuation Coverage Rights under COBRA.)
- (3) The date a covered Spouse loses coverage due to loss of eligibility status. (See the section entitled Continuation Coverage Rights under COBRA.)
- (4) Coverage on the last day of the month in which the Qualified Dependent ceases to meet the applicable eligibility requirements. (See the section entitled Continuation Coverage Rights under COBRA.)
- (5) Coverage will end on the last day of the month in which the Child ceases to meet the applicable eligibility requirements. (See the section entitled Continuation Coverage Rights under COBRA.)
- (6) The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due.
- (7) If a Dependent commits fraud or makes an intentional misrepresentation of material fact in applying for or obtaining coverage, or obtaining benefits under the Plan, or fails to notify the Plan Administrator that he or she has become ineligible for coverage, then the Employer or Plan may either void coverage for the Dependent for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage. If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the Plan will provide at least 30 days' advance written notice of such action.

OPEN ENROLLMENT

The last quarter of each year, during the annual open enrollment period, eligible Employees and their eligible Dependents who are Late Enrollees will be able to enroll in the Plan. At this time, covered Employees and their covered Dependents will also be able to change some of their benefit decisions based on which benefits and coverages are right for them.

Benefit choices made during the open enrollment period will become effective January 1 and remain in effect until the next January 1 unless there is a Special Enrollment event or a change in family status during the year (birth, death, marriage, divorce, adoption) or loss of coverage due to loss of a Spouse's employment.

Benefit choices for Late Enrollees made during the open enrollment period will become effective January 1.

A Plan Participant who fails to make an election during open enrollment will automatically retain his or her present coverages.

Plan Participants will receive detailed information regarding open enrollment from their Employer.

**SCHEDULE OF BENEFITS
High Deductible Health Plan**

MEDICAL BENEFITS

All benefits described in this Schedule are subject to the Claims Administrator’s established Coverage Policy, which the Plan Administrator has adopted for purposes of defining the benefits due under this Plan, the Allowable Charge (as defined herein), and the benefit limits and exclusions described more fully herein including, but not limited to the determination that: care and treatment is or is not Medically Necessary; or that services, supplies and care are or are not Experimental and/or Investigational. The meanings of these capitalized terms are in the Defined Terms section of this document.

High Deductible Health Plan

A qualified High Deductible Health Plan (HDHP) with a Health Savings Account provides comprehensive coverage for high-cost medical events and a tax-advantaged way to help build savings for future medical expenses. The Plan gives a Covered Person greater control over how health care benefits are used. A HDHP satisfies certain statutory requirements with respect to minimum deductibles and out-of-pocket expenses for both single and family coverage. These minimum deductibles and limits for out-of-pocket expenses' limit are set forth by the U.S. Department of Treasury and will be indexed for inflation in the future.

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

Therefore, when a Covered Person uses an In-Network Provider, that Covered Person will receive a higher payment from the Plan than when an Out-of-Network Provider is used. It is the Covered Person's choice as to which Provider to use.

A listing of In-Network Providers is available on the web at www.blueadvantagearkansas.com.

Deductibles Payable by Plan Participants, per Calendar Year

A deductible is an amount of money that is paid once a Calendar Year per Covered Person or Family Unit. On the first day of each Calendar Year, a new deductible amount is required.

Individual Plan Deductible

In-Network services.....	\$2,000
Out-of-Network services	\$4,000

Family Plan Deductible

In-Network services.....	\$4,000
Out-of-Network services	\$8,000

Deductible Accumulation

The In-Network and Out-of-Network deductibles are totally separate and do not contribute toward or offset each other.

For single coverage, the Covered Person must meet the individual deductible before any money is paid by the Plan for any Covered Charge. For two-member or family coverage, the overall family deductible must be satisfied in its entirety before the Plan begins to pay.

The Calendar Year deductible is waived for the following Covered Charges:

- In-Network Standard and Routine Preventive Care
- In-Network office/outpatient lab, x-ray, and diagnostic testing
- In-Network independent lab, radiology, and pathology services

Annual Out-of-Pocket Limits

Unless stated otherwise in this document, the Plan will pay 80% of In-Network Covered Charges and 60% of Out-of-Network Covered Charges until the annual Out-of-Pocket Limit is satisfied, at which time the Plan will pay 100% of the remainder of In-Network Covered Charges for the rest of the Calendar Year.

Individual Plan Out-of-Pocket Limit

In-Network services.....	\$4,000
Out-of-Network services	\$8,000

Family Plan Out-of-Pocket Limit

In-Network services, per person.....	\$6,550
In-Network services, per family	\$8,000

Family Plan Out-of-Pocket Limit

Out-of-Network services, per person.....	\$8,000
Out-of-Network services, per family	\$16,000

Out-of-Pocket Accumulation

The In-Network and Out-of-Network Out-of-Pocket amounts are totally separate and do not contribute toward or offset each other.

For single coverage, the Covered Person must meet the individual out-of-pocket limit, at which point the Plan will pay Covered Charges at 100% for that Covered Person for the remainder of the Calendar Year. For two-member or family coverage, each family member must meet their family plan individual out-of-pocket limit until the overall family out-of-pocket limit has been met, at which point the Plan will pay Covered Charges at 100% for that Family Unit for the remainder of the Calendar Year.

The charges for the following do not apply to the annual Out-of-Pocket Limit:

- Penalties for failure to obtain Prior Approval for certain Out-of-Network services
- Amounts in excess of the Allowable Charge
- Non-covered services

HOSPITAL BENEFITS

Prior Approval is required for all inpatient admissions, except for a Hospital admission following a Medical Emergency

For In-Network Hospital Admissions: In-Network Hospitals are responsible for obtaining Prior Approval for an inpatient admission. The In-Network Hospital is responsible for any penalty amounts incurred for failure to obtain Prior Approval.

NOTE: For inpatient admissions related to treatment of a Medical Emergency, the Covered Person or the treating Provider should notify the Plan of the admission within 48 hours of the admission.

Room and Board Allowances

Covered Charges for room and board during an inpatient admission shall be limited to the lesser of the billed charge or the Allowable Charge established by the Plan.

Inpatient and Outpatient Services

In-Network facility reimbursement rate	80%, after deductible
Out-of-Network facility reimbursement rate.....	60%, after deductible

Emergency Room Services

In-Network and Out-of-Network reimbursement rate..... 80%, after deductible
• The Out-of-Network emergency room services will apply to the In-Network out-of-pocket limit.

PHYSICIAN BENEFITS

In-Network Physician Reimbursement rates

Services rendered in an office setting:

Standard Preventive Care 100%, deductible waived
Lab, x-ray, and diagnostic testing..... 100%, deductible waived
Services other than lab, x-ray, and diagnostic testing 80%, after deductible
Independent lab, radiology, and pathology 100%, deductible waived

Services rendered in an outpatient setting:

Lab, x-ray, and diagnostic testing..... 100%, deductible waived
Services other than lab, x-ray, and diagnostic testing 80%, after deductible
Inpatient and Outpatient services 80%, after deductible
Emergency room services 80%, after deductible

Out-of-Network Physician reimbursement rates

Services rendered in an office setting:

Standard Preventive Care 60%, after deductible
Medical condition..... 60%, after deductible
Independent lab, radiology, and pathology 60%, after deductible
Inpatient and Outpatient services 60%, after deductible
Emergency room services 80%, after deductible

PREVENTIVE CARE BENEFITS

Standard Preventive Care

Reimbursement rates

In-Network services..... 100%, deductible waived
Out-of-Network services 60%, after deductible

At all times, the Plan will comply with the Patient Protection and Affordable Care Act (PPACA). The list of services included as Standard Preventive Care may change from time to time depending upon government guidelines. A current listing of required preventive care can be accessed at:

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

Routine Preventive Care

Reimbursement rates

In-Network services..... 100%, deductible waived
Out-of-Network services 60%, after deductible

In addition to the preventive services mandated by the ACA, the Plan also provides more generous coverage for the following services:

- Diagnostic **Colonoscopies** with related anesthesia & lab work.
- **Cervical Cancer Screenings and Pap Smears**, limited to one every three years, unless family history or other medical criteria allow annually.

OTHER BENEFIT LIMITS AND MAXIMUMS

Advanced Diagnostic Imaging

- Prior Approval is required for Advanced Diagnostic Imaging services, such as magnetic resonance angiography or imaging (MRA/MRI), computed tomography scanning (CT Scan), nuclear cardiology, echo cardiography, and positron emission tomography (PET Scan). The Provider or the Covered Person may call the phone number on the back of the Covered Person's health plan identification card to receive Prior Approval. Failure to receive Prior Approval may result in the denial or reduction of benefits paid by the Plan.

Ambulance services

In-Network and Out-of-Network reimbursement rate..... 80%, after deductible

- The Out-of-Network ambulance services will apply to the In-Network Out-of-Pocket Limit.

Breast Cancer, Diagnostic Exams

In-Network reimbursement rate 100%, deductible waived

Out-of-Network reimbursement rate 60%, after deductible

- "Diagnostic examination for breast cancer" means a medically necessary and appropriate examination, as determined by a clinician who is evaluating the individual for breast cancer, to evaluate an abnormality in the breast that is: (a) seen or suspected from a screening examination for breast cancer; (b) detected by another means of examination; or (c) suspected based on the medical history or family medical history of the individual.

Breast pumps, electric

In-Network and Out-of-Network reimbursement rate..... 100%, deductible waived

- Manual breast pumps are classified as a Standard Preventive Care service and payable at Standard Preventive Care reimbursement rates.

Cardiac Rehabilitation Services

Calendar Year limit 36 visits

Chiropractic Services

Calendar Year limit 20 visits

Colorectal Cancer Screening, Follow-up Colonoscopy

In-Network reimbursement rate 100%, deductible waived

Out-of-Network reimbursement rate 60%, after deductible

- A Covered Person shall not be subject to any cost-sharing requirement for a follow-up colonoscopy received from an In-Network Provider following an abnormal non-colonoscopy screening test, as an initial screening test is not considered complete until a follow-up colonoscopy is performed.

Dietitian

Calendar Year limit 12 visits

- The dietitian limit Calendar Year limit is in excess of Standard Preventive Care.

Eyeglasses or contact lenses following cataract surgery

Lifetime limit initial pair of glasses or contact lenses

Hearing Aid

Limit, per ear one every three Calendar Years

Maximum reimbursement rate, per ear \$1,400

In-Network and Out-of-Network reimbursement rate..... 100%, after deductible

Home Health Care

Calendar Year limit 60 visits

Infertility Services

In-Vitro Fertilization, Artificial Insemination, and Infertility Treatment
Combined Lifetime maximum\$15,000

Inhalation Therapy (Respiratory Therapy)

Calendar Year limit 20 visits

Medical or Radiation Oncology Services

- Prior Approval is required for Medical or Radiation Oncology services, including but not limited to chemotherapy, brachytherapy, proton beam therapy, and 3-D conformal radiation therapy. The Provider or the Covered Person may call the phone number on the back of the Covered Person’s health plan identification card to receive Prior Approval. Failure to receive Prior Approval may result in the denial or reduction of benefits paid by the Plan.

Mental Illness and Substance Abuse Treatment

- Prior Approval is required for inpatient admissions related to the treatment of Mental Illness or Substance Abuse at a Hospital or a residential treatment facility. Please refer to the health plan identification card for the MHSA phone number.
- Prior Approval is required for repetitive transcranial magnetic stimulation for depression and applied behavioral analysis for autism. Failure to obtain Prior Approval may result in denial of reimbursement from the Plan. Please refer to the health plan identification card for the MHSA phone number.

Orthotic and Prosthetic Appliances

Appliance limit, one replacement every three years
In-Network and Out-of-Network reimbursement rate..... 80%, after deductible

Outpatient Habilitative Therapy Services

Occupational, Physical, and Speech Therapies
Combined Calendar Year limit..... 60 visits

Outpatient Rehabilitative Therapy Services

Aural Therapies- Post Cochlear implant
Calendar Year limit 30 visits

Cognitive Rehabilitative Therapies
Calendar Year limit 20 visits

Occupational, Physical, and Speech Therapies
Combined Calendar Year limit..... 60 visits

Residential Treatment Facilities

Calendar Year limit 60 days

Routine Obstetrical Ultrasound

Limit, per pregnancy three ultrasounds

Skilled Nursing Facilities, Extended Nursing Care Facilities, Nursing Homes

Calendar Year limit 60 days

Telehealth Benefits

Telemedicine services	
In-Network reimbursement rate.....	80%, after deductible
Out-of-Network reimbursement rate	60%, after deductible
Telephone-based services	
In-Network reimbursement rate.....	80%, after deductible
Out-of-Network reimbursement rate	60%, after deductible

Temporomandibular Joint Syndrome

Calendar Year maximum.....	\$3,000
----------------------------	---------

Transportation and Lodging Expenses

Reimbursement rate.....	100%, after deductible
Lifetime maximum, per eligible class of service	\$10,000

- Each eligible class of service includes cancer-related treatment, congenital heart disease, and organ transplant.
- Lodging is eligible for reimbursement for the patient (while not a Hospital inpatient) and one companion.
- If the patient is an enrolled Dependent minor child, the lodging expenses of two companions will be covered. Lodging expenses will be reimbursed at a per diem rate up to \$150 per day.
- See “Transportation and Lodging” in the Medical Benefits section for additional information.

Urgent Care Clinics

For treatment sought due to a Medical Emergency, as defined by the Plan:

In-Network reimbursement rate and Out-of-Network reimbursement rate	80%, after deductible
---	-----------------------

- The Out-of-Network Urgent Care services will apply to the In-Network out-of-pocket limit.

For emergency room services which are not related to a Medical Emergency, as defined by the Plan:

In-Network reimbursement rate.....	80%, after deductible
Out-of-Network reimbursement rate	60%, after deductible

**SCHEDULE OF BENEFITS
PPO Plan**

MEDICAL BENEFITS

All benefits described in this Schedule are subject to the Claims Administrator’s established Coverage Policy, which the Plan Administrator has adopted for purposes of defining the benefits due under this Plan, the Allowable Charge (as defined herein), and the benefit limits and exclusions described more fully herein including, but not limited to the determination that: care and treatment is or is not Medically Necessary; or that services, supplies, and care are or are not Experimental and/or Investigational. The meanings of these capitalized terms are in the Defined Terms section of this document.

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

Therefore, when a Covered Person uses an In-Network Provider, that Covered Person will receive a higher payment from the Plan than when an Out-of-Network Provider is used. It is the Covered Person's choice as to which Provider to use.

A listing of In-Network Providers is available on the web at www.blueadvantagearkansas.com.

Deductibles Payable by Plan Participants, per Calendar Year

A deductible is an amount of money that is paid once a Calendar Year per Covered Person or Family Unit. On the first day of each Calendar Year, a new deductible amount is required.

In-Network Deductible

Per Covered Person	\$1,500
Per Family Unit	\$3,000

Out-of-Network Deductible

Per Covered Person	\$2,000
Per Family Unit	\$4,000

Deductible Accumulation

The In-Network and Out-of-Network deductibles are totally separate and do not contribute toward or offset each other.

For single coverage, the Covered Person must meet the individual deductible before any money is paid by the Plan for any Covered Charge. For two-member or family coverages, each family member must meet his or her own individual deductible until the total amount of deductible expenses paid by all family members meets the overall Family Unit deductible.

The Calendar Year deductible is waived for the following Covered Charges:

- In-Network Standard and Routine Preventive Care
- In-Network office visits and telehealth consultations
- In-Network office/outpatient lab x-ray, and diagnostic testing
- In-Network independent lab, radiology, and pathology services
- In-Network office/outpatient services for aural therapies, autism treatment, cardiac rehabilitation, chiropractic, occupational therapy, speech therapy, and physical therapy
- Emergency Room services
- In-Network prescription drug coverage

Annual Out-of-Pocket Limits

Unless stated otherwise in this document, the Plan will pay 80% of In-Network Covered Charges and 60% of Out-of-Network Covered Charges until the annual Out-of-Pocket Limit is satisfied, at which time the Plan will pay 100% of the remainder of In-Network Covered Charges for the rest of the Calendar Year.

Individual Plan Out-of-Pocket Limit

Per Covered Person	\$4,000
Per Family Unit	\$8,000

Out-of-Network Out-of-Pocket Limit

Per Covered Person	\$10,000
Per Family Unit	\$20,000

Out-of-Pocket Accumulation

The In-Network and Out-of-Network Out-of-Pocket amounts are totally separate and do not contribute toward or offset each other.

For single coverage, the Covered Person must meet the individual Out-of-Pocket Limit, at which point the Plan will pay Covered Charges at 100% for the Covered Person for the remainder of the Calendar Year. For two-member or family coverage, each family member must meet his or her own individual Out-of-Pocket Limit until the overall Family Unit Out-of-Pocket Limit has been met, at which point the Plan will pay Covered Charges at 100% for that Family Unit for the remainder of the Calendar Year.

The charges for the following do not apply to the annual Out-of-Pocket Limit:

- Penalties for failure to obtaining Prior Approval for certain Out-of-Network services
- Amounts in excess of the Allowable Charge
- Non-covered services

HOSPITAL BENEFITS

Prior Approval is required for all inpatient admissions, except for a Hospital admission following a Medical Emergency

For In-Network Hospital Admissions: In-Network Hospitals are responsible for obtaining Prior Approval for an inpatient admission. The In-Network Hospital is responsible for any penalty amounts incurred for failure to obtain Prior Approval.

NOTE: For inpatient admissions related to treatment of a Medical Emergency, the Covered Person or the treating Provider should notify the Plan of the admission within 48 hours of the admission.

Room and Board Allowances

Covered Charges for room and board during an inpatient admission shall be limited to the lesser of the billed charge or the Allowable Charge established by the Plan.

Inpatient and Outpatient Services

In-Network facility reimbursement rate	80%, after deductible
Out-of-Network facility reimbursement rate	60%, after deductible

Emergency Room Services

- In-Network and Out-of-Network copay\$200
In-Network and Out-of-Network reimbursement rate..... copay, then 100%, deductible waived
- Copay is waived if the patient is admitted to the Hospital for an inpatient stay directly from the Emergency Room.
 - The Out-of-Network emergency room services will apply to the In-Network out-of-pocket limit.

PHYSICIAN BENEFITS

Primary Care Physicians

Includes In-Network general practitioners, family practitioners, doctors of internal medicine, pediatricians, geriatricians, and obstetrician/gynecologists.

Covered Charges billed by physician assistants, registered nurse practitioners, certified nurse practitioners, and clinical nurse specialists that work under the direction of a Primary Care Physician will also be paid at the Primary Care Physician reimbursement rate.

In-Network PCP reimbursement rates

Services rendered in an office setting:

Mental Health/Substance Abuse.....	\$20 copay per office visit charge, then 100%, deductible waived
Standard Preventive Care	100%, deductible waived
Any other medical condition	\$20 copay per office visit charge, then 100%, deductible waived
Lab, x-ray, and diagnostic testing.....	100%, deductible waived
Services other than lab, x-ray, and diagnostic testing	80%, after deductible
Independent lab, radiology, and pathology	100%, deductible waived
Services rendered in an outpatient setting:	
Lab, x-ray, and diagnostic testing.....	100%, deductible waived
Services other than lab, x-ray, and diagnostic testing	80%, after deductible
Inpatient services.....	80%, after deductible
Emergency room services	100%, deductible waived

In-Network Specialist reimbursement rates

Services rendered in an office setting:

Mental Health/Substance Abuse.....	\$20 copay per office visit charge, then 100%, deductible waived
Standard Preventive Care	100%, deductible waived
Any other medical condition	\$35 copay per office visit charge, then 100%, deductible waived
Lab, x-ray, and diagnostic testing.....	100%, deductible waived
Services other than lab, x-ray, and diagnostic testing	80%, after deductible
Independent lab, radiology, and pathology	100%, deductible waived
Services rendered in an outpatient setting:	
Lab, x-ray, and diagnostic testing.....	100%, deductible waived
Services other than lab, x-ray, and diagnostic testing	80%, after deductible
Inpatient services.....	80%, after deductible
Emergency room services	100%, deductible waived

Out-of-Network Physician reimbursement rates

Services rendered in an office setting:

Mental Health/Substance Abuse.....	60%, after deductible
Standard Preventive Care	60%, after deductible
Any other medical condition	60%, after deductible
Independent lab, radiology, and pathology	60%, after deductible
Outpatient and Inpatient services	60%, after deductible
Emergency room services	100%, deductible waived

PREVENTIVE CARE BENEFITS

Standard Preventive Care

Reimbursement rates

In-Network services..... 100%, deductible waived
Out-of-Network services 60%, after deductible

At all times, the Plan will comply with the Patient Protection and Affordable Care Act (ACA). The list of services included as Standard Preventive Care may change from time to time depending upon government guidelines. A current listing of required preventive care can be accessed at: www.HealthCare.gov/center/regulations/prevention.html and www.cdc.gov/vaccines/.

Routine Preventive Care

Reimbursement rates

In-Network services..... 100%, deductible waived
Out-of-Network services 60%, after deductible

In addition to the preventive services mandated by the ACA, the Plan also provides more generous coverage for the following services:

- Diagnostic Colonoscopies with related anesthesia & lab work.
- Cervical Cancer Screenings and Pap Smears, limited to one every three years, unless family history or other medical criteria allow annually.

OTHER BENEFIT LIMITS AND MAXIMUMS

Advanced Diagnostic Imaging

- Prior Approval is required for Advanced Diagnostic Imaging services, such as magnetic resonance angiography or imaging (MRA/MRI), computed tomography scanning (CT Scan), nuclear cardiology, echo cardiography, and positron emission tomography (PET Scan). The Provider or the Covered Person may call the phone number on the back of the Covered Person’s health plan identification card to receive Prior Approval. Failure to receive Prior Approval may result in the denial or reduction of benefits paid by the Plan.

Ambulance services

In-Network and Out-of-Network reimbursement rate..... 80%, after deductible

- The Out-of-Network ambulance services will apply to the In-Network out-of-pocket limit.

Autism Treatment

In-Network office/outpatient services \$20 copay per encounter, then 100%, deductible waived
Out-of-Network services 60%, after deductible

Breast Cancer, Diagnostic Exams

In-Network reimbursement rate 100%, deductible waived
Out-of-Network reimbursement rate 60%, after deductible

- “Diagnostic examination for breast cancer” means a medically necessary and appropriate examination, as determined by a clinician who is evaluating the individual for breast cancer, to evaluate an abnormality in the breast that is: (a) seen or suspected from a screening examination for breast cancer; (b) detected by another means of examination; or (c) suspected based on the medical history or family medical history of the individual.

Breast pumps, electric

In-Network and Out-of-Network reimbursement rate..... 100%, deductible waived

- Manual breast pumps are classified as a Standard Preventive Care service and payable at Standard Preventive Care reimbursement rates.

Cardiac Rehabilitation Services

Calendar Year limit 36 visits

In-Network office/outpatient services \$20 copay per encounter, then 100%, deductible waived

Out-of-Network services 60%, after deductible

Chiropractic Services

Calendar Year limit 20 visits

In-Network office \$20 copay per visit then 100%, deductible waived

In-Network office related services 100%, deductible waived

Out-of-Network services 60%, after deductible

Colorectal Cancer Screening, Follow-up Colonoscopy

In-Network reimbursement rate 100%, deductible waived

Out-of-Network reimbursement rate 60%, after deductible

- A Covered Person shall not be subject to any cost-sharing requirement for a follow-up colonoscopy received from an In-Network Provider following an abnormal non-colonoscopy screening test, as an initial screening test is not considered complete until a follow-up colonoscopy is performed.

Dietitian

Calendar Year limit 12 visits

- The dietitian Calendar Year limit is in excess of Standard Preventive Care.

Eyeglasses or contact lenses following cataract surgery

Lifetime limit initial pair of glasses or contact lenses

Hearing Aid

Limit, per ear one every three Calendar Years

Maximum reimbursement rate, per ear\$1,400

In-Network and Out-of-Network reimbursement rate..... 100%, deductible waived

Home Health Care

Calendar Year limit 60 visits

Infertility Services

In-Vitro Fertilization, Artificial Insemination, and Infertility Treatment

Combined Lifetime maximum\$15,000

Inhalation Therapy (Respiratory Therapy)

Calendar Year limit 20 visits

In-Network office/outpatient services \$20 copay per encounter, then 100%, deductible waived

Out-of-Network services 60%, after deductible

Medical or Radiation Oncology Services

- Prior Approval is required for Medical or Radiation Oncology services, including but not limited to chemotherapy, brachytherapy, proton beam therapy, and 3-D conformal radiation therapy. The Provider or the Covered Person may call the phone number on the back of the Covered Person’s health plan identification card to receive Prior Approval. Failure to receive Prior Approval may result in the denial or reduction of benefits paid by the Plan.

Mental Illness and Substance Abuse Treatment

- Prior Approval is required for inpatient admissions related to the treatment of Mental Illness or Substance Abuse at a Hospital or a residential treatment facility. Please refer to the health plan identification card for the MHSA phone number.
- Prior Approval is required for repetitive transcranial magnetic stimulation for depression and applied behavioral analysis for autism. Failure to obtain Prior Approval may result in denial of reimbursement from the Plan. Please refer to the health plan identification card for the MHSA phone number.

Orthotic and Prosthetic Appliances

Appliance limit..... one replacement every three years
 In-Network and Out-of-Network reimbursement rate..... 80%, after deductible

Outpatient Habilitative Therapy Services

Occupational, Physical, and Speech Therapies

Combined Calendar Year limit..... 60 visits
 In-Network office/outpatient services \$20 copay per encounter, then 100%, deductible waived
 Out-of-Network services 60%, after deductible

Outpatient Rehabilitative Therapy Services

Aural Therapies- Post Cochlear implant

Calendar Year limit 30 visits
 In-Network office/outpatient services \$20 copay per encounter, then 100%, deductible waived
 Out-of-Network services 60%, after deductible

Cognitive Rehabilitative Therapies

Calendar Year limit 20 visits
 In-Network office/outpatient services \$20 copay per encounter, then 100%, deductible waived
 Out-of-Network services 60%, after deductible

Occupational, Physical, and Speech Therapies

Combined Calendar Year limit..... 60 visits
 In-Network office/outpatient services \$20 copay per encounter, then 100%, deductible waived
 Out-of-Network services 60%, after deductible

Residential Treatment Facilities

Calendar Year limit 60 days

Routine Obstetrical Ultrasound

Limit, per pregnancy three ultrasounds

Skilled Nursing Facilities, Extended Nursing Care Facilities, Nursing Homes

Calendar Year limit 60 days

Telehealth Benefits

Telemedicine services

In-Network PCP reimbursement rate \$20 copay per consultation, then 100%, deductible waived
In-Network Specialist reimbursement rate \$35 copay per consultation, then 100%, deductible waived
Out-of-Network reimbursement rate 60%, after deductible

Telephone-based services

In-Network PCP reimbursement rate \$20 copay per consultation, then 100%, deductible waived
In-Network Specialist reimbursement rate \$35 copay per consultation, then 100%, deductible waived
Out-of-Network reimbursement rate 60%, after deductible

Temporomandibular Joint Syndrome

Calendar Year maximum.....\$3,000

Transportation and Lodging Expenses

Reimbursement rate..... 100%, deductible waived
Lifetime maximum, per eligible class of service\$10,000

- Each eligible class of service includes cancer-related treatment, congenital heart disease, and organ transplant.
- Lodging that are eligible for reimbursement for the patient (while not a Hospital inpatient) and one companion.
- If the patient is an enrolled Dependent minor child, the lodging expenses of two companions will be covered. Lodging expenses will be reimbursed at a per diem rate up to \$150 per day.
- See “Transportation and Lodging” in the Medical Benefits section for additional information.

Urgent Care Clinics

For treatment sought due to a Medical Emergency, as defined by the Plan:

In-Network reimbursement rate..... \$50 copay per encounter, then 100%, deductible waived
Out-of-Network reimbursement rate \$50 copay per encounter, then 100%, deductible waived

- The Out-of-Network urgent care services will apply to the In-Network out-of-pocket limit.

For emergency room services which are not related to a Medical Emergency, as defined by the Plan:

In-Network reimbursement rate..... \$50 copay per encounter, then 100%, deductible waived
Out-of-Network reimbursement rate 60%, after deductible

PROVIDER NETWORK PROVISIONS AND COST SHARING PROCEDURES

The Plan may afford significant savings to members who obtain coverage from In-Network Providers. This Section describes how Covered Persons can maximize their benefits under the Plan by using In-Network Providers.

NETWORK PROCEDURES

Standard Benefits. All benefits described in this document are subject to the Claims Administrator's established Coverage Policy, which the Plan Administrator has adopted for purposes of defining the benefits due under this Plan, the Allowable Charge (as defined herein), and the benefit limits and exclusions described more fully herein including, but not limited to the determination that: care and treatment is or is not Medically Necessary and that services, supplies and care are or are not Experimental and/or Investigational. A charge is incurred on the date that the service or supply is performed or furnished.

In-Network Services. This coverage is most effective and advantageous when the services of In-Network Providers are used. Claims associated with services provided by In-Network Providers may have a more advantageous deductible, coinsurance and copayment than claims for services of Out-of-Network Providers. The In-Network deductible, coinsurance and any applicable copayment cited in the Schedule of Benefits are applied to Allowable Charges for services and supplies received from an In-Network Provider, unless this document shows a different deductible, coinsurance or copayment for the particular service.

Out-of-Network Benefits. Reimbursement for services by Out-of-Network Providers generally will be less than payment for the same services when provided by an In Network Provider and could result in substantial additional out-of-pocket expenses. The Out-of-Network deductible, coinsurance, and any applicable copayment described in the Schedule of Benefits are applied to Allowable Charges for services and supplies received from an Out-of-Network Provider, except under the following circumstances:

- (1) **Plan Provision.** If, this document specifies elsewhere that a different deductible, coinsurance or copayment is applicable to the particular service or supply that is the subject of the claim.
- (2) **Emergency Services.** The Intervention is for a Medical Emergency, in which case the In-Network deductible, coinsurance and copayment apply.
- (3) **Continuity of Care, Change in the Plan's Claims Administrator.** A Covered Person may notify the Claims Administrator that prior to the effective date of the Plan's coverage with BlueAdvantage Administrators of Arkansas as the Claims Administrator, the Covered Person was engaged with an Out-of-Network Provider for a scheduled procedure or ongoing treatment covered under this Plan, that such procedure or treatment is for a condition requiring immediate care, and that the Covered Person requests In-Network benefits for such scheduled procedure or ongoing treatment. If the Claims Administrator approves In-Network coverage for the scheduled procedure or ongoing treatment, any applicable In-Network deductible, coinsurance, and any Copayment will apply to claims for eligible services and supplies rendered by the Out-of-Network Provider for such condition until the procedure or treatment ends or until the end of 90 days, whichever occurs first.
- (4) **Continuity of Care, Pregnancy, Prior to Coverage.** A Covered Person may notify the Claims Administrator that prior to the effective date of coverage, the Covered Person was receiving obstetrical care from an Out-of-Network Provider for a Pregnancy covered under the terms of this Plan, and request In-Network benefits for continuation of such obstetrical care from the Out-of-Network Provider. If the Claims Administrator approves In-Network coverage for the requested obstetrical care, any applicable In-Network deductible, coinsurance and copayment will apply to claims for services and supplies received from this Out-of-Network Provider and will continue to apply to claims for eligible services and supplies rendered by the Out-of-Network Provider until the completion of the Pregnancy, including two months of postnatal visits.

- (5) **Provider Leaves Network.** A Covered Person may notify the Claims Administrator that their Out-of-Network Provider was formerly an In-Network Provider when ongoing treatment for an acute condition began, and request In-Network benefits for the continuation of such ongoing treatment. If the Claims Administrator approves In-Network coverage for the ongoing treatment, any applicable In-Network deductible, coinsurance and copayment will apply to claims for eligible services and supplies rendered by the Out-of-Network Provider for such condition until the end of the current episode of treatment or until the end of 90 days, whichever occurs first.
- (6) **Services Not Available or Accessible from In-Network Provider.** If a Covered Person notifies the Claims Administrator prior to receiving a Health Intervention and the Claims Administrator determines that the required covered services or supplies associated with such Health Intervention are not accessible or available from an In-Network Provider, the Claims Administrator may provide the Covered Person with written approval of In-Network coverage for such services or supplies, and any In-Network deductible, coinsurance and copayment will apply to the claims for the eligible services that are received from the Out-of-Network Provider. In the event that a member fails to notify the Claims Administrator prior to receiving a Health Intervention from an Out-of-Network Provider, the Claims Administrator will determine whether or not an exception will be made to allow In-Network benefits due to potential inaccessibility or unavailability of an In-Network provider.

PROVIDER DIRECTORY

The determination of whether a Physician or Hospital is an In-Network Provider is the responsibility of the Plan and Claims Administrator. The Claims Administrator can provide a list of In-Network Providers upon request. A Covered Person may also obtain a list of In-Network Providers on the web site www.blueadvantagearkansas.com. A Provider's status may change. A Covered Person can verify the Provider's status by calling Customer Service at the phone number on the back of their health plan identification card. If a Covered Person is informed incorrectly prior to receiving a Covered Service, either by accessing the directory or in response to a request for such information (via telephone, electronic, web-based or internet-based means), the Covered Person may be eligible for cost sharing that would be no greater than if the covered service had been provided by an In-Network Provider.

BlueCard PPO Program. The Plan includes access to the BlueCard PPO network. This benefit allows Covered Persons to receive In-Network benefits from Providers located outside of Arkansas, provided such Provider is in the BlueCard PPO network of the local Blue Cross or Blue Shield Company. A Covered Person may obtain a list of In-Network Providers in an out-of-Arkansas location or verify the status of an out of state Provider by calling Customer Service at the phone number on the back of their health plan identification card. A Covered Person may also obtain a list of In-Network Providers on the web site www.blueadvantagearkansas.com.

PROVIDER STATUS MAY CHANGE

It is possible that a Covered Person might not be able to obtain services from a particular In-Network Provider. The network of Providers is subject to change. A particular Network Provider may not be accepting new patients. If a Provider leaves the Network or is otherwise not available, the Covered Person must choose another Provider to get In-Network benefits.

NO BALANCE BILLING FROM PREFERRED PROVIDERS AND CONTRACTING PROVIDERS

In-Network and Preferred Providers are Physicians or Hospitals who are paid directly by the Plan and have agreed to accept payment for covered services as payment in full except for the Covered Person's deductible, coinsurance, copayment, and any specific benefit limitation, if applicable. In contrast, a Covered Person is responsible for billed charges in excess of the Plan's payment when Out-of-Network Physicians or Hospitals render services, except as provided in OUT-OF-NETWORK PROVIDERS AND BALANCE BILLING, subsection (2), below. These excess charges could amount to thousands of dollars in additional out of pocket expenses to the Covered Person.

OUT-OF-NETWORK PROVIDERS AND BALANCE BILLING

- (1) **NOTICE: Certain Services may not be eligible for In-Network Benefits.** Additional costs, including balance billing, may be incurred for a covered Health Intervention provided by an Out-of-Network Provider, even if treatment is rendered in an In-Network Hospital unless it meets the exception as provided in subsection (2), below. These additional charges may not count toward the In-Network Out-of-Pocket Limit. The Covered Person should not assume that an In-Network Provider's agreement includes all covered benefits or that all services provided at an In-Network Hospital are provided by In-Network Providers. Some Providers are contracted to provide only certain covered benefits, but not all covered benefits.
- (2) **Balance billing by Out-of-Network Providers is prohibited in the following instances:**
 - (a) When Ancillary Services, as described in the No Surprises Act, are received at certain In-Network facilities on a non-emergency basis from Out-of-Network Providers.
 - (b) When Medical Emergency services are provided by an Out-of-Network Provider in an Emergency Room, a free-standing Emergency Department, or in an urgent care clinic which is licensed as a free-standing emergency department.
 - (c) When air Ambulance Services are provided by an Out-of-Network Provider.
 - (d) When a Provider leaves the network voluntarily, a Covered Person engaged with the Out-of-Network Provider for a scheduled procedure or ongoing treatment covered under this Plan, when such procedure or treatment is for a condition requiring immediate care, and the Covered Person's request is approved for Continuity of Care benefits until the end of the current episode of treatment or until the end of 90 days, whichever occurs first.

In these instances, when the services are eligible for coverage, the Out-of-Network Provider may not bill the Covered Person for amounts in excess of any In-Network copayment, coinsurance or deductible (cost share). Except for air ambulance, the cost share is based on the Recognized Amount as described in the No Surprises Act and as set forth in the Defined Terms section. The cost share for air ambulance is based on the rates that would apply if the service was provided by an In-Network Provider.

When Covered Services are received from Out-of-Network Providers as stated above, Allowed Amounts are based upon one of the following as applicable:

- (a) The initial payment made by the Plan or the amount subsequently agreed to by the Out-of-Network Provider.
- (b) The amount determined by Independent Dispute Resolution (IDR).

RELATION OF THE PLAN TO PROVIDERS

The decision about whether to use a particular Provider is the sole responsibility of a Covered Person. A treating Provider is not an agent of the Plan or the Claims Administrator. The Plan and the Claims Administrator makes no representations or guarantees regarding the qualification or experience of any Provider with respect to any service. The evaluation of such factors and the decision about whether to use any Provider is the sole responsibility of the Covered Person.

CORONAVIRUS PANDEMIC, TEMPORARY BENEFITS

During the coronavirus (COVID-19) pandemic, the Plan will provide temporary benefits as specified below. These benefit enhancements apply solely and exclusively during the temporary period specified herein and will not be available at the conclusion of the public health emergency. All other terms, conditions, exclusions or limitations in the Plan Document continue to apply and must be satisfied in order for any benefits to be paid.

Families First Coronavirus Response Act (FFCRA) and Coronavirus Aid, Relief, and Economic Security (CARES) Act

Effective March 18, 2020, in accordance with the FFCRA and CARES Act, the Plan shall provide coverage, and shall not impose any cost sharing (including deductibles, copayments, and coinsurance) requirements or prior authorization or other medical management requirements, for the following items and services furnished during the federally declared public health emergency period. Benefits are available for services rendered by an In-Network or Out-of-Network Provider.

- (1) FDA-approved diagnostic testing products for the detection of SARS-CoV-2 or the diagnosis of the virus that causes COVID-19 and the administration of such diagnostic tests.
- (2) Items and services furnished to an individual during health care Provider office visits (including in-person visits and telehealth visits), urgent care center visits, and emergency room visits that result in an order for or administration of a diagnostic test, or an evaluation to determine if a diagnostic test is necessary.

In the event that any new federal laws or regulations are enacted, the Plan will comply with the applicable law or regulation.

MEDICAL BENEFITS

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

BENEFIT PAYMENT

Each Calendar Year, benefits will be paid for the Covered Charges of a Covered Person that are in excess of the deductible. Payment will be made at the rate shown under reimbursement rate in the Schedule of Benefits. No benefits will be paid in excess of the Maximum Benefit Amount or any listed limit of the Plan.

PLAN ALLOWANCE

The Plan has defined an outer limit on Plan benefits that applies whether a Covered Person chooses to receive services from an In-Network Provider or an Out-of-Network Provider. This overall limit on the amount of Plan benefits available under the Plan is defined in this Plan Document description as the “Plan Allowance,” and may also be referred to from time to time as the “Allowable Charge” or “Allowance” under the Plan. Benefits under the Plan will always be limited by the Plan Allowance that the Plan has adopted, as further defined in this section. This means that regardless of how much a health care Provider may bill for any service, drug, medical device, equipment or supplies, the benefits under the Plan will be limited to the Plan Allowance, as established in this section. The Plan Allowance may be established in the following ways:

(1) Covered In-Network Services

For covered In-Network services (those received from an In-Network Provider) received in Arkansas, the Plan Allowance is the Network Fee Schedule established by the terms of the Provider’s contract with the Claims Administrator. For covered In-Network services received outside the state of Arkansas, the Claims Administrator may not have a direct contract with each Provider outside Arkansas; where that is the case, the Plan Allowance for covered In-Network services is determined by the allowance or fee schedule of the Provider’s contract with the Blue Cross and Blue Shield plan in the state where services were provided (known as the “Host Plan”).

(2) Covered Out-of-Network Services

For covered Out-of-Network services (those received from an Out-of-Network Provider), the Plan Allowance is the amount determined by the Claims Administrator, using the following standards:

- (a)** For services received in Arkansas, the Plan Allowance for covered Out-of-Network services of Physicians and other individual Providers, as well as Ambulatory Surgery Centers, Home Health Care Agencies, Hospice Agencies, and freestanding dialysis centers or imaging centers, will be the amount of the fee schedule that the Claims Administrator has contracted with Providers in Arkansas for its Preferred Payment Plan network (“PPP”). For Hospitals classified as acute care Hospitals, the Plan Allowance for covered Out-of-Network Inpatient and Outpatient Services will be the amount calculated using the Arkansas Blue Cross and Blue Shield Facility Pricing Guidelines. On some occasions, the Plan Allowance for Out-of-Network services inside Arkansas may be determined as referenced in (c), below.
- (b)** For services received outside of Arkansas, the Plan Allowance for covered Out-of-Network services will be either the amount provided to the Claims Administrator by the Host Plan in that state or, if no such amount is available to the Claims Administrator from a Host Plan, then the Plan Allowance will be the amount determined under the formulas for services received in Arkansas, as referenced in (a), above, or (c) or (d), below.
- (c)** The Claims Administrator has contracted with an independent network sponsor-facilitator and third party vendor (the “Wrap Network Vendor” or “WNV”), whereby, in many states/locations, the Plan has access to a suite of Out-of-Network potential savings strategies, which range from supplemental or “wrap networks” in numerous states, (in essence providing a discount option

for otherwise Out-of-Network services in many areas of the nation), to certain reference pricing services and case-specific pricing negotiation services. The Plan participates in these WNV out-of-network pricing options, where available, and receives the benefit of any cost savings that the WNV may be able to provide in cases where a Plan participant or beneficiary goes outside the Plan's preferred BlueCard network for services. The WNV Out-of-Network pricing option is not available in all instances and thus neither the Claims Administrator nor WNV can or do guarantee any cost savings or availability of a WNV pricing or discount option in any given state or area. However, to the extent that a WNV option is available in a given state/region/location with respect to any Out-of-Network provider services, the Claims Administrator may utilize and apply the WNV option and related pricing, in which case such pricing shall constitute the Plan Allowance for purposes of calculating and applying Plan benefits.

- (d) For any services of any Provider that are not addressed in any of the existing Provider contracts or pricing guidelines referenced above, the Plan Allowance for covered Out-of-Network services will be the amount established by the Claims Administrator using such pricing methods, benchmarks or sources as the Claims Administrator may deem appropriate in the circumstances.

The Claims Administrator's calculation of a Plan Allowance shall be considered conclusive as to the amount that the Plan covers or will pay in Plan benefits for any covered service, treatment drug, supplies, equipment, or devices.

(3) **Patient's Share of the Plan Allowance and Billed Charges of the Provider**

The Plan calculates and pays Plan benefits on the basis of the Plan Allowance, an amount that may vary substantially from the amount a Provider chooses to bill. Once the Plan Allowance is determined with respect to any Provider's billed charges, the Covered Person may be responsible for a percentage or portion of the Plan Allowance, depending on the terms of the Plan with respect to copays, coinsurance and deductible. For example, if services are provided by an In-Network Provider, the Plan may pay 80% of the Plan Allowance, in which case the Covered Person would be responsible for the remaining 20% of the Plan Allowance, but not for the difference between the Plan Allowance and the Provider's billed charges. In this situation, the In-Network Provider contract protects the Covered Person from additional billing beyond the Plan Allowance. For an Out-of-Network Provider, the circumstances are substantially different. For example, if services are provided by an Out-of-Network Provider, the Plan may pay only 50% of the Plan Allowance, in which case the Covered Person would be responsible for the remaining 50% of the Plan Allowance. However, the Covered Person might also be held responsible by the Out-of-Network Provider for paying the difference between the Plan Allowance and the Provider's full, billed charges, leaving Plan participants or beneficiaries with "surprise" medical bills, in the form of so-called "balance billing" by Out-of-Network Providers.

COVERED CHARGES

All benefits described in this document are subject to the Claims Administrator's established Coverage Policy, which the Plan Administrator has adopted for purposes of defining the benefits due under this Plan, the Allowable Charge (as defined herein), and the benefit limits and exclusions described more fully herein including, but not limited to the determination that: care and treatment is or is not Medically Necessary; and that services, supplies and care are or are not Experimental and/or Investigational. A charge is incurred on the date that the service or supply is performed or furnished.

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

If a Covered Person is hospitalized on the date of termination, the Plan will cover eligible Hospital facility charges only through the date of discharge from the Hospital. Any charges other than those billed by the Hospital, which are incurred in conjunction with an inpatient hospitalization, are not covered after the Covered Person's coverage is terminated.

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

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

- (a) Coverage is provided for services of Physicians for surgery, either as an inpatient or outpatient. If coverage is provided for two or more surgical operations performed during the same surgical encounter or for bilateral procedures, payment for the secondary or subsequent procedure will be made at a reduced rate.
- (b) Payment for a covered assistant surgeon shall be limited to a single Physician, qualified to act as an assistant for the surgical procedure. Covered Charges for assistant surgery services or minimum assistant surgery services will be paid at a reduced rate which will never exceed 20% of the surgeon's Allowable Charge.

- (3) **Coverage of Pregnancy.** The Allowable Charges for the care and treatment of Pregnancy are covered the same as any other Sickness.

The Expectant Mother is encouraged to enroll in the Special Delivery Program by the 14th week of Pregnancy. Special Delivery can be accessed by calling 1-800-225-1891 ext. 20225. This program is designed to encourage the Covered Person to actively participate in obtaining comprehensive prenatal care. Services that are not normally offered, such as skilled nursing assessments or nursing assistant care in the home for conditions including Pregnancy-induced hypertension, diabetes mellitus, and preterm labor, are covered through the Special Delivery program. The Special Delivery nurse can assist in coordinating Home Health Care in lieu of hospitalization for those high-risk patients who the Physician feels would benefit from this alternative care.

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

- (4) **Skilled Nursing Facility Care.** The Inpatient care in a Skilled Nursing Facility, Extended Nursing Facility or Nursing Home, for patients who no longer need the full range of the acute care Hospital's services.

The facility must be approved by the Claims Administrator, the patient must be certified by the attending Physician as needing such care, and the care must be substantially more than seeing to the patient's day-to-day living activities.

Covered services include skilled care ordered by a Physician, room and board, general nursing care, and Prescription Drugs during a covered admission.

- (6) **Home Health Care Services.** Charges for Home Health Care Services and Supplies are covered only for care and treatment of an Injury or Sickness when Hospital or Skilled Nursing Facility confinement would otherwise be required. Covered services must be provided through and billed by a licensed Home Health Care Agency.

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

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

Bereavement counseling services for the patient's immediate family (covered Spouse and/or covered Dependent Children) when rendered by a Hospice Care team.

Respite care in a home or inpatient setting is covered when integrated with the hospice care program.

- (8) **Diabetes Management Services.** The Plan will pay for diabetes self-management training which is classified as Standard Preventive Care. This benefit is payable for training in or out of the Hospital that has been prescribed by a Physician

The following services related to diabetes management are also covered by the Plan:

- (a) Coverage is provided for glucometers and diabetic testing supplies.
- (b) Coverage is provided for insulin pumps and pump supplies.
- (c) The Plan will cover eye examinations to screen for diabetic retinopathy for Covered Persons who are diagnosed with diabetes.
- (d) Coverage of routine foot care, orthopedic shoes and custom foot orthotics is provided when required for prevention of complications associated with diabetes mellitus.

- (9) **Mental Illness and Substance Abuse Services (Alcohol and Drug Abuse).** Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Plan Document, coverage is provided for Health Interventions to treat Mental Illness and Substance Abuse.

Inpatient, Partial Hospitalization Program and Intensive Outpatient Program Health Interventions

- (a) Coverage for inpatient hospitalization, partial hospitalization programs or intensive outpatient programs for Mental Illness or Substance Abuse Health Interventions is subject to the following requirements.
 - (i) Inpatient hospitalization requires a patient to receive covered services 24 hours a day as an inpatient in a Hospital.
 - (ii) Partial hospitalization programs generally require the patient to receive covered services six to eight hours a day, five to seven days per week in a Hospital outpatient setting.
 - (iii) Intensive outpatient programs generally require the patient to receive covered services lasting two to four hours a day, three to five days per week in a Hospital outpatient setting.
- (b) Inpatient Hospital admissions require Prior Approval. The Provider or member may call the MHSA phone number on the back of their health plan identification card to receive Prior Approval.

Non-Hospital Health Interventions

- (a) Coverage is provided for a Health Intervention provided during an office visit with a psychiatrist, psychologist or other Provider licensed to provide psychiatric or substance use disorder treatment.
 - (b) Coverage is provided for a Health Intervention at a licensed psychiatric or substance use disorder treatment facility and accredited by the Joint Commission (TJC) or the Commission on Accreditation of Rehabilitation Facilities (CARF International).
 - (c) Coverage for counseling or treatment of marriage, family or child relationship dysfunction is only covered if the dysfunction is due to a condition defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.
- (10) **Therapy Services.** Coverage is provided for inpatient and outpatient therapy services when performed or prescribed by a Physician. Such therapy services include physical, occupational, and speech therapy. Such therapy services shall include services provided for developmental delay, developmental speech or language disorder, developmental coordination disorder and mixed developmental disorder. Therapy services must be performed by an appropriate registered physical, occupational or speech-language therapist licensed by the appropriate State Licensing Board.
- (11) **Standard Preventive Care.** Standard Preventive Care shall be provided as required by applicable law. Standard Preventive Care includes services with an "A" or "B" rating from the United States Preventive Services Task Force.

The list of services included as Standard Preventive Care may change from time to time depending upon government guidelines. A current listing of required preventive care can be accessed at: www.HealthCare.gov/center/regulations/prevention.html and www.cdc.gov/vaccines/.

Examples of Standard Preventive Care for adults include:

- (a) Screenings for: breast cancer (including 3-D mammograms), cervical cancer, colorectal cancer, high blood pressure, Type 2 Diabetes Mellitus, cholesterol, and obesity.
- (b) Immunizations for adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; and
- (c) Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration, including the following:
 - Women's contraceptives, sterilization procedures, and counseling.
 - Breastfeeding support, supplies, and counseling.
 - Gestational diabetes screening.

Examples of Standard Preventive Care for children include:

- (a) Immunizations for children and adolescents recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. These may include:
 - Diphtheria,
 - Pertussis,
 - Tetanus,
 - Polio,
 - Measles,

- Mumps,
- Rubella,
- Hemophilus influenza b (Hib),
- Hepatitis B,
- Varicella.

- (b) Preventive care and screenings for infants, children and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration

Charges for Routine Preventive Care. Routine Preventive Care is care by a Physician that is not for an Injury or Sickness. Covered Charges under Medical Benefits are payable for Routine Preventive Care as described in the Schedule of Benefits.

- (12) **Infertility testing, artificial insemination and in vitro fertilization.** Subject to prior approval from the Claims Administrator and in accordance with established Coverage Policy, coverage is provided for infertility testing, and once a diagnosis of infertility has been established, coverage is also provided for artificial insemination and in vitro fertilization. Coverage is limited as shown in the Schedule of Benefits.

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

- (a) Treatment of **Acquired Immunodeficiency Syndrome (AIDS)** is covered as any other Illness.
- (b) Covered charges for services billed by **Advanced Practice Registered Nurses** and Physician Assistants.
- (c) **Allergy-related services**, including testing, extracts and injections.
- (d) **Ambulance Services.** Coverage is provided for Ambulance Services for local transportation to the nearest Hospital in the event Medical Emergency care is needed, for Medically Necessary transportation between health care facilities, or to the nearest neonatal special care unit for newborn infants for treatment of accidental Injuries, Illnesses, congenital birth defects or complication of premature birth that require the level of care provided at a neonatal special care unit.

Specific Ambulance Service Exclusions. No benefits will be paid for:

- (i) expenses incurred for Ambulance Services covered by a local governmental or municipal body, unless otherwise required by law;
- (ii) non-emergency ambulance, including services provided for a Covered Person's comfort or convenience; or
- (iii) non-emergency transport by any means other than ambulances.
- (e) **Anesthetic;** oxygen; blood and blood derivatives that are not donated or replaced; intravenous injections and solutions. Administration of these items is included.
- (f) **Autism Spectrum Disorder.** Coverage is provided for the treatment of autism spectrum disorder, including applied behavioral analysis when ordered by a medical doctor or a psychologist and provided by a Board-Certified Behavioral Analyst (BCBA). Coverage of applied behavioral analysis requires Prior Approval from the Claims Administrator, acting on the Plan's behalf, and is subject to established Coverage Policy and limits set forth. Failure to

obtain Prior Approval may result in denial of reimbursement from the Plan. Please refer to the health plan identification card for the MHSA prior approval phone number.

- (g) **Cardiac rehabilitation** services are covered when the services are ordered by a Physician. Coverage is limited as shown in the Schedule of Benefits.
- (h) Radiation or **chemotherapy** and treatment with radioactive substances. The materials and services of technicians are included.
- (i) Initial **contact lenses** or glasses required following cataract surgery. A single acquisition of eyeglasses or contact lenses within the first six months following cataract surgery is covered. With respect to such eyeglasses or contact lenses, tinting or anti-reflective coating and progressive lenses are not covered. The Allowable Charge is based on the cost for basic glasses or contact lenses.
- (j) **Dietitian services** for treatment of a covered medical condition.
- (k) Coverage is provided for **Durable Medical Equipment (DME)** when prescribed by a Physician according to the guidelines specified below.
 - (i) Durable Medical Equipment is equipment which (1) can withstand repeated use; and (2) is primarily and customarily used to serve a medical purpose; and (3) generally is not useful to a person in the absence of an Illness or Injury; and (4) is appropriate for use in the home.
 - (ii) Coverage for Durable Medical Equipment and Medical Supplies is provided when the Durable Medical Equipment is provided in accordance with Coverage Policy. Examples of Durable Medical Equipment include, but are not limited to, oxygen equipment, wheelchairs and crutches.
 - (iii) Replacement of DME is covered only when necessitated by normal growth or when it exceeds its useful life. Maintenance and repairs resulting from misuse or abuse of DME are the responsibility of the Covered Person.
 - (iv) When it is more cost effective, the Plan, in its discretion will purchase rather than lease equipment. In making such purchase, the Plan may deduct previous rental payments from its purchase Allowance.
- (l) **Eye exams** are covered when ordered by a Physician during treatment of a medical condition or Injury. Routine eye exams for children are covered under Standard Preventive Care.
- (m) **Genetic testing** is covered in accordance with established Coverage Policy.
- (n) **Hearing exams** are covered when ordered by a Physician during treatment of a medical condition or Injury or classified as Standard Preventive Care.
- (o) **Laboratory services.**
- (p) **Oral Surgery, Dental Care and Orthodontic Services.** Oral Surgery, Dental Care and orthodontic services are generally not covered. However, coverage is provided for the following specific conditions.
 - (i) **Benefits for Oral surgery.** The Plan will pay only for the following non-dental oral surgical procedures:

- a. Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth when pathological examination is required.
 - b. Surgical procedures required to treat an Injury to jaws, cheeks, lips, tongue, roof and floor of the mouth. Treatment of an injury to a tooth or teeth incurred while eating is not covered.
 - c. Excision of exostoses of jaws and hard palate.
 - d. External incision and drainage of abscess.
 - e. Incision of accessory sinuses, salivary glands or ducts.
 - f. Removal of impacted teeth is not covered.
- (ii) **Benefits for Injury.** If a Covered Person has an Injury, benefits will be provided for Dental Care and x-rays necessary to correct damage to a Non-Diseased Tooth or surrounding tissue caused by the Accidental Injury. The Covered Person must seek treatment within seven days of the Accidental Injury for services to be covered.
- a. Only the non-diseased tooth or teeth avulsed or extracted as a direct result of the Injury and the non-diseased tooth or teeth immediately adjacent will be considered for replacement.
 - b. Orthodontic services are limited to the stabilization and re-alignment of the accident-involved teeth to their pre-accident position. Reimbursement for this service will be based on a per tooth allowance.
 - c. This benefit is limited to the first 12 months immediately following the Injury. If the Covered Person is under age 15, reimbursement for Dental Care services provided after such 12-month period will be provided if:
 - such reimbursement is requested within such 12-month period,
 - the request for reimbursement is accompanied by a plan of treatment
 - under standard dental practices the treatment could not have been provided within such 12-month period, and
 - coverage for the injured Covered Person is in force when the treatment is rendered.
 - d. Injury to teeth while eating is not considered an Accidental Injury.
 - e. Any Health Intervention related to dental caries or tooth decay is not covered.
- (iii) **Benefits for dental services required in connection with Covered Services.**
- a. Dental services in connection with radiation treatment for any malignancy of the head or neck are covered.
 - b. Dental services perioperative to organ transplant when dental infection precludes listing for a transplant are covered.

- c. Dental services perioperative to valve replacement or surgery when dental infection precludes surgery are covered.
 - d. Dental services perioperative for hematopoietic stem cell transplant when dental infection precludes listing for a transplant are covered; and
- (iv) **Benefits for anesthesia services.** Hospital and Ambulatory Surgery Center services and anesthesia services related to dental procedures, including services to children, are covered in connection with treatment for a complex dental condition provided to: (i) a Participant under seven years of age who is determined by two dentists (in separate practices) to require the dental treatment without delay; (ii) a Participant with a diagnosis of serious mental or physical condition; or (iii) a Participant, certified by his or her primary care physician to have a significant behavioral problem.
- (v) **Benefits for dental reconstructive surgery.**
- a. Dental implants of titanium osseointegrated fixtures, or of any other material, are not covered regardless of the diagnosis, medical condition, accident or injury.
 - b. Subject to Prior Approval, coverage is provided for surgery and orthodontics performed on a child for the correction of a cleft palate when prescribed or ordered by a Physician and consistent with established Coverage Policy.
- (q) **Organ transplant limits.** Coverage is provided for human-to-human organ or tissue transplants in accordance with the following specific conditions:
- (i) Not all transplants are covered. There must be a specific Coverage Policy which allows benefits for the transplant in question, and the Covered Person must meet all of the required criteria necessary for coverage set forth in the Coverage Policy and in this Plan Document.
 - (ii) Except for kidney and cornea transplants, coverage for transplant services requires Prior Approval from the Claims Administrator. A request for approval must be submitted to the Claims Administrator prior to receiving any transplant services, including transplant evaluation.
 - (iii) The transplant benefit is subject to the deductible, coinsurance and any applicable copays or maximums specified in the Schedule of Benefits.
 - (iv) Notwithstanding any other provisions, the Allowable Charge for an organ transplant, including any charge for the procurement of the organ, Hospital services, Physician services and associated costs, including costs of complications arising from the original procedure that occur within the Transplant Global Period, shall be limited to the lesser of (a) 90% of the billed charges or (b) the global payment determined as payment in full by a Blue Cross and Blue Shield Association Blue Distinction Centers for Transplant participating facility, if the Covered Person chooses to use that facility. If the Covered Person receives the transplant from a facility that is not in the Blue Distinction Centers for Transplant network but is contracted with a local Blue Cross and/or Blue Shield Plan, the Allowable Charge shall be the price contracted by such Blue Cross and/or Blue Shield Plan. If the Covered Person receives the transplant from a facility that is not in the Blue Distinction Centers for Transplant network and does not contract with the local Blue Cross and/or Blue Shield plan, the Allowable Charge for the transplant services provided in the Transplant Global Period is 80% of the average usual and reasonable charge authorized by participating facilities in the Blue Distinction Centers

for Transplant network located in the geographic region where the transplant is performed.

- (v) Transportation and lodging are covered as described under “Transportation and Lodging” later in this section and limited as shown in the Schedule of Benefits.
- (vi) Charges for obtaining donor organs or tissues are Covered Charges under the Plan when the recipient is a Covered Person. Benefits under this Plan will be payable only if there is no coverage available under the donor's plan. Donor charges include those for evaluating the organ or tissue, removing the organ or tissue from the donor, and transportation of the organ or tissue from within the United States and Canada to the place where the transplant is to take place.
- (vii) Please note that payments for any transplant (whether performed within the transplant network or by a non-participating facility) are limited to a global payment that applies to all covered transplant services; payment will not be made for any amounts in excess of the global payment for services the facility or any Physician or other Health Care Provider or supplier may bill or attempt to bill separately, because the global payment is deemed to include payment for all related necessary services (other than non-covered services). If a Covered Person uses a facility participating in the Blue Distinction Centers for Transplant network, that facility has agreed to accept the global payment as payment in full, and should not bill for any excess amount above the global payment, except for applicable deductible, coinsurance or non-covered services; however, a non-participating facility may bill the Covered Person for all amounts it may charge above the global payment. These charges above the global payment could amount to thousands of dollars in additional out-of-pocket expenses.
- (viii) When the Covered Person is the potential transplant recipient, a living donor’s Hospital costs for the removal of the organ are covered with the following limitations:
 - Allowable Charges are only covered for the period beginning on the day before the transplant to the date of discharge or 39 days, whichever is less; and
 - Donor testing is covered only if the tested donor is found compatible.
- (r) The initial purchase, fitting, and repair of **orthotic appliances** such as braces, splints or other appliances which are required for support for an injured or deformed part of the body as a result of a disabling congenital condition or an Injury or Sickness.
- (s) **Podiatry services** are limited to surgical services, including incision and drainage of infected tissues of the foot, removal of lesions of the foot, removal or débridement of infected toenails, surgical removal of nail root, and treatment of fractures or dislocations of bones of the foot.
- (t) **Prescription Drugs** (as defined) are covered under the Prescription Drug program administered by the pharmacy benefits manager. Coverage under Medical Benefits is available for injectable medications while confined as an inpatient, or when provided and administered by a Physician in a clinic setting.
- (u) The initial purchase, fitting and repair of fitted **prosthetic devices** which replace body parts.
- (v) **Reconstructive Surgery.** Correction of abnormal congenital conditions, reconstructive procedures following surgical treatment of an Illness or Accidental Injury, and reconstructive mammoplasties will be considered Covered Charges.

This mammoplasty coverage will include reimbursement for:

- (i) reconstruction of the breast on which a mastectomy has been performed,
- (ii) surgery and reconstruction of the other breast to produce a symmetrical appearance, and
- (iii) coverage of prostheses and physical complications during all stages of mastectomy, including lymphedemas,

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

- (w) **Sleep apnea treatment and sleep studies** is covered in accordance with established Coverage Policy.
- (x) **Spinal Manipulation/Chiropractic services** by a Provider acting within the scope of his or her license. Coverage is limited as shown in the Schedule of Benefits when performed by a licensed D.C.
- (y) **Sterilization** procedures (tubal ligation and vasectomy).
- (z) **Surgical dressings**, splints, casts and other devices used in the reduction of fractures and dislocations.
- (aa) **Telehealth benefits.** Coverage is provided for Telemedicine services performed by a person licensed, certified, or otherwise authorized to administer health care in the ordinary course of the practice of his or her profession at the same rate as if it had been performed in-person provided the Telemedicine service is comparable to the same service provided in person.

Coverage also includes communications made by a Physician responsible for the direct care of a Covered Person in Case Management with involved health care Providers.

Audio-only communication is covered if it is real-time, interactive, and substantially meets the requirements for a covered service that would otherwise be covered by the Plan.

However, electronic consultations such as, but not limited to fax; email; or for services, which are, by their nature, hands-on (e.g., surgery, interventional radiology, coronary, angiography, anesthesia, and endoscopy) are not covered.

- (bb) Treatment of **Temporomandibular Joint (TMJ) Disorder** consistent with established Coverage Policy, limited as shown in the Schedule of Benefits.
- (cc) **Transportation and Lodging Expenses.** Travel and lodging are covered when services are not available within 50 miles of the member's home. Lifetime limits applies to each class of eligible services including cancer-related treatment, congenital heart disease, and organ transplant.

Coverage is available to the following extent:

- (i) Transportation of the patient and one companion who is traveling on the same day(s) to and/or from the site of the cancer-related treatment, the congenital heart disease service, or organ transplant for the purposes of an evaluation, the procedure or necessary post-discharge follow-up.
- (ii) Eligible expenses for lodging for the patient (while not a Hospital inpatient) and one companion are paid at a per diem (per day) rate of up to \$50 per day for the patient or

up to \$100 per day for the patient plus one companion. Examples of lodging items that are not covered:

- Groceries
 - Alcoholic beverages
 - Personal or cleaning supplies
 - Meals
 - Over-the-Counter dressings or medical supplies
 - Deposits
 - Utilities and furniture rental, when billed separate from the rent payment
 - Phone calls, newspapers, or movie rentals
- (iv) If the patient is an enrolled Dependent minor child, two persons may accompany the Dependent minor child. If the patient is an enrolled Dependent minor child, the lodging expenses of two companions will be covered at a per diem rate up to \$150 per day.
- (v) Travel and lodging expenses are only available if the patient is not covered by Medicare.
- (vi) Travel and lodging expenses are only available if the recipient lives more than 50 miles from the facility. Automobile mileage (reimbursed at the IRS medical rate) for the most direct route between the patient's home and the designated Provider.
- (vii) The Covered Person must receive and submit valid receipts with a travel and lodging claim form for such charges. Travel and lodging claim form is available at www.blueadvantagearkansas.com.

Examples of travel expenses may include automobile mileage, airfare at economy or coach rate, taxi fares (not including limos or car services) and parking. A Lifetime maximum benefit of \$10,000, per Covered Person, applies for all transportation and lodging expenses reimbursed under this Plan in connection with each class of eligible services as listed above.

(dd) Coverage of Well Newborn Nursery/Physician Care.

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

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

The benefit is limited to Allowable Charges for nursery care for the first five days after birth while the newborn child is Hospital confined as a result of the child's birth or until the mother is discharged, whichever is less.

Charges for covered routine nursery care will be applied toward the Plan of the mother. If the mother is not covered under this Plan, charges will be applied toward the Plan of the newborn child.

Group health plans generally may not, under Federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However,

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

Charges for Routine Physician Care. The benefit is limited to the Allowable Charges made by a Physician for routine pediatric care for the first five days after birth while the newborn child is Hospital confined, or until the mother is discharged, whichever is less.

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

- (ee) Diagnostic x-rays.

COST MANAGEMENT SERVICES

UTILIZATION REVIEW SERVICES PROGRAM

Utilization review is a program for Covered Persons which promotes access to necessary and appropriate health care.

The program consists of:

- (1) Prior Approval of the Medical Necessity for the following services before Medical and/or Surgical services are provided:

Inpatient Admissions
Specific Medical Services and Procedures
Specific Outpatient Surgical Procedures
- (2) Retrospective review of the Medical Necessity for hospitalizations provided on the basis of an Emergency Illness or Emergency Injury.
- (3) Concurrent review, based on the admitting diagnosis, for hospitalizations requested by the attending Physician.
- (4) Planning for discharge from a Hospital or cessation of medical treatment.

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

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

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

To maximize Plan reimbursements, please read the following provisions carefully.

PLEASE NOTE: Failure to receive Prior Approval may result in a denial or reduction of benefits payable by the Plan. The Covered Person will be responsible for reimbursing the Provider for any penalty amounts. Any costs incurred because of reduced reimbursement due to failure to follow Prior Approval procedures will not accrue toward the Covered Person's Out-of-Pocket Limit.

Here's how the program works:

The responsible party must call the appropriate telephone number on the Covered Person's health plan identification card.

Through the Prior Approval process, the number of days of medical care facility confinement which are Medically Necessary will be determined.

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

Responsibility for Obtaining Prior Approval

The following table identifies services which are subject to Prior Approval. If the service or procedure is provided by an In-Network Provider, in some cases the Provider may be held financially responsible for failure to obtain Prior Approval. However, it is always in the Covered Person’s best interest to verify that the treating Provider did obtain Prior Approval in order to avoid any potential penalties that could result in additional out-of-pocket expenses. If the service or procedure is provided by an Out-of-Network Provider, any penalty for failure to receive Prior Approval will be the Covered Person’s responsibility.

SERVICES REQUIRING PRIOR APPROVAL									
<p>NOTE: This is not a complete list. Information regarding whether or not a specific service or procedure requires prior approval may be obtained by calling BlueAdvantage Administrators customer service or by consulting Coverage Policies available at www.blueadvantagearkansas.com.</p>									
<p>Inpatient admissions, including emergency admissions and concurrent care extension, at a Hospital and similar facilities, such as:</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%;">Acute Care Facility</td> <td style="width: 50%;">Skilled Nursing Facility</td> </tr> <tr> <td>Inpatient Rehabilitation (Physical)</td> <td>Long Term Acute Care (LTACH)</td> </tr> <tr> <td>Residential Treatment Facility</td> <td></td> </tr> </table>		Acute Care Facility	Skilled Nursing Facility	Inpatient Rehabilitation (Physical)	Long Term Acute Care (LTACH)	Residential Treatment Facility			
Acute Care Facility	Skilled Nursing Facility								
Inpatient Rehabilitation (Physical)	Long Term Acute Care (LTACH)								
Residential Treatment Facility									
<p>Specific Medical Services</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%;">Durable Medical Equipment over \$1,500</td> <td style="width: 50%;">Genetic Testing</td> </tr> <tr> <td>Home Health Care</td> <td>Non-Emergent Ambulance Services</td> </tr> <tr> <td>Organ Transplants</td> <td></td> </tr> </table>		Durable Medical Equipment over \$1,500	Genetic Testing	Home Health Care	Non-Emergent Ambulance Services	Organ Transplants			
Durable Medical Equipment over \$1,500	Genetic Testing								
Home Health Care	Non-Emergent Ambulance Services								
Organ Transplants									
<p>Certain Outpatient Surgeries, including, but not limited to:</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%;">Neurostimulators</td> <td style="width: 50%;">Bone stimulators</td> </tr> <tr> <td>Gastric procedures</td> <td>Breast surgeries</td> </tr> <tr> <td>Cochlear implant Surgeries</td> <td>Joint surgeries</td> </tr> <tr> <td>Spine surgeries</td> <td>Facial surgeries</td> </tr> </table>		Neurostimulators	Bone stimulators	Gastric procedures	Breast surgeries	Cochlear implant Surgeries	Joint surgeries	Spine surgeries	Facial surgeries
Neurostimulators	Bone stimulators								
Gastric procedures	Breast surgeries								
Cochlear implant Surgeries	Joint surgeries								
Spine surgeries	Facial surgeries								
<p>Outpatient radiological imaging services, such as Magnetic Resonance Angiography or Imaging (“MRA/MRI”), Computed Tomography Scanning (“CT Scan”), Nuclear Cardiology, Echo Cardiography and positron emission tomography scans (“PET Scan”), collectively referred to as “Advanced Diagnostic Imaging.” Please refer to the health plan identification card for the “High-Tech” phone number.</p>									
<p>Medical or Radiation Oncology services, including but not limited to chemotherapy, Brachytherapy, Proton Beam Therapy, and 3D Conformal. Please refer to the health plan identification card for the “High-Tech” phone number.</p>									
<p>Behavioral health services, including repetitive transcranial magnetic stimulation (rTMS) for treatment of depression and applied behavioral analysis related to autism therapy. Please refer to the health plan identification card for the “MHSA” phone number.</p>									

PREADMISSION TESTING SERVICE

Diagnostic lab tests and x-ray exams will be reimbursed according to standard Plan benefit levels when:

- (1) performed on an outpatient basis within seven days before a Hospital confinement;
- (2) related to the condition which causes the confinement; and
- (3) performed in place of tests while Hospital confined.

Covered charges for this testing will be paid even if tests show the condition requires medical treatment prior to Hospital confinement or the Hospital confinement is not required.

SECOND AND/OR THIRD OPINION PROGRAM

Certain surgical procedures are performed either inappropriately or unnecessarily. In some cases, surgery is only one of several treatment options. In other cases, surgery will not help the condition.

In order to prevent unnecessary or potentially harmful surgical treatments, the second and/or third opinion program fulfills the dual purpose of protecting the health of the Plan's Covered Persons and protecting the financial integrity of the Plan.

Benefits will be provided for a second (and third, if necessary) opinion consultation to determine the Medical Necessity of an elective surgical procedure. An elective surgical procedure is one that can be scheduled in advance; that is, it is not an emergency or of a life-threatening nature. Benefits for the second (and third, if necessary) opinion will be paid as any other Sickness.

CASE MANAGEMENT

Case Management is a program under which nurses communicate with Plan Participants' Physicians to facilitate access to benefits under the Plan Participants' Medical Benefits Plan, to identify benefit options for outpatient or home treatment settings, and, where appropriate in the Physician's independent professional judgment, to identify and offer Plan Participants a choice of cost-effective alternatives to hospitalization. Case management nurses are licensed professionals who use their specialized skills to communicate effectively with Physicians; they do not, however, provide any medical services to Plan Participants. All treatment decisions remain exclusively with the Plan Participant and his or her physicians.

Case management services can provide the following value-added benefits for Plan Participants and the Plan:

- (1) maximize the benefits available under the Medical Benefits Plan;
- (2) at the same time, identify cost-effective alternatives to high-cost treatment settings such as hospitalization;
- (3) educate Plan Participants and their Physicians on cost-effective alternatives from which they may choose;
- (4) provide health education to Plan Participants to empower them and their families to self-manage aspects of their care as deemed appropriate by their Physician; and,
- (5) help Plan Participants better understand and deal with the complexities of the health care system and their Medical Benefits Plan.

DEFINED TERMS

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

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

Ambulance Service means surface or air transportation in a regularly equipped ambulance licensed by an appropriate agency and where the use of any other means of transportation is not medically indicated.

Ancillary Services means services provided by Out-of-Network Providers at an In-Network facility such as: related to emergency medicine – anesthesiology, pathology, radiology and neonatology; provided by assistant surgeons, hospitalists and intensivists; diagnostic services, including radiology and laboratory services, unless such items and services are excluded from the definition of ancillary services as determined by the Secretary (as that term is applied in the No Surprises Act); provided by such other specialty practitioners as determined by the Secretary; and provided by an Out-of-Network Physician when no other In-Network Physician is available.

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

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

Break in Service means a period of at least 13 consecutive weeks during which the Employee has no Hours of Service. A Break in Service may also include any period for which the Employee has no Hours of Service that is at least four (4) consecutive weeks in duration and longer than the prior period of employment (determined after application of the procedures applicable to Special Unpaid Leaves.

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

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

Cosmetic Surgery means any surgical procedure, including corrective plastic or reconstructive plastic surgical procedures, having the primary purpose of improving physical appearance. Cosmetic Surgery also includes any procedure required in order to correct complications caused by or arising from prior Cosmetic Surgery. However, Cosmetic Surgery does not include in connection with a mastectomy, (a) reconstruction of the breast on which the mastectomy has been performed, and (b) surgery and reconstruction of the other breast to produce a symmetrical appearance.

Coverage Policy - The Plan has delegated to the Claims Administrator, BlueAdvantage Administrators of Arkansas, the development of Coverage Policies that may apply to certain types of claims, drugs, services, supplies, equipment, devices or treatments. In addition, the Plan had adopted existing BlueAdvantage Coverage Policies and intends that all such Coverage Policies, current and future, as developed by BlueAdvantage, shall apply to benefit determinations under the Plan, including any claim for Plan benefits that a Covered Person may have, where applicable. Existing BlueAdvantage Coverage Policies (which are adopted by the Plan and therefore apply to any Plan benefits a Covered Person may claim) are available on the BlueAdvantage website at www.blueadvantagearkansas.com or obtained from BlueAdvantage by calling BlueAdvantage customer service or writing to BlueAdvantage requesting a copy. A Covered Person and their selected health care Provider should review such Coverage Policies prior to undertaking a specific operation, surgery, or treatment regimen, to be sure that coverage is available under the Plan because Plan coverage may be determined by the specific elements, conditions, or limitations of a specific Coverage Policy. Please note that the absence of a specific Coverage Policy with respect to any particular drug, treatment, service, test,

equipment or supply shall not be construed to mean that such drug, treatment, service, test, equipment or supply meets the coverage criteria, as other terms, conditions, limitations or exclusions of the Plan may still apply.

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

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

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

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

Employee means a person who is classified by his Employer as an Active, common-law employee.

Employer is University of Central Arkansas.

Experimental or Investigational. The Plan shall have full discretion to determine whether a drug, device or medical treatment is experimental or investigational. Any drug, device or medical treatment may be deemed experimental or investigational, in the Plan's discretion, if:

- (1) the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and final regulatory approval for marketing has not been announced to the public at the time the drug or device is furnished; or
- (2) the drug, device, treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review and approval;
- (3) Reliable Evidence (as defined below) shows that the drug, device or medical treatment or procedure is the subject of on-going phase I, II or III clinical trials or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis;
- (4) Reliable Evidence (as defined below) shows that the majority opinion among experts, as stated in the published authoritative literature, regarding the drug, device or medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.
- (5) Reliable Evidence (as defined below) shows that a majority opinion among experts, as stated in the published authoritative literature, regarding the drug, device or medical treatment or procedure neither supports nor denies its use for a particular condition or disease.
- (6) Reliable Evidence (as defined below) shows that the majority opinion among experts, as stated in the published authoritative literature, regarding the drug, device or medical treatment or procedure is that it should not be used as a first line therapy for a particular condition or disease.

"Reliable Evidence" shall mean only the following sources:

- (a) the patient's medical records or other information from the treating Physician(s) or from a

consultant(s) regarding the patient's medical history, treatment or condition;

- (b) the written protocol(s) under which the drug, device, treatment or procedure is provided to the patient;
- (c) any consent document the patient has executed or will be asked to execute, in order to receive the drug, device, treatment or procedure;
- (d) published reports and articles in the authoritative medical and scientific literature, signed by or published in the name of a recognized medical expert, regarding the drug, device, treatment or procedure at issue as applied to the injury, illness or condition at issue; or
- (e) the written protocol(s) used by another facility studying substantially the same drug, device, medical treatment or procedure.

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

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

Health Intervention or Intervention means an item or service delivered or undertaken primarily to diagnose, detect, treat, palliate or alleviate a medical condition or to maintain or restore functional ability of the mind or body.

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

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

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

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

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

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

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

Hospital means an acute general care Hospital, a psychiatric Hospital and a rehabilitation Hospital licensed as such by the appropriate state agency. It does not include any of the following, unless required by applicable law: Hospitals owned or operated by state or federal agencies, convalescent homes or Hospitals, homes for the aged, sanitariums, long term care facilities, infirmaries, or any institution operated mainly for treatment of long-term chronic diseases.

Hours of Service means each hour for which the Employee is paid or entitled to payment for performance of services for the Employer AND any hour for which the employee is paid or entitled to payment by the Employer for a period of time during which no duties are performed due to any of the following, consistent with 29 C.F.R. 2530.200b-2(a)(i):

- Vacation
- Holiday
- Illness or incapacity
- Layoff
- Jury duty
- Military duty or leave of absence

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

Independent Dispute Resolution is the process that Out-of-Network or non-participating Providers may use following the end of an unsuccessful open negotiation period to determine the Out-of-Network rate for certain services. More specifically, the Federal IDR process may be used to determine the Out-of-Network rate for certain emergency services, non-emergency items and services furnished by non-participating Providers at participating health care facilities, and air Ambulance Services furnished by non-participating Providers of air Ambulance Services where an All-Payer Model Agreement or specified state law does not apply. Additionally, a party may not initiate the Federal IDR process if, with respect to an item or service, the party knows or reasonably should have known that the Provider or facility provided notice and obtained consent from a participant, beneficiary, or enrollee to waive surprise billing protections consistent with PHS Act sections 2799B-1(a) and 2799B-2(a) and the implementing regulations at 45 CFR 149.410(b) and 149.420(c)-(i).

Infertility means incapable of producing offspring.

Initial Measurement Period means the 12-month period that coincides with the Employee's Date of Hire. Notwithstanding the foregoing, the Employer may make adjustments to the Initial Measurement Period with respect to Employees on payroll periods that are weekly, bi-weekly or semi-monthly in duration, as set forth herein.

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

In-Network Provider means a health care provider who has entered into a network participation contract with either the Claims Administrator or, outside the state of Arkansas, with the Blue Cross and Blue Shield plan in the state where services were provided ("Host Plan").

Late Enrollee means a Plan Participant who enrolls under the Plan other than during the first 30-day period in which the individual is eligible to enroll under the Plan or during a Special Enrollment Period.

Legal Guardian means a person recognized by a court of law as having the duty of taking care of the person and managing the property and rights of a minor child.

Long Term Acute Care means the medical and nursing care treatment of medically stable but fragile patients over an extended period of time, anticipated to be at least 25 days. Long Term Acute Care includes but is not limited to treatment of chronic cardiac disorders, ventilator dependent respiratory disorder, post-operative complications and total parenteral nutrition (TPN) issues.

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

Medical Emergency means medical conditions of a recent onset and severity, including, but not limited to, severe pain that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that a condition, Sickness, or Injury is of such a nature that failure to get immediate medical care could result in (a) placing the patient's health in serious jeopardy; (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part.

Medically Necessary means care and/or treatment that is recommended or approved by a Physician; is consistent with the patient's condition or accepted standards of good medical practice; is medically proven to be effective treatment of the condition; is not performed mainly for the convenience of the patient or provider of medical services; is not conducted for research purposes; and is the most appropriate level of services which can be safely provided to the patient.

All of these criteria must be met; merely because a Physician recommends or approves certain care does not mean that it is Medically Necessary.

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

Mental Illness means and includes (whether organic or non-organic, whether of biological, non-biological, chemical or non-chemical origin, and irrespective of cause, basis or inducement) mental disorders, mental illnesses, psychiatric illnesses, mental conditions, and psychiatric conditions. This includes, but is not limited to psychoses, neurotic disorders, schizophrenic disorders, affective disorders, personality disorders and psychological or behavioral abnormalities associated with transient or permanent dysfunction of the brain or related neurohormonal systems. (This is intended to include only illnesses classified on Axes I and II in the current edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association, Washington, D.C.)

Morbid Obesity is a diagnosed condition in which the patient has a BMI of 40 or greater, or a BMI of 36-39 with the presence of other high-risk co-morbid conditions.

New Employee Stability Period means the 12 Calendar Month period that begins on the first day of the Calendar Month following the Calendar Month that begins on or after the Employee's anniversary date.

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

Ongoing Employee Stability Period means the 12 Calendar Month period that begins on the first day of the month following the end of each Standard Measurement Period.

Out-of-Network Provider means a health care Provider who does not have a network participation contract with the Claims Administrator, or, outside of Arkansas, with the Blue Cross and Blue Shield plan in the state where services were provided ("Host Plan"). Out-of-Network Providers are free to bill and collect from members any charges for Covered Charges which are in excess of the Plan's Allowance or Allowable Charge except when prohibited by law.

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

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

Physician means a Doctor of Medicine (M.D.) or a Doctor of Osteopathy (D.O.) duly licensed and qualified to practice medicine and perform surgery at the time and place a claimed intervention is rendered. Physician also means a Doctor of Podiatry (D.P.M.), a Chiropractor (D.C.), a Psychologist (Ph.D.), an Oral Surgeon (D.D.S.) or an Optometrist (O.D.) duly licensed and qualified to perform the claimed health intervention at the time and place such intervention is rendered.

Plan means The University of Central Arkansas Medical Plan, which is a benefits plan for certain Employees of University of Central Arkansas and is described in this document.

Plan Allowance means the maximum amount the Plan will cover or pay for any health care services, drugs, medical devices, equipment, supplies or benefits covered by the Plan. This overall limit on the amount of Plan benefits available under the Plan may also be referred to as the "Allowable Charge or "Allowance" under the Plan.

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

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

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

Prior Approval means a health plan coverage management feature which requires that an approval be obtained from the Claims Administrator or from a subcontractor engaged by the Claims Administrator, acting on behalf of the Plan, before incurring expenses for certain Covered Charges. The Plan's procedures and timeframes for making decisions on Prior Approval requests may differ depending on when the request is received, and the type of service involved. Ongoing therapy of a prior authorized medication may require periodic assessments that could include an efficacy measure intended to demonstrate positive outcomes for continuation of therapy.

Please note that Prior Approval does NOT guarantee coverage for, or the payment of, the service or procedure reviewed. The sole effect and meaning of receiving Prior Approval is simply that, if Prior Approval is given, coverage for the specific service will not be denied for lack of Medical Necessity, including length of stay in a facility. All other Plan coverage criteria, including but not limited to, eligibility, contribution payment, if any, Coverage Policies, exclusions, and limitations shall continue to apply, and must be satisfied in order to receive Plan coverage for the Prior Approved services. In other words, if a Covered Person or their treating Provider receives Prior Approval, that Prior Approval takes care of the Medical Necessity issue for the particular admission or service that is Prior Approved, but there may be other Plan coverage standards that still must be reviewed, and if any of those standards are not also met, coverage for the Prior Approved service still could be denied upon further review of the Plan benefits claim. Prior Approval does not in any way control or attempt to control whether or not a Covered Person receives any particular medical service, drug, supply, equipment, device, or treatment – the decision on whether to undergo any particular course of treatment is entirely up to the Covered Person and their treating health care Providers. The only effect of a denial of Prior Approval is that a Covered Person may not receive Plan benefits for the service, drug, supply, equipment, device, or treatment in question. Accordingly, if the Covered Person and their treating health care Provider believe that a particular service, drug, supply, equipment, device, or treatment is essential or in the Covered Person's best interests, even though Prior Approval has been denied, the Covered Person should make their own decision regarding such matters, without regard to the Prior Approval decision. In other words, Prior Approval will only affect the Plan's coverage of medical care or treatment; it does not prevent a Covered Person and their doctors or other health care Providers from doing whatever they believe necessary in the best interests of the Covered Person's health and safety.

Provider means a Hospital or a Physician. Provider also means a certified registered nurse anesthetist; certified nurse practitioner; clinical nurse specialist; certified nurse midwife; a licensed audiologist; a chiropractor; a dentist; a licensed certified social worker; a licensed Durable Medical Equipment Provider; an optometrist; a pharmacist; a physical therapist; a podiatrist; a psychologist; a respiratory therapist; a speech pathologist and any other type of health care Provider which the Plan Administrator, in its sole discretion, approves for reimbursement for services rendered.

Recognized Amount is the amount which a Covered Person's cost sharing is based on for the following Covered Services when provided by Out-of-Network Providers: Out-of-Network Emergency Care; non-Emergency Care received at certain In-Network facilities by Out-of-Network Providers, when such services are Ancillary Services. For the purpose of this provision, "certain In-Network facilities" are limited to a hospital (as defined in 1861(e) of the Social Security Act), a hospital outpatient department, a critical access hospital (as defined in 1861(mm)(1) of the Social Security Act), an ambulatory surgical center described in section 1833(i)(1)(A) of the Social Security Act, and any other facility specified by the Secretary. The Recognized Amount is based on the qualifying payment amount as determined under applicable law.

Note: Covered Services that use the Recognized Amount to determine a Covered Person's cost sharing may be higher or lower than if cost sharing for these Covered Services were determined based upon an Allowed Amount.

Retired Employee is a former Active Employee of the Employer who was retired while employed by the Employer under the formal written plan of the Employer and elects to contribute to the Plan the contribution required from the Retired Employee.

Sickness is a Covered Person's Illness, disease or Pregnancy (including complications).

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

- (1) It is licensed to provide professional nursing services on an inpatient basis to persons convalescing from Injury or Sickness. The service must be rendered by a registered nurse (R.N.) or by a licensed practical nurse (L.P.N.) under the direction of a registered nurse. Services to help restore patients to self-care in essential daily living activities must be provided.
- (2) Its services are provided for compensation and under the full-time supervision of a Physician.
- (3) It provides 24 hour per day nursing services by licensed nurses, under the direction of a full-time registered nurse.
- (4) It maintains a complete medical record on each patient.
- (5) It has an effective utilization review plan.
- (6) It is not, other than incidentally, a place for rest, the aged, Custodial or educational care.
- (7) It is approved and licensed by Medicare.

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

Special Unpaid Leave of Absence means any of the following types of unpaid leaves of absence that do not constitute a Break in Service: (i) Leave protected by the Family and Medical Leave Act, (ii) leave protected by the Uniformed Services Employment and Reemployment Rights Act or (iii) Jury Duty (as reasonably defined by the Employer).

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

Standard Measurement Period means the 12-month period that begins each year on October 16th and ends on October 15th of the following year. Notwithstanding the foregoing, the Employer may make adjustments to the Standard Measurement Period with respect to Employees on payroll periods that are weekly, bi-weekly or semi-monthly in duration, as set forth herein.

Substance Abuse means a maladaptive pattern of substance use manifested by recurrent and significant adverse consequences related to the repeated use of substances.

Telemedicine means the use of information and communication technology to deliver health care services, including without limitation to the assessment, diagnosis, consultation, treatment, education, care management, and self-management. Telemedicine includes store-and-forward technology and remote patient monitoring but does not include audio-only communication, unless it is real-time, interactive and substantially meets the requirements for a covered service that would otherwise be covered by the Plan, including without limitation interactive audio, a facsimile machine, text messaging, or electronic mail systems.

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

Total Disability (Totally Disabled) means: In the case of a Dependent, the complete inability as a result of Injury or Sickness to perform the normal activities of a person of like age and sex in good health.

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

PLAN EXCLUSIONS

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

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

- (1) **Abortion.** Services, supplies, care or treatment in connection with an abortion unless the life of the mother is endangered by the continued Pregnancy. Services must be performed in a Hospital or Outpatient Hospital setting to be considered eligible for coverage.
- (2) **Active Duty.** Charges for an Injury sustained, or an Illness contracted while on active duty or military service, unless payment is legally required.
- (3) **Acupuncture.** Services, supplies, care or treatment in connection with acupuncture.
- (4) **Administrative Fees.** Fees incurred for acquiring or copying medical records, sales tax, preparation of records for other insurance carriers or insurance agencies, medical evaluation for life, disability or any type of insurance coverage.
- (5) **Alcohol.** Services, supplies, care or treatment to a Covered Person for an Injury or Sickness which occurred as a result of that Covered Person's illegal use of alcohol. Expenses will be covered for Injured Covered Persons other than the person illegally using alcohol. The following must be present for there to be sufficient evidence for the purpose of this exclusion: (1) the results of a valid blood, breath or urine test performed by a qualified Provider indicating the Covered Person's alcohol level exceeds the legal limit in the state where the Injury or Sickness occurred or (2) a written citation from a law enforcement officer, in attendance where the Injury or Sickness occurred, indicating the Covered Person was under the influence of alcohol. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.
- (6) **Appointments.** Charges resulting from the failure to keep a scheduled visit with a Physician or other Provider.
- (7) **Bereavement services.** Medical social services and outpatient family counseling and/or therapy for bereavement, except if provided as Hospice Care.
- (8) **Biofeedback.** Biofeedback and other forms of self-care or self-help training, and any related diagnostic testing are not covered for any diagnosis or medical condition.
- (9) **Blood typing.** Blood typing for paternity testing.
- (10) **Clinical Trials.** Services or supplies provided in connection with a phase I, II, III or IV clinical trial or any study to determine the maximum tolerated dose, toxicity, safety, efficacy, or efficacy as compared with a standard means of treatment or diagnosis of a drug, device or medical treatment or procedure are not covered. This exclusion will not apply to routine items and services that (a) would have been Covered Expenses had they not be incurred during an approved clinical trial, and (b) are provided during an approved clinical trial, as required and defined under PHS Section 2709.
- (11) **Complications of non-covered treatments.** Care, services or treatment required as a result of complications from a treatment not covered under the Plan.
- (12) **Cosmetic Surgery.** Cosmetic Surgery, care and treatment provided for cosmetic reasons. This exclusion will not apply if services are for reconstructive procedures following surgical treatment of an Illness or Accidental Injury, or correction of an abnormal congenital condition. Reconstructive mammoplasty will be covered after Medically Necessary surgery.

- (13) **Cranial Mandibular Disharmony.** Services, supplies, care or treatment in connection with Cranial Mandibular Disharmony.
- (14) **Custodial Care.** Services or supplies for custodial, convalescent, domiciliary or support care and non-medical services to assist a Covered Person with activities of daily living.
- (15) **Custodial Care Facility.** Services or supplies furnished by an institution which is primarily a place of rest or a place for the aged. Youth homes, schools, or therapeutic wilderness, ranch or camp programs, or any similar institution are not covered.
- (16) **Delivery Charges.** Charges for shipping, packaging, handling or delivering Medications are not separately covered.
- (17) **Dental Care.** Dental Care is not generally covered. See the Medical Benefits section for a list of limited services.
- (18) **Diabetic Supplies.** Charges for diabetic supplies and equipment are not covered under Medical Benefits but instead are covered under the Prescription Drug Card Program. Insulin pumps and insulin pump supplies are covered under Medical Benefits, subject to the Durable Medical Equipment benefit limits.
- (19) **Dietary and nutritional services.** Services or supplies provided for dietary and nutritional services, unless such services are for the sole source of nutrition for a Covered Person.
- (20) **Educational or vocational testing.** Services for educational or vocational testing or training.
- (21) **Environmental change.** Charges for environmental change including hospital or physician charges connected with prescribing an environmental change.
- (22) **Excess charges.** The part of an expense for care and treatment of an Injury or Sickness that is in excess of the Allowable Charge.
- (23) **Exercise programs.** Exercise programs for treatment of any condition, including but not limited to physical education programs in a group setting, health club memberships, athletic training, back schools, or work hardening. This exclusion does not apply to Physician-supervised cardiac rehabilitation, or occupational or physical therapy.
- (24) **Experimental or not Medically Necessary.** Care and treatment that is either Experimental/Investigational or not Medically Necessary.
- (25) **Eye care.** Radial keratotomy or other eye surgery to correct refractive disorders. Also, including refractions, lenses for the eyes and exams for their fitting. A procedure, treatment, service, equipment or supply to correct a refractive error of the eye is covered in two instances: (1) if such refractive error results from traumatic injury or corneal disease, infectious or non-infectious, and (2) the single acquisition of eyeglasses or contact lenses within the first six months following cataract surgery. With respect to such eyeglasses or contact lenses, tinting or anti-reflective coating and progressive lenses are not covered.
- (26) **Foot care.** Treatment of weak, strained, flat, unstable or unbalanced feet, foot orthoses, metatarsalgia, bunions or other such routine foot care, are not covered unless services are medical related open cutting operations, or treatment is in relation to a metabolic or peripheral-vascular disease.
- (27) **Foreign travel.** Care, treatment or supplies out of the United States if travel is for the sole purpose of obtaining medical services. Services received outside of the United States must be Medically Necessary to be considered eligible for coverage.

- (28) **Growth hormones.** Charges related to growth hormones.
- (29) **Habilitative Services.** Services provided in order for a person to attain and maintain a skill or function that was never learned or acquired are not covered.
- (30) **Hair loss.** Care and treatment for hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a Physician.
- (31) **Hearing tests.** Charges for routine hearing tests unless classified as Standard Preventive Care.
- (32) **Hippo therapy.** Charges associated with hippo therapy.
- (33) **Hospital employees.** Professional services billed by a Physician or nurse who is an employee of a Hospital or Skilled Nursing Facility and paid by the Hospital or facility for the service.
- (34) **Hypnotherapy.** Hypnotherapy is not covered for any diagnosis or medical condition.
- (35) **Illegal Acts.** Charges for services received as a result of Injury or Sickness caused by or contributed to by engaging in an illegal act or occupation; by committing or attempting to commit any crime, criminal act, assault or other felonious behavior; or by participating in a riot or public disturbance. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.
- (36) **Illegal drugs or medications.** Services, supplies, care or treatment to a Covered Person for an Injury or Sickness resulting from that Covered Person's voluntary taking or being under the influence of any controlled substance, drug, hallucinogen or narcotic not administered on the advice of a Physician. Expenses will be covered for Injured Covered Persons other than the person illegally using the controlled substances. A written citation from a law enforcement officer, in attendance where the Injury or Sickness occurred, indicating the Covered Person was under the influence of a controlled substance, drug, hallucinogen, or narcotic not administered on the advice of a Physician must be present for there to be sufficient evidence for the purpose of this exclusion. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.
- (37) **Impacted teeth.** Charges related to surgical extraction of impacted teeth.
- (38) **Learning Disabilities.** Services or supplies provided for learning disabilities, i.e., reading disorder, alexia, developmental dyslexia, dyscalculia, spelling difficulty, and other learning difficulties.
- (39) **Nicotine replacement products.** Charges for nicotine replacement products, including lozenges, nasal sprays, inhalers, nicotine gum and transdermal nicotine patches purchased over the counter or with a prescription, are not covered under Medical Benefits.
- (40) **No charge.** Care and treatment for which there would not have been a charge if no coverage had been in force.
- (41) **Non-emergency Hospital admissions.** Care and treatment billed by a Hospital for non-Medical Emergency admissions on a Friday or a Saturday. This does not apply if surgery is performed within 24 hours of admission.
- (42) **No obligation to pay.** Charges incurred for which the Plan has no legal obligation to pay.
- (43) **No Physician recommendation.** Care, treatment, services or supplies not recommended and approved by a Physician; or treatment, services or supplies when the Covered Person is not under the regular care of a Physician. Regular care means ongoing medical supervision or treatment which is appropriate care for the Injury or Sickness.

- (44) **Not specified as covered.** Non-traditional medical services, treatments and supplies which are not specified as covered under this Plan.
- (45) **Obesity.** Care and treatment of obesity, Morbid Obesity, weight loss or dietary control whether or not it is, in any case, a part of the treatment plan for another Sickness.
- (46) **Occupational.** Care and treatment of an Injury or Sickness that is occupational -- that is, arises from work for wage or profit including self-employment.
- (47) **Orthopedic shoes.** Charges for orthopedic shoes (except when they are an integral part of the leg brace and the cost is included in the orthotist's charge) or shoe inserts, or the purchase of orthotic services or appliances. This exclusion does not apply to orthopedic shoes or custom foot orthotics prescribed during the treatment of a metabolic or peripheral-vascular disease.
- (48) **Personal comfort items.** Personal comfort items or other equipment, such as, but not limited to, air conditioners, air-purification units, humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, elastic bandages or stockings, nonprescription drugs and medicines, and first-aid supplies and nonhospital adjustable beds.
- (49) **Prescription drugs** are not covered under Medical Benefits but are covered under the Prescription Drug Card program administered by the pharmacy benefits manager.
- (50) **Private duty nursing.** Charges for private duty nursing are not covered unless services are provided through and billed by a licensed home health agency.
- (51) **Provider Not Defined.** Services or supplies provided by an individual or entity that is not a Provider as defined in this Plan Document.
- (52) **Recreational therapy.** Services or supplies provided by a recreational therapist.
- (53) **Relative giving services.** Professional services performed by a person who ordinarily resides in the Covered Person's home or is related to the Covered Person as a Spouse, parent, child, brother or sister, whether the relationship is by blood or exists in law.
- (54) **Replacement prosthetic and orthotic devices.** Replacement of a prosthetic or orthotic device is covered no more frequently than once per three-year period except when necessitated by normal growth or when the age of the prosthetic or orthotic device exceeds the useful life. Maintenance and repair resulting from misuse or abuse of a prosthetic or orthotic device, are the responsibility of the Covered Person.
- (55) **Respite care.** Charges for services which provide temporary relief to family members or friends from the duties of caring for the Covered Person are not covered, unless billed integrated with the hospice care program.
- (56) **Routine care.** Charges for routine or periodic examinations, screening examinations, evaluation procedures, preventive medical care or treatment or services not directly related to the diagnosis or treatment of a specific Injury, Sickness or pregnancy-related condition, which is known or reasonably suspected, unless such care is specifically covered in the Schedule of Benefits or required by applicable law.
- (57) **Seasonal Affective Disorder (SAD).** Use of photo therapy or light therapy to treat seasonal affective disorder or depression.

- (58) **Self-Inflicted.** Any loss due to an intentionally self-inflicted Injury. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.
- (59) **Services before or after coverage.** Care, treatment or supplies for which a charge was incurred before a person was covered under this Plan or after coverage ceased under this Plan. However, if a Covered Person is hospitalized on the date of termination, dependent on the type of contractual agreement with the Hospital, the Plan may cover eligible Hospital facility charges through the date of discharge from the Hospital. Any charges other than those billed by the Hospital, which are incurred in conjunction with an inpatient hospitalization, are not covered after the individual's coverage is terminated.
- (60) **Sex changes/sex therapy.** Care, services or treatment for non-congenital transsexualism, gender dysphoria or sexual reassignment or change are not covered. This exclusion includes medications, implants, hormone therapy, surgery, medical or psychiatric treatment or other treatment of sexual dysfunction including Prescription Medications and sex therapy.
- (61) **Surgical sterilization reversal.** Care and treatment for reversal of surgical sterilization
- (62) **Telephone and Other Electronic Consultation.** Electronic consultations such as, but not limited to fax; email; or for services, which are, by their nature, hands-on (e.g., surgery, interventional radiology, coronary, angiography, anesthesia, and endoscopy) are not covered. Audio-only communication is not covered unless it is real-time, interactive, and substantially meets the requirements for a Covered Service that would otherwise be covered by the Plan.
- (63) **Third party recommended treatment.** Services required or recommended by third parties, including physicals and/or vaccines/immunizations for employment, overseas travel, camp, marriage licensing, insurance, unless otherwise covered by this Plan are not covered.
- (64) **Temporomandibular Joint Disorders (TMJ).** Diagnosis and treatment for TMJ are not covered for the following services: Surface electromyography, Doppler analysis, vibration analysis, computerized mandibular scan or jaw tracking, craniosacral therapy, orthodontic, occlusal adjustment, and dental restorations.
- (65) **Travel or accommodations.** Charges for travel or accommodations, whether or not recommended by a Physician, except for ambulance charges as defined as a covered expense.
- (66) **Unlicensed Provider.** Coverage is not provided for treatment, procedures or services received from any person or entity, including but not limited to Physicians, who is required to be licensed to perform the treatment, procedure or service, but (1) is not so licensed, or (2) has had his license suspended, revoked or otherwise terminated for any reason, or (3) has a license that does not include within its scope the treatment, procedure or service provided.
- (67) **Vertical dimension.** Any charges related to alteration of vertical dimension, including but not limited to dental implants, surgical procedures, or appliances.
- (68) **Vision Enhancement.** Vision enhancements are generally not covered. A procedure, treatment, service, equipment or supply to correct a refractive error of the eye are covered in two instances: (1) if such refractive error results from traumatic injury or corneal disease, infectious or non-infectious, and (2) the implant of a monofocal lens following cataract extraction and the single acquisition of eyeglasses or contact lenses within the first six months following cataract surgery. The Plan does not cover the implantation of a multi-focal lens; however, if a multifocal lens is implanted after cataract extraction, the Plan will pay the Allowable Charge for a monofocal lens.
- (69) **War.** Any loss that is due to a declared or undeclared act of war.

- (70) **Weekend pass.** Charges for room and board in a facility for days on which the covered person is permitted to leave (a weekend pass, for example).
- (71) **Workers' Compensation.** Any condition for which benefits of any nature are payable or are found to be eligible, either by adjudication or settlement, under any Worker's Compensation law, Employer's liability law, or occupational disease law, even though the covered person fails to claim rights to such benefits or fails to enroll or purchase such coverage.

HOW TO SUBMIT A CLAIM

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

Benefits under this Plan shall be paid only if the Claims Administrator, acting on the Plan's behalf, decides in its discretion that a Covered Person is entitled to them.

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

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

A "Claim" does not include a request for a determination of an individual's eligibility to participate in the Plan.

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

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

A claimant must follow and complete all Claims and Appeal procedures both internal and external, before he or she can file a lawsuit. If a lawsuit is brought, it must be filed within two years after the final determination of an Appeal.

Authority and responsibilities of the Plan Administrator under the Claims and Appeal Procedures, including the discretionary authority to interpret the terms of the Plan, have been delegated to the Claims Administrator for those Plan benefits administered by the Claims Administrator. If the Covered Person has any questions regarding these procedures, they should contact the Claims Administrator.

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

The definitions of the types of Claims are:

Urgent Care Claim

A Claim involving Urgent Care is any Claim for medical care or treatment where the Plan conditions receipt of benefits, in whole or in part, on approval in advance of obtaining the care or treatment, and using the timetable for a

non-urgent care determination could seriously jeopardize the life or health of the claimant; or the ability of the claimant to regain maximum function; or in the opinion of the attending or consulting Physician, would subject the claimant to severe pain that could not be adequately managed without the care or treatment that is the subject of the Claim.

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

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

Notification to claimant of Claim determination72 hours

Insufficient information on the Claim, or failure to follow the Plan's procedure for filing a Claim:

Notification to claimant, orally or in writing24 hours

Response by claimant, orally or in writing48 hours

Benefit determination, orally or in writing48 hours

Notification of Adverse Benefit Determination on Appeal72 hours

If there is an Adverse Benefit Determination on a Claim involving Urgent Care, a request for an expedited Appeal may be submitted orally or in writing by the claimant. All necessary information, including the Plan's benefit determination on review, may be transmitted between the Plan and the claimant by telephone, facsimile, or other similarly expeditious method. Alternatively, the claimant may request an expedited review under the External Review Process.

Concurrent Care Claims

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

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

Notification to claimant of benefit reduction.....Sufficiently prior to scheduled termination of course of treatment to allow claimant to appeal

Notification to claimant of rescission.....30 days

Notification of determination on Appeal of Urgent Care Claims24 hours (provided claimant files Appeal more than 24 hours prior to scheduled termination of course of treatment)

Notification of Adverse Benefit Determination on Appeal for non-Urgent Claims15 days

Notification of Adverse Benefit Determination
on Appeal for Rescission Claims30 days

Pre-Service Claim

A Pre-Service Claim means any Claim for a benefit under this Plan where the Plan conditions receipt of the benefit, in whole or in part, on approval in advance of obtaining medical care. These are, for example, Claims subject to Predetermination of Benefits, Prior Approval or mandatory second opinions. Please see the Cost Management section of this booklet for further information about Pre-Service Claims.

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

Notification to claimant of Adverse Benefit Determination..... 15 days

Extension due to matters beyond the control of the Plan 15 days

Insufficient information on the Claim:

Notification of..... 15 days

Response by claimant45 days

Notification, orally or in writing, of failure to follow
the Plan’s procedures for filing a Claim5 days

Notification of Adverse Benefit Determination on Appeal30 days

Reduction or termination before the end of the treatment 15 days

Request to extend course of treatment..... 15 days

Post-Service Claim

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

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

Notification to claimant of Adverse Benefit Determination.....30 days

Extension due to matters beyond the control of the Plan 15 days

Extension due to insufficient information on the Claim..... 15 days

Response by claimant following notice
of insufficient information.....45 days

Notification of Adverse Benefit Determination on Appeal60 days

PREFERRED PAYMENT PLAN AND HOSPITAL REIMBURSEMENT PROGRAM PARTICIPATING PROVIDERS

The Plan participates in the Preferred Payment Plan (PPP) and the Hospital Reimbursement Program (HRP) with BlueAdvantage Administrators of Arkansas. Participating Providers agree to accept the allowances of BlueAdvantage Administrators of Arkansas and not charge the Covered Person more than that amount. No Assignment of Benefits by the Covered Person shall be valid until approved and accepted by the Claims Administrator. The Claims Administrator reserves the right to make payment of benefits, in its sole discretion, directly to the Provider of service or to the Covered Person.

A list of participating Providers is available on the web at www.blueadvantagearkansas.com.

The Claim Process

This Plan uses a direct claims administration system. Under this approach, the PPP or HRP Provider submits the claims directly to the Claims Administrator.

Any payment due for eligible services rendered by Preferred Providers will be made directly to the Provider unless the Provider requests payment be made directly to the Covered Person.

Any payment due for eligible services rendered by Non-Preferred Providers will typically be made directly to the Covered Person; however, the Plan reserves the right to make payment of benefits directly to the Provider of service or to the Covered Person.

PREFERRED PROVIDER ORGANIZATION (PPO)

The Plan participates in a Preferred Provider Organization (PPO). Participating Providers agree to accept the PPO allowances and not charge the Covered Person more than that amount.

No Assignment of Benefits by the Covered Person shall be valid until approved and accepted by the Claims Administrator. The Claims Administrator reserves the right to make payment of benefits, in its sole discretion, directly to the Provider of service or to the Covered Person.

A list of participating Providers is available on the web at www.blueadvantagearkansas.com.

The Claims Process

The Plan uses a direct claims administration system. Under this approach, the PPO Provider submits the claims directly to the Claims Administrator.

Any payment due for eligible services rendered by PPO Providers will be made directly to the Provider unless the Provider requests payment be made directly to the Covered Person.

Any payment due for eligible services rendered by Non-PPO Providers will typically be made directly to the Covered Person; however, the Plan reserves the right to make payment of benefits directly to the Provider of service or to the Covered Person.

BLUECARD® PROGRAM

Out-of-Arkansas Services. The Health Plan participates in a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as “Inter-Plan Programs.” Whenever a Covered Person obtains health care services outside of the State of Arkansas (“the service area”), the claims for these services may be processed through one of these Inter-Plan Programs, which include the BlueCard Program and may include negotiated National Account arrangements available between the Health Plan and other Blue Cross and Blue Shield Licensees.

Typically, when accessing care outside the service area, a Covered Person will obtain care from health care Providers that have a contractual agreement (i.e., are “participating Providers”) with the local Blue Cross and/or Blue Shield

Licensee in that other geographic area (“Host Blue”). In some instances, a Covered Person may obtain care from nonparticipating health care Providers. The Health Plan’s practices for consideration of payment in both instances are described below.

(1) BlueCard® Program.

- (a)** Under the BlueCard® Program, when a Covered Person accesses covered health care services within the geographic area served by a Host Blue, the Health Plan will remain responsible for fulfilling its contractual obligations. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating health care Providers. Whenever a Covered Person accesses covered health care services outside the service area and the claim is processed through the BlueCard Program, the amount a Covered Person pays for covered health care services is calculated based on the lower of:
 - The billed covered charges for the covered services; or
 - The negotiated price that the Host Blue makes available to the Health Plan.
- (b)** Often, this “negotiated price” will be a simple discount that reflects an actual price that the Host Blue pays to the health care Provider. Sometimes, it is an estimated price that takes into account special arrangements with the health care Provider or Provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of health care Providers after taking into account the same types of transactions as with an estimated price.
- (c)** Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price used for a Covered Person’s claim because the adjustments will not be applied retroactively to claims already paid.
- (d)** Laws in a small number of states may require the Host Blue to add a surcharge to the calculation. If any state laws mandate other liability calculation methods, including a surcharge, the Health Plan would then calculate the Covered Person’s liability for any covered health care services according to applicable law.

(2) Non-Participating Health Care Providers Outside the Service Area

- (a)** When covered health care services are provided outside of the service area by non-participating health care Providers, the amount a Covered Person pays for such services will generally be based on either the Host Blue’s nonparticipating health care Provider local payment or the pricing arrangements required by applicable state law. In these situations, a Covered Person may be liable for the difference between the amount that the non-participating health care Provider bills and any payment made for the covered services as set forth in this paragraph.
- (b)** In certain situations, the Health Plan may use other payment bases, such as billed covered charges, the payment the Health Plan would make if the health care services had been obtained within the service area, or a special negotiated payment, as permitted under Inter-Plan Programs Policies, to determine the amount the Health Plan will pay for services rendered by nonparticipating health care Providers. In these situations, a Covered Person may be liable for the difference between the amount that the non-participating health care Provider bills and the payment the Health Plan will make for the covered services as set forth in this paragraph

BLUE CROSS BLUE SHIELD GLOBAL CORE

If the Covered Person is outside the United States (hereinafter “BlueCard service area”), they may be able to take advantage of Blue Cross Blue Shield Global Core when accessing Covered Services. Blue Cross Blue Shield Global Core is unlike the BlueCard Program available in the BlueCard service area in certain ways. For instance, although Blue Cross Blue Shield Global Core assists with accessing a network of inpatient, outpatient and professional Providers, the network is not served by a Host Blue. As such, when a Covered Person receives care from Providers outside the BlueCard service area, they will typically have to pay the Provider directly. If a Covered Person needs medical assistance services (including locating a doctor or hospital) outside the BlueCard service area, they may contact customer service at the number on the back of their health plan identification card or additional information can be found at www.bcbsglobalcore.com.

- (1) **Inpatient Services.** In most cases, if the Covered Person contacts Blue Cross Blue Shield Global Core for assistance, Hospitals will not require a Covered Person to pay for covered inpatient services, except for applicable cost-share amounts (deductibles, coinsurance, etc.). In such cases, the Hospital will submit claims to the service center to begin claims processing. However, if the Covered Person paid in full at the time of service, they must submit a claim. Contact the Claims Administrator to obtain prior approval for non-emergency inpatient services.
- (2) **Outpatient Services.** Physicians, urgent care centers and other outpatient Providers located outside the BlueCard service area will typically require the Covered Person to pay in full at the time of service. A claim must be submitted to receive a benefit determination.
- (3) **Submitting a Blue Cross Blue Shield Global Core Claim.** When the Covered Person pays for services outside the BlueCard service area, a claim must be submitted to receive a benefit determination. For institutional and professional claims, a Blue Cross Blue Shield Global Core claim form should be completed and sent with the Provider’s itemized bill(s) to the service center (the address is on the form) to initiate claims processing. Following the instructions on the claim form will help ensure timely processing of the claim. The claim form is available from the service center or online at www.bcbsglobalcore.com.

ALL OTHER PROVIDERS

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

- Obtain a Claim form from the Plan Administrator or at www.blueadvantagearkansas.com.
- Complete the Employee portion of the form. ALL QUESTIONS MUST BE ANSWERED.
- For Plan reimbursements, attach bills for services rendered. ALL BILLS MUST SHOW:

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

Send the above to the Claims Administrator at this address:

BlueAdvantage Administrators of Arkansas
P.O. Box 1460
Little Rock, Arkansas
72203

DEADLINE FOR FILING A PLAN BENEFITS CLAIM

The Plan has established and will enforce a one-year timely filing deadline for all claims for benefits under the Plan, meaning that the Covered Person, the treating Provider, or an Authorized Representative acting on the Covered Person's behalf, must submit the claim to the Claims Administrator within one year from the date of service. However, In-Network Providers must submit claims within the time limits provided in their applicable Provider contract, if shorter than one year. Claims are not payable if they are not submitted to the Claims Administrator within the applicable time limit.

The Claims Administrator will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested from the claimant. The Plan reserves the right to have a Plan Participant seek a second medical opinion. Please note that in order to constitute a valid Plan claim, and start the clock with respect to the Plan's and Claims Administrator's adjudication deadlines, the claim must be submitted in writing, and must comply with the Plan and the Claims Administrator's standard claims submission and processing forms, policies and procedures.

EXPLANATION OF BENEFITS (EOB)

A Plan Participant will be notified within 90 days of receipt of the claim as to the acceptance or denial of a claim and if not notified within 90 days, the claim shall be deemed denied. Upon making a determination of a claim, the Claims Administrator will deliver to the Covered Person an Explanation of Benefit Determination (EOB) containing the following information:

- (1) the specific reason or reasons for the determination;
- (2) specific reference to those Plan provisions on which the denial is based;
- (3) a description of any additional information or material necessary to correct the claim and an explanation of why such material or information is necessary; and
- (4) appropriate information as to the steps to be taken if a Plan Participant wishes to submit the claim for review.

If special circumstances require an extension of time for processing the claim, the Claims Administrator shall send written notice of the extension to the Plan Participant. The extension notice will indicate the special circumstances requiring the extension of time and the date by which the Plan expects to render the final decision on the claim. In no event will the extension exceed a period of 90 days from the end of the initial 90-day period.

INFORMAL CLAIM REVIEW

In cases where a claim for benefits payment is denied or reduced in whole or in part, the Plan Participant or the Authorized Representative may request an informal claim review. An informal claim review is not an appeal or a substitute for an appeal. Pursuit of an informal review will not relieve the claimant from the responsibility for exhausting any appeal rights under the Plan within the appeal deadline. In a situation where the determination, after informal review, remains adverse, the Plan Participant or the Authorized Representative may request an appeal of the denial.

The Plan Administrator's written response to the Plan Participant shall cite the specific Plan provision(s) upon which the denial is based.

A Plan Participant must exhaust the claims appeal procedure before filing a suit for benefits. If a lawsuit is brought, it must be filed within two years after the final determination of an appeal.

Requests for review may be submitted in writing, email, or by telephone to the Claims Administrator. The request should provide the patient's name, Plan identification number and the specific claim(s) to be reviewed. Additional relevant documentation may also be provided to the Claims Administrator to assist in the review. A request for an informal claim review must be submitted within 180 days after notice is received of the denial or reduction in benefits. This 180-day period runs concurrently with the Plan's 180-day deadline to submit an appeal.

A determination shall be rendered with a reasonable period of time, but notification of the determination will be provided not later than 60 days after received. A review of the denial will be made by the Plan Administrator and the Plan Administrator will provide the Plan Participant with a written response within 60 days of the date the Plan Administrator receives the Plan Participant's written request for review and if not notified, the Plan Participant may deem the claim denied. If, because of extenuating circumstances, the Plan Administrator is unable to complete the review process within 60 days, the Plan Administrator shall notify the Plan Participant of the delay within the 60-day period and shall provide a final written response to the request for review within 120 days of the date the Plan Administrator received the Plan Participant's written request for review.

APPEALS PROCESS

The Plan Participant will receive an EOB explaining the claim determination, and if applicable, the reason or reasons for any denial or reduction of benefits. In cases where a claim for benefits payment is denied or reduced in whole or in part, the Plan Participant or the Authorized Representative may file an appeal. This Plan appeal process allows the Plan Participants to:

- (1) Request from the Claims Administrator a review of any partial or complete denial of any claim for Plan benefits. Such request must be submitted in writing by the Plan Participant/beneficiary or by a duly-appointed Authorized Representative, and must include: the name of the Employee, his or her Social Security number, the name of the patient and the Group Identification Number, if any.
- (2) The written appeal request should identify the specific services or benefits in dispute, including the date(s) of service and health care Provider(s) involved, as well as, stating in clear and concise terms the reason or reasons for this disagreement with the handling of the claim.

DEADLINE FOR SUBMISSION OF APPEALS

The request for review must be submitted to the Claims Administrator not later than 180 days after the date of the notification of payment or denial of any disputed benefits.

Failure to submit an appeal within the 180-day period allowed under the Plan waives any further challenge to the Plan's or Claims Administrator's benefits adjudication.

Upon timely submission of a properly submitted appeal, the Claims Administrator will conduct its review and will provide the Plan Participant with a written response within 60 days. If not notified, the Plan Participant may deem the claim denied. If, because of extenuating circumstances, the Claims Administrator is unable to complete the review process within 60 days, the Claims Administrator shall notify the Plan Participant of the delay within the 60-day period and shall provide a final written response to the request for review within 120 days of the date the Claims Administrator received the Plan Participant's written request for review.

The Claims Administrator's written response to the Plan Participant shall cite the specific Plan provision(s) upon which the denial is based.

A Plan Participant must exhaust this Plan appeal procedure before filing a suit for benefits. If a lawsuit is brought, it must be filed within two years after the final determination of a timely appeal, or otherwise any such lawsuit is barred.

NOTICE TO CLAIMANT OF ADVERSE BENEFIT DETERMINATIONS

If a Claim, or an Appeal of a Claim, is denied in whole or in part, the denial is considered to be an Adverse Benefit Determination. Except with Urgent Care Claims, when the notification may be oral, followed by written or electronic notification within three days of the oral notification, the Claims Administrator or Plan Administrator shall provide written or electronic notification of the Adverse Benefit Determination, including in such notification the content required under applicable U.S. Department of Labor claims regulations.

EXTERNAL REVIEW PROCESS

If an appeal of a claim benefit determination is denied, the claimant may be entitled to request and receive an external review by an independent review organization. In order to be eligible for external review, the following conditions must apply:

- (1) The claimant must submit a request for external review in writing to the Claims Administrator within 125 days after receiving notice of the denial of the appeal. External review requests submitted more than 125 days after a claimant receives notice of denial of an appeal will be denied for lack of timely submission.
- (2) The claimant must have been eligible for coverage under the Plan at the time the services in question were or will be provided; and
- (3) The denial or claim must not be based on the claimant's failure to meet the Plan's eligibility requirements;
- (4) The claimant must have completed the Plan appeals process outlined in this document;
- (5) The claimant must have provided all information required by the Claims Administrator in order to process an external review request; and
- (6) The denial of the claim must be based on a medical judgement, which may include but is not limited to questions of Medical Necessity, medical appropriateness or safety of treatment or care, appropriateness of health care setting, or medical effectiveness of a treatment, service or covered benefits.

Upon submission to the Claims Administrator of the claimant's written request for external review, the Claims Administrator will review the request to determine whether the conditions outlined above are met.

Within one business day after completion of this preliminary review, the Claims Administrator will provide written notification to the claimant of whether the external review request satisfies the conditions for external review, including a description of any additional information or material necessary to complete the external review request.

If the Claims Administrator notifies the claimant or their representative that the request is not complete, the claimant will have 48 hours or until the last day of the 125-day filing period, whichever is later, to submit the additional information.

If the request satisfies the conditions for external review, the Claims Administrator will refer the request to a qualified independent review organization (IRO). The IRO will then be responsible for notifying the claimant, in writing, that the request for external review has been accepted. The IRO's notice should include a statement that the claimant may submit in writing, within 10 business days, any additional information the claimant wishes the IRO to consider when conducting the review. The IRO will share this information with the Plan and Claims Administrator. The Claims Administrator, acting as the delegate of the Plan Administrator, may consider this information and decide to reverse its denial of the Claim. If the denial is reversed, the external review process will end.

If the Claims Administrator does not reverse the denial, the IRO will make its decision on the basis of its review of all of the information in the record, as well as additional information where appropriate and available, such as:

- (1) The claimant's medical records as available and relevant;
- (2) The attending health care professional's recommendation;
- (3) Reports from appropriate health care professionals and other documents submitted by the claimant, the Plan, the Claims Administrator, or the treating Provider;
- (4) The terms of the Plan;
- (5) Appropriate practice guidelines;
- (6) Any applicable clinical review criteria developed and used by the plan; and
- (7) The opinion of the IRO's clinical reviewer.

The IRO must provide written notice to the Plan and the claimant of its final decision within 45 days after the IRO receives the request for the External Review. The IRO's decision notice should contain:

- (1) A general description of the reason for the External Review, including information sufficient to identify the claim;
- (2) The date the IRO received the assignment to conduct the review and the date of the IRO's decision;
- (3) References to the evidence or documentation the IRO considered in reaching its decision;
- (4) A discussion of the principal reason(s) for the IRO's decision;
- (5) A statement that the determination is binding and that judicial review may be available to the claimant; and
- (6) Contact information for any applicable office of health insurance consumer assistance or ombudsman established under federal law.

Expedited External Review

Generally, as noted above, a claimant must first complete the Plan's appeals process before requesting and receiving an external review of a claim denial. However, in some cases the Plan provides for an expedited external review of a claim denial if:

- (1) The claimant submits a written request to the Claims Administrator specifically requesting expedited external review; and
- (2) The time to complete the Plan's appeal process would seriously jeopardize the claimant's life or health or ability to regain maximum function; or
- (3) The time to complete the Plan's standard external review process would seriously jeopardize the claimant's life or health or ability to regain maximum function, or if the claim denial in dispute concerns a Hospital admission, availability of care, continued stay, or health care item or service for which the claimant received emergency services, but has not been discharged from a facility.

Immediately upon receipt of a request for external review, the Claims Administrator will undertake to determine and notify the claimant whether the request satisfies the requirements for expedited review, including the conditions for external review listed above. If the request qualifies for expedited external review, it will be assigned to an IRO. The IRO must make its determination and provide a notice of the decision as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an

expedited External Review. If the original notice of its decision is not in writing, the IRO must provide written confirmation of the decision within 48 hours to both the claimant and the Claims Administrator.

AUTHORIZED REPRESENTATIVE

One Authorized Representative. A Covered Person may have one representative and only one representative at a time, to assist in submitting a claim or appealing an Adverse Benefit Determination.

Authority of Authorized Representative. An Authorized Representative shall have the authority to represent the Covered Person in all matters concerning the Covered Person's claim or appeal of a claim determination. If the Covered Person has an Authorized Representative, references to a "Covered Person" in the provision of this document entitled "How to Submit a Claim" refer to the Authorized Representative.

Designation of Authorized Representative. Except to the extent mandated by the U.S. Department of Labor claims rules in the case of a treating health care professionals and urgent care claims, the Plan does not permit appeals on a Covered Person's behalf by any person or entity not properly designated as an "authorized representative" in the manner specified in this section.

One of the following persons may act as a Covered Person's Authorized Representative:

- (1) An individual designated by the Covered Person in writing in a form approved by the Claims Administrator. A "Designation of Authorized Appeal Representative" form is available from the Claims Administrator;
- (2) The treating Provider, if the claim is a claim involving urgent care, or if the Covered Person has designated the Provider in writing in a form approved by the Claims Administrator. A "Designation of Authorized Appeal Representative" form is available from the Claims Administrator;
- (3) A person holding the Covered Person's durable power of attorney;
- (4) If the Covered Person is incapacitated due to illness or injury, a person appointed as guardian to have care and custody of the Covered Person by a court of competent jurisdiction; or
- (5) If the Covered Person is a minor, the Covered Person's parent or Legal Guardian, unless the Claims Administrator is notified that the Covered Person's claim involves health care services where the consent of the Covered Person's parent or Legal Guardian is or was not required by law and the Covered Person shall represent himself or herself with respect to the claim.

Term of the Authorized Representative. The authority of an Authorized Representative shall continue for the period specified in the Covered Person's appointment of the Authorized Representative or until the Covered Person is legally competent to represent him or herself and notifies the Claims Administrator in writing that the Authorized Representative is no longer required.

Communication with Authorized Representative.

- (1) If the Authorized Representative represents the Covered Person because the Authorized Representative is the Covered Person's parent or Legal Guardian or attorney in fact under a durable power of attorney, the Claims Administrator shall send all correspondence, notices and benefit determinations in connection with the Covered Person's claim to the Authorized Representative.
- (2) If the Authorized Representative represents the Covered Person in connection with the submission of a pre-service claim, including a claim involving urgent care, or in connection with an appeal, the Claims Administrator shall send all correspondence, notices and benefit determinations in connection with the Covered Person's claim to the Authorized Representative.

- (3) If the Authorized Representative represents the Covered Person in connection with the submission of a post-service claim, the Claims Administrator will send all correspondence, notices and benefit determinations in connection with the Covered Person's claim to the Covered Person, but the Claims Administrator will provide copies of such correspondence to the Authorized Representative upon request.
- (4) The Covered Person understands that it will take the Claims Administrator at least 30 days to notify all its personnel about the termination of the Covered Person's Authorized Representative and it is possible that the Claims Administrator may communicate information about the Covered Person to the Authorized Representative during this 30-day period.

COORDINATION OF BENEFITS

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

The plan that pays first according to the rules will pay as if there were no other plan involved. The secondary and subsequent plans will pay the balance due up to 100% of the total Allowable Charges.

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

- (1) Group or group-type plans, including franchise or blanket benefit plans.
- (2) Blue Cross and Blue Shield group plans.
- (3) Group practice and other group prepayment plans.
- (4) Federal government plans or programs. This includes, but is not limited to, Medicare and Tricare.
- (5) Other plans required or provided by law. This does not include Medicaid or any benefit plan like it that, by its terms, does not allow coordination.
- (6) No Fault Auto Insurance, by whatever name it is called, when not prohibited by law.

Eligible Charge. For a charge to be eligible it must be an Allowable Charge and at least part of it must be covered under this Plan.

In the case of HMO (Health Maintenance Organization) or other in-network only plans: This Plan will not consider any charges in excess of what an HMO or network provider has agreed to accept as payment in full.

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

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

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

- (1) Plans that do not have a coordination provision, or one like it, will pay first. Plans with such a provision will be considered after those without one.
- (2) Plans with a coordination provision will pay their benefits up to the Allowable Charge:
 - (a) The benefits of the plan which covers the person directly (that is, as an employee, member or subscriber) ("Plan A") are determined before those of the plan which covers the person as a dependent ("Plan B").
 - (b) The benefits of a benefit plan which covers a person as an Employee who is neither laid off nor retired are determined before those of a benefit plan which covers that person as a laid-off or Retired Employee. The benefits of a benefit plan which covers a person as a Dependent of an Employee who is neither laid off nor retired are determined before those of a benefit plan which

covers a person as a Dependent of a laid off or Retired Employee. If the other benefit plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.

- (c) The benefits of a benefit plan which covers a person as an Employee who is neither laid off nor retired or a Dependent of an Employee who is neither laid off nor retired are determined before those of a plan which covers the person as a COBRA beneficiary.
 - (d) When a child is covered as a Dependent and the parents are not separated or divorced, these rules will apply:
 - (i) The benefits of the benefit plan of the parent whose birthday falls earlier in a year are determined before those of the benefit plan of the parent whose birthday falls later in that year;
 - (ii) If both parents have the same birthday, the benefits of the benefit plan which has covered the parent for the longer time are determined before those of the benefit plan which covers the other parent.
 - (e) When a child's parents are divorced or legally separated, these rules will apply:
 - (i) This rule applies when the parent with custody of the child has not remarried. The benefit plan of the parent with custody will be considered before the benefit plan of the parent without custody.
 - (ii) This rule applies when the parent with custody of the child has remarried. The benefit plan of the parent with custody will be considered first. The benefit plan of the stepparent that covers the child as a Dependent will be considered next. The benefit plan of the parent without custody will be considered last.
 - (iii) This rule will be in place of items (i) and (ii) above when it applies. A court decree may state which parent is financially responsible for medical and dental benefits of the child. In this case, the benefit plan of that parent will be considered before other plans that cover the child as a Dependent.
 - (iv) If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined above when a child is covered as a Dependent and the parents are not separated or divorced.
 - (v) For parents who were never married to each other, the rules apply as set out above as long as paternity has been established.
 - (f) If there is still a conflict after these rules have been applied, the benefit plan which has covered the patient for the longer time will be considered first. This includes situations in which a person who is covered as a dependent child under one benefit plan is also covered as a dependent spouse under another benefit plan. When there is a conflict in coordination of benefit rules, the Plan will never pay more than 50% of Allowable Charges when paying secondary.
- (3) Medicare will pay primary, secondary or last to the extent stated in federal law.

- (4) If a Plan Participant is under a disability extension from a previous benefit plan, that benefit plan will pay first and this Plan will pay second.
- (5) The Plan will pay primary to Tricare and a State child health plan to the extent required by federal law.

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

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

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

Right of recovery. This Plan may pay benefits that should be paid by another benefit plan. In this case this Plan may recover the amount paid.

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

THIRD PARTY RECOVERY PROVISION

Reimbursement

This section applies when a Covered Person, or the legal representative, estate or heirs of the Covered Person (sometimes collectively referred to as the “Covered Person”) recovers damages, by settlement, verdict or otherwise, for an Injury, Sickness or other condition. If the Covered Person has made, or in the future may make, such a recovery, including a recovery from any insurance carrier, the Plan will not cover either the reasonable value of the services to treat such an Injury or Illness or the treatment of such an Injury or Illness. These benefits are specifically excluded.

However, if the Plan does advance moneys or provide care for such an Injury, Sickness or other condition, the Covered Person shall promptly convey moneys or other property from any settlement, arbitration award, verdict or any insurance proceeds or monetary recovery from any party received by the Covered Person (or by the legal representative, estate or heirs of the Covered Person), to the Plan for the reasonable value of the medical benefits advanced or provided by the Plan to the Covered Person, regardless of whether or not [1] the Covered Person has been fully compensated, or “made-whole” for his/her loss; [2] liability for payment is admitted by the Covered Person or any other party; or [3] the recovery by the Covered Person is itemized or called anything other than a recovery for medical expenses incurred.

If a recovery is made, the Plan shall have first priority in payment over the Covered Person, or any other party, to receive reimbursement of the benefits advanced on the Covered Person’s behalf. This reimbursement shall be from any recovery made by the Covered Person, and includes, but is not limited to, uninsured and underinsured motorist coverage, any No-Fault Auto Insurance, medical payment coverage (auto, homeowners or otherwise), workers’ compensation settlement, compromises or awards, other group insurance (including student plans), and direct recoveries from liable parties.

In order to secure the rights of the Plan under this section, and because of the Plan’s advancement of benefits, the Covered Person hereby [1] acknowledges that the Plan shall have first priority against proceeds of any such settlement, arbitration award, verdict, or any other amounts received by the Covered Person; and [2] assigns the Plan any benefits the Covered Person may have under any automobile policy or other coverage, to the extent of the Plan’s claim for reimbursement. The Covered Person shall sign and deliver, at the request of the Plan or its agents, any documents needed to protect such priority or reimbursement right, or to effect such assignment of benefits. By accepting any benefits advanced by the Plan under this section, the Covered Person acknowledges that any proceeds of settlement or judgment, including a Covered Person’s claim to such proceeds held by another person, held by the Covered Person or by another, are being held for the benefit of the Plan under these provisions.

The Covered Person shall cooperate with the Plan and its agents, and shall sign and deliver such documents as the Plan or its agents reasonably request to protect the Plan’s right of reimbursement, provide any relevant information, and take such actions as the Plan or its agents reasonably request to assist the Plan making a full recovery of the reasonable value of the benefits provided. The Covered Person shall not take any action that prejudices the Plan’s rights of reimbursement and consents to the right of the Plan, by and through its agent, to impress an equitable lien or constructive trust on the proceeds of any settlement to enforce the Plan’s rights under this section, and/or to set off from any future benefits otherwise payable under the Plan the value of benefits advanced under this section to the extent not recovered by the Plan.

The Plan shall be responsible only for those legal fees and expenses to which it agrees in writing. No Covered Person hereunder shall incur any expenses on behalf of the Plan in pursuit of the Plan’s rights hereunder. Specifically, no court costs or attorney’s fees may be deducted from the Plan’s recovery without the express written consent of the Plan. Any so-called “Fund Doctrine” or “Common Fund Doctrine” or “Attorney’s Fund Doctrine” shall not defeat this right.

The Plan shall recover the full amount of benefits advanced and paid hereunder, without regard to any claim or fault on the part of any beneficiary of Covered Person, whether under comparative negligence or otherwise.

Subrogation

This section applies when another party is, or may be considered, liable for a Covered Person's Injury, Sickness or other condition (including insurance carriers who are so financially liable) and the Plan has advanced benefits.

In consideration for the advancement of benefits, the Plan is subrogated to all of the rights of the Covered Person against any party liable for the Covered Person's Injury or Illness or is or may be liable for the payment for the medical treatment of such Injury or occupational Illness (including any insurance carrier), to the extent of the value of the medical benefits advanced to the Covered Person under the Plan. The Plan may assert this right independently of the Covered Person. This right includes, but is not limited to, the Covered Person's rights under uninsured and underinsured motorist coverage, any No-Fault Auto Insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, or other insurance, as well as the Covered Person's rights under the Plan to bring an action to clarify his or her rights under the Plan. The Plan is not obligated in any way to pursue this right independently or on behalf of the Covered Person but may choose to pursue its rights to reimbursement under the Plan, at its sole discretion.

The Covered Person is obligated to cooperate with the Plan and its agents in order to protect the Plan's subrogation rights. Cooperation means providing the Plan or its agents with any relevant information requested by them, signing and delivering such documents as the Plan or its agents reasonably request to secure the Plan's subrogation claim, and obtaining the consent of the Plan or its agents before releasing any party from liability for payment of medical expenses.

If the Covered Person enters into litigation or settlement negotiations regarding the obligations of other parties, the Covered Person must not prejudice, in any way, the subrogation rights of the Plan under this section. In the event that the Covered Person fails to cooperate with this provision, including executing any documents required herein, the Plan may, in addition to remedies provided elsewhere in the Plan and/or under the law, set off from any future benefits otherwise payable under the Plan the value of benefits advanced under this section to the extent not recovered by the Plan.

The costs of legal representation of the Plan in matters related to subrogation shall be borne solely by the Plan. The costs of legal representation of the Covered Person shall be borne solely by the Covered Person.

CONTINUATION COVERAGE RIGHTS UNDER COBRA

Under federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), certain Employees and their families covered under The University of Central Arkansas Medical Plan (the Plan) will be entitled to the opportunity to elect a temporary extension of health coverage (called "COBRA continuation coverage") where coverage under the Plan would otherwise end. This notice is intended to inform Plan Participants and beneficiaries, in summary fashion, of their rights and obligations under the continuation coverage provisions of COBRA, as amended and reflected in final and proposed regulations published by the Department of the Treasury. This notice is intended to reflect the law and does not grant or take away any rights under the law.

COBRA continuation coverage under the Plan is administered by the COBRA Administrator. Complete instructions on COBRA, as well as election forms and other information, will be provided by the COBRA Administrator to Plan Participants who become Qualified Beneficiaries under COBRA.

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

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

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

- (1) Any individual who, on the day before a Qualifying Event, is covered under a Plan by virtue of being on that day either a covered Employee, the Spouse of a covered Employee, or a Dependent child of a covered Employee. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.
- (2) Any child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, and any individual who is covered by the Plan as an alternate recipient under a qualified medical support order. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.
- (3) A covered Employee who retired on or before the date of substantial elimination of Plan coverage which is the result of a bankruptcy proceeding under Title 11 of the U.S. Code with respect to the Employer, as is the Spouse, surviving Spouse or Dependent child of such a covered Employee if, on the day before the bankruptcy Qualifying Event, the Spouse, surviving Spouse or Dependent child was a beneficiary under the Plan.

The term "covered Employee" includes any individual who is provided coverage under the Plan due to his or her performance of services for the employer sponsoring the Plan (e.g., common-law employees (full or part-time),

self-employed individuals, independent contractor, or corporate director). However, this provision does not establish eligibility of these individuals. Eligibility for Plan Coverage shall be determined in accordance with Plan Eligibility provisions.

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

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

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

- (1) The death of a covered Employee.
- (2) The termination (other than by reason of the Employee's gross misconduct), or reduction of hours, of a covered Employee's employment.
- (3) The divorce or legal separation of a covered Employee from the Employee's Spouse. If the Employee reduces or eliminates the Employee's Spouse's Plan coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a Qualifying Event even though the Spouse's coverage was reduced or eliminated before the divorce or legal separation.
- (4) A covered Employee's enrollment in any part of the Medicare program.
- (5) A Dependent child's ceasing to satisfy the Plan's requirements for a Dependent child (for example, attainment of the maximum age for dependency under the Plan).
- (6) A proceeding in bankruptcy under Title 11 of the U.S. Code with respect to an Employer from whose employment a covered Employee retired at any time.

If the Qualifying Event causes the covered Employee, or the covered Spouse or a Dependent child of the covered Employee, to cease to be covered under the Plan under the same terms and conditions as in effect immediately before the Qualifying Event (or in the case of the bankruptcy of the Employer, any substantial elimination of coverage under the Plan occurring within 12 months before or after the date the bankruptcy proceeding commences), the persons losing such coverage become Qualified Beneficiaries under COBRA if all the other conditions of COBRA are also met. For example, any increase in contribution that must be paid by a covered Employee, or the Spouse, or a Dependent child of the covered Employee, for coverage under the Plan that results from the occurrence of one of the events listed above is a loss of coverage.

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

What factors should be considered when determining to elect COBRA continuation coverage? When considering options for health coverage, Qualified Beneficiaries should consider:

- **Premiums:** This plan can charge up to 102% of total plan premiums for COBRA coverage. Other options, like coverage on a spouse's plan or through the Marketplace, may be less expensive. Qualified Beneficiaries have special enrollment rights under federal law (HIPAA). They have the right to request special enrollment in another group health plan for which they are otherwise eligible (such as a plan sponsored by a spouse's employer) within 30 days after Plan coverage ends due to one of the Qualifying Events listed above.
- **Provider Networks:** If a Qualified Beneficiary is currently getting care or treatment for a condition, a change in health coverage may affect access to a particular health care provider. An individual may want to check to see if their current health care providers participate in a network in considering options for health coverage.
- **Drug Formularies:** For Qualified Beneficiaries taking medication, a change in health coverage may affect costs for medication - and in some cases, the medication may not be covered by another plan. Qualified beneficiaries should check to see if current medications are listed in drug formularies for other health coverage.
- **Severance payments:** If COBRA rights arise because the Employee has lost his job and there is a severance package available from the employer, the former employer may have offered to pay some or all of the Employee's COBRA payments for a period of time. This can affect the timing of coverage available in the Marketplace. In this scenario, the Employee may want to contact the Department of Labor at 1-866-444-3272 to discuss options.
- **Medicare Eligibility:** Individuals should be aware of how COBRA coverage coordinates with Medicare eligibility. If an individual is eligible for Medicare at the time of the Qualifying Event, or if he or she will become eligible soon after the Qualifying Event, he or she has eight months to enroll in Medicare after employment -related health coverage ends. Electing COBRA coverage does not extend this eight-month period. For more information, see <https://www.medicare.gov/sign-up-change-plans/>.
- **Service Areas:** If benefits under the Plan are limited to specific service or coverage areas, benefits may not be available to a Qualified Beneficiary who moves out of the area.
- **Other Cost-Sharing:** In addition to premiums or contributions for health coverage, the Plan requires participants to pay copayments, deductibles, coinsurance, or other amounts as benefits are used. Qualified beneficiaries should check to see what the cost-sharing requirements are for other health coverage options. For example, one option may have much lower monthly premiums, but a much higher deductible and higher copayments.

Are there other coverage options besides COBRA Continuation Coverage? Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for Qualified Beneficiaries through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. More information about these options is available at www.healthcare.gov.

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

What is the election period and how long must it last? The election period is the time period within which the Qualified Beneficiary must elect COBRA continuation coverage under the Plan. The election period must begin no later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event and ends 60

days after the later of the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event or the date notice is provided to the Qualified Beneficiary of her or his right to elect COBRA continuation coverage. If coverage is not elected within the 60 day period, all rights to elect COBRA continuation coverage are forfeited.

Note: If a covered Employee who has been terminated or experienced a reduction of hours qualifies for a trade readjustment allowance or alternative trade adjustment assistance under a federal law called the Trade Act of 2002, as extended by the Trade Preferences Extension Act of 2015, and the Employee and his or her covered Dependents have not elected COBRA coverage within the normal election period, a second opportunity to elect COBRA coverage will be made available for themselves and certain family members, but only within a limited period of 60 days or less and only during the six months immediately after their group health plan coverage ended. Any person who qualifies or thinks that he and/or his family members may qualify for assistance under this special provision should contact the Plan Administrator for further information about the special second election period. If continuation coverage is elected under this extension, it will not become effective prior to the beginning of this special second election period.

Is a covered Employee or Qualified Beneficiary responsible for informing the Plan Administrator of the occurrence of a Qualifying Event? The Plan will offer COBRA continuation coverage to Qualified Beneficiaries only after the Plan Administrator has been timely notified that a Qualifying Event has occurred. The employer (if the employer is not the Plan Administrator) will notify the Plan Administrator of the Qualifying Event within 30 days following the date coverage ends when the Qualifying Event is:

- (1) the end of employment or reduction of hours of employment,
- (2) death of the Employee,
- (3) commencement of a proceeding in bankruptcy with respect to the employer, or
- (4) entitlement of the employee to any part of Medicare.

IMPORTANT:

For the other Qualifying Events (divorce, termination of domestic partnership or legal separation of the Employee and Spouse or a Dependent child's losing eligibility for coverage as a Dependent child), the Covered Person, or someone acting on their behalf must notify the Plan Administrator within 60 days after the Qualifying Event occurs, using the procedures specified below. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator or its designee during the 60-day notice period, any Spouse or Dependent child who loses coverage will not be offered the option to elect continuation coverage.

NOTICE PROCEDURES:

Any notice must be ***in writing***. Oral notice, including notice by telephone, is not acceptable. The notice must be mailed, faxed or hand delivered.

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

- the name of the plan or plans under which coverage has been lost or is being lost,
- the name and address of the Employee covered under the plan,
- the name(s) and address(es) of the Qualified Beneficiary(ies), and
- the Qualifying Event and the date it happened.

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

There are other notice requirements in other contexts, for example, in order to qualify for a disability extension.

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

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

Is COBRA coverage available if a Qualified Beneficiary has other group health plan coverage or Medicare? Qualified beneficiaries who are entitled to elect COBRA continuation coverage may do so even if they are covered under another group health plan or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, a Qualified Beneficiary's COBRA coverage may terminate if, after electing COBRA, he or she becomes entitled to Medicare or becomes covered under other group health plan coverage.

When may a Qualified Beneficiary's COBRA continuation coverage be terminated? During the election period, a Qualified Beneficiary may waive COBRA continuation coverage. Except for an interruption of coverage in connection with a waiver, COBRA continuation coverage that has been elected for a Qualified Beneficiary must extend for at least the period beginning on the date of the Qualifying Event and ending not before the earliest of the following dates:

- (1) The last day of the applicable maximum coverage period.
- (2) The first day for which Timely Payment is not made to the Plan with respect to the Qualified Beneficiary.
- (3) The date upon which the Employer ceases to provide any group health plan (including a successor plan) to any employee.
- (4) The date, after the date of the election, that the Qualified Beneficiary first becomes covered under any other Plan that does not contain any exclusion or limitation with respect to any pre-existing condition, other than such an exclusion or limitation that does not apply to, or is satisfied by, the Qualified Beneficiary.
- (5) In the case of a Qualified Beneficiary entitled to a disability extension, the later of:
 - (a) (i) 29 months after the date of the Qualifying Event, or (ii) the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier; or
 - (b) the end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension.

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

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

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

- (1) In the case of a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period ends 18 months after the Qualifying Event if there is not a disability extension and 29 months after the Qualifying Event if there is a disability extension.
- (2) In the case of a covered Employee's enrollment in the Medicare program before experiencing a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period for Qualified Beneficiaries ends on the later of:
 - (a) 36 months after the date the covered Employee becomes enrolled in the Medicare program. This extension does not apply to the covered Employee; or
 - (b) 18 months (or 29 months, if there is a disability extension) after the date of the covered Employee's termination of employment or reduction of hours of employment.
- (3) In the case of a bankruptcy Qualifying Event, the maximum coverage period for a Qualified Beneficiary who is the covered retiree ends on the date of the retiree's death. The maximum coverage period for a Qualified Beneficiary who is the covered Spouse, surviving Spouse or Dependent child of the retiree ends on the earlier of the Qualified Beneficiary's death or 36 months after the death of the retiree.
- (4) In the case of a Qualified Beneficiary who is a child born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, the maximum coverage period is the maximum coverage period applicable to the Qualifying Event giving rise to the period of COBRA continuation coverage during which the child was born or placed for adoption.
- (5) In the case of any other Qualifying Event than that described above, the maximum coverage period ends 36 months after the Qualifying Event.

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

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

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

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

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

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

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

IF YOU HAVE QUESTIONS

If an individual has questions about COBRA continuation coverage, they should contact Plan Administrator. For more information about your rights under COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

KEEP YOUR PLAN ADMINISTRATOR INFORMED OF ADDRESS CHANGES

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

RESPONSIBILITIES FOR PLAN ADMINISTRATION

PLAN ADMINISTRATOR. The University of Central Arkansas Medical Plan is the benefit plan of University of Central Arkansas, the Plan Administrator, also called the Plan Sponsor. An individual or committee may be appointed by University of Central Arkansas to be Plan Administrator and serve at the convenience of the Employer. If the Plan Administrator or a committee member resigns, dies or is otherwise removed from the position, University of Central Arkansas shall appoint a new Plan Administrator as soon as reasonably possible.

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

DUTIES OF THE PLAN ADMINISTRATOR.

- (1) To administer the Plan in accordance with its terms.
- (2) To interpret the Plan, including the right to remedy possible ambiguities, inconsistencies or omissions.
- (3) To decide disputes which may arise relative to a Plan Participant's rights.
- (4) To prescribe procedures for filing a claim for benefits and to review claim denials.
- (5) To keep and maintain the Plan documents and all other records pertaining to the Plan.
- (6) To appoint a Claims Administrator to pay claims.
- (7) To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate.

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

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

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

Under the Standards for Privacy of Individually Identifiable Health Information (45 CFR Part 164, the "Privacy Standards"), these employees are permitted to have such access subject to the following:

- (1) **General.** The Plan shall not disclose Protected Health Information to any member of the Employer's workforce unless each of the conditions set out in this HIPAA Privacy section is met. "Protected Health Information" shall have the same definition as set out in the Privacy Standards but generally shall mean individually identifiable health information about the past, present or future physical or mental health or condition of an individual, including genetic information and information about treatment or payment for treatment.
- (2) **Permitted Uses and Disclosures.** Protected Health Information disclosed to members of the Employer's workforce shall be used or disclosed by them only for purposes of Plan administrative functions. The Plan's administrative functions shall include all Plan payment and health care operations. The terms "payment" and "health care operations" shall have the same definitions as set out in the Privacy

Standards, but the term "payment" generally shall mean activities taken with respect to payment of premiums or contributions, or to determine or fulfill Plan responsibilities with respect to coverage, provision of benefits, or reimbursement for health care. "Health care operations" generally shall mean activities on behalf of the Plan that are related to quality assessment; evaluation, training or accreditation of health care providers; underwriting, premium rating and other functions related to obtaining or renewing an insurance contract, including stop-loss insurance; medical review; legal services or auditing functions; or business planning, management and general administrative activities. However, Protected Health Information that consists of genetic information will not be used or disclosed for underwriting purposes.

- (3) **Authorized Employees.** The Plan shall disclose Protected Health Information only to members of the Employer's workforce who are designated and are authorized to receive such Protected Health Information, and only to the extent and in the minimum amount necessary for these persons to perform duties with respect to the Plan. For purposes of this HIPAA Privacy section, "members of the Employer's workforce" shall refer to all employees and other persons under the control of the Employer.
- (a) **Updates Required.** The Employer shall amend the Plan promptly with respect to any changes in the members of its workforce who are authorized to receive Protected Health Information.
- (b) **Use and Disclosure Restricted.** An authorized member of the Employer's workforce who receives Protected Health Information shall use or disclose the Protected Health Information only to the extent necessary to perform his or her duties with respect to the Plan.
- (c) **Resolution of Issues of Noncompliance.** In the event that any member of the Employer's workforce uses or discloses Protected Health Information other than as permitted by the Privacy Standards, the incident shall be reported to the privacy official. The privacy official shall take appropriate action, including:
- (i) Investigation of the incident to determine whether the breach occurred inadvertently, through negligence, or deliberately; whether there is a pattern of breaches; and the degree of harm caused by the breach;
 - (ii) Applying appropriate sanctions against the persons causing the breach, which, depending upon the nature of the breach, may include, oral or written reprimand, additional training, or termination of employment;
 - (iii) Mitigating any harm caused by the breach, to the extent practicable; and
 - (iv) Documentation of the incident and all actions taken to resolve the issue and mitigate any damages.
- (4) **Certification of Employer.** The Employer must provide certification to the Plan that it agrees to:
- (a) Not use or further disclose the Protected Health Information other than as permitted or required by the Plan documents or as required by law;
 - (b) Ensure that any agent or subcontractor, to whom it provides Protected Health Information received from the Plan, agrees to the same restrictions and conditions that apply to the Employer with respect to such information;
 - (c) Not use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer;
 - (d) Report to the Plan any use or disclosure of the Protected Health Information of which it becomes aware that is inconsistent with the uses or disclosures hereunder or required by law;

- (e) Make available Protected Health Information to individual Plan members in accordance with Section 164.524 of the Privacy Standards;
- (f) Make available Protected Health Information for amendment by individual Plan members and incorporate any amendments to Protected Health Information in accordance with Section 164.526 of the Privacy Standards;
- (g) Make available the Protected Health Information required to provide any accounting of disclosures to individual Plan members in accordance with Section 164.528 of the Privacy Standards;
- (h) Make its internal practices, books and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Department of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Standards;
- (i) If feasible, return or destroy all Protected Health Information received from the Plan that the Employer still maintains in any form, and retain no copies of such information when no longer needed for the purpose of which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information unfeasible; and
- (j) Ensure the adequate separation between the Plan and member of the Employer's workforce, as required by Section 164.504(f)(2)(iii) of the Privacy Standards.

The following members of University of Central Arkansas's workforce are designated as authorized to receive Protected Health Information from The University of Central Arkansas Medical Plan ("the Plan") in order to perform their duties with respect to the Plan: Human Resource Department.

COMPLIANCE WITH HIPAA ELECTRONIC SECURITY STANDARDS. Under the Security Standards for the Protection of Electronic Protected Health Information (45 CFR Part 164.300 et. seq., the "Security Standards"), the Employer agrees to the following:

- (1) The Employer agrees to implement reasonable and appropriate administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of Electronic Protected Health Information that the Employer creates, maintains or transmits on behalf of the Plan. "Electronic Protected Health Information" shall have the same definition as set out in the Security Standards, but generally shall mean Protected Health Information that is transmitted by or maintained in electronic media.
- (2) The Employer shall ensure that any agent or subcontractor to whom it provides Electronic Protected Health Information shall agree, in writing, to implement reasonable and appropriate security measures to protect the Electronic Protected Health Information.
- (3) The Employer shall ensure that reasonable and appropriate security measures are implemented to comply with the conditions and requirements set forth in Compliance With HIPAA Privacy Standards provisions (3) Authorized Employees and (4) Certification of Employers described above.

The Plan's current Notice of Privacy Practices is available on the web at <https://uca.edu/hr/files/2022/05/Notice-Of-Privacy-Practices.pdf>.

FUNDING THE PLAN AND PAYMENT OF BENEFITS

The cost of the Plan is funded as follows:

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

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

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

PLAN IS NOT AN EMPLOYMENT CONTRACT

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

ASSIGNMENT OF BENEFITS

Any payment due for eligible services rendered by Preferred Providers will be made directly to the provider unless the provider requests payment be made directly to the Covered Person.

Any payment due for eligible services rendered by Non-Preferred Providers will typically be made directly to the Covered Person; however, the Plan reserves the right to make payment of benefits directly to the Provider of service or to the Covered Person.

Any payment due for eligible services rendered by PPO Providers will be made directly to the provider unless the provider requests payment be made directly to the Covered Person.

Any payment due for eligible services rendered by Non-PPO Providers will typically be made directly to the Covered Person; however, the Plan reserves the right to make payment of benefits directly to the Provider of service or to the Covered Person.

CLERICAL ERROR

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

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

AMENDING AND TERMINATING THE PLAN

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

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

GENERAL PLAN INFORMATION

TYPE OF ADMINISTRATION

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

PLAN NAME

The University of Central Arkansas Medical Plan

TAX ID NUMBER: 71-6001828

PLAN EFFECTIVE DATE: January 1, 2023

PLAN YEAR ENDS: December 31

EMPLOYER INFORMATION

University of Central Arkansas
201 Donaghey Ave., 106 Wingo Hall
Conway, Arkansas 72035
501-450-5052

PLAN ADMINISTRATOR

University of Central Arkansas
201 Donaghey Ave., 106 Wingo Hall
Conway, Arkansas 72035
501-450-5052

AGENT FOR SERVICE OF LEGAL PROCESS

Agent for Service of Legal Process
201 Donaghey Ave., 106 Wingo Hall
Conway, Arkansas 72035

CLAIMS ADMINISTRATOR

BlueAdvantage Administrators of Arkansas
P.O. Box 1460
Little Rock, Arkansas 72203
1-800-370-5852

BY THIS AGREEMENT, The University of Central Arkansas Medical Plan is hereby adopted as shown.

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

By *Amy Whitehead*
University of Central Arkansas

Date *11-28-22*

Witness

Date

**PLAN SUMMARY
FOR**

UNIVERSITY CENTAL ARKANSAS

IMPORTANT NOTICES

IMPORTANT NOTICES

Women's Health and Cancer Rights Act Notice

Important information about benefits that may be available to women who have had or are going to have a mastectomy:

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, 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;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits are subject to the plan provisions, limitations and requirements, including annual deductible and coinsurance limitations, provided under the UCA group health plan.

If you would like more information about mastectomy-related benefits under the UCA Group Health plan, contact the UCA Office of Human Resources at 501-450-3181.

For additional information about WHCRA provisions, visit http://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/whcra_factsheet.html

Newborns' and Mothers' Health Protection Act Notice

Important information protecting mothers and their newborn children in regards to the length of the hospital stay following childbirth:

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

If you would like more information about the childbirth benefits provided under the UCA Group Health plan, contact the UCA Office of Human Resources at 501-450-3181.

For additional information about NMHPA provisions and how Self-funded non Federal governmental plans may opt-out of the NMHPA requirements, visit http://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/nmhp_a_factsheet.html.

Qualified Medical Child Support Orders (QMCSOs) Notice

A qualified medical child support order (QMCSO) is a judgment, decree or order issued by a court or appropriate state agency that requires a child to be covered for medical benefits. Generally, a QMCSO is issued as part of a paternity, divorce, or other child support settlement.

If the Plan receives a medical child support order for your child that instructs the Plan to cover the child, the Plan Administrator will review it to determine if it meets the requirements for a QMCSO. If it determines that it does, your child will be enrolled in the Plan as your Dependent, and the Plan will be required to pay Benefits as directed by the order.

You may obtain, without charge, a copy of the procedures governing QMCSOs from the Plan Administrator by contacting the UCA Office of Human Resources at 501-450-3181.

Note: A National Medical Support Notice will be recognized as a QMCSO if it meets the requirements of a QMCSO.

**PLAN SUMMARY
FOR**

**UNIVERSITY CENTAL ARKANSAS
IMPORTANT NOTICES**

IMPORTANT NOTICES

Women's Health and Cancer Rights Act Notice

Important information about benefits that may be available to women who have had or are going to have a mastectomy:

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, 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;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits are subject to the plan provisions, limitations and requirements, including annual deductible and coinsurance limitations, provided under the UCA group health plan.

If you would like more information about mastectomy-related benefits under the UCA Group Health plan, contact the UCA Office of Human Resources at 501-450-3181.

For additional information about WHCRA provisions, visit http://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/whcra_factsheet.html

Newborns' and Mothers' Health Protection Act Notice

Important information protecting mothers and their newborn children in regards to the length of the hospital stay following childbirth:

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

If you would like more information about the childbirth benefits provided under the UCA Group Health plan, contact the UCA Office of Human Resources at 501-450-3181.

For additional information about NMHPA provisions and how Self-funded non Federal governmental plans may opt-out of the NMHPA requirements, visit http://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/nmhp_a_factsheet.html.

Qualified Medical Child Support Orders (QMCSOs) Notice

A qualified medical child support order (QMCSO) is a judgment, decree or order issued by a court or appropriate state agency that requires a child to be covered for medical benefits. Generally, a QMCSO is issued as part of a paternity, divorce, or other child support settlement.

If the Plan receives a medical child support order for your child that instructs the Plan to cover the child, the Plan Administrator will review it to determine if it meets the requirements for a QMCSO. If it determines that it does, your child will be enrolled in the Plan as your Dependent, and the Plan will be required to pay Benefits as directed by the order.

You may obtain, without charge, a copy of the procedures governing QMCSOs from the Plan Administrator by contacting the UCA Office of Human Resources at 501-450-3181.

Note: A National Medical Support Notice will be recognized as a QMCSO if it meets the requirements of a QMCSO.