PLAN DOCUMENT AND
SUMMARY PLAN DESCRIPTION
FOR
ARKANSAS HIGHER EDUCATION CONSORTIUM
EMPLOYEE BENEFIT PLAN

Restated 07.01.2017

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INTRODUCTION

This document is a description of Arkansas Higher Education Consortium Employee Health Plan (also referred to as "the Plan", "us", "we," or "our"). No oral interpretations can change this Plan. The Plan described is designed to protect Covered Persons against certain health expenses.

Coverage under the Plan will take effect for an eligible Employee and designated Dependents when the Employee and such Dependents satisfy the Waiting Period and all the eligibility requirements of the Plan.

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, copayments, exclusions, limitations, definitions, eligibility and the like.

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, and 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.

No action at law or in equity shall be brought to recover under any section of this Plan until the appeal rights provided have been exercised and the Plan benefits requested in such appeals have been denied in whole or in part.

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 Covered Person 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 orders 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.

ERISA Information. Explains the Plan's structure and the Covered Persons' rights under the Plan.

Establishment of the Plan

THIS PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION ("Plan Document") made by Arkansas Higher Education Consortium Employee Health Plan, (the Company" or the "Plan Sponsor") as of Effective Date, hereby sets forth the provisions of the Arkansas Higher Education Consortium Employee Health Plan, (the "Plan").

Effective Date

The Plan Document is effective as of the date first set forth above, and each amendment is effective as of the date set forth therein, (the "Effective Date").

Adoption of the Plan Document .

The Plan Sponsor, as the settlor of the Plan, hereby adopts this Plan Document as the written description of the Plan. This Plan Document represents both the Plan Document and the Summary Plan Description, which is required by the Employee Retirement Income Security Act of 1974, 29 U.S.C. et seq. ("ERISA"). This Plan Document amends and replaces any prior statement of the health care coverage contained in the Plan or any predecessor to the Plan.

IN WITNESS WHEREOF, the Plan Sponsor has caused this Plan Document to be executed.

Arkansas Higher Education Consortium

By: DeEdra Steed

Name: DeEdra Steed

Date: November 15, 2017

Title: Chair

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: Arkansas Higher Education Consortium Employee Health Benefit Plan

PLAN STATUS: Non-Grandfathered

PLAN NUMBER: 501

TAX ID NUMBER: 71-6157730

PLAN EFFECTIVE DATE: July 1st

PLAN YEAR ENDS: June 30th

APPLICABLE LAW: ERISA

PLAN TYPE:

Medical
Prescription Drug

EMPLOYER INFORMATION

Arkansas Higher Education Consortium
P.O. Box 10
Melbourne, AR, 72556

PLAN ADMINISTRATOR

Arkansas Higher Education Consortium
P.O. Box 10
Melbourne, AR, 72556

NAMED FIDUCIARY

Arkansas Higher Education Consortium
P.O. Box 10
Melbourne, AR, 72556

AGENT FOR SERVICE OF LEGAL PROCESS

Arkansas Higher Education Consortium Board
Arkansas Higher Education Consortium
P.O. Box 10
Melbourne, AR, 72556

CLAIMS ADMINISTRATOR

QualChoice Health Plan Services, Inc.
12615 Chenal Parkway, Suite 300
Little Rock, Arkansas 72211
1-800-235-7111

The Plan shall take effect for each Participating Employer on the Effective Date, unless a different date is set forth above opposite such Participating Employer's name.

Legal Entity; Service of Process
The Plan is a legal entity. Legal notice may be filed with, and legal process served upon, the Plan Administrator.

Not a Contract
This Plan Document and any amendments constitute the terms and provisions of coverage under this Plan. The Plan Document shall not be deemed to constitute a contract of any type between the Company and any Covered Person or to be consideration for, or an inducement or condition of, the employment of any Employee. Nothing in this Plan Document shall be deemed to give any Employee the right to be retained in the service of the Company or to interfere with the right of the Company to discharge any Employee at any time; provided, however, that the foregoing shall not be deemed to modify the provisions of any collective bargaining agreements which may be entered into by the Company with the bargaining representatives of any Employees.

Mental Health Parity
Pursuant to the Mental Health Parity Act of 1996 (MHPA) and Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), collectively, the mental health parity provisions in Part 7 of ERISA, this Plan applies its terms uniformly and enforces parity between covered health care benefits and covered mental health and substance disorder benefits relating to financial cost sharing restrictions and treatment duration limitations. For further details, please contact the Plan Administrator.

Applicable Law
This is a self-funded benefit plan coming within the purview of the Employee Retirement Income Security Act of 1974 ("ERISA"). The Plan is funded with Employee and/or Employer contributions. As such, when applicable, Federal law and jurisdiction preempt State law and jurisdiction.

Discretionary Authority
The Plan Administrator shall have sole, full and final discretionary authority to interpret all Plan provisions, including the right to remedy possible ambiguities, inconsistencies and/or omissions in the Plan and related documents; to make determinations in regards to issues relating to eligibility for benefits; to decide disputes that may arise relative to a Covered Persons' rights; and to determine all questions of fact and law arising under the Plan.

SCHEDULE OF BENEFITS

Verification of Eligibility 1-800-235-7111

Call this number to verify eligibility for Plan benefits **before** the charge is incurred.

MEDICAL BENEFITS

All benefits described in this Schedule are subject to the exclusions and limitations described more fully herein including, but not limited to, the Plan Administrator's determination that: care and treatment is Medically Necessary; that charges are Usual and Reasonable; that services, supplies and care are not Experimental and/or Investigational. The meanings of these capitalized terms are in the Defined Terms section of this document.

Only a general description of health benefits covered by this Plan is included in this document. A more detailed schedule of coverage is available to any Plan Participant, at no cost, who requests one from the Plan Administrator.

Pre-Authorization of Services

Pre-authorization is a determination made prior to services or supplies being provided of whether the services or supplies are Medical Necessity. The Plan must receive sufficient clinical information to establish Medical Necessity. The Medical Necessity for an Out-of-Network Referral will include the absence of or the exhaustion of all In-Network resources. Pre-authorizations are all time-limited.

The Plan requires that certain Covered Services must be pre-authorized. The specific procedures requiring pre-authorization can change based upon new or changing medical technology. We reserve the right to modify the official listing of services requiring pre-authorization as deemed necessary. A listing of the services requiring pre-authorization is maintained on QualChoice's web site at www.qualchoice.com on the Member Home Page. You may also contact our Customer Service Department to obtain a copy of the listing.

The attending Physician does not have to obtain precertification 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.

This Plan has entered into an agreement with certain Hospitals, Physicians and other health care providers, which are called Network Providers. Because these 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.

If the Plan generally requires or allows the designation of a primary care provider, a Covered Person has the right to designate any primary care provider who is a Network Provider and who is available to accept the Covered Person. For children, a Covered Person may designate a pediatrician as the primary care provider if the pediatrician is a Network Provider and is available to accept the child as a patient.

Therefore, when a Covered Person uses a Network Provider, that Covered Person will receive better benefits from the Plan than when a Non-Network Provider is used. It is the Covered Person's choice as to which Provider to use.

Under the following circumstances, the higher In-Network payment will be made for certain Non-Network services:

If a Covered Person has no choice of Network Providers in the specialty that the Covered Person is seeking within the service area.*

If a Covered Person is out of the service area and has a Medical Emergency requiring immediate care.

If a Covered Person receives Physician or anesthesia services by a Non-Network Provider at an In-Network facility.

If a Covered Person is referred to a Non-Network Provider by an In-Network Provider.*

*These services require pre-authorization.

Additional information about this option, including any rules that apply to designation of a primary care provider, as well as a list of Network Providers, will be given to Covered Persons, at no cost, and updated as needed. This list will include providers who specialize in obstetrics or gynecology.

Deductibles/Copayments payable by Covered Persons

Deductibles/Copayments are dollar amounts that the Covered Person must pay before the Plan pays.

A deductible is an amount of money that is paid once a Calendar Year per Covered Person. Typically, there is one deductible amount per Plan and it must be paid, if applicable, before any money is paid by the Plan for any Covered Charges. Each January 1st, a new deductible amount is required. Deductible for Out-of-Network charges do not accrue toward the 100% maximum out-of-pocket payment.

A copayment is the amount of money that is paid each time a particular service is used. Typically, there may be copayments on some services and other services will not have any copayments. Copayments for Out-of-Network charges do not accrue toward the 100% maximum out-of-pocket payment.

Claims Audit

In addition to the Plan's Medical Record Review process, the Plan Administrator may use its discretionary authority to utilize an independent bill review and/or claim audit program or service for a complete claim. While every claim may not be subject to a bill review or audit, the Plan Administrator has the sole discretionary authority for selection of claims subject to review or audit.

The analysis will be employed to identify charges billed in error and/or charges that are not Usual and Customary and/or Medically Necessary and Reasonable, if any, and may include a patient medical billing records review and/or audit of the patient's medical charts and records.

Upon completion of an analysis, a report will be submitted to the Plan Administrator or its agent to identify the charges deemed in excess of the Usual and Customary and Reasonable amounts or other applicable provisions, as outlined in this Plan Document.

Despite the existence of any agreement to the contrary, the Plan Administrator has the discretionary authority to reduce any charge to a Usual and Customary and Reasonable charge, in accord with the terms of this Plan Document.

ARKANSAS HIGHER EDUCATION CONSORTIUM BENEFITS TRUST
SCHEDULE OF BENEFITS - BASIC

For both In-Network and Out-of-Network Benefits, some services may require pre-authorization by QualChoice. For details and to access the most current listing of services requiring pre-authorization, visit www.qualchoice.com.

All benefit payments are subject to the Maximum Allowable Charge. Use of an Out-of-Network provider may result in you being balanced billed and having higher out-of-pocket costs. Amounts in excess of the Maximum Allowable Charge do not count toward Deductible or Coinsurance limits.

Note: Calendar Year maximums listed are combined between In-Network and Out-of-Network. For example, if "30 Visits per Calendar Year" are listed under both In-Network and Out-of-Network Providers, you are only allowed a combined maximum of 30 visits.

Note: There are two (2) separate deductible and out-of-pocket maximums that must be met for In-Network and Out-of-Network providers. Once two (2) family members have met their deductible and out-of-pocket maximums, then they will be considered satisfied for the remaining family members on the plan for that calendar year.

BENEFITS	IN-NETWORK PROVIDERS YOU PAY	OUT-OF-NETWORK PROVIDERS YOU PAY
ESSENTIAL HEALTH BENEFITS	Unlimited	
DEDUCTIBLE, PER CALENDAR YEAR		
Per Covered Person	$3,500	$7,000
Per Family Unit	$7,000	$14,000
Coinsurance	20%	40%
MAXIMUM OUT-OF-POCKET, PER CALENDAR YEAR		
Per Covered Person	$7,100	No Limit
Per Family Unit	$14,200	No Limit
The following charges apply towards the maximum out-of-pocket. Once this amount is reached, the Plan will pay 100% of the remainder of Covered Charges for the rest of the Calendar Year unless stated otherwise: • Deductible(s) • Coinsurance • Medical and Pharmacy Copayments The following charges ***do not apply*** to the maximum out-of-pocket amount: • Amounts over the Maximum Allowable Payment • Out of Network Services • Manufacturing Assistance Programs for Prescription Drugs		
COVERED CHARGES *Refer to the QualChoice medical policies for specific procedures covered under each category. These policies can be viewed online at www.qualchoice.com.*		
Inpatient Services	$200 Copayment + 20% after deductible	$200 Copayment + 40% after deductible
Outpatient Surgery/Ambulatory Surgical Center	$100 Copayment + 20% after deductible	$100 Copayment + 40% after deductible
Emergency Room Services	$200 Copayment + 20% after deductible	
Urgent Care Services	$70 Copayment	40% after deductible
Ambulance Service Per Trip Maximum: $5,000 for Ground Ambulance and $10,000 for Air Ambulance	20%; deductible waived	
Skilled Nursing/Rehabilitation Facility 60 days Calendar Year Maximum	20% after deductible	40% after deductible

COVERED CHARGES	IN-NETWORK PROVIDERS YOU PAY	OUT-OF-NETWORK PROVIDERS YOU PAY
Physician Services		
Inpatient visits	20% after deductible	40% after deductible
Primary Care Physician Office Visits (PCP) Evaluation & Management	$35 Copayment	40% after deductible
Specialists Office Visits (SCP) Evaluation & Management	$70 Copayment	40% after deductible
Routine Procedures such as Routine X-rays & Lab in a physician's office	0% after Copayment	40% after deductible
Complex Procedures such as Minor Surgeries and Specialized Lab performed in a physician's office	20% after Copayment	40% after deductible
Advanced Diagnostic services, such as advanced imaging (CT, MRI, PET, MRA), Nuclear Medicine, Pharmaceutical Products, Scopic Procedures; Therapeutic Treatments and Genetic Testing. As well as advanced surgical services performed in a physician's office.	20% after deductible	40% after deductible
Preventative Care Services		
Preventive health benefits are intended for the early detection of diseases by screening for their presence in an individual who has neither symptoms nor findings suggestive of those diseases. Some tests are not covered as part of the preventive health screening benefit because they are not recommended by the United States Preventive Services Task Force (USPSTF) or approved medical polices. Those services that will be considered to be a preventive health service are subject to change at any time in order to align with and be consistent with the USPSTF guidelines and medical policies.		
Routine Well Baby Care & Immunizations	No Cost to You	Not Covered
Routine Well Child/Adult Care & Immunizations	No Cost to You	Not Covered
Routine vision exam (limit 1 every 24 months)	No Cost to You	Not Covered
Maternity Services		
Physician Services Initial Office Visit	$35 Copayment	40% after deductible
All other Services	20% after deductible	40% after deductible
Facility Services	$200 Copayment + 20% after deductible	$200 Copayment + 40% after deductible
Allergy Services		
Office Visit	$70 Copayment	40% after deductible
Allergy Testing & Serums	20% after Copayment	40% after deductible
Allergy Shots	No Cost to You	40% after deductible
Home Health Care 100 days per Calendar Year Maximum	20% after deductible	40% after deductible
Hospice Care 6 months per Calendar Year Maximum	20% after deductible	40% after deductible
Therapy Services Limited to 30 visits per Calendar Year for all therapies combined		
Occupational Therapy Physical Therapy Speech & Audiology Spinal Manipulation/Chiropractic	$70 Copayment	40% after deductible
Durable Medical Equipment	20% after deductible	40% after deductible

COVERED CHARGES	IN-NETWORK PROVIDERS YOU PAY	OUT-OF-NETWORK PROVIDERS YOU PAY
Mental Disorders/Substance Abuse		
Inpatient Hospital Services	$200 Copayment + 20% after deductible	$200 Copayment + 40% after deductible
Professional Services (Office/Outpatient Visits)	$35 Copayment	40% after deductible
Professional Services (Inpatient/Outpatient Facility)	20% after deductible	40% after deductible
Prosthetic and Orthotic Services and Devices	20% after deductible	40% after deductible
Organ Transplants Lifetime maximum of 2 transplants	$200 Copayment + 20% after deductible	$200 Copayment + 40% after deductible
Temporomandibular Joint Disorders (TMJ)	20% after deductible	40% after deductible
Hearing Aid Device Covered up to $1,400 per ear, once every 3 years	No Cost to You	
Hearing Exam Covered once every 3 years	No Cost to You	
Infertility Coverage		
Infertility Diagnostic Services Only	20% after deductible	Not Covered
Infertility Treatment	Not Covered	Not Covered
Supplemental Accident Benefit - Payable at 100% for first $500 of covered charges. Injury/Accident Expense Benefits are paid at 100% for Covered Services incurred as a results of an injury. The Covered Services must be incurred within 60 days of the injury. Covered Services that exceed the Injury/Accident Maximum will be subject to deductible and coinsurance.		
Bariatric Services Lifetime Maximum of $10,000	20% after deductible	40% after deductible

PRESCRIPTION DRUG BENEFITS	30 Day Supply Retail (You Pay)	90 Day Supply Retail or Mail Order (You Pay)
▪ Tier 1 – Generic ▪ Tier 2 – Preferred ▪ Tier 3 – Nonpreferred ▪ Specialty Pharmacy – Brand ▪ Specialty Pharmacy – Generic	$15 Copayment $55 Copayment $75 Copayment 50% Coinsurance $200 Copayment	$30 Copayment $110 Copayment $150 Copayment Not Covered Not Covered
If dispensed in your physician's office or at a facility see your medical benefits.		

Limitations

- All new prescriptions are limited to a 30 day supply.
- Refills are limited to a 90 day supply at certain contracted pharmacies and through retail or mail order.

Step Therapy

Certain medications may be required to be used before another medication is covered. Step Therpay is the process of beginning drug therapy for a medical condition with the most cost-effective and safest drug therapy, and progessing to other and more costly therpay if the first line medication fails.

Examples of step therapy drugs under this plan include anti-hypertensive and Attention Deficit Disorder (ADD) medications. Contact Customer Service at 1-800-235-7111 for more details.

Benefit Details

- Benefits are subject to all benefit terms, conditions, limitation and exclusions.
- Benefits are provided for formulary prescription drugs when prescribed by a physician or by a licensed healthcare provider within the scope of their license.
- Benefits are available through a network pharmacy, a network mail order pharmacy or an out of network pharmacy, provided that the drug is a Covered Prescription Drug.

For information about specific medications, visit our website at www.qualchoice.com. Some medications may require pre-authorization by QualChoice. For details and to access the most current listing of services requiring pre-authorization, visit www.qualchoice.com.

ARKANSAS HIGHER EDUCATION CONSORTIUM BENEFITS TRUST
SCHEDULE OF BENEFITS - CORE

For both In-Network and Out-of-Network Benefits, some services may require pre-authorization by QualChoice. For details and to access the most current listing of services requiring pre-authorization, visit www.qualchoice.com.

All benefit payments are subject to the Maximum Allowable Charge. Use of an Out-of-Network provider may result in you being balanced billed and having higher out-of-pocket costs. Amounts in excess of the Maximum Allowable Charge do not count toward Deductible or Coinsurance limits.

Note: Calendar Year maximums listed are combined between In-Network and Out-of-Network. For example, if "30 Visits per Calendar Year" are listed under both In-Network and Out-of-Network Providers, you are only allowed a combined maximum of 30 visits.

Note: There are two (2) separate deductible and out-of-pocket maximums that must be met for In-Network and Out-of-Network providers. Once two (2) family members have met their deductible and out-of-pocket maximums, then they will be considered satisfied for the remaining family members on the plan for that calendar year.

BENEFITS	**IN-NETWORK PROVIDERS YOU PAY**	**OUT-OF-NETWORK PROVIDERS YOU PAY**
ESSENTIAL HEALTH BENEFITS	Unlimited	
DEDUCTIBLE, PER CALENDAR YEAR		
Per Covered Person	$2,500	$5,000
Per Family Unit	$5,000	$10,000
Coinsurance	20%	40%
MAXIMUM OUT-OF-POCKET, PER CALENDAR YEAR		
Per Covered Person	$7,100	No Limit
Per Family Unit	$14,200	No Limit
The following charges apply towards the maximum out-of-pocket. Once this amount is reached, the Plan will pay 100% of the remainder of Covered Charges for the rest of the Calendar Year unless stated otherwise: • Deductible(s) • Coinsurance • Medical and Pharmacy Copayments The following charges ***do not apply*** to the maximum out-of-pocket amount: • Amounts over the Maximum Allowable Payment • Out of Network Services • Manufacturing Assistance Programs for Prescription Drugs		
COVERED CHARGES *Refer to the QualChoice medical policies for specific procedures covered under each category. These policies can be viewed online at www.qualchoice.com.*		
Inpatient Services	$200 Copayment + 20% after deductible	$200 Copayment + 40% after deductible
Outpatient Surgery/Ambulatory Surgical Center	$100 Copayment + 20% after deductible	$100 Copayment + 40% after deductible
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Urgent Care Services	$60 Copayment	40% after deductible
Ambulance Service Per Trip Maximum: $5,000 for Ground Ambulance and $10,000 for Air Ambulance	20%; deductible waived	
Skilled Nursing/Rehabilitation Facility 60 days Calendar Year Maximum	20% after deductible	40% after deductible

COVERED CHARGES	IN-NETWORK PROVIDERS YOU PAY	OUT-OF-NETWORK PROVIDERS YOU PAY
Physician Services		
Inpatient visits	20% after deductible	40% after deductible
Primary Care Physician Office Visits (PCP) Evaluation & Management	$30 Copayment	40% after deductible
Specialists Office Visits (SCP) Evaluation & Management	$60 Copayment	40% after deductible
Routine Procedures such as Routine X-rays & Lab in a physician's office	0% after Copayment	40% after deductible
Complex Procedures such as Minor Surgeries and Specialized Lab performed in a physician's office	20% after Copayment	40% after deductible
Advanced Diagnostic services, such as advanced imaging (CT, MRI, PET, MRA), Nuclear Medicine, Pharmaceutical Products, Scopic Procedures; Therapeutic Treatments and Genetic Testing. As well as advanced surgical services performed in a physician's office.	20% after deductible	40% after deductible
Preventative Care Services		
Preventive health benefits are intended for the early detection of diseases by screening for their presence in an individual who has neither symptoms nor findings suggestive of those diseases. Some tests are not covered as part of the preventive health screening benefit because they are not recommended by the United States Preventive Services Task Force (USPSTF) or approved medical polices. Those services that will be considered to be a preventive health service are subject to change at any time in order to align with and be consistent with the USPSTF guidelines and medical policies.		
Routine Well Baby Care & Immunizations	No Cost to You	Not Covered
Routine Well Child/Adult Care & Immunizations	No Cost to You	Not Covered
Routine vision exam (limit 1 every 24 months)	No Cost to You	Not Covered
Maternity Services		
Physician Services Initial Office Visit	$30 Copayment	40% after deductible
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Facility Services	$200 Copayment + 20% after deductible	$200 Copayment + 40% after deductible
Allergy Services		
Office Visit	$60 Copayment	40% after deductible
Allergy Testing & Serums	20% after Copayment	40% after deductible
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Durable Medical Equipment	20% after deductible	40% after deductible

COVERED CHARGES	IN-NETWORK PROVIDERS YOU PAY	OUT-OF-NETWORK PROVIDERS YOU PAY
Mental Disorders/Substance Abuse		
Inpatient Hospital Services	$200 Copayment + 20% after deductible	$200 Copayment + 40% after deductible
Professional Services (Office/Outpatient Visits)	$30 Copayment	40% after deductible
Professional Services (Inpatient/Outpatient Facility)	20% after deductible	40% after deductible
Prosthetic and Orthotic Services and Devices	20% after deductible	40% after deductible
Organ Transplants Lifetime maximum of 2 transplants	$200 Copayment + 20% after deductible	$200 Copayment + 40% after deductible
Temporomandibular Joint Disorders (TMJ)	20% after deductible	40% after deductible
Hearing Aid Device Covered up to $1,400 per ear, once every 3 years	No Cost to You	
Hearing Exam Covered once every 3 years	No Cost to You	
Infertility Coverage		
Infertility Diagnostic Services Only	20% after deductible	Not Covered
Infertility Treatment	Not Covered	Not Covered
Supplemental Accident Benefit - Payable at 100% for first $500 of covered charges. Injury/Accident Expense Benefits are paid at 100% for Covered Services incurred as a results of an injury. The Covered Services must be incurred within 60 days of the injury. Covered Services that exceed the Injury/Accident Maximum will be subject to deductible and coinsurance.		
Bariatric Services Lifetime Maximum of $10,000	20% after deductible	40% after deductible

PRESCRIPTION DRUG BENEFITS	30 Day Supply Retail (You Pay)	90 Day Supply Retail or Mail Order (You Pay)
▪ Tier 1 – Generic ▪ Tier 2 – Preferred ▪ Tier 3 – Nonpreferred ▪ Specialty Pharmacy – Brand ▪ Specialty Pharmacy – Generic	$15 Copayment $55 Copayment $75 Copayment 50% Coinsurance $200 Copayment	$30 Copayment $110 Copayment $150 Copayment Not Covered Not Covered
If dispensed in your physician's office or at a facility see your medical benefits.		

Limitations

- All new prescriptions are limited to a 30 day supply.
- Refills are limited to a 90 day supply at certain contracted pharmacies and through retail or mail order.

Step Therapy

Certain medications may be required to be used before another medication is covered. Step Therpay is the process of beginning drug therapy for a medical condition with the most cost-effective and safest drug therapy, and progessing to other and more costly therpay if the first line medication fails.

Examples of step therapy drugs under this plan include anti-hypertensive and Attention Deficit Disorder (ADD) medications. Contact Customer Service at 1-800-235-7111 for more details.

Benefit Details

- Benefits are subject to all benefit terms, conditions, limitation and exclusions.
- Benefits are provided for formulary prescription drugs when prescribed by a physician or by a licensed healthcare provider within the scope of their license.
- Benefits are available through a network pharmacy, a network mail order pharmacy or an out of network pharmacy, provided that the drug is a Covered Prescription Drug.

For information about specific medications, visit our website at www.qualchoice.com. Some medications may require pre-authorization by QualChoice. For details and to access the most current listing of services requiring pre-authorization, visit www.qualchoice.com.

ARKANSAS HIGHER EDUCATION CONSORTIUM BENEFITS TRUST
SCHEDULE OF BENEFITS - ENHANCED

For both In-Network and Out-of-Network Benefits, some services may require pre-authorization by QualChoice. For details and to access the most current listing of services requiring pre-authorization, visit www.qualchoice.com.

All benefit payments are subject to the Maximum Allowable Charge. Use of an Out-of-Network provider may result in you being balanced billed and having higher out-of-pocket costs. Amounts in excess of the Maximum Allowable Charge do not count toward Deductible or Coinsurance limits.

Note: Calendar Year maximums listed are combined between In-Network and Out-of-Network. For example, if "30 Visits per Calendar Year" are listed under both In-Network and Out-of-Network Providers, you are only allowed a combined maximum of 30 visits.

Note: There are two (2) separate deductible and out-of-pocket maximums that must be met for In-Network and Out-of-Network providers. Once two (2) family members have met their deductible and out-of-pocket maximums, then they will be considered satisfied for the remaining family members on the plan for that calendar year.

BENEFITS	**IN-NETWORK PROVIDERS YOU PAY**	**OUT-OF-NETWORK PROVIDERS YOU PAY**
ESSENTIAL HEALTH BENEFITS	Unlimited	
DEDUCTIBLE, PER CALENDAR YEAR		
Per Covered Person	$1,500	$3,000
Per Family Unit	$3,000	$6,000
Coinsurance	20%	40%
MAXIMUM OUT-OF-POCKET, PER CALENDAR YEAR		
Per Covered Person	$5,500	No Limit
Per Family Unit	$11,000	No Limit
The following charges apply towards the maximum out-of-pocket. Once this amount is reached, the Plan will pay 100% of the remainder of Covered Charges for the rest of the Calendar Year unless stated otherwise: • Deductible(s) • Coinsurance • Medical and Pharmacy Copayments The following charges ***do not apply*** to the maximum out-of-pocket amount: • Amounts over the Maximum Allowable Payment • Out of Network Services • Manufacturing Assistance Programs for Prescription Drugs		
COVERED CHARGES *Refer to the QualChoice medical policies for specific procedures covered under each category. These policies can be viewed online at www.qualchoice.com.*		
Inpatient Services	$200 Copayment + 20% after deductible	$200 Copayment + 40% after deductible
Outpatient Surgery/Ambulatory Surgical Center	$100 Copayment + 20% after deductible	$100 Copayment + 40% after deductible
Emergency Room Services	$100 Copayment + 20% after deductible	
Urgent Care Services	$50 Copayment	40% after deductible
Ambulance Service Per Trip Maximum: $5,000 for Ground Ambulance and $10,000 for Air Ambulance	20%; deductible waived	
Skilled Nursing/Rehabilitation Facility 60 days Calendar Year Maximum	20% after deductible	40% after deductible

COVERED CHARGES	IN-NETWORK PROVIDERS YOU PAY	OUT-OF-NETWORK PROVIDERS YOU PAY
Physician Services		
Inpatient visits	20% after deductible	40% after deductible
Primary Care Physician Office Visits (PCP) Evaluation & Management	$25 Copayment	40% after deductible
Specialists Office Visits (SCP) Evaluation & Management	$50 Copayment	40% after deductible
Routine Procedures such as Routine X-rays & Lab in a physician's office	0% after Copayment	40% after deductible
Complex Procedures such as Minor Surgeries and Specialized Lab performed in a physician's office	20% after Copayment	40% after deductible
Advanced Diagnostic services, such as advanced imaging (CT, MRI, PET, MRA), Nuclear Medicine, Pharmaceutical Products, Scopic Procedures; Therapeutic Treatments and Genetic Testing. As well as advanced surgical services performed in a physician's office.	20% after deductible	40% after deductible
Preventative Care Services		
Preventive health benefits are intended for the early detection of diseases by screening for their presence in an individual who has neither symptoms nor findings suggestive of those diseases. Some tests are not covered as part of the preventive health screening benefit because they are not recommended by the United States Preventive Services Task Force (USPSTF) or approved medical polices. Those services that will be considered to be a preventive health service are subject to change at any time in order to align with and be consistent with the USPSTF guidelines and medical policies.		
Routine Well Baby Care & Immunizations	No Cost to You	Not Covered
Routine Well Child/Adult Care & Immunizations	No Cost to You	Not Covered
Routine vision exam (limit 1 every 24 months)	No Cost to You	Not Covered
Maternity Services		
Physician Services Initial Office Visit	$25 Copayment	40% after deductible
All other Services	20% after deductible	40% after deductible
Facility Services	$200 Copayment + 20% after deductible	$200 Copayment + 40% after deductible
Allergy Services		
Office Visit	$50 Copayment	40% after deductible
Allergy Testing & Serums	20% after Copayment	40% after deductible
Allergy Shots	No Cost to You	40% after deductible
Home Health Care 100 days per Calendar Year Maximum	20% after deductible	40% after deductible
Hospice Care 6 months per Calendar Year Maximum	20% after deductible	40% after deductible
Therapy Services Limited to 30 visits per Calendar Year for all therapies combined		
Occupational Therapy Physical Therapy Speech & Audiology Spinal Manipulation/Chiropractic	$50 Copayment	40% after deductible
Durable Medical Equipment	20% after deductible	40% after deductible

COVERED CHARGES	IN-NETWORK PROVIDERS YOU PAY	OUT-OF-NETWORK PROVIDERS YOU PAY
Mental Disorders/Substance Abuse		
Inpatient Hospital Services	$200 Copayment + 20% after deductible	$200 Copayment + 40% after deductible
Professional Services (Office/Outpatient Visits)	$25 Copayment	40% after deductible
Professional Services (Inpatient/Outpatient Facility)	20% after deductible	40% after deductible
Prosthetic and Orthotic Services and Devices	20% after deductible	40% after deductible
Organ Transplants Lifetime maximum of 2 transplants	$200 Copayment + 20% after deductible	$200 Copayment + 40% after deductible
Temporomandibular Joint Disorders (TMJ)	20% after deductible	40% after deductible
Hearing Aid Device Covered up to $1,400 per ear, once every 3 years	No Cost to You	
Hearing Exam Covered once every 3 years	No Cost to You	
Infertility Coverage		
Infertility Diagnostic Services Only	20% after deductible	Not Covered
Infertility Treatment	Not Covered	Not Covered
Supplemental Accident Benefit - Payable at 100% for first $500 of covered charges. Injury/Accident Expense Benefits are paid at 100% for Covered Services incurred as a results of an injury. The Covered Services must be incurred within 60 days of the injury. Covered Services that exceed the Injury/Accident Maximum will be subject to deductible and coinsurance.		
Bariatric Services Lifetime Maximum of $10,000	20% after deductible	40% after deductible

PRESCRIPTION DRUG BENEFITS	30 Day Supply Retail (You Pay)	90 Day Supply Retail or Mail Order (You Pay)
▪ Tier 1 – Generic ▪ Tier 2 – Preferred ▪ Tier 3 – Nonpreferred ▪ Specialty Pharmacy – Brand ▪ Specialty Pharmacy – Generic	$15 Copayment $45 Copayment $60 Copayment 50% Coinsurance $200 Copayment	$30 Copayment $90 Copayment $120 Copayment Not Covered Not Covered
If dispensed in your physician's office or at a facility see your medical benefits.		

Limitations

- All new prescriptions are limited to a 30 day supply.
- Refills are limited to a 90 day supply at certain contracted pharmacies and through retail or mail order.

Step Therapy

Certain medications may be required to be used before another medication is covered. Step Therpay is the process of beginning drug therapy for a medical condition with the most cost-effective and safest drug therapy, and progessing to other and more costly therpay if the first line medication fails.

Examples of step therapy drugs under this plan include anti-hypertensive and Attention Deficit Disorder (ADD) medications. Contact Customer Service at 1-800-235-7111 for more details.

Benefit Details

- Benefits are subject to all benefit terms, conditions, limitation and exclusions.
- Benefits are provided for formulary prescription drugs when prescribed by a physician or by a licensed healthcare provider within the scope of their license.
- Benefits are available through a network pharmacy, a network mail order pharmacy or an out of network pharmacy, provided that the drug is a Covered Prescription Drug.

For information about specific medications, visit our website at www.qualchoice.com. Some medications may require pre-authorization by QualChoice. For details and to access the most current listing of services requiring pre-authorization, visit www.qualchoice.com.

ELIGIBILITY, FUNDING, EFFECTIVE DATE AND TERMINATION PROVISIONS

A Covered Person 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 Employees of the Employer.

Eligibility Requirements for Employee Coverage. A person is eligible for Employee coverage from the first day that he or she:

1. Is an Employee who is employed by the Employer on a full-time basis and regularly scheduled to work at least 30 hours per week (i.e. Non-variable Hour Employee) or a Variable Hour Employee who has averaged at least 30 hours per week for a complete Measurement Period and is currently in a Stability Period, as determined by the Plan Sponsor. An Employee will remain eligible throughout the Stability Period regardless of a change in employment status (including, but not limited to, a reduction in hours) provided the individual continues to be an employee in accordance with the Patient Protection and Affordable Care Act (as amended).

Measurement Period - a period of time selected by the Employer during which Variable Hour Employee's and/or Ongoing Employee's hours of service are tracked to determine your employment status for benefit purposes.

Initial Measurement Period - for a newly hired Variable Hour Employee, this Measurement Period will start from the date of hire and ends after 12 months consecutive months of service.

Standard Measurement Period - for Ongoing Employees, this Measurement Period will start on January 1st each year and will last for 12 months consecutive months.

2. Is in a class eligible for coverage.

3. Is a Part-Time, Active Employee of the Employer. See the applicable institution's guidelines regarding the definition of a Part-Time employee. Part-Time Employees that elect coverage prior to full time status will be given credit from part-time effective date. Part-Time eligibility qualifies under the applicable institution's guidelines

4. Is a Retired Employee of the institution and meets the institution’s eligibility for coverage.

5. Completes the employment Waiting Period as an Active Employee.

A "Waiting Period" is the time between the first day of employment as an eligible Employee and the first day of coverage under the Plan.

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 recognized as the covered Employee's husband or wife under the laws of the state where the covered Employee lives or was married, and shall not include common law marriages. The term "Spouse" shall include partners of the same sex who were legally married under the laws of the State in which they were married. 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, foster child, 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 the Employee or Spouse intends to adopt, whether or not the adoption has become final, who has not attained the age of 18 as of the date of such placement for adoption. The term "placed" means the assumption and retention by such Employee or Spouse 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 "children" shall include children for whom the Employee is a Legal Guardian who reside in the Employee's household.

To be eligible for Dependent coverage under the Plan, a Qualified Dependent must be under the limiting age of 26 years. When a Qualified Dependent reaches the applicable limiting age, coverage will end.

Any Child of a Covered Person who is an alternate recipient under a qualified medical child support order shall be considered as having a right to Dependent coverage under this Plan.

A participant of this Plan may obtain, without charge, a copy of the procedures governing qualified medical child support order (QMCSO) determinations from the Plan Administrator.

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 who reaches the limiting age and is Totally Disabled, incapable of self-sustaining employment by reason of mental or physical handicap, primarily dependent upon the covered Employee for support and maintenance and unmarried. The Plan Administrator may require, at reasonable intervals during the two years following the Dependent reaching the limiting age, subsequent proof of the child’s Total Disability and dependency.

After such two-year period, the Plan Administrator may require subsequent proof not more than once each year. 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 home, but who are not eligible as defined; the legally separated or divorced former Spouse of the Employee; 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.

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 mother and father are Employees, their children will be covered as Dependents of the mother or father, 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. Arkansas Higher Education Consortium 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 filled out, signed and returned with the enrollment application.

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.

The Claims Administrator provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

ENROLLMENT

Enrollment Requirements. An Employee must enroll for coverage by filling out and signing an enrollment application along with the appropriate payroll deduction authorization. The covered Employee is required to enroll for Dependent coverage also.

Enrollment Requirements for Newborn Children.

A newborn child of a covered Employee who has Dependent coverage is not automatically enrolled in this Plan. Charges for covered nursery care will be applied toward the Plan of the newborn child. If the newborn child is required to be enrolled and is not enrolled in this Plan on a timely basis, as defined in the section "Timely Enrollment" following this section, there will be no payment from the Plan and the parents will be responsible for all costs.

Charges for covered routine Physician care will be applied toward the Plan of the newborn child. If the newborn child is required to be enrolled and is not enrolled in this Plan on a timely basis, there will be no payment from the Plan and the covered parent will be responsible for all costs.

If the child is required to be enrolled and is not enrolled within 31 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 becomes eligible for the coverage, either initially or under a Special Enrollment Period.

   If two Employees (husband and wife) 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 with no Waiting Period 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 Covered Persons and their Dependents who are not eligible to join the Plan during a Special Enrollment Period may join only during open enrollment.

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 Covered Person.

The time between the dates a Late Covered Person first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a Waiting Period.

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 31 days after the birth, marriage, 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.

SPECIAL ENROLLMENT PERIODS

The Enrollment Date for anyone who enrolls under a Special Enrollment Period is the first date of coverage. Thus, the time between the date a special Covered Person first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a Waiting Period.

1. **Individuals losing other coverage creating a Special Enrollment right.** An Employee or Dependent, who is eligible, but not enrolled in this Plan, may enroll if 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. The coverage of the Employee or Dependent who had lost the coverage was under COBRA and the COBRA coverage was exhausted, or was not under COBRA and either 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 31 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 (i.e.: 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. **Dependent beneficiaries.** If:

a. The Employee is a participant under this Plan (or has met the Waiting Period applicable to becoming a participant under this Plan and 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 (and if not otherwise enrolled, the Employee) may be enrolled under this Plan. 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. 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.

The Dependent Special Enrollment Period is a period of 31 days and begins on 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 during this 31-day period.

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

a. in the case of marriage, the first day of the first month beginning after the date of the completed request for enrollment is received;

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. **Medicaid and State Child Health Insurance Programs.** 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

Effective Date of Employee Coverage. An Employee will be covered under this Plan as of the first day that the Employee satisfies all of the following:

1. The Eligibility Requirement.

2. The Active Employee Requirement.

3. The Enrollment Requirements of the Plan.

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 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 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 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 ceases to be in one of the Eligible Classes or the Eligible Class is eliminated. 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.

3. 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.

4. If an Employee commits fraud or makes an intentional misrepresentation of material fact in applying for or obtaining coverage, or obtaining benefits under the Plan, 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.

If a Covered Person is hospitalized on the date of termination, the Plan will cover 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 date of termination.

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 of 1993 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. If coverage terminates and employment resumes within 13 continuous weeks, coverage will be reinstated on the day of the return to work.

For an approved Leave of Absence, an Employee will remain eligible for coverage under the Plan as long as the Employee is otherwise eligible (and enrolled) under the Plan. Note that for an approved Leave of Absence, an Employee will be treated as on Ongoing Employee, even if the Employee's absence was longer than 13 continuous weeks.

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 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 your individual institution. 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 dependency status. (See the section entitled Continuation Coverage Rights under COBRA.)

4. On the first date that a person ceases to be a Dependent, except for Dependent Children, as defined by the Plan. (See the section entitled Continuation Coverage Rights under COBRA.)

5. The last day of the month that a Child ceases to be a Dependent, as defined by the Plan.

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, 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, the Plan will provide at least 30 days' advance written notice of such action.

Genetic Information Nondiscrimination Act ("GINA")

"GINA" prohibits group health plans, issuers of individual health care policies, and Employers from discriminating on the basis of genetic information.

The term "genetic information" means, with respect to any individual, information about:

1. Such individual's genetic tests;
2. The genetic tests of family members of such individual; and
3. The manifestation of a Disease or disorder in family members of such individual.

The term "genetic information" includes participating in clinical research involving genetic services. Genetic tests would include analysis of human DNA, RNA, chromosomes, proteins, or metabolite that detects genotypes, mutations, or chromosomal changes. Genetic information is a form of Protected Health Information (PHI) as defined by and in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and is subject to applicable Privacy and Security Standards.

Family members as it relates to GINA include Dependents, plus all relatives to the fourth degree, without regard to whether they are related by blood, marriage, or adoption. Underwriting as it relates to GINA includes any rules for determining eligibility, computing premiums or contributions. Offering reduced premiums or other rewards for providing genetic information would be impermissible underwriting.

GINA will not prohibit a health care Provider who is treating an individual from requesting that the patient undergo genetic testing. The rules permit the Plan to obtain genetic test results and use them to make claims payment determinations when it is necessary to do so to determine whether the treatment provided to the patient was medically advisable and/or necessary.

The Plan may request, but not require, genetic testing in certain very limited circumstances involving research, so long as the results are not used for underwriting, and then only with written notice to the individual that participation is voluntary and will not affect eligibility for benefits, premiums or contributions. In addition, the Plan will notify and describe its activity to the Health and Human Services secretary of its activities falling within this exception.

While the Plan may collect genetic information after initial enrollment, it may not do so in connection with any annual renewal process where the collection of information affects subsequent enrollment. The Plan will not adjust premiums or increase group contributions based upon genetic information, request or require genetic testing or collect genetic information either prior to or in connection with enrollment or for underwriting purposes.

OPEN ENROLLMENT

Every year there is an annual open enrollment period during which, Employees and their Dependents who are Late Covered Persons will be able to enroll in the Plan.

Benefit choices for Late Covered Persons made during the open enrollment period will become effective July 1st.

Covered Persons will receive detailed information regarding open enrollment from their Employer.

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.

DEDUCTIBLE

Deductible Amount. This is an amount of Covered Charges for which no benefits will be paid. Before benefits can be paid in a Calendar Year a Covered Person must meet the deductible shown in the Schedule of Benefits.

Deductible Three Month Carryover. Covered Charges incurred in, and applied toward the deductible in October, November and December will be applied toward the deductible in the next Calendar Year. This does not apply if you have a Qualified High Deductible benefit plan.

The Out-of-Network deductible will not accrue toward the 100% maximum out-of-pocket payment.

Family Unit Limit. When the maximum amount shown in the Schedule of Benefits has been incurred by members of a Family Unit toward their Calendar Year deductibles, the deductibles of all members of that Family Unit will be considered satisfied for that year.

BENEFIT PAYMENT

Each Calendar Year, benefits will be paid for the Covered Charges of a Covered Person that are in excess of the deductible and any copayments. 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.

MAXIMUM OUT-OF-POCKET

Covered Charges are payable at the percentages shown each Calendar Year until the out-of-pocket limit shown in the Schedule of Benefits is reached. Then, Covered Charges incurred by a Covered Person will be payable at 100% (except for the charges excluded) for the rest of the Calendar Year.

When a Family Unit reaches the out-of-pocket limit, Covered Charges for that Family Unit will be payable at 100% (except for the charges excluded) for the rest of the Calendar Year.

The maximum out of pocket includes your Deductible, Coinsurance and Copayments for Medical and Pharmacy charges.

MAXIMUM BENEFIT AMOUNT FOR NON-ESSENTIAL HEALTH BENEFITS

The Maximum Benefit Amount is shown in the Schedule of Benefits. It is the total amount of benefits that will be paid under the Plan for all Covered Charges incurred by a Covered Person for non-essential health benefits during the Plan Year. The Maximum Benefit for non-essential health benefits applies to all plans and benefit options offered under the benefit plan, including the ones described in this document.

COVERED CHARGES

Covered Charges are the Usual and Customary and Reasonable Charges that are incurred for the following items of service and supply. These charges are subject to the benefit limits, exclusions and other provisions of this Plan. A charge is incurred on the date that the service or supply is performed or furnished.

(1) **Advanced Diagnostic Imaging -** Advanced Diagnostic Imaging consists of the following studies (though other may be added as new studies are developed): Pre-Authorization is required

a. All imaging using Computerized Axial Tomography (CAT) technology;

b. All imaging using Magnetic Resonance Imaging (MRI) technology;

c. All imaging using Positron Emission Tomography (PET) technology;

d. All imaging using nuclear medicine techniques (in which a radioactive substance is administered to the patient to permit or enhance imaging, which is done at least in part with detection techniques to assess the locations at which the radioactive substance is concentrated in the body).

The following rules apply to these imaging procedures:
Regardless of where they are performed, they always fall under the required cost sharing amounts of your Plan as set forth in the Schedule of Benefits. Pre-authorization is required for these tests.

(2) **Ambulance Services -** The plan will cover licensed ambulance transportation subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this document. This benefit is subject to the cost sharing amounts and benefit limitations specified in the Schedule of Benefits and the following criteria:

a. When an accident or other medical Emergency occurs, we cover transport to the nearest hospital when Emergency services are required;
b. The Plan will cover ambulance transportation from one hospital to another for one of the reasons identified below:
   i. To access equipment or expertise necessary to care for you properly;
   ii. To receive a test or service which is not available at the hospital where you have been admitted and you return after the test or service is completed;
   iii. To transport you from an Out-of-Network Provider hospital to a Network Facility; and
   iv. To transport you directly from an acute care setting to an alternate level of care.

(3) **Anesthetic -** Covered charges of oxygen, blood and blood derivatives that are not donated or replaced; intravenous injections and solutions. Administration of these items is included.

(4) **Cardiac Rehabilitation -** As deemed medically necessary provided services are rendered (a) under the supervision of a Physician; (b) in connection with a myocardial infarction, coronary occlusion or coronary bypass surgery; (c) initiated within 12 weeks after other treatment for the medical condition ends; and (d) in a medical care facility as defined by this plan.

(5) **Chemotherapy -** and radiation and treatment with radioactive substances. The materials and services of technicians are included.

(6) **Contact Lenses -** the initial pair and/or glasses required following cataract surgery.

(7) **Dental - Accidental Injury -** The Plan will provide coverage if a Covered Person has an accidental injury that damages a sound, natural tooth. Treatment must be pre-authorized. Benefits are subject to a maximum limit per Covered Person per accident. See the Schedule of Benefits for the limitation. Dental services must be received from a Doctor of Dental Surgery ("D.D.S.") or a Doctor of Medical Dentistry ("D.M.D"). The damage

must be severe enough that initial contact with a physician or dentist occurred within forty-eight (48) hours of the accident.

The physician or dentist must certify that the injured tooth was:

A. A virgin or un-restored tooth; or

B. A tooth that has no decay, no filling on more than two (2) surfaces, no gum disease associated with any bone loss, or no root canal therapy, is not a dental implant and functions normally in chewing and speech.

Unless otherwise approved by QualChoice, dental services for final treatment to repair the damage must be started within thirty (30) days of the original accident date and completed within six (6) months of the original accident date.

If an Covered Person is under age fifteen (15), then reimbursement for dental care services provided after such six (6) month period will be provided if: (a) such reimbursement is requested within such six (6) month period; (b) the request for reimbursement is accompanied by a plan of treatment; (c) in the opinion of QualChoice, under standard dental practices the treatment could not have been provided within such six (6) month period; and, (d) coverage for the injured Covered Person is in force when the treatment is rendered.

Please note that dental damage that occurs as a result of normal activities of daily living or extraordinary use of the teeth is not considered an Accidental Injury. Benefits are not available for repairs to teeth that are injured as a result of such activities.

The following limitations for treatments also apply to repair of damaged teeth:

i. Only the sound and natural tooth or teeth avulsed or extracted as a direct result of the accidental injury will be considered for replacement;
ii. 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 upon a Maximum Allowable Payment per tooth;
iii. Double abutments are not covered;
iv. Any health intervention related to dental caries or tooth decay is not covered;
v. Removal of teeth is not covered; and
vi. Dental implants of titanium osseointegrated fixtures or fixtures of any other material are not covered.

(8) Dental Anesthesia - The plan will cover charges for anesthesia and facilities for dental procedures which would ordinarily be done under local anesthesia provided:

A. The procedure is performed in a Network Facility; and

B. The situation meets medical necessity criteria, and the patient is:

i. A child under 7 years of age who is determined by two network dentists to be unable to undergo the procedure without general anesthesia and who cannot wait until an older age for the procedure, when undergoing the procedure without general anesthesia would be possible;
ii. A person with a serious mental health condition that prevents use of local anesthesia for the procedure;
iii. A person with a serious physical condition making hospital care necessary for the safe performance of dental work; or
iv. A person with a significant behavioral problem (as certified by a Network Physician) which precludes safe performance of the dental work under local anesthesia.

All network requirements, Medical Necessity determinations, and such other limitations as are applied to other covered services will apply.

(9) **Dental- Oral Surgery-** Oral surgery dental care is covered for treatment of the following diseases of the mouth, but not of the teeth or supporting structure of the teeth:

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 Accidental Injury to jaws, cheeks, lips, tongue, roof and Accidental Injury; treatment of such injury will not be covered.
C. Excision of exostosis of jaws and hard palate;
D. Extraction of teeth is required as a direct result of radiation or chemotherapy;
E. Frenectomy;
F. External incision and drainage of abscess;
G. Incision of accessory sinuses, salivary glands or ducts;
H. Certain dental services, as reflected in the Medical Policies, performed in conjunction with Medically Necessary reconstructive surgery; and
I. Dental services integral to medical services covered by the Plan.

The covered person or the dentist may request a pre-determination of benefits prior to seeking services to determine if the plan covers a particular oral surgery treatment.

Other dental care and orthodontic services are not covered.

(10) **Durable Medical Equipment -** Rental if deemed medically necessary. These items may be bought rather than rented, with the cost not to exceed the fair market value of the equipment at the time of purchase, but only if agreed to in advance by the Plan Administrator.

Repair or replacement of purchased DME which is medically necessary due to normal use or growth of a child will be considered a covered expense.

The Covered Person must obtain all DME through a Network Provider. The plan retains the right to recover any equipment purchased by the plan for the use by a Covered Person upon cancellation or termination of coverage for the Covered Person.

Important Note: DME dispensed by a Physician in an office setting and billed by a DME provider must be provided through a Network DME Provider. It is the Covered Person's responsibility to confirm this with your Physician. If the DME dispensed by your Physician is not from a Network DME Provider, the Covered Persons can obtain a prescription from their Physician for the DME and contact the plan to assist in obtaining the equipment. Failure to insure all DME is obtained from a Network DME Provider will result in the denial of services.

(11) **Emergency Health Services -** The plan will cover emergency room services that meet the definition of "True Emergency" as stated in section defined terms.

If a Covered Person obtains services in an emergency room when the circumstances were not a True Emergency, then it may result in a denial of benefits for the services provided.

IN THE EVENT OF AN EMERGENCY ADMISSION AT AN OUT-OF- NETWORK FACILITY:

If in an Emergency a Covered Person goes to an Out-of-Network Facility's emergency room for treatment and the Covered Person is admitted at that Out-of-Network Facility for further care or in-patient treatment, the Covered Person, a family member or the Facility must notify our Care Management Department once the

Covered Person is stabilized, but in no event more than two (2) Business Days after initial treatment. **Failure to notify us within the specified two (2) Business Day time requirements may result in a denial of Benefits.**

Upon receipt of such notification, the plan may either authorize the Covered Person's admission to, or further treatment at, the Out-of-Network provider hospital, or coordinate appropriate transfer to a Network Facility through communication with the Out-of-Network Provider facility, the admitting physician, and the Covered Person's Network Provider. **If the Covered Person stays at the Out-of-Network Facility beyond the period for which the plan has determined further treatment is considered Medically Necessary, then the Covered Person will be responsible for all charges billed by the facility and other providers providing care Covered Person.**

(12) Eye Examinations - Eye Examinations for active illness or injury that are received from a health care provider in the provider's office are a covered service.

Benefits also include one routine vision exam, including refraction, to detect vision impairment by a Network Provider once every 24 months. A refraction is only covered when provided in conjunction with a routine vision examination.

Benefits are not available for charges connected to the purchase or fitting of eyeglasses or contacts except for the initial acquisition following cataract surgery.

(13) Gastric Pacemaker - The plan will cover Gastric Pacemaker but treatment must be for gastroparesis. Pre-authorization is required.

(14) Hearing Exam - Covered charges when ordered by a physician during treatment of a medical condition.

(15) Home Health Care Services and Supplies - Charges for Home Health Care Services and Supplies are covered only for care and treatment of an injury or sickness when Hospital and Skilled Nursing Facility confinement would otherwise be required. The diagnosis, care and treatment must be certified by the attending Physician and be contained in a Home Health Care Plan.

Benefit payment for nursing, home health aide and therapy services is subject to the Home Health Care limit shown in the Schedule of Benefits.

A Home Health Care visit will be considered a periodic visit by either a nurse or therapist, as the case may be, or four (4) hours of home health aide services.

No home health care benefits will be provided for dietitian services, homemaker services (except as may be specifically provided herein), maintenance therapy, dialysis treatment, food or home delivered meals, rental or purchase of durable medical equipment or prescription or non-prescription drugs or biologicals.

(16) Home Infusion Therapy - The plan will cover medications received from licensed specialty pharmacy or a licensed retail pharmacy designated by QualChoice as a Home Infusion Therapy provider upon obtaining pre-authorization and upon the Maximum Allowable Charge for the medication.

a. Covered Medication: A home infusion therapy medication is covered as a medical benefit (as opposed to a prescription drug benefit) and is subject to copayment, if applicable, and/or deductible and coinsurance.
b. FDA approved medications that exist as separate components and are intended for reconstitutions prior to administration are covered. Examples include, but are not limited to, total parenteral nutrition, intravenous antibiotics, and hydration therapy and specialty infusions.
c. Medical supplies used in conjunction with home infusion therapy are covered if the home infusion is approved.

d. When home infusion therapy services are provided separately from home health services, then the home infusion therapy service does not apply to the home health benefit.

(17) 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. Hospice services must be pre-authorized.

Covered charges for Hospice Care Services and Supplies are payable as described in the schedule of benefits.

A. In-patient care in a freestanding hospice, a hospice unit within a hospital or skilled nursing facility, or in an acute care hospital bed; and

B. Home care services provided by the hospice either directly or under arrangements with other licensed providers, including, but not limited to, the following:

i. Intermittent nursing care by registered nurses, licensed practical nursed or home health aides,
ii. Respiratory therapy;
iii. Social services;
iv. Nutritional services;
v. Laboratory examinations;
vi. Chemotherapy and radiation therapy when required for control of symptoms;
vii. Medical supplies; and
viii. Medical care provided by a physician.

(18) Hospital-In-patient Care. In-patient hospital care benefits are available for services and supplies received during the hospital stay and room and board in a semi-private room (a room with two (2) or more beds). The plan will not pay for any hospital services unless the service is provided to the Covered Person by an employee of the hospital, the hospital bills for the service, the service is not primarily for convenience, and the hospital retains the payment collected for the service.

Hospital in-patient care is also subject to the following conditions:

A. The plan covers medically necessary acute in-patient hospital care for the care or treatment of the Covered Person's condition, illness or injury;

B. The plan does not provide benefits while a Covered Person is waiting for custodial care;

C. The plan does not provide benefits while waiting for a preferred bed, room or facility;

D. The following applies when a Covered Person is waiting for transfer from an acute hospital to another facility for continuing care (e.g., nursing home, rehabilitation facility, skilled nursing facility and long term acute care facility);

i. The acute hospital that the Covered Person is in a waiting a transfer should provide care equivalent to the care provided by the facility to which the Covered Person is waiting to be transferred;
ii. The days a Covered Person spends in the acute hospital waiting for a transfer may count toward the limits for sub-acute and rehabilitation benefits;
iii. The plan will pay the acute hospital while the Covered Person is awaiting a transfer the lesser of that acute hospital's rate or the rate at the facility to which the Covered Person is being transferred;

iv. If the acute hospital the Covered Person is in waiting a transfer is not providing the care the plan expects, the plan will deny those days and make no payment; this could have a significant financial impact on the Covered Person if the acute hospital the Covered Person is in while waiting to be transferred is an Out-of-Network Provider.

(19) Injectable Prescription Medications - Covered charges are available for Injectable Prescription Medication(s) received in a physician's office or from a specialty pharmacy provider based upon the Maximum Allowable Payment for the Injectable Prescription Medication and subject to the applicable cost sharing amounts specified in the Schedule of Benefits. Injectable Prescription Medications that Covered Persons may have the ability to self-administer may be obtained with direct delivery to the Covered Person's home. Case Management staff will assist the Covered Persons in coordinating this service.

(20) Laboratory Studies - Covered charges for diagnostic and preventive lab testing and services.

(21) Medical Foods - Charges will be covered for Medical Foods and Low Protein Modified Food Products. If prescribed, administered and under the direction of a licensed Network physician for the treatment of: Phenylketonuria, Galactosemia, Organic Acidemias and Disorders of Amino Acid Metabolism. The covered amount will be the incurred cost of medical food or low protein modified food products.

(22) Medical Supplies - Charges will be covered for items that are consumed or reduced with use so that supplies cannot be repeatedly used, are primarily or customarily used for medical purposes, and are generally not useful in the absence of an illness or injury. Medical Supplies do not include medications or implants. Medical Supplies are only covered when prescribed by a physician and when medically necessary. Supplies are limited to a 31-day supply per month.

(23) Mental Disorders and Substance Abuse - Covered charges for care, supplies and treatment of Mental Disorders and Substance Abuse as stated in the schedule of benefits.

a. Professional Services - Services for treatment of a Mental Health or Substance Abuse will be covered for crisis resolution or symptom relief;

b. Hospital Care - Services for short-term in-patient or partial hospitalization for treatment of a Mental Health or Substance Abuse will be covered. Services will only be covered when provided in a Psychiatric Hospital or Substance Abuse Unit of a general acute care hospital. Services for treatment of a Mental Health or Substance Abuse are not covered when provided by a facility that is not licensed as a hospital.

The Covered Person may self-refer to a Mental Health Specialist for the initial outpatient visit only. Any and all subsequent visits to a Mental Health provider or to any Mental Health Facility must be "Pre-Authorized".

The only providers covered for treatment of a Mental Health or Substance Abuse is: Psychiatrists, Licensed Clinical Psychologists, Licensed Clinical Social Workers, Licensed Professional Counselors and Licensed Psychological Examiners.

Refer to the Schedule of Benefits for the cost sharing requirements and any benefit limitations.

Residential Treatment for a Mental Health and Substance Abuse is not a covered service.

(24) Occupational Therapy - Services must be performed by a licensed occupational therapist. Therapy must be ordered by a Physician, result from an Injury or Sickness and improve a body function. Covered charges do not include recreational programs, maintenance therapy or supplies used in occupational therapy.

(25) Orthotic Services and Orthotic Devices - Orthotic services and orthotic devices are covered as described below.

All "orthotic devices and services" including the fitting and/or repair of orthotic devices, require pre-authorizations.

An "orthotic service" is an evaluation and treatment of a condition that requires the use of an "orthotic device".

A. The external device is (i) Intended to restore physiological function or cosmesis to a patient; and (ii) Custom-designed, fabricated, assembled, fitted, or adjusted for the patient using the device prior to or concurrent with the delivery of the device to the patient; and

B. The device must be provided and prescribed by a (i) Licensed Doctor of Medicine, (ii) Licensed Doctor of Osteopathy, (iii) Licensed Doctor of Podiatric Medicine, (iv) Licensed Orthotist, or (v) Licensed Prosthetist.

An orthotic device does not include a/an: cane, crutch, corset, dental appliance, elastic hose, elastic support, fabric support, generic arch support, low-temperature plastic splint, soft cervical collar, truss or any similar device meeting both of the following requirements:

1. It is carried in stock and sold with or without a prescription or therapeutic modification by a corset shop, department store, drug store, surgical supply facility, or similar retail entity; and
2. It has no significant impact on the neuromuscular, musculoskeletal or neuromusculoskeletal functions of the body.

An orthotic device also does not include foot orthotics that has the goal of improving foot function and minimizing stress forces that could ultimately cause foot deformity and pain. This applies to all of the broad categories of orthotics, including those that primarily attempt to change foot function, are mainly protective in nature, and/or combine functional control and protection. This also applies to rigid orthotic devices, soft orthotic devices or semi-rigid orthotic devices.

The plan does not cover replacement of an orthotic device or associated orthotic services more frequently than one (1) time every three (3) years unless Medically Necessary or indicated by other coverage criteria under this plan. However, the plan will replace or repair an orthotic device if necessary due to anatomical changes or normal use.

(26) Outpatient Services - Outpatient covered services are as follows:

Outpatient Hospital Services: Covered services shall include services provided in a licensed outpatient facility or at a hospital outpatient department. Examples include diagnostic services, radiation therapy, chemotherapy, x-ray services, laboratory services, surgical services, physical, occupational and speech therapy services, audiology services and renal dialysis. The plan will also cover up to 23 hours of outpatient observation for the purpose of extended recovery from a surgical or invasive procedure or for evaluation of the possible need for in-patient admission.

Outpatient Surgery: Coverage is provided for outpatient surgical services received from an ambulatory surgery center or in an outpatient hospital setting when performed or prescribed by a physician. Covered services include diagnostic imaging and laboratory services required to augment surgical services and performed on the same day as such surgical service.

If the covered person uses an Out-of-Network Provider hospital or ambulatory surgery center, payment from the plan will be limited to the Maximum Allowable Payment or $500, whichever is less.

The plan covers Medically Necessary surgical services. The plan will apply multiple surgical procedures reduction when the same provider performs two or more surgical procedures on the same Covered Person within the same operative session.

(27) Physician Office Services - The plan will cover clinical care provided in a physician's office to diagnose and treat disease, injury, or other conditions, surgical procedures performed in the physician's office and consultations with specialists including:

A. Advanced Diagnostic Imaging, treadmill stress test and other diagnostic testing performed in connection with diagnostic services, subject to the cost sharing amounts set forth in the Schedule of Benefits; and

B. Surgery and other treatments, including chemotherapy and radiation therapy, performed in a physician's office, subject to the cost sharing amounts set forth in the schedule of benefits.

(28) Physical Therapy - Services must be performed by a licensed physical therapist. The therapy must be in accord with a Physician's exact orders as to type, frequency and duration and for conditions which are subject to significant improvement through short -term therapy.

(29) Pregnancy/Maternity Coverage - The Charges for the care and treatment of Pregnancy are covered the same as any other sickness. Coverage shall be provided for a covered female employee and a covered female spouse of a covered employee.

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). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, the Covered Person may be required to obtain pre-authorization. For further information on maternity-related pre-authorization, please contact our Customer Service department.

Maternity Care and Obstetrical Care: Coverage is provided for Maternity Care and Obstetrical care, including routine prenatal care, postnatal care, and delivery in an in-patient facility setting, and any related complications. **Routine Prenatal Care** includes coverage of only one (1) routine ultrasound done between the 16th and 22nd week of pregnancy. If additional ultrasounds are needed due to Medical Necessity, then **Pre-Authorization is required.** Note: This benefit is in addition to the preventive screenings/prenatal visits for pregnant women that are covered under the Preventive Care Services benefit.

The Plan provides special prenatal programs designed to benefit you and your baby during pregnancy. These are available at no additional cost and are voluntary. To sign up, the Covered Person should contact us as early as possible during your pregnancy.

Fetal Testing: Amniocentesis or chorionic villus samplings are covered when performed in accordance with recognized standards of care.

Midwives: Coverage is provided for services received from a certified nurse midwife, but only if that nurse midwife is a Network Provider and the delivery is done in an in-patient hospital setting. Services of a midwife will be covered that is acting within his/her license or registrations and are a covered expense provided that the state in which such service is performed has legally recognized midwife delivery.

Newborn Care in the Hospital: A newborn Child of the Subscriber or the Subscriber's spouse will be covered from the date of birth, including use of newborn nursery and related services, provided the Child's coverage becomes effective on his/her date of birth subject to the terms, exclusions and limitations of the policy.

(30) Prescription Drugs - as defined in the prescription section of the Schedule of Benefits.

(31) Preventive Care Services - The Plan covers those services that are recognized and defined as being preventive in nature. A listing of those services the plan considers to be preventive care services is included with the Schedule of Benefits. The most complete list of those services the plan considers to be preventive care services is available at www.qualchoice.com or you may contact QualChoice's Customer Service department to obtain specific coverage guidelines.

NOTE: Sterilizations, oral contraceptive and prescription barrier methods for women are covered under the Preventive Care Services Benefit.

There are certain FDA approved contraceptive methods are covered under the Prescription Drug portion of the Plan and not the medical plan.

(32) Professional Services for Surgical/Medical/Multiple Surgical Procedures - The plan will cover surgery subject to the limitations described below including application of all cost sharing amounts and other limitations of the Plan as set forth in this document.

The Benefit amount payable for surgery includes payment for related or follow-up care by the surgeon before and after the operation. Payment for surgery is subject to the following limitations:

Multiple surgical procedures will be a covered service subject to the following provisions:

a. If bilateral or multiple surgical procedures are performed by one (1) surgeon, benefits will be determined based on the Usual and Reasonable Charge that is allowed for the primary procedures; 50% of the Usual and Reasonable Charge will be allowed for each additional procedure performed through the same incision. Any procedure that would not be an integral part of the primary procedure or is unrelated to the diagnosis will be considered "incidental" and o benefits will be provided for such procedures;

b. If multiple unrelated surgical procedures are performed by two (2) or more surgeons on separate operative fields, benefits will be based on the Usual and Reasonable Charge for each surgeon's primary procedure. If two (2) or more surgeons perform a procedure that is normally performed by one (1) surgeon, benefits for all surgeons will not exceed the Usual and Reasonable percentage allowed for that procedure; and

c. If an assistant surgeon is required, the assistant surgeon's covered charge will not exceed 20% of the surgeon's Usual and Reasonable Allowance.

d. The Plan will cover an assistant surgeon only if that assistant surgeon is required to assist with certain high-risk deliveries identified by us and only if the physician is in the immediate proximity to the Covered Person during the standby period.

(33) Prosthetic Services and Devices - Prosthetic services and devices are covered as described below:

All "prosthetic services and devices" including the fitting and/or repair of a device requires a pre-authorization.

A "prosthetic service" is an evaluation and treatment of a condition that requires the use of a "prosthetic device".

In order for a device to be a "prosthetic device" under the plan, the device must meet the following requirements:

a. The device is (i) intended to replace an absent external body part for the purpose of restoring physiological function or cosmesis to a patient and (ii) custom-design, fabricated, assembled, fitted, or adjusted for the patient using the device prior to or concurrent with delivery of the device to the patient; and
b. The device must be prescribed and/or provided by a (i) Licensed Doctor of Medicine, (ii) Licensed Doctor of Osteopathy, (iii) Licensed Doctor of Podiatric Medicine, (iv) Licensed Orthotist, (v) Licensed Prosthetist.

A prosthetic device includes Breast Prosthesis to the extent required pursuant to the Women's Health and Cancer Rights Act of 1998.

A prosthetic device does not include a/an, artificial eye, artificial ear, dental appliance(which would include corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome), cosmetic device such as artificial eyelashes or wigs, device used exclusively for athletic purposes, artificial facial device, or any other device that does not have a significant impact on the neuromuscular, musculoskeletal, or neuromusculoskeletal functions of the body.

Coverage for prosthetic devices and prosthetic services is subject to co-payments, deductibles, and co-insurance as set out in the Schedule of Benefits.

The plan does not cover replacement of a prosthetic device or associated prosthetic services more frequently than one (1) time every three (3) years unless Medically Necessary or indicated by other coverage criteria under this plan. However, the plan will replace or repair a prosthetic device if necessary due to anatomical changes or normal use, subject to co-payments, deductibles, and co-insurance as set out in the Schedule of Benefits.

(34) Reconstructive Surgery - Covered services are as follows:

a. **Reconstruction of a Surgically Removed Breast:** The plan will pay for reconstruction of a surgically removed breast, which is the result of breast cancer, in accordance with Federal and State Law. Coverage includes both reconstruction of the breast removed during the mastectomy, and reconstruction of the other breast to produce a symmetrical appearance. Coverage is provided for a minimum of forty-eight (48) hours for the hospital in-patient stay related to a mastectomy. Prostheses and treatment of physical complications at all stages of the mastectomy, including Lymphedema are covered services.

b. **Reconstructive Surgery - Other:** The plan will pay for services in connection with reconstructive surgery if necessary to restore the part of the body injured or deformed by acute trauma, infection or cancer subject to the following:

i Restoration must be aimed at restoration of function, not just restoration of appearance
ii. Restoration is intended to achieve an average person's normal function (for example, restoration aimed at athletic performance is not covered);
iii. The reconstructive surgery is necessary to correct congenital malformations or anomalies resulting in a severe functional impairment of a child covered under this plan.

Coverage is provided for the following Reconstructive Surgery procedures when prescribed or ordered by a Physician:

1b. Treatment provided for the correction of defects incurred in an Accidental Injury sustained by the Covered Person;

2b. Surgery performed on a Child for the correction of a cleft palate or cleft lip, removal of a port-wine stain (only on the face), or correction of a congenital abnormality. In order to be covered, such corrective surgery for a congenital defect must be performed when the Child is twelve (12) years or younger, unless, in its sole discretion the plan determines that due to the complexity of the procedure, such surgery could not be performed prior to the Child's twelfth (12th) birthday. Dental care to correct congenital defects is not a covered benefit;

3b. Treatment provided when it is incidental to disease or for reconstructive surgery following neoplastic (cancer) surgery;

b. **Reduction Mammoplasty:** Reduction mammoplasty that meets criteria for coverage Pre-authorization is required.

The correction of a defect that could have been corrected prior to the Covered Person's coverage under this plan is not covered.

Cosmetic services are intended primarily to improve your appearance or for your psychological benefit. The plan does not pay for any procedures, surgeries, services, equipment or supplies provided in connection with elective cosmetic services.

(35) Rehabilitation Services: Services for rehabilitative outpatient physical, occupational or speech therapy and chiropractic, audiology or pulmonary rehabilitation are covered. This includes services performed in the office of a physician, chiropractic or licensed or registered therapist, outpatient therapy center, or in the outpatient department of a hospital. Refer to the Summary of Benefits for specific limits. Cardiac rehabilitation services are covered separately and are not subject to this limitation. Please note that benefits are available only for covered services that are expected to result in a significant improvement in the Covered Person's condition within two (2) months of the documented start of the treatment.

(36) Skilled Nursing Facility Care/Extended Care Facility - The room and board and nursing care furnished by a Skilled Nursing Facility will be covered if and when:

a. the patient is confined as a bed patient in the facility; and

b. the confinement starts within seven (7) days of a hospital confinement of a least three (3) days;

c. the attending physician certifies that the confinement is needed for further care of the condition that caused the hospital confinement; and

d. the attending physician completes a treatment plan which includes a diagnosis, the proposed course of treatment and the projected date of discharge from the Skilled Nursing/Extended Care Facility.

Pre-Authorization is required. Care will be limited to the number of covered days provided by the Plan and if Medically Necessary for continued improvement. See the Schedule of Benefits for details.

Custodial Care is not covered.

(37) Special Equipment and Supplies - Covered charges shall include medically necessary special equipment and supplies including, but not limited to: casts, splints, braces; trusses; surgical and orthopedic appliances; colostomy and ileostomy bags and supplies required for their use; catheters; blood sugar measurement devices; allergy serums; crutches; electronic pacemaker; oxygen and the administration thereof; soft lenses or sclera shells intended for use in the treatment of illness or injury of the eye; support stocking, such as jobst

stockings, shall be limited to two (2) pairs per calendar year; surgical dressings and other medical supplies ordered by a professional provider in connection with medical treatment, but not common first aid supplies.

(38) Speech Therapy - Services must be performed by a licensed Speech Therapist. Therapy must be order by a Physician and follow either: (i) surgery for correction of a congenital condition of the oral cavity, throat or nasal complex (other than a frenectomy) of a person; (ii) an injury; or (iii) a sickness that is other than a learning or mental disorder.

(39) Spinal Manipulation/Chiropractic Services - Services must be performed by a licensed M.D., D.O., or D.C., and maintenance is not covered.

(40) Therapeutic and Rehabilitation Services - Services for outpatient physical, occupational, or speech therapy and chiropractic, audiology or pulmonary rehabilitation are covered. This includes services performed in the office of a physician, chiropractor or therapist, outpatient therapy center, or in the outpatient department of a hospital. Refer to the Schedule of Benefits for specific limits. Cardiac rehabilitation services are covered separately and are not subject to visit limitation. Please note that benefits are available only for services that are expected to result in a significant improvement in the Covered Person's condition within two (2) months of the start of the treatment.

(41) Transplantation Services - Benefits are available subject to the general conditions for payment and all other applicable conditions, limitations and exclusions of the plan. Review your Schedule of Benefits for applicable cost sharing amounts and other limitation amounts.

a. **Pre-Authorization Required: The covered person or an authorized representative must call the number on the identification card to obtain pre-authorization before the evaluation for the transplant and placement on any transplant list.** Once the evaluation is complete, the covered person must obtain an additional pre-authorization for the transplant procedure. The Plan will coordinate all transplant services, including evaluation and transplant. Failure to coordinate all transplant related services with the Plan, or failure to comply with pre-authorization procedures, may result in the denial of these services.

b. **Transplant Standards:** The plan will cover transplant procedures under the standards as stated:

Transplant Covered Services: The plan will cover any hospital, medical, surgical, and other services related to the transplant, including blood and blood plasma. **The Plan will only cover transplants and transplant related services performed at a transplant center approved by the plan.**

Hospital Care: The plan will cover all in-patient and outpatient care at a designated transplant center. When the plan authorizes the transplant to occur at an Out-of-Network Provider facility, the plan may require Network Physicians at a Network Facility to provide some follow-up care.

Organ Procurement: The plan will cover services directly related to organ procurement including tissue typing, surgical extraction, and storage and transportation costs of the organ or other human tissues used in a covered transplant procedure. This coverage applies only to the donor whose organ has been selected to be used in the transplantation. (If the donor has other insurance, this plan must receive an explanation of benefits from the donor's insurance indicating coverage or denial for the donation.) Please refer to the Schedule of Benefits for cost sharing amounts and lifetime maximums.

c. **Bone Marrow and Stem Cell Transplantation:** Bone marrow and stem cell transplantation is only covered for medical conditions specifically identified in QualChoice's Medical Policies. This limitation applies to the bone marrow and stem cell transplantation and any related procedure including High Dose Chemotherapy. The limitation applies to transplants of bone marrow or of peripheral blood cells intended to reconstitute the marrow. Bone marrow and stem cell transplantation must be Pre- Authorized by QualChoice and requires specific donor matches for certain procedures.

Covered diseases are:

- Aplastic Anemia
- Wiscott-Aldrich syndrome
- Albers-Schonberg syndrome
- Hemoglobinopathy, e.g., Thalassemia major
- Myelodysplastic syndromes - primary and acquired
- Immunodeficiency syndrome
- Non-Hodgkin's lymphoma, intermediate or high grade, stage III or IV
- Hodgkin's disease, stage IIIA or IIIB, or stage IVA or IVB
- Neuroblastoma, stage III or IV
- Chronic myelogenous blast leukemia in blast crisis or chronic phase
- Chronic myelogenous leukemia in the chronic phase
- Multiple myeloma
- Acute lymphocytic or myelocytic leukemia in patients who are in remission but at high risk for relapse
- Chronic Lymphocytic Leukemia
- Marrow failure, Fanconi's , red cell aplasia
- Amyloidoosis
- Paroxysmal Nocturnal Hemoglobinuria

d. **Cornea Transplantation:** Cornea transplantation is covered subject to all terms, limitations and exclusions set forth in the plan. Cornea transplants do not require pre-authorization.

IMPORTANT NOTE REGARDING TRANSPLANTATION SERVICES: It is important that you review and understand the benefit limitations for Transplant Services indicated in the Plan.

(42) Well Newborn Nursery/Physician Care:

Routine Nursery Care - Routine well newborn nursery care is care while the newborn is hospital-confined after birth and includes room and 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/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 the Usual and Reasonable Charges for nursery care for the newborn child while hospital confined as a result of the child's birth.

Charges for covered routine nursery care will be applied toward the plan of the newborn child.

Charges for Routine Physician Care - The benefit is limited to the Usual and Reasonable Charges made by a Physician for the newborn child while hospital confined as a result of the child's birth.

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

(43) X-Rays - Covered charges for diagnostic x-rays will be covered.

Additional items covered under this Plan:

(1) **Tobacco Cessation Services -** The Plan offers an entirely voluntary tobacco cessation program designed to give you tools and information to help you stop smoking or using other tobacco products. The Covered Person can learn more about the details of the tobacco cessation program by going to our web site www.qualchoice.com.

The Plan's tobacco cessation program allows you two (2) attempts to stop smoking, with each attempt being a twelve (12) week program consisting of the following:

a. You enroll in the program by contacting a QCARE health coach by calling (501) 228-7111;
b. QualChoice will mail you a voucher to present to your treating Network Provider that will cover up to two (2) office visits with that provider for tobacco cessation counseling and tobacco cessation covered medication management. That treating Network Provider must submit the voucher with the claim when filing with QualChoice for reimbursement;
c. You must participate in telephone counseling sessions with a QCARE health coach; and,
d. The Plan will cover at no cost to you a prescription for varenicline if ordered by a Network Provider. Other tobacco cessation Covered Prescription Drugs, as defined in the plan, will be covered as set out in your Prescription Benefits Summary.

(2) **Infertility -** Limited diagnostic work-up for infertility is covered. This is designed to screen for basic problems that might cause infertility. Any other services required for the diagnosis or treatment of infertility or of any associated disease whose primary manifestation is infertility are not covered. The Covered Person may contact the plan to obtain specific coverage guidelines.

(3) **Diabetes Management -** Diabetes Self-Management Training is limited to one program per lifetime per Covered Person. If there is a significant change in the Covered Person's symptoms or condition making it necessary to change the Covered Person's Diabetic Management process, the plan may authorize additional training if prescribed by a physician. Covered services are limited to a program that is in compliance with the National Standards for Diabetes Self-Management Education developed by the American Diabetes Association (ADA). A licensed provider certified by the ADA must provide the training.

(4) **Approved Clinical Trial -** Routine Patient Costs for Participation in an Approved Clinical Trial. Charges for any Medically Necessary services, for which benefits are provided by the Plan, when a Covered Person is participating in a phase I, II, III or IV clinical trial, conducted in relation to the prevention detection or treatment of a life-threatening Disease or condition, as defined under the ACA provided:

a. The clinical trial is approved by:
   - The Centers for Disease Control and Prevention of the U.S. Department of Health and Human Services;
   - The National Institute of Health
   - The U.S. Food and Drug Administration
   - The U.S. Department of Defense
   - The U.S. Department of Veterans Affairs; or
   - An Institutional review board of an Institution that has an agreement with the Office for Human Research Protections of the U.S. Department of Health and Human Services; and

b. The research Institution conducting the Approved Clinical Trial and each health professional providing routine patient care through the Institution, agree to accept reimbursement at the applicable Allowable Expense, as payment in full for routine patient care provided in connection with the Approved Clinical Trial.

i. The cost of an Investigational new drug or device that is not approved for any indication by the U.S. Food and Drug Administration, including a drug or device that is the subject of the Approved Clinical Trial;

ii. The cost of a service that is not a health care service, regardless of whether the service is required in connection with participation in an Approved Clinical Trial;

iii. The cost of a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;

iv. A cost associated with managing an Approved Clinical Trial;

v. The cost of a health care service that is specifically excluded by the Plan; or

vi. Services that are part of the subject matter of the Approved Clinical Trial and that are customarily paid for by the research Institution conducting the Approved Clinical Trial.

If a participating provider is participating in an approved clinical trial, the plan may require the individual to participate in the trial through that participating provider, if the provider will accept the individual as a participant in the trial. Plan sponsors should review their process and procedures related to clinical trials to ensure that their practices comply with ACA, and consult with their own legal counsel.

(5) **Temporomandibular Joint Syndrome (TMJ):** Medically necessary services for care and treatment of TMJ and jaw joint conditions. This benefit may be limited. Refer to the Benefit Summary for limitations.

(6) **Morbid Obesity** – Medically necessary services for treatment of obesity are excluded, unless the Covered Person has been diagnosed by a Plan approved Physician as having Morbid Obesity.

Surgical Treatment - If surgical intervention of Morbid Obesity is recommended by a Plan approved Physician, the Plan will cover the surgical procedure.

There may be a separate maximum limit for surgical intervention of Morbid Obesity. Refer to the Benefit Summary for limitations.

(7) **Hearing or Talking Aids.** Hearing aids, prosthetic devices to assist hearing, or talking devices, including special computers, are not covered. Fitting or repair of such devices is not covered.

PRESCRIPTION DRUG BENEFITS

Participating pharmacies have contracted with the Plan to charge Covered Persons reduced fees for covered Prescription Drugs. **Optum Rx** is the administrator of the pharmacy drug plan. Under this prescription drug benefit, you will pay one or more of the following as reflected in the Prescription Benefits Summary: a fixed Co-payment, if applicable, a Deductible, and/or Coinsurance for each Covered Prescription Drug obtained. **Consult the Prescription Benefits Summary for your applicable Cost Sharing Amounts by Tier.**

Covered Prescription Drugs
A "Covered Prescription Drug" is one that is (1) an injectable or non-injectable medication, (2) approved by the Food and Drug Administration (FDA), (3) obtainable only with a physician's written prescription, (4) not excluded or limited in the Plan, and (5) has been placed by on a Formulary as described below.

There may be limitations on coverage for Covered Prescription Drugs. Those limitations are set out in the Plan.

Formulary and Tiers
The list of Covered Prescription Drugs approved for coverage is called the "Formulary". The Formulary is subject to periodic review and modification by us as set forth herein.

All Covered Prescription Drugs placed on a specific Formulary will be assigned to a "Tier". The Tiers defined for Covered Prescription Drugs are described in your Prescription Benefits Summary. The Formulary is subject to periodic review and modification by us in our sole discretion and without notice, including the placement of prescription drugs in certain Tiers.

You can find out whether a medication is on the Formulary and, if so, in what Tier it has been placed by logging onto our website at www.qualchoice.com and selecting the drug formulary link on your member home page. The Tier determines the Covered Person Cost Sharing Amount (see your Prescription Benefits Summary for details regarding Covered Person cost sharing for different Tiers).

Purchase from Retail Pharmacy
An Covered Person must show his/her QualChoice identification card when purchasing a prescription at a participating network retail pharmacy, otherwise the pharmacy may require the Covered Person to pay the full cost of the medication and the discounted rates will not be available. The Covered Person may remit the claim for benefits by going to our website, www.qualchoice.com, to obtain a prescription drug claim form. This form includes instructions and mailing address to submit claims. The claim for benefits must be submitted within sixty (60) days of the medication being dispensed for reimbursement. The claim for benefits will be subject to all terms, conditions, exclusions and limitations set forth in this plan and the Prescription Benefits Summary. Reimbursement to the Covered Person will not exceed what would have been paid if the Covered Person had presented his/her QualChoice identification card at the time the prescription was filled, less the Covered Person's appropriate Cost Sharing Amount.

All participating network retail pharmacies can fill a thirty (34) day prescription. A select group of participating network retail pharmacies is allowed to fill a ninety (90) day prescription for a maintenance medication. You can identify these pharmacies by logging onto our website at www.qualchoice.com.

Purchase from Mail Order Pharmacy
In addition to a retail pharmacy network, Covered Persons may obtain their Covered Prescription Drugs through our mail order pharmacy. You can find out more about purchasing your prescription drugs through our mail order pharmacy by contacting our Customer Service department. The Covered Person cost sharing amount described in the plan for mail order is the same as it is for participating retail drug stores.

Purchase from Out-of-Network Pharmacy
If you purchase a Covered Prescription Drug from a pharmacy that is *not* a participating network pharmacy, you must pay the full amount of the Covered Prescription Drug to the pharmacy. You can then request reimbursement from by submitting your receipt from the pharmacy, along with a pharmacy claim form. The Plan will reimburse you based on the standard contract rate, less your Cost Sharing Amounts described in your Prescription Benefits Summary. In addition to your Cost Sharing Amounts, you will be responsible for the difference between the pharmacy's charge and the amount allowed, plus a standard processing fee described in your Prescription Benefits Summary.

Obtaining Benefits for Covered OTC Products
Only those over-the-counter (non-prescription or OTC) medications listed on the Formulary are covered. A written prescription is necessary to obtain covered over-the-counter products. At the retail pharmacy, the Covered Person should present their over-the-counter product prescription and identification card. The purchase will be processed in the same way as a prescription drug is processed. You can find out whether a particular over-the-counter medication is on the Formulary by logging onto our website at www.qualchoice.com and selecting the drug formulary link on your member home page.

Brand Drugs with Generic Equivalent Available
A "Brand Drug" is one that is sold under a proprietary name. A "Generic Drug" is one that is sold under a nonproprietary name. Most Brand Drugs with a Generic Drug available are considered non-preferred products and are placed in a higher tier. When a Brand Drug becomes available as a Generic Drug, the Brand Drug may no longer be available on the Formulary, the tier may change, or you may be required to pay a penalty if you receive the Brand drug instead of the Generic Drug.

New Drugs Entering the Market
New drugs entering the market and drugs in new dosage forms will not automatically be placed on the Formulary. Tier placement on the Formulary will be made at the discretion of the Plan.

Maintenance Medications
Some Maintenance Medications (as defined in this paragraph) are allowed at a ninety (90) day supply. If your Plan has Co-payments, then you will pay two (2) Co-payments for a ninety (90) day supply. See Purchase from Retail Pharmacy Section. For purposes of this Plan, "Maintenance Medications" are defined as follows:

A. A drug that is usually administered continuously, rather than intermittently, and for longer than 90 days, typically for the remainder of one's life. This means the patient is taking the medication on a scheduled basis year round and not as needed or seasonally.
B. A drug in which the most common use is to treat a chronic disease state when a therapeutic endpoint cannot be determined. Therapy with the drug is not considered curative.
C. A drug that has a low probability for dosage or therapy changes due to side effects, serum drug concentration monitoring, or therapeutic responses over a course of prolonged therapy.
D. While certain drugs may sometimes be used on a chronic basis, the drug will only meet the above definition if it is most commonly used in this way. The most common examples of maintenance medications are medicines used to treat high blood pressure, diabetes, high cholesterol, or hypothyroidism.
E. Drugs in the following classes are considered to be Maintenance Medications. If your medication falls in one of these categories you will be able to get a 90 day supply either from your retail pharmacy (if it participates in the 90-day network) or from the mail order pharmacy. You will need a prescription from your doctor with enough refills to allow 90 days. If your Plan has Co-payments, then one Co-payment will be charged for each 30 day supply.

   Maintenance Medications:

   - Alzheimer Disease medication
   - Antipsychotic medication
   - Antidepressants

- Asthma and other respiratory medication
- Benign Prostatic hyperplasia (BPH) medication
- Blood pressure medication (e.g., beta blockers, calcium channel blockers, diuretic, ACE-inhibitors)
- Certain cancer medication (other cancer medication may be a Specialty Pharmacy medication)
- Cholesterol lowering drugs
- Contraceptives--(All Other FDA Approved Contraceptive Methods Are Covered Under The Medical Plan)
- Diabetes medication
- Estrogens
- Glaucoma medication
- Gout medication
- Heart medication
- Organ transplant medication
- Osteoporosis medication
- Parkinson's disease medication
- Potassium supplements
- Seizure medication
- Thyroid medication

Diabetes Supplies
The following diabetes supplies are covered under your pharmacy benefit as reflected in the Prescription Benefits Summary. Specifically, diabetes supplies should be filled for a 30-day supply (if possible) to minimize Covered Person cost sharing.

- Test strips and lancets, if filled together, will be considered to be a single prescription
- Insulin and syringes, if filled together, will be considered to be a single prescription

Immunizations
Zoster (shingles) vaccine (Zostavax) and influenza virus vaccine (flu shots) are covered under your pharmacy benefit.

Specialty Pharmacy
Some Covered Prescription Drugs are designated as "Specialty Pharmacy" medications. These are medications generally used to treat relatively uncommon and/or potentially catastrophic illnesses. Specialty Pharmacy medications may require our pre-authorization and must be obtained through a contracted Specialty Pharmacy identified by QualChoice instead of a retail pharmacy. You will be able to get a 30-day supply of Specialty Pharmacy medications. Some Specialty Pharmacy medications may be covered under the medical plan instead of the pharmacy Benefit and they are subject to your medical plan Deductible and Coinsurance. You can find out whether a particular medication is considered to be a Specialty Pharmacy medication, a particular Specialty Pharmacy medication requires pre-authorization, and if Specialty Pharmacy medication has been placed on a tier or is covered under the medical plan by logging onto our website at www.qualchoice.com and selecting the drug formulary link on your member home page.

Cost Sharing Amounts
The Covered Person will be responsible for paying the member Cost Sharing Amounts reflected in the Prescription Benefits Summary. The Cost Sharing Amounts will be different for drugs on different Tiers.

Any payments that you make for non-Covered Prescription Drugs will not accumulate toward satisfying your Deductible or Out-of-Pocket Limits.

All formularies are subject to changes during the year. These changes can be caused by events such as the introduction of new medications, wholesale price changes by drug manufacturers, or review of current coverage status based on new clinical information. These changes can affect your Cost Sharing Amounts.

Exclusions from Coverage

The following products or categories of drugs are not covered;

- Drugs not approved by the Food and Drug Administration;
- Drugs prescribed for an unproven indication;
- Over-the-counter drugs (unless stated elsewhere in this Plan);
- Drugs that are not Medically Necessary for the Covered Person's medical condition for which the drug has been prescribed;
- Drugs used or intended to be used in connection with or arising from a treatment, service, condition, sickness, disease, injury, or bodily malfunction that is not a Covered Service;
- Drugs for which payment or benefits are provided by the local, state or federal government;
- Compounded drugs that do not contain at least one ingredient that requires a prescription ;
- Drugs whose primary purpose is the removal, destruction, or interference with the implantation of a fertilized ovum, embryo or fetus;
- Drugs prescribed to treat infertility;
- Research drugs;
- Experimental or investigational drugs;
- Drugs prescribed as part of treatment to change an Covered Person's sex from one gender to another ; and
- General and injectable vitamins.
- Smoking Cessation. A charge for Prescription Drugs, such as nicotine gum or smoking deterrent products, for smoking cessation, except to the extent required by the Patient Protection and Affordable Care Act.
- Steroids;
- Rogaine. Charges for Rogaine (topical Minoxidil);
- Impotency. A charge for impotency medication, including Viagra;
- Immunologicals. Charges for Immunologicals (vaccines);
- Anorexiants. Weight loss medication;
- Growth Hormones. Charges for growth hormones.

Replacement of previously filled prescription medications because the initial prescription medication was lost, stolen, spilled, contaminated, etc., are not covered.

Excessive use of medications is not covered. For purposes of this exclusion, each Covered Person agrees that the Plan shall be entitled to deny coverage of medications under this Plan, on grounds of excessive use when it is determined that: (a) an Covered Person has exceeded the dosage level, frequency or duration of medications recommended as safe or reasonable by major peer-reviewed medical journals specified by the United States Department of Health and Human Services pursuant to section 186(t)(2)(B) of the Social Security Act, 42 U.S.C.#1395(x)(t)(2)(B), as amended, standard reference compendia or by the Pharmacy & Therapeutics Committee; or, (b) an Covered Person has obtained or attempted to obtain the same medication from more than one physician for the same or overlapping periods of time; or, (c) the pattern of prescription medication purchases, changes of physicians or pharmacy or other information indicates that an Covered Person has obtained or sought to obtain excessive quantities of medications.

Each Covered Person hereby authorizes the Plan and its Administrator to communicate with any physician, healthcare provider or pharmacy for the purpose of reviewing and discussing the Covered Person's prescription history, use or activity to evaluate for excessive use.

Limitations of Coverage

Coverage for Covered Prescription Drugs is subject to the following limitations:

- Covered prescription Drugs filled at most retail pharmacies are subject to a 34-day supply.
- Covered prescription Drugs at a limited number of select contracted retail and mail order pharmacies are subject to a 90-day supply. You may contact our Customer Service Department to obtain a copy of the listing.

NOTE: Prescriptions filled at a non-participating retail pharmacy must be paid for by the Covered Person who may Seek reimbursement by remitting the Claim for Benefits directly to us within sixty (60) days of the medication being dispensed, subject to all terms, conditions, exclusions and limitations set forth in the Plan and the Prescription Benefits Summary. In such a case, reimbursement to the Covered Person from the Plan will be the amount that would have been paid to a participating retail network pharmacy.

We limit the number of doses of a particular medication that will be covered for a single prescription or the number of doses that will be covered if dispensed over a particular span of time. Example of these dosage limitations include, but are not limited to:

- Anti-nausea medications used for the treatment of nausea and vomiting associated with chemotherapy, radiation therapy, and surgery are limited to a 5-day supply per prescription and must be pre-authorized.
- Coverage for sedative and hypnotic products is limited to a maximum of 30 tablets per 30 day supply, with a maximum quantity of 360 tablets per Covered Person per calendar year; and
- Anti-migraine medications are covered subject to limitations of the number of doses per month, based on the recommended maximum number of episodes to treat per month.

We do not cover smoking cessation drugs and devices unless an Covered Person is enrolled in the Kick the Nic tobacco cessation program described in the plan.

We do not cover a prescription that is in excess of what has been prescribed by the prescribing physician or that is being refilled more than one year following the prescribing physician writing the initial prescription.

If it is determined an Covered Person is using prescription drugs in a harmful or abusive manner or with harmful frequency, the Covered Person may be limited to specific participating network pharmacies to obtain medication. The Covered Person will be notified of this determination. The Covered Person's failure to use the identified participating pharmacy will result in that Covered Person's prescription drugs not being covered.

Steps-Therapy Program
In the step-therapy program, a certain medication may be required to be used before another medication will be covered. Unless an exception is made, the second drug will not be covered unless the first drug has been tried first. You may obtain a description of the specific medications subject to the step-therapy program by contacting our customer service department.

Pre-Authorization May Be Required
Prior to certain Covered Prescription Drugs being covered, you physician must obtain pre-authorization from us as described in the Plan. The list of Covered Prescription Drugs requiring pre-authorization is subject to review and change. For a current list of those Covered Prescription Drugs requiring pre-authorization, access our website at www.qualchoice.com

COST MANAGEMENT SERVICES

Cost Management Services Phone Number

QualChoice
1-800-235-7111

The provider, patient or family member must call this number to receive certification of certain Cost Management Services. This call must be made at least 15 days in advance of services being rendered or within 48 hours after a Medical Emergency.

Any reduced reimbursement due to failure to follow cost management procedures will not accrue toward the 100% maximum out-of-pocket payment.

UTILIZATION REVIEW

Utilization review is a program designed to help insure that all Covered Persons receive necessary and appropriate health care while avoiding unnecessary expenses.

The program consists of:

a. Precertification of Medical Necessity for the following non-emergency services before Medical and/or surgical services are provided:

Hospitalizations
Organ transplants

b. Retrospective review of the Medical Necessity of the listed services provided on an emergency basis;

c. Concurrent review, based on the admitting diagnosis, of the listed services requested by the attending Physician; and

d. Certification of services and planning for discharge from a Medical Care Facility 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 certified, 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 precertification 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.

In order to maximize Plan reimbursements, please read the following provisions carefully.

Here's how the program works.

Precertification. Before a Covered Person enters a Medical Care Facility on a non-emergency basis, the utilization review administrator will, in conjunction with the attending Physician, certify the care as appropriate for Plan reimbursement. A non-emergency stay in a Medical Care Facility is one that can be scheduled in advance.

The utilization review program is set in motion by a telephone call from, or on behalf of, the Covered Person. Contact the utilization review administrator QualChoice **at least 3 days before** services are scheduled to be rendered with the following information:

- The name of the patient and relationship to the covered Employee
- The name, employee identification number and address of the covered Employee
- The name of the Employer
- The name and telephone number of the attending Physician
- The name of the Medical Care Facility, proposed date of admission, and proposed length of stay
- The proposed medical services

If there is an **emergency** admission to the Medical Care Facility, the patient, patient's family member, Medical Care Facility or attending Physician must contact QualChoice **within 48 hours** of the first business day after the admission.

The utilization review administrator will determine the number of days of Medical Care Facility confinement authorized for payment. **Failure to follow this procedure may reduce reimbursement received from the Plan.**

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

If the attending Physician feels that it is Medically Necessary for a Covered Person to receive additional services or to stay in the Medical Care Facility for a greater length of time than has been precertified, the attending Physician must request the additional services or days.

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 at 100% before the deductible.

The patient may choose any board-certified specialist who is not an associate of the attending Physician and who is affiliated in the appropriate specialty.

PREADMISSION TESTING SERVICE

The Medical Benefits percentage payable will be for diagnostic lab tests and x-ray exams 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.

CASE MANAGEMENT

Case Management. The Plan may elect, in its sole discretion, when acting on a basis that precludes individual selection, to provide alternative benefits that are otherwise excluded under the Plan. The alternative benefits, called "Case Management," shall be determined on a case-by-case basis, and the Plan's determination to provide the benefits in one instance shall not obligate the Plan to provide the same or similar alternative benefits for the same or any other Covered Person, nor shall it be deemed to waive the right of the Plan to strictly enforce the provisions of the Plan.

A case manager consults with the patient, the family and the attending Physician in order to develop a plan of care for approval by the patient's attending Physician and the patient. This plan of care may include some or all of the following:

-- personal support to the patient;

-- contacting the family to offer assistance and support;

-- monitoring Hospital or Skilled Nursing Facility;

-- determining alternative care options; and

-- assisting in obtaining any necessary equipment and services.

Case Management occurs when this alternate benefit will be beneficial to both the patient and the Plan.

The case manager will coordinate and implement the Case Management program by providing guidance and information on available resources and suggesting the most appropriate treatment plan. The Plan Administrator, attending Physician, patient and patient's family must all agree to the alternate treatment plan.

Once agreement has been reached, the Plan Administrator will direct the Plan to cover Medically Necessary expenses as stated in the treatment plan, even if these expenses normally would not be paid by the Plan. Unless specifically provided to the contrary in the Plan Administrator's instructions, reimbursement for expenses incurred in connection with the treatment plan shall be subject to all Plan limits and cost sharing provisions.

Note: Case Management is a voluntary service. There are no reductions of benefits or penalties if the patient and family choose not to participate.

Each treatment plan is individually tailored to a specific patient and should not be seen as appropriate or recommended for any other patient, even one with the same diagnosis.

DEFINED TERMS

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

Accidental Injury means a bodily injury (other than intentionally self-inflicted injury) happening unexpectedly and taking place not according to the usual course of events (for example an automobile accident), and that is the direct cause of the loss, independent of disease or bodily infirmity. Accidental Injury to teeth does not include any damage caused by chewing or biting any object.

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.

ADA shall mean the American Dental Association.

Adverse Benefit Determination shall mean any of the following:

1. A denial in benefits;
2. A reduction in benefits;
3. A rescission of coverage;
4. A termination of benefits; or
5. A failure to provide or make payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a claimant's eligibility to participate in the Plan.

AHA shall mean the American Hospital Association.

Allowable Expense when used in connection with covered services or supplies will be the amount deemed by the provider network contracts, in its sole discretion to be reasonable. The customary allowance is the basic Allowable Expense. Please note that all benefits under this Plan are subject to and shall be paid only be reference to the Allowable Expense as determined at the discretion of the Plan. This means that regardless of how much a health care provider may bill for a given service, the benefits under this Plan will be limited by the established Allowable Expense. If services are rendered by a participating Provider, the Provider is obligated to accept the established rate as payment in full, and should only bill the member for the Deductible, Coinsurance and any non-covered services; however, if services are rendered by a non-participating Provider, the member will be responsible for all amounts billed in excess of the Allowable Expense.

AMA shall mean the American Medical Association.

Ambulatory Surgical Center is a licensed facility that is used mainly for performing outpatient surgery, has a staff of Physicians, has continuous Physician and nursing care by registered nurses (R.N.s) and does not provide for overnight stays.

Applied Behavior Analysis means the design, implementation, and evaluation of environmental modifications by a board certified applied behavior analyst using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

Approved Clinical Trial means a phase I, II, III or IV trial that is federally funded by specified Agencies (National Institutes of Health, CDCP, Agency for Health Care Research, CMS, Dept. of Defense or Veterans Affairs, or a non-governmental entity identified by NIH guidelines) or is conducted under an investigational new drug application reviewed by the FDA (if such application is required).

The Patient Protection and Affordable Care Act requires that if a "qualified individual" is in an "Approved Clinincal Trial" the Plan cannot deny coverage for related services ("routine patient costs").

A “qualified individual” is someone who is eligible to participate in an “approved clinical trial” and either the individual’s doctor has concluded that participation is appropriate or the participant provides medical and scientific information establishing that their participation is appropriate.

“Routine patient costs” include all items and services consistent with the coverage provided in the plan that is typically covered for a qualified individual who is not enrolled in a clinical trial. Routine patient costs do not include 1) the investigational item, device or service itself; 2) items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; and 3) a service that is clearly inconsistent with the widely accepted and established standards of care for a particular diagnosis. Plans are not required to provide benefits for routine patient care services provided outside of the plan’s network area unless out-of network benefits are otherwise provided under the plan.

Assignment of Benefits shall mean an arrangement whereby the Covered Person, assigns his/her right to seek and receive payment of eligible Plan benefits, less deductible, co-payments and the coinsurance percentage that is not paid by the Plan, in strict accordance with the terms of this Plan Document, to a Provider. If a provider accepts said arrangement, Providers’ rights to receive Plan benefits are equal to those of a Covered Person, and are limited by the terms of this Plan Document. A Provider that accepts this arrangement indicates acceptance of an “Assignment of Benefits” and deductibles, co-payments and the coinsurance percentage that is the responsibility of the Covered Person, as consideration in full for services, supplies, and/or treatment rendered.

Autism Spectrum Disorder means any of the pervasive developmental disorders as defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, including: Autistic Disorder, Asperger's Disorder, and Pervasive developmental disorder not otherwise specified.

Benefits means reimbursement or payments for healthcare available to Covered Persons covered under this Plan.

Benefit Maximum means the aggregate charges allowed for a particular Covered Service. Benefit Maximums are subject to the Cost Sharing Amount reflected in your Benefits Summary.

Benefits Summary means a document containing specific information relating to your coverage and Cost Sharing Amounts under this Plan. The information may include amounts for Deductibles, Co-payments, if applicable, Coinsurance, Out-of-Pocket Limits, Benefit Maximums and lifetime maximum benefits, as well as visit and day maximums for limited services.

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.

Brand Name means a trade name medication.

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

Child shall mean, in addition to the Employee’s own blood descendant of the first degree or lawfully adopted Child, a Child placed with a covered Employee in anticipation of adoption, a covered Employee’s Child who is an Alternate Recipient under a Qualified Medical Child Support Order as required by the Federal Omnibus Budget Reconciliation Act of 1993, any stepchild, an “eligible foster Child,” which is defined as an individual placed with the Employee by an authorized placement agency or by judgment, decree or other order of a court of competent jurisdiction or any other Child for whom the Employee has obtained legal guardianship.

CHIP refers to the Children's Health Insurance Program or any provision or section thereof, which is herein specifically referred to; as such act, provision or section may be amended from time to time.

CHIPRA refers to the Children's Health Insurance Program Reauthorization Act of 2009 or any provision or section thereof, which is herein specifically referred to, as such act.

A **"Clean Claim"** is one that can be processed in accordance with the terms of this document without obtaining additional information from the service Provider or a third party. It is a claim which has no defect or impropriety. A defect or impropriety shall include a lack of required sustaining documentation as set forth and in accordance with this document, or a particular circumstance requiring special treatment which prevents timely payment as set forth in this document, and only as permitted by this document, from being made. A Clean Claim does not include claims under investigation for fraud and abuse or claims under review for Medical Necessity and Reasonableness, or fees under review for Usual and Customariness, or any other matter that may prevent the charge(s) from being Covered Charges in accordance with the terms of this document.

Filing a Clean Claim. A Provider submits a Clean Claim by providing the required data elements on the standard claims forms, along with any attachments and additional elements or revisions to data elements, attachments and additional elements, of which the Provider has knowledge. The Plan Administrator may require attachments or other information in addition to these standard forms (as noted elsewhere in this document and at other times prior to claim submittal) to ensure charges constitute Covered Charges as defined by and in accordance with the terms of this document. The paper claim form or electronic file record must include all required data elements and must be complete, legible, and accurate. A claim will not be considered to be a Clean Claim if the Covered Person has failed to submit required forms or additional information to the Plan as well.

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

Coinsurance means fixed percentage of the Maximum Allowable Charge you must pay toward the cost of certain Covered Services. Those Covered Services subject to the application of Coinsurance are identified in your Benefits Summary. Coinsurance is subject to the Coinsurance Out-of-Pocket Limit.

Coinsurance Out-of-Pocket Limit means the maximum amount of Coinsurance you pay every Calendar Year as set out in this Plan and your Benefits Summary.

Complication of Pregnancy means a condition requiring facility confinement, when the pregnancy is not terminated, the diagnosis of which is unrelated to the pregnancy but causes the mother's health to be adversely affected. These conditions include acute nephritis, nephrosis, cardiac decompensation, missed abortion and similar medical and surgical conditions of comparable severity which threaten the mother's health or life.

The following will also be considered a Complication of Pregnancy:

A C-section occurring after failure of a trial of labor;
An emergency C-section required because of fetal or maternal distress during labor;
An ectopic pregnancy which is terminated;
A spontaneous termination of pregnancy which occurs during a period of gestation in which a viable birth is not possible; and
A non-scheduled C-section.

Cosmetic Dentistry means dentally unnecessary procedures.

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 – With respect to certain drugs, treatment, services, tests, equipment or supplies, the Claims Administrator has developed specific Coverage Policies, which have been put into writing, and are available upon request from the Claims Administrator. If the Claims Administrator has developed a specific Coverage Policy that applies to the drug, treatment, service, test, equipment or supply that you received or seek to have covered under your Plan, the Coverage Policy shall be deemed to be determinative in evaluating whether such drug, treatment, service, test, equipment or supply meets the coverage criteria; however, 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.

Covered Charge(s) means a Usual and Customary fee for a Reasonable, Medically Necessary service, treatment or supply, meant to improve a condition or participant's health, which is eligible for coverage in this Plan. Covered Charges will be determined based upon all other Plan provisions. When more than one treatment option is available, and one option is no more effective than another, the Covered Charge is the least costly option that is no less effective than any other option.

All treatment is subject to benefit payment maximums shown in the Summary of Benefits and as determined elsewhere in this document.

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

Creditable Coverage includes most health coverage, such as coverage under a group health plan (including COBRA continuation coverage), HMO membership, an individual health insurance policy, Medicaid, Medicare or public health plans.

Creditable Coverage does not include coverage consisting solely of dental or vision benefits.

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.

Dentist is a person who is properly trained and licensed to practice dentistry and who is practicing within the scope of such license.

Dependent shall mean one or more of the following person(s):

1. An Employee's lawfully married spouse possessing a marriage license who is not divorced from the Employee.
2. An Employee's common law spouse, based upon a common law marriage which is legally recognized in the jurisdiction in which the Employee has his or her principal residence;
3. An Employee's Child who is less than twenty-six (26) years of age; or
4. An Employee's Child, regardless of age, who was continuously covered prior to attaining the limiting age as stated in the numbers above, who is mentally or physically incapable of sustaining his or her own living. Such Child must have been mentally or physically incapable of earning his or her own living prior to attaining the limiting age as stated in the numbers above. Written proof of such incapacity and dependency satisfactory to the Plan must be furnished and approved by the Plan within thirty-one (31) days after the date the Child attains the limiting age as stated in the numbers above. The Plan may require, at reasonable intervals, subsequent proof satisfactory to the Plan during the next two years after such date. After such two year period, the Plan may require such proof, but not more often than once each year.

"Dependent" does not include any person who is a member of the armed forces of any Country or who is a resident of a Country outside the United States.

The Plan reserves the right to require documentation, satisfactory to the Plan Administrator, which establishes a Dependent relationship.

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.

Emergency Services means a medical screening examination (as required under Section 1867 of the Social Security Act (EMTALA)) within the capability of the Hospital emergency department, including routine ancillary services, to evaluate a Medical Emergency and such further medical examination and treatment as are within the capabilities of the staff and facilities of the Hospital and required under EMTALA to stabilize the patient.

Employee means a person who is an Active, regular Employee of the Employer, regularly scheduled to work for the Employer in an Employee/Employer relationship.

Employer is **Arkansas Higher Education Consortium.**

Enrollment Date is the first day of coverage or, if there is a Waiting Period, the first day of the Waiting Period.

ERISA is the Employee Retirement Income Security Act of 1974, as amended.

Essential Health Benefits include, to the extent they are covered under the Plan, ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

Exogenous Obesity is obesity caused by over-eating rather than by bodily dysfunction.

Experimental and/or Investigational (Experimental) shall mean services or treatments that are not widely used or accepted by most practitioners or lack credible evidence to support positive short or long-term outcomes from those services or treatments, and that are not the subject of, or in some manner related to, the conduct of an Approved Clinical Trial, as such term is defined herein; these services are not included under or as Medicare reimbursable procedures, and include services, supplies, care, procedures, treatments or courses of treatment which:

1. Do not constitute accepted medical practice under the standards of the case and by the standards of a reasonable segment of the medical community or government oversight agencies at the time rendered; or
2. Are rendered on a research basis as determined by the United States Food and Drug Administration and the AMA's Council on Medical Specialty Societies.

A Drug, device, or medical treatment or procedure is Experimental:

1. If the Drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the Drug or device is furnished;
2. If reliable evidence shows that the Drug, device or medical treatment or procedure is the subject of ongoing Phase I, II, or III clinical trials or under study to determine its:
    a. Maximum tolerated dose;
    b. Toxicity;
    c. Safety;
    d. Efficacy; and
    e. Efficacy as compared with the standard means of treatment or diagnosis; or

3. If reliable evidence shows that the consensus among experts regarding the Drug, device, or medical treatment or procedure is that further studies or clinical trials are necessary to determine its:
    a. Maximum tolerated dose;
    b. Toxicity;
    c. Safety;
    d. Efficacy; and
    e. Efficacy as compared with the standard means of treatment or Diagnosis.

Reliable evidence shall mean:

1. Only published reports and articles in the authoritative medical and scientific literature;
2. The written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same Drug, device, or medical treatment or procedure; or
3. The written informed consent used by the treating facility or by another facility studying substantially the same Drug, device, or medical treatment or procedure.

Subject to a medical opinion, if no other FDA approved treatment is feasible and as a result the Covered Person faces a life or death medical condition, the Plan Administrator retains discretionary authority to cover the services or treatment.

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

Final Internal Adverse Benefit Determination shall mean an Adverse Benefit Determination that has been upheld by the Plan at the conclusion of the internal claims and appeals process, or an Adverse Benefit Determination with respect to which the internal claims and appeals process has been deemed exhausted.

FMLA shall mean the Family and Medical Leave Act of 1993, as amended.

FMLA Leave shall mean a Leave of Absence, which the Company is required to extend to an Employee under the provisions of the FMLA.

Formulary means a list of prescription medications compiled by the third party payor of safe, effective therapeutic drugs specifically covered by this Plan.

Generic drug means a Prescription Drug which has the equivalency of the brand name drug with the same use and metabolic disintegration. This Plan will consider as a Generic drug any Food and Drug Administration approved generic pharmaceutical dispensed according to the professional standards of a licensed pharmacist and clearly designated by the pharmacist as being generic.

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.

GINA shall mean the Genetic Information Nondiscrimination Act of 2008 (Public Law No. 110-233), which prohibits group health plans, issuers of individual health care policies, and Employers from discriminating on the basis of genetic information.

HIPAA shall mean the Health Insurance Portability and Accountability Act of 1996, as amended.

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 is an institution which is engaged primarily in providing medical care and treatment of sick and injured persons on an inpatient basis at the patient's expense and which fully meets these tests: it is accredited as a Hospital by the Joint Commission on Accreditation of Healthcare Organizations or the American Osteopathic Association Healthcare Facilities Accreditation Program; it is approved by Medicare as a Hospital; it maintains diagnostic and therapeutic facilities on the premises for surgical and medical diagnosis and treatment of sick and injured persons by or under the supervision of a staff of Physicians; it continuously provides on the premises 24-hour-a-day nursing services by or under the supervision of registered nurses (R.N.s); and it is operated continuously with organized facilities for operative surgery on the premises.
The definition of "Hospital" shall be expanded to include the following:

- A facility operating legally as a psychiatric Hospital or residential treatment facility for mental health and licensed as such by the state in which the facility operates.

- A facility operating primarily for the treatment of Substance Abuse if it meets these tests: maintains permanent and full-time facilities for bed care and full-time confinement of at least 15 resident patients; has a Physician in regular attendance; continuously provides 24-hour a day nursing service by a registered nurse (R.N.); has a full-time psychiatrist or psychologist on the staff; and is primarily engaged in providing diagnostic and therapeutic services and facilities for treatment of Substance Abuse.

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

Incurred shall mean that a Covered Charge is incurred on the date the service is rendered or the supply is obtained. With respect to a course of treatment or procedure which includes several steps or phases of treatment, Covered Charges are Incurred for the various steps or phases as the services related to each step are rendered and not when services relating to the initial step or phase are rendered. More specifically, Covered Charges for the entire

procedure or course of treatment are not incurred upon commencement of the first stage of the procedure or course of treatment.

Infertility means incapable of producing offspring.

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

Intensive Care Unit is defined as a separate, clearly designated service area which is maintained within a Hospital solely for the care and treatment of patients who are critically ill. This also includes what is referred to as a "coronary care unit" or an "acute care unit." It has: facilities for special nursing care not available in regular rooms and wards of the Hospital; special life saving equipment which is immediately available at all times; at least two beds for the accommodation of the critically ill; and at least one registered nurse (R.N.) in continuous and constant attendance 24 hours a day.

Late Covered Person means a Covered Person who enrolls under the Plan other than during the first 31-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.

Maximum Amount or Maximum Allowable Expense means the schedule of fees established by the network for payments to providers for Covered Services and that may be less than actual charges billed by the provider rendering the services. **Please Note:** All benefits under this Plan are subject to and shall be paid only by reference to the Maximum Allowable Expense as determined at the discretion of the Plan. This means that regardless of how much a healthcare provider may bill for a given service, the benefits under this Plan will be limited by the Maximum Allowable Expense established under this Plan. If you use a Network Provider and it is the primary payor, that provider is obligated to accept our established rate as the Maximum Allowable Expense, and may only bill you for your Cost Sharing Amounts and any non-Covered Services; however, **if you use an Out-of-Network, you will be responsible for all amounts billed in excess of the Maximum Allowable Expense.** The Maximum Allowable Expense will not include any identifiable billing mistakes including, but not limited to up-coding, duplicate charges, and charges for service not performed.

Medical Advisory Committee means an internal committee composed of practicing physicians selected by QualChoice from the Arkansas medical community.

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 a medical condition manifesting itself by acute symptoms of sufficient severity including severe pain such that a prudent layperson with average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in (1) serious jeopardy to the health of an individual (or, in the case of a pregnant woman, the health of the woman or her unborn child), (2) serious impairment to body functions, or (3) serious dysfunction of any body organ or part. A Medical Emergency includes such conditions as heart attacks, cardiovascular accidents, poisonings, loss of consciousness or respiration, convulsions or other such acute medical conditions.

Medical Non-Emergency Care means care which can safely and adequately be provided other than in a Hospital.

Medical Care Necessity, Medically Necessary, Medical Necessity and similar language refers to health care services ordered by a Physician exercising prudent clinical judgment provided to a Covered Person for the purposes of evaluation, diagnosis or treatment of that Covered Persons Sickness or Injury. Such services, to be considered Medically Necessary, must be clinically appropriate in terms of type, frequency, extent, site and duration for the diagnosis or treatment of the Covered Persons Sickness or Injury. The Medically Necessary setting and level of service is that setting and level of service which, considering the Covered Persons medical symptoms and

conditions, cannot be provided in a less intensive medical setting. Such services, to be considered Medically Necessary must be no more costly than alternative interventions, including no intervention and are at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the Covered Persons Sickness or Injury without adversely affecting the Covered Persons medical condition.

1. It must not be maintenance therapy or maintenance treatment;
2. Its purpose must be to restore health;
3. It must not be primarily custodial in nature;
4. It must not be a listed item or treatment not allowed for reimbursement by CMS (Medicare); and
5. The Plan reserves the right to incorporate CMS (Medicare) guidelines in effect on the date of treatment as additional criteria for determination of Medical Necessity and/or an Allowable Expense.

For Hospital stays, this means that acute care as an Inpatient is necessary due to the kind of services the Covered Person is receiving or the severity of the Covered Person's condition and that safe and adequate care cannot be received as an outpatient or in a less intensified medical setting. The mere fact that the service is furnished, prescribed or approved by a Physician does not mean that it is "Medically Necessary." In addition, the fact that certain services are excluded from coverage under this Plan because they are not "Medically Necessary" does not mean that any other services are deemed to be "Medically Necessary."

To be Medically Necessary, all of these criteria must be met. Merely because a Physician or Dentist recommends, approves, or orders certain care does not mean that it is Medically Necessary. The determination of whether a service, supply, or treatment is or is not Medically Necessary may include findings of the American Medical Association and the Plan Administrator's own medical advisors. The Plan Administrator has the discretionary authority to decide whether care or treatment is Medically Necessary.

Off-label Drug use is considered Medically Necessary when all of the following conditions are met:

a. The Drug is approved by the FDA;
b. The prescribed Drug use is supported by one of the following standard reference sources:
    1) DRUGDEX;
    2) The American Hospital Formulary Service Drug Information;
    3) Medicare approved Compendia; or
    4) Scientific evidence is supported in well-designed clinical trials published in peer-reviewed medical journals, which demonstrate that the Drug is safe and effective for the specific condition; and

c. The Drug is Medically Necessary to treat the specific condition, including life threatening conditions or chronic and seriously debilitating conditions.

Medical Policy or Medical Policies means a statement developed by QualChoice that sets for the medical criteria for coverage under the benefit plan. Limitations of benefits related to coverage of a medication, treatment, service, equipment or supply are also outlined in the Medical Policies. Medical Policies are based on nationally accepted guidelines and peer reviewed medical literature. Medical Policies are subject to change at the discretion of the Plan. Medical Policies are available and can be reviewed on QualChoice's web site at www.qualchoice.com.

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

Mental or Nervous Disorder means any disease or condition, regardless of whether the cause is organic, that is classified as a Mental Disorder in the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services or is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association.

Mental Health Parity Act of 1996 (MHPA) and Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), Collectively, the Mental Health Parity Provisions in Part 7 of ERISA shall mean in the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides both medical and surgical benefits and mental health or substance use disorder benefits, such plan or coverage shall ensure that:

1. The financial requirements applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the Plan (or coverage) and that there are no separate cost sharing requirements that are applicable only with respect to mental health or substance use disorder benefits. If these benefits are covered by the group health plan (or health insurance coverage is offered in connection with such a plan); and
2. The treatment limitations applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the Plan (or coverage), and that there are no separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits. If these benefits are covered by the group health plan (or health insurance coverage offered in connection with such a plan).

Morbid Obesity is a diagnosed condition in which the body weight exceeds the medically recommended weight by either 100 pounds or is twice the medically recommended weight for a person of the same height, age and mobility as the Covered Person.

Network is the facilities, providers and suppliers who have by contract via a medical Provider Network agreed to allow the Plan access to discounted fees for service(s) provided to Covered Person, and by whose terms they have agreed to accept Assignment of Benefits and the discounted fees thereby paid to them by the Plan as payment in full for Covered Charges. The applicable Provider Network will be identified on the Covered Person's identification card.

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

Other Plan includes, but is not limited to:

1. Any primary payer besides the Plan;
2. Any other group health plan;
3. Any other coverage or policy the Covered Person;
4. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
5. Any policy of insurance from any insurance company or guarantor of a responsible party;
6. Any policy of insurance from any insurance company or guarantor of a third party;
7. Workers' compensation or other liability insurance company; or
8. Any other source, including but not limited to crime victim restitution funds, any medical disability or other benefit payments and school insurance coverage.

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 Ambulatory 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.), Doctor of Osteopathy (D.O.), Optometrist (O.D.), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), Audiologist, Certified Nurse Anesthetist, Licensed Professional Counselor, Licensed Professional Physical Therapist, Master of Social Work (M.S.W.), Midwife, Occupational Therapist, Doctor of Dental Surgery (D.D.S.), Physiotherapist, Psychiatrist, Psychologist (Ph.D.), Speech Language Pathologist and any

other practitioner of the healing arts who is licensed and regulated by a state or federal agency and is acting within the scope of his or her license.

Plan means **Arkansas Higher Education Consortium Employee Benefit Plan**, which is a benefit, plan for certain, Employees of Arkansas Higher Education Consortium and is described in this document.

Plan Year is the 12-month period beginning on either the effective date of the Plan or on the day following the end of the first Plan Year which is a short Plan Year.

Pregnancy is childbirth and conditions associated with Pregnancy, including complications.

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.

Preventive Care shall mean certain Preventive Care services.

This Plan intends to comply with the Patient Protection and Affordable Care Act's (PPACA) requirement to offer in-Network coverage for certain preventive services without cost-sharing. To comply with PPACA, and in accordance with the recommendations and guidelines, the Plan will provide in-Network coverage for:

1. Evidence-based items or services rated A or B in the United States Preventive Services Task Force recommendations;
2. Recommendations of the Advisory Committee on Immunization Practices adopted by the Director of the Centers for Disease Control and Prevention;
3. Comprehensive guidelines for infants, children, and adolescents supported by the Health Resources and Services Administration (HRSA); and
4. Comprehensive guidelines for women supported by the Health Resources and Services Administration (HRSA).

Copies of the recommendations and guidelines may be found here:
http://www.uspreventiveservicestaskforce.org/ or at
https://www.healthcare.gov/preventive-care-benefits/. For more information, you may contact the Plan Administrator / Employer.

Provider means an entity whose primary responsibility is related to the supply of medical care. Each Provider must be licensed, registered, or certified by the appropriate State agency where the medical care is performed, as required by that State's law where applicable. Where there is no applicable State agency, licensure, or regulation, the Provider must be register or certified by the appropriate professional body. The Plan Administrator may determine that an entity is not a "Provider" by CMS for purposes arising from payment and/or enrollment with Medicare; however, the Plan Administrator is not so bound by CMS' determination of an entity's status as a Provider.

Reasonable and/or Reasonableness shall mean in the administrator's discretion, services or supplies, or fees for services or supplies which are necessary for the care and treatment of Illness or Injury not caused by the treating Provider. Determination that fee(s) or services are Reasonable will be made by the Plan Administrator, taking into consideration unusual circumstances or complications requiring additional time, skill and experience in connection with a particular service or supply; industry standards and practices as they relate to similar scenarios; and the cause of Injury or Illness necessitating the service(s) and/or charge(s).

This determination will consider, but will not be limited to, the findings and assessments of the following entities: (a) The National Medical Associations, Societies, and organizations; and (b) The Food and Drug Administration. To be Reasonable, service(s) and/or fee(s) must be in compliance with generally accepted billing practices for unbundling or multiple procedures. Services, supplies, care and/or treatment that results from errors in medical

care that are clearly identifiable, preventable, and serious in their consequence for patients, are not Reasonable. The Plan Administrator retains discretionary authority to determine whether service(s) and/or fee(s) are Reasonable based upon information presented to the Plan Administrator. A finding of Provider negligence and/or malpractice is not required for service(s) and/or fee(s) to be considered not Reasonable.

Charge(s) and/or services are not considered to be Reasonable, and as such are not eligible for payment (exceed the Maximum Allowable Expense), when they result from Provider error(s) and/or facility-acquired conditions deemed "reasonably preventable" through the use of evidence-based guidelines, taking into consideration but not limited to CMS guidelines.

The Plan reserves for itself and parties acting on its behalf the right to review charges processed and/or paid by the Plan, to identify charge(s) and/or service(s) that are not Reasonable and therefore not eligible for payment by the Plan.

Sickness is:

For a covered Employee and covered Spouse: Illness, disease or Pregnancy.

For a covered Dependent other than Spouse: Illness or disease, not including Pregnancy, or its 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, drug addicts, alcoholics, mentally disabled, Custodial or educational care or care of Mental Disorders.

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.

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.

Substance Abuse shall mean any use of alcohol, any Drug (whether obtained legally or illegally), any narcotic, or any hallucinogenic or other illegal substance, which produces a pattern of pathological use, causing impairment in social or occupational functioning, or which produces physiological dependency evidenced by physical tolerance or withdrawal. It is the excessive use of a substance, especially alcohol or a Drug. The Diagnostic and Statistical Manual of Mental Disorders (DSM) definition of "Substance Use Disorder" is applied as follows:

1. A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one (or more) of the following, occurring within a twelve (12) month period:

    a. Recurrent substance use resulting in a failure to fulfill major role obligations at work, school or home(e.g., repeated absences or poor work performance related to substance use; substance-related absences, suspensions or expulsions from school; neglect of children or household);
    b. Recurrent substance use in situations in which it is physically hazardous (e.g., driving an automobile or operating a machine when impaired by substance use);
    c. Craving or a strong desire or urge to use a substance; or
    d. Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (e.g., arguments with spouse about consequences of intoxication, physical fights);
2. The symptoms have never met the criteria for Substance Dependence for this class of substance.

Substance Abuse Treatment Center shall mean an Institution which provides a program for the treatment of Substance Abuse by means of a written treatment plan approved and monitored by a Physician. This Institution must be:

1. Affiliated with a Hospital under a contractual agreement with an established system for patient referral;
2. Accredited as such a facility by the Joint Commission on Accreditation of Hospitals; or
3. Licensed, certified or approved as an alcohol or Substance Abuse treatment program or center by a State agency having legal authority to do so.

Substance Dependence: Substance use history which includes the following: (1) Substance Abuse (see above); (2) continuation of use despite related problems; (3) development of tolerance (more of the Drug is needed to achieve the same effect); and (4) withdrawal symptoms.

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.

Uniformed Services shall mean the Armed Forces, the Army National Guard and the Air National Guard, when engaged in active duty for training, inactive duty training, or full time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President of the United States in time of war or Emergency.

USERRA shall mean the Uniformed Services Employment and Reemployment Rights Act of 1994 (“USERRA”).

Usual and Customary (U&C) shall mean Covered Charges which are identified by the Plan Administrator, taking into consideration the fee(s) which the Provider most frequently charges (or accepts for) the majority of patients for the service or supply, the cost to the Provider for providing the services, the prevailing range of fees charged in the same “area” by Providers of similar training and experience for the service or supply, and the Medicare reimbursement rates. The term(s) “same geographic locale” and/or “area” shall be defined as a metropolitan area, county, or such greater area as is necessary to obtain a representative cross-section of Providers, persons or organizations rendering such treatment, services, or supplies for which a specific charge is made. To be Usual and Customary, fee(s) must be in compliance with generally accepted billing practices for unbundling or multiple procedures.

The term “Usual” refers to the amount of a charge made or accepted for medical services, care, or supplies, to the extent that the charge does not exceed the common level of charges made by other medical professionals with similar credentials, or health care facilities, pharmacies, or equipment suppliers of similar standing, which are located in the same geographic locale in which the charge was Incurred.

The term “Customary” refers to the form and substance of a service, supply, or treatment provided in accordance with generally accepted standards of medical practice to one individual, which is appropriate for the care or treatment of an individual of the same sex, comparable age and who has received such services or supplies within the same geographic locale.

The term “Usual and Customary” does not necessarily mean the actual charge made (or accepted) nor the specific service or supply furnished to a Covered Person by a Provider of services or supplies, such as a Physician, therapist, Nurse, Hospital, or pharmacist. The Plan Administrator will determine the usual charge for any procedure, service, or supply, and whether a specific procedure, service or supply is customary.

Usual and Customary charges may, at the Plan Administrator’s discretion, alternatively be determined and established by the Plan using normative data such as, but not limited to, Medicare cost to charge ratios, average wholesale price (AWP) for prescriptions and/or manufacturer’s retail pricing (MRP) for supplies and devices.

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. **Acupuncture.** Services, supplies, care or treatment in connection with acupuncture for analgesic or anesthetic purposes.

2. **Adoption and Surrogate Parenting.** The plan does not cover services, supplies, treatment or other costs relating to the care of the biological mother of an adopted Child. Maternity charges incurred by an Covered Person acting as a surrogate mother are not covered charges. For the purpose of this Plan, the child of a surrogate mother will not be considered a dependent of the surrogate mother or her spouse if the mother has entered into a contract or other understanding pursuant to which she relinquishes the child following its birth. Refer to the plan information regarding coverage of adopted children.

3. **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 are not covered.

4. **Against Medical Advice**. Services related to an in-patient admission, observation admission, or emergency room visit resulting in the Covered Person's discharge against medical advice. The Plan will also not cover any services required for complications resulting from the Covered Person's discharge against medical advice.

5. **Alcohol**. Services, supplies, care or treatment to a Covered Person for Injury or Sickness which occurred as a result of that Covered Person’s illegal use of alcohol or a state of intoxication. Expenses will be covered for Injured Covered Persons other than the person partaking in an activity made illegal due to the use of alcohol or a state of intoxication, and expenses may be covered for Substance Abuse treatment as specified in this Plan, if applicable. This exclusion does not apply (a) if the Injury resulted from being the victim of an act of domestic violence, or (b) resulted from a documented medical condition (including both physical and mental health conditions).

6. **Alternative or Complementary Medicine.** We will not cover devices or services relating to alternative systems of medical practice such as the following:

   A. Acupuncture;
   B. Homeopathy or Naturopathy;
   C. Bioelectromagnetic care;
   D. Herbal medicine;
   E. Hippo therapy (equine therapy);
   F. Hypnotherapy (except to the extent it is for the treatment of a Mental Health or Substance Use Disorder that is part of a mental health treatment plan that has pre-approved);
   G. Aromatherapy;
   H. Reflexology;
   I. Mind/body control such as dance or prayer therapies;
   J. Pharmacological and biological therapy not accepted by mainstream medical practitioners such as chelation therapy or metabolic therapy.
   K. Massage therapy

7. **Appointments**. Charges resulting from the failure to keep a scheduled visit with a Physician or other Provider are not covered.

8. **Baby Formula.** Baby formula and thickening agents, even if prescribed by a physician or acquired over-the-counter are not covered.

9. **Bereavement services**. Medical social services and outpatient family counseling and/or therapy for bereavement, except if provided as Hospice Care, are not covered.

10. **Biofeedback**.

11. **Blood and Blood Donation.** The plan will not cover for any charges associated with blood donations. The plan will not cover for procurement, or storage of donated blood. The plan will not cover umbilical cord blood banking or blood banking for blood or blood products with unscheduled future use. The plan will cover the charges for administration of blood and blood products and banking charges for covered procedures planed in the next one hundred eighty (180) days.

12. **Blood typing**. Blood typing or DNA analysis for paternity testing is not covered**.**

13. **Cerebellar Stimulator or Pacemaker.** Cerebellar stimulator or pacemaker for the treatment of neurological disease is not covered.

14. **Chelation Therapy.** Services or supplies provided as, or in conjunction with, chelation therapy are not covered, except for treatment of acute heavy metal poisoning.

15. **Chemical Ecology.** Diagnostic studies and treatment of multiple chemical sensitivities, environmental illness, environmental hypersensitivity disorder, total allergy syndrome or chemical ecology are not covered.

16. **Cochlear implants. See Limitations of Benefits.**

17. **Complications of non-covered treatments.** The Plan will not cover medical or surgical complications resulting from a non-covered service. The plan will not cover medical or surgical complications as a direct or closely related result of the Covered Person's refusal to accept treatment, medicines, or a course of treatment recommended by a provider.

18. **Contraceptives Devices or Supplies**. Contraceptive devices or supplies available over-the-counter (without a prescription) are not covered.

19. **Cosmetic or Reconstructive Services**. Cosmetic services are intended primarily to improve your appearance or for your psychological benefit. The plan will not pay for any procedures, surgeries, services, equipment or supplies provided in connection with cosmetic surgery even if coverage was provided by another health plan. Procedures or services that change or improve appearance without improving physiological function are also not covered. Procedures or services that correct a physical developmental defect present at the time of birth without improving or restoring physiologic function are considered cosmetic procedures. The fact that an Covered Person may suffer psychological consequences as a result of an injury, sickness or developmental defect present at the time of birth, does not make the service Medically Necessary.

20. **Custodial Care.** The plan will not cover Custodial Care. Persons without professional skills or training can provide Custodial Care. For example, Custodial Care includes assistance in activities of daily living (walking, getting in and out of bed, bathing, dressing, eating and taking medication). Custodial Care also includes medical services not seeking to cure or improve the patient. They may be provided during periods when the medical condition of the patient is not changing. They generally do not require continued administration by trained medical personnel. Examples include long-term maintenance activities such as dressing changes, tube feeding, or range of motion exercises.

21. **Custodial Care Facility**. Services or supplies furnished by an institution which is primarily a place of rest or a place for the aged are not covered. Residential long term care facilities for mental health or eating disorders are not covered. Youth homes or any similar institution are not covered. Non-covered Custodial Care may be rendered in a facility, domiciliary facility, nursing home, skilled nursing facility, or home. Non-covered

Custodial Care may be residential care, respite care, private duty nursing, or any other service custodial in nature.

22. **Delivery Charges**. Charges for shipping, packaging, handling or delivering Medications are not separately covered.

23. **Dental Care.** This Plan does not provide Benefits for dental care. Except as otherwise stated, we do not cover:

    A. Treatment of cavities;
    B. Tooth extractions;
    C. Care of the gums;
    D. Care of the bones supporting the teeth;
    E. Treatment of periodontal disease;
    F. Treatment of dental abscess;
    G. Treatment of dental pain;
    H. Treatment of dentigerous cysts;
    I. Removal of soft tissue supporting or surrounding teeth;
    J. Orthodontia (including braces);
    K. False teeth;
    L. Orthognathic surgery; or
    M. Any other dental services you may receive, except as specifically set out in your Benefits Summary.

24. **Dental Implants.** Dental implants are not covered.

25. **Developmental Delay.** Services or provided for developmental delay, including learning disabilities, communication delay, perceptual disorder, sensory deficit, and motor dysfunctions are not covered.

26. **Dietitian and Nutritional Services.** Except as stated under the benefit for "Medical Foods", any services or supplies provided for dietary or nutritional services, including, but not limited to, medical nutrition therapy, are not covered. Baby formulas or thickening agents, whether prescribed by a physician or acquired over-the-counter, are not covered.

27. **Domestic Partners.** The plan will not provide coverage for domestic partners unless or until the partnership provides a marriage license issued by the State of Arkansas

28. **Donor Expenses for Transplant.** Services and supplies associated with an organ and tissue transplant where the Covered Person is the donor are not covered.

29. **Educational or vocational testing.** Services for educational or vocational testing or training.

30. **Electrogastrography.** Electrogastrography is not covered

31. **Electron Beam Computed Tomography.** Electron beam computed tomography is not covered.

32. **Electronic Consultations.** We do not cover charges for a healthcare provider's consultation by telephone, email, or other electronic communications with you or another healthcare provider.

33. **Electrotherapy and Electromagnetic Stimulators.** All treatment using electrotherapy and electromagnetic stimulators, including services and supplies used in conjunction with such stimulators, and complications resulting from such treatment, are not covered. However, subject to all terms, conditions, exclusion and limitations of the Plan as set forth in this Certificate; coverage is provided for a Transcutaneous Electrical Nerve Stimulator (TENS) to treat chronic pain due to peripheral nerve injury when that pain is unresponsive to medication.

34. **Enteral Nutrition.** Except as stated in "Medical Foods" above, the plan will not cover food or nutritional source provided via tube feedings even if the tube feeding is the Covered Person's sole source of nutrition.

35. **Error.** That are required to treat injuries that are sustained or an Illness that is contracted, including infections and complications, while the Covered Person was under, and due to, the care of a Provider wherein such Illness, Injury, infection or complication is not reasonably expected to occur. This exclusion will apply to expenses directly or indirectly resulting from the circumstances of the course of treatment that, in the opinion of the Plan Administrator, in its sole discretion, unreasonably gave rise to the expense.

36. **Excess charges.** The part of an expense for care and treatment of an Injury or Sickness that are not payable under the Plan due to application of any Plan maximum or limit or because the charges are in excess of the Usual and Customary amount, or are for services not deemed to be Reasonable or Medically Necessary, based upon the Plan Administrator's determination as set forth by and within the terms of this document.

37. **Exercise programs.** Exercise programs for treatment of any condition are not covered. Examples would be gym memberships, personal trainers and home exercise equipment, even if recommended or prescribed by a physician. Except for Physician-supervised cardiac rehabilitation, occupational or physical therapy if covered by this Plan.

38. **Experimental or Investigational Procedures and Related Equipment and Supplies.** The plan will not cover any procedure or service we consider to be experimental or investigational. The plan also will not pay for equipment or supplies related to such procedures. The plan will base decisions on what is experimental or investigational on unbiased technology reviews and national scientific, peer-reviewed medical literature. Any therapy subject to government agency approval must have received final approval before we may consider it as a Covered Service. A new treatment with no outcome advantage over existing treatments may be considered investigational while studies are in progress to determine if any treatment advantage exists in any subpopulation of the affected group

39. **Eye care.** Radial keratotomy or other eye surgery to correct refractive disorders. Also, routine eye examinations, including refractions, lenses for the eyes and exams for their fitting. However, refer to the Schedule of Benefits for Vision Benefits and coverage under the Vision Plan. This exclusion does not apply to aphakic patients and soft lenses or sclera shells intended for use as corneal bandages or as may be covered under the well adult or well child sections of this Plan

40. **Foot care.** Services or supplies for palliative or cosmetic foot care or for flat foot conditions are not covered. This includes but is not limited to supporting devices for the foot such as shoe inserts, elastic stockings, Jobst stockings, the treatment of subluxations of the foot, arthroeresis for flat feet, care of corns, non-surgical care of bunions, calluses, routine trimming of toe nails, fallen arches, weak feet and chronic foot strain. However, subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Plan, foot care is provided when required for prevention of complications associated with diabetes mellitus or other peripheral sensory neuropathy.

41. **Foot Supports.** Foot supports that have the goal of improving foot function and minimizing stress forces that could ultimately cause foot deformity and pain are not covered. This exclusion applies to all of the broad categories of supports, including those that primarily attempt to change foot function, those that are mainly protective in nature, and those that combine functional control and protection. The exclusion applies to rigid devices, soft devices or semi-rigid devices.

42. **Foreign travel.** Care, treatment or supplies out of the U.S. if travel is for the sole purpose of obtaining medical services.

43. **Fraud or Misrepresentation.** Health interventions or health services, including, but not limited to, medications obtained by unauthorized or fraudulent use of a Covered Person's identification card or by material misrepresentation as part of your enrollment process or at other times, are not covered.

44. **Gastric Electrical Stimulators.** Gastric electrical stimulators, gastric pacemakers, or electrogastrography are not covered.

45. **Government Coverage.** Care, treatment or supplies furnished by a program or agency funded by any government. This exclusion does not apply to Medicaid or when otherwise prohibited by applicable law.

46. **Group Therapy.** Group therapy or group counseling at any time in any setting by any provider is not covered.

47. **Hair Loss or Growth.** Wigs, hair transplants, or any medication (e.g. Rogaine, minoxidil, etc.) that is taken for hair growth, whether or not prescribed by a physician, are not covered. Treatment of male or female pattern baldness is not covered. Exception: wigs required because of hair loss as a direct result of chemotherapy.

48. **Health and Behavior Assessment/Intervention.** Evaluation of psychosocial factors potentially impacting physical health problems and treatments are not covered. This includes health and behavior assessment procedures used to identify psychological, behavioral, emotional, cognitive, and social factors affecting physical health problems.

49. **Heat Bandage.** Treatment of a wound with a warm active wound therapy device or a non-contact radiant heat bandage is not covered.

50. **High Dose Chemotherapy, Autologous Transplants, Allogeneic Transplants or Nonmyeloablative Allogeneic Stem Cell Transplantation.** High Dose Chemotherapy, Autologous Transplants, Allogeneic Transplants and Nonmyeloablative Allogeneic Stem Cell Transplantation are not covered, except in the circumstances set forth in the benefit section under "Transplantation Services".

51. **High frequency chest wall oscillators.** Charges associated with high frequency chest wall oscillators.

52. **Hippotherapy**. Charges associated with hippotherapy-(means movements of a horse) not covered.

53. **Home Uterine Activity Monitor.** Home uterine activity monitors or their use is not covered.

54. **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.

55. **Hypnotherapy -** means Hypnosis/subconscious-not covered.

56. **Illegal acts.** Charges for services received as a result of Injury or Sickness which is incurred while taking part or attempting to take part in an illegal activity, including but not limited to misdemeanors and felonies. It is not necessary that an arrest occur, criminal charges be filed, or, if filed, that a conviction result. Proof beyond a reasonable doubt is not required to be deemed an illegal act. This exclusion does not apply (a) if the Injury resulted from being the victim of an act of domestic violence, or (b) resulted from a documented medical condition (including both physical and mental health conditions).

57. **Illegal drugs or medications.** Services, supplies, care or treatment to a Covered Personal for an Injury or Sickness resulting from that Covered Person's voluntary taking of 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 using controlled substances and expenses will be covered for Substance Abuse treatment as specified in this Plan. This exclusion does not apply if the Injury (a) resulted from being the victim of an act of domestic violence, or (b) resulted from a documented medical condition (including both physical and mental health conditions).

58. **Impotence or Sexual Dysfunction.** We will not cover medical, surgical, or pharmacological treatment for impotence, frigidity, or other sexual dysfunction unless such dysfunction is the result of diabetic neuropathy, spinal cord injury, or prostate surgery.

59. **In Vitro Chemoresistance and Chemosensitivity Assays.** In Vitro chemoresistance and chemosensitivity assays for neoplastic disease, including, but not limited to, extreme drug resistance assays, histoculture drug response assay, or a fluorescent cytoprint assay are not covered.

60. **Incurred by Other Persons.** For expenses actually incurred by other persons.

62. **Inotropic Agents for Congestive Heart Failure.** Chronic, intermittent infusion of positive agents for patients with severe congestive heart failure is not covered. However, subject to all terms, conditions, exclusions and limitations of the Plan set forth in this Plan, where the Covered Person is on a Cardiac Transplant list at a facility where there is an ongoing Cardiac Transplantation program, the Plan will cover infusion of inotropic agents.

63. **Instructional Programs.** The plan will not pay for instructional or educational testing, programs, group type programs, seminars or workshops such as, but not limited to, childbirth classes, vocational training or testing, diet programs, nutritional programs, smoking cessation classes, educational or neuroeducational testing, or general or remedial education classes. Diabetic education is covered as set forth in benefit listed as "Diabetes Management".

64. **Laser Treatment of Spinal Intradiscal and Paravertebral Disc Disorders.** Laser treatment of spinal intradiscal and paravertebral disc disorders is not covered.

65. **Learning Disabilities**. Services or supplies provided for learning disabilities, i.e. reading disorder, alexis, developmental dyslexia, dyscalculia, spelling difficulty, applied behavior analysis and other learning difficulties, are not covered.

66. **Lost Medications.** Replacement of previously filled prescription medications because the initial prescription medication was lost, stolen, spilled, contaminated, etc. is not covered.

67. **Low Vision Enhancement system (LVES).** Charges associated with LVES.

68. **Magnetic Innervation Therapy.** Extracorporeal magnetic innervation therapy for the treatment of urinary incontinence is not covered.

69. **Maintenance Therapy.** The plan will not cover maintenance therapy for chiropractic therapy, physical therapy, occupational therapy, or speech therapy.

70. **Mammoplasty.** Except as stated in Schedule of Benefits "Reconstructive Surgery" the plan will not cover mammoplasty for reasons of augmentation or asymmetry of the breasts. The will not cover removal of breast implants placed or removed for cosmetic purposes.

71. **Mandated or Court Ordered Care.** The plan will not cover any medical, psychological, or psychiatric care that is the result of a Court order or otherwise mandated by a third party (such as, but not limited to, an employer, licensing board, recreation council, or school).

72. **Marital or pre-marital counseling.** Marriage and relationship counseling services are not covered.

73. **Medical Necessity.** Charges that are not medically necessary.

74. **Medical Reports.** We will not cover expenses for medical report preparation and presentation. We will not pay for provider appearances at hearings and court proceedings. We will not pay for charges for the completion of insurance forms or the preparation or copying of medical records.

75. **Medicare.** For benefits that are provided, or which would have been provided had the Covered Person enrolled, applied for, or maintained eligibility for such care and service benefits, under Title XVIII of the Federal Social Security Act of 1965 (Medicare), including any amendments thereto, or under any Federal law or regulation, except as provided in the sections entitled "Coordination of Benefits" and "Medicare."

76. **Medication Therapy Management Services.** Medication therapy management services by a pharmacist, including, but not limited to, a review of an Covered Person's history and medical profile, an evaluation of prescription medication, over-the-counter medications and herbal medications, are not covered.

77. **Mental Health or Substance Use Disorder.** In addition to all other terms, conditions, and limitations set out in this Plan, coverage for treatment of a Mental Health or Substance Use Disorder is subject to the following exclusions:
    a. A service performed in connection with treatment of a condition not classified as being an Axis I diagnosis in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association by the diagnosing or treating provider is not covered;
    b. Outpatient Psychotherapy or counseling for personal growth or life and social enrichment is not covered;
    c. A service that is not scientifically supported for the treatment of the Axis I diagnosis recorded is not covered;
    d. Residential treatment is not covered; and
    e. A service not provided by a Psychiatrist, Licensed Clinical Psychologist, Licensed Clinical Social Worker, Licensed Professional Counselor, Advanced Practice Nurse or Licensed Psychological Examiner is not covered.

78. **Negligence.** For Injuries resulting from negligence, misfeasance, malfeasance, nonfeasance or malpractice on the part of any licensed Physician;

79. **No charge.** Care and treatment for which there would not have been a charge if no coverage had been in force.

80. **Non-compliance.** The Plan will not cover services provided as the result of an Covered Person's refusal to comply with a physician's or other provider's recommendations or orders or failure to cooperate with a prescribed plan of treatment or recovery.

81. **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.

82. **No obligation to pay.** That are provided to a Covered Person for which the Provider of a service customarily makes no direct charge, or for which the Covered Person is not legally obligated to pay, or for which no charges would be made in the absence of this coverage, including but not limited to fees, care, supplies, or services for which a person, company or any other entity except the Covered Person or this benefit plan, may be liable for necessitating the fees, care, supplies, or services.

83. **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.

84. **Not specified as covered.** Non-traditional medical services, treatments and supplies which are not specified as covered under this Plan.

85. **Nutritional Counseling or Nutritional Supplements.** The Plan will not cover services for dietary control counseling or weight maintenance programs. For Covered Person's with Diabetes, see "Diabetes Management".

86. **Occupational.** Care and treatment of an Injury or Sickness that is occupational -- that is, arises from work for wage or profit including self-employment.

87. **Oral, Implantable and Injectable Contraceptives.** Oral and prescription contraceptive methods that are not on the formulary are not covered.

88. **Oral surgery**. Treatment of injury or disease of the teeth, oral surgery, treatment of gums or structures directly supporting or attached to the teeth, removal or replacement of teeth or dental implants.

89. **Orthognathic Surgery.** The surgical repositioning of segments of the mandible or maxilla containing one to several teeth, or the bodily reposition of entire jaws, whether to reduce a dislocation of temporomandibular joint or for any other purpose, is not covered.

90. **Orthopedic shoes**. Charges for orthopedic shoes (except when they are integral part of a leg brace and the cost is included in the orthotist's charge) or shoe inserts, or the purchase of orthotic services or appliances.

91. **Orthoptic or Pleoptic Therapy.** Orthoptic or Pleoptic therapy is not covered.

92. **Over-the-Counter Medications.** Medications (except insulin) that do not by law require a prescription from a physician are not covered.

93. **Pain Pump, Disposable.** Disposable pain pumps following surgery are not covered.

94. **Parkinson's disease, Treatment with Fetal Mesencephalic Transplantation.** Fetal mesencephalic transplantation (FMT) for treatment of Parkinson's disease is not covered.

95. **Percutaneous diskectomy.** Any method of percutaneous diskectomy, including, but not limited to, automated or manual percutaneous diskectomy, laser diskectomy, radiofrequency nucleotomy or nucleolysis, and coblation therapy, is not covered.

96. **Percutaneous Kyphoplasty.** Percutaneous kyphoplasty is not covered.

97. **Percutaneous Sacroplasty.** Percutaneous sacroplasty is not covered.

98. **Performance Enhancement.** We will not cover medical, surgical, or rehabilitation services primarily intended to improve the level of physical functioning for purposes of enhanced job, athletic, or recreational performance, including, but not limited to, work hardening programs, back schools, programs of general physical conditioning, athletic trainers, and special or specially modified surgical procedures designed to enhance performance above normal.

99. **Peripheral Nerve Stimulators.** Peripheral nerve stimulators are not covered.

100. **Peripheral Vascular Disease Rehabilitation Therapy.** Peripheral vascular disease rehabilitation therapy is not covered.

101. **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.

102. **Plan design excludes.** Charges excluded by the Plan design as mentioned in this document.

103. **Pre-Implantation Genetic Diagnosis.** The plan will not cover pre-implantation genetic diagnosis or treatment.

104. **Premarital Laboratory Work.** The Plan will not cover premarital laboratory work even if such premarital laboratory work is required by any state or local law.

105. **Private Room.** At the sole discretion of the Plan for an exception, the plan will not cover a private facility room. The Plan will pay the most common charge for semi-private accommodations. If you are charged for a private room, you must pay the difference between the charges for a private room and our payment.

106. **Prolotherapy.** Prolotherapy or Sclerotherapy for the stimulation of tendon or ligament tissue or for pain relief in a localized area of musculoskeletal origin is not covered.

107. **Provider Error.** That are required as a result of unreasonable Provider error;

108. **Provider not defined.** Services or supplies provided by an individual or entity that is not a Provider as defined in this Plan Document are not covered.

109. **Radio-frequency Thermal Therapy for Treatment of Orthopedic Conditions.** The use of radio-frequency thermal therapy for treatment of orthopedic conditions is not covered.

110. **Recreational therapy.** Services or supplies provided by a recreational therapist.

111. **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.

112. **Replacement braces.** Replacement of braces of the leg, arm, back, neck, or artificial arms or legs, unless there is sufficient change in the Covered Person's physical condition to make the original device no longer functional.

113. **Required Examinations or Services.** The Plan will not cover examinations or services required or recommended by a third party. This would include services for the purpose of:
    a. Obtaining employment;
    b. Maintaining employment;
    c. Obtaining insurance;
    d. Obtaining professional or other licenses;
    e. Engaging in travel;
    f. Athletic or recreational activities; or
    g. Attending a school, camp, or other program.

114. **Research Studies.** The plan will not cover any service provided in connection with research studies or clinical trials.

115. **Reversal of Sterilization.** The plan will not cover any procedures or related care to reverse previous sterilization.

116. **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.

117. **Seasonal Affective Disorder.** Use of photo therapy or light therapy to treat seasonal affective disorder or depression is not covered.

118. **Second Surgical Opinion and Consultation with Specialist.** The Plan will not cover a second surgical opinion and a consultation from the same physician or from two (2) who are in practice together.

119. **Self-Inflicted.** That are the result of intentionally self-inflicted Injuries or Illnesses. This exclusion does not apply (a) if the Injury resulted from being the victim of an act of domestic violence, or (b) resulted from a documented medical condition (including both physical and mental health conditions).

120. **Sensory Stimulation of Coma Patients.** Sensory stimulations, whether visual, auditory, olfactory, gustatory, cutaneous or kinesthetic, for coma patients is not covered.

121. **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.

122. **Services Not Specified as Covered Services.** The plan will not cover any services not specifically described in Schedule of Benefits under Covered Medical Benefits as being a covered service.

123. **Services Received Outside the United States.** Services or supplies received outside of the United States of America shall not be covered except at the sole discretion of Plan.

124. **Sex - Change Treatment.** Care, services or treatment for non-congenital transsexualism, gender dysphoria or sexual reassignment or change. This exclusion includes medications, implants, hormone therapy, and surgery, medical or psychiatric treatment.

125. **Sexual and Gender Identity Disorders.** Any services related to the treatment of sexual and gender identity disorders are not covered.

126. **Short Stature Syndrome.** Any services related to the treatment of short stature syndrome are not covered, except when short stature is caused by laboratory documented growth hormone deficiency.

127. **Sleep Apnea, Portable Studies.** Studies for the diagnosis, assessment, or management of obstructive sleep apnea, not continuously attended by a qualified technician, are not covered.

128. **Snoring.** Devices, procedures, or supplies to treat snoring are not covered.

129. **Sperm and Embryo Preservation and Donation.** We will not cover charges related to the donation, collection, or preservation of sperm or embryos for later use.

130. **Sterilization, Voluntary Hysterectomy**. The Plan will not cover charges related to a hysterectomy for the primary purpose of voluntary sterilization.

131. **Telephone and Other Electronic Consultation**. Telephone calls or other forms of electronic consultation (e.g. email, internet, or video) between a Provider and a Covered Person, or between a Provider and another Provider, for medical management or coordinating care, are not covered. This includes reporting or obtaining tests or laboratory results. However, subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Benefit Certificate, communications made by a Physician responsible for the direct care of a Covered Person in Care Management with involved health care Providers are covered.

132. **Thermography.** Thermography, which is the measuring of self-emanating infrared radiation that reveals temperature variation at the surface of the body, is not covered.

133. **Third Party Liability Exclusion.** We will not pay any Benefits to a Covered Person to the extent the Covered Person has received payment, in whole or in part, from a third party, or its insurer, for past or future medical or hospital or other health care charges as the result of the negligence or intentional act of a third party. If a Covered Person makes a Claim for Benefits under this Certificate prior to receiving payment from a third party, or its insurer, the Covered Person (or legal representative for a minor or incompetent) agrees to repay us from any amount of money received by the Covered Person from the third party, or its insurer.

134. **Thoracic Electrical Bioimpedance.** Thoracic electrical bioimpedance is not covered.

135. **Thoracoscopic Laser Ablation of Emphysematous Pulmonary Bullae.** Thoracoscopic laser ablation of emphysematous pulmonary bullae is not covered.

136. **Trans-telephonic Home Spirometry.** Trans-telephonic home or ambulatory spirometry is generally not covered. However, subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Certificate, trans-telephonic home or ambulatory spirometry is covered for patients who have had a lung transplant, when pre-approved by the QualChoice Care Management Department.

137. **Travel and Transportation Expenses.** The plan will not cover travel and transportation expenses, even if prescribed by a physician, except for ground or air emergency ambulance service or ambulance service for transfer coordinated by the QualChoice Care Management Department. Refer to your Benefits Summary for limitations.

138. **Travel, School, Recreation, or Work Related Immunizations.** Except to the extent coverage is specifically provided in this Plan, as a preventive health benefit, the plan will not cover immunizations to fulfill requirements for travel, school, recreation, or for work.

139. **Unlicensed Provider.** Coverage is not provided for treatment, procedures or services received from any person or entity, including but not limited to Physicians, who are required to be licensed to perform the treatment, procedure or service, but (1) is not so licensed, or (2) has had his/her 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.

140. **Vision and Hearing Services.** Except as set forth in the Benefits Summary, we will not cover routine eye or hearing examinations, services or tests, eyeglasses, contact lenses, hearing aids and other vision care and hearing care services and supplies, except as required for the diagnosis and treatment of diseases of, or injury to, the eyes or ears.

141. **Vision Correction.** We will not cover eye surgery to correct refractive errors. This includes refractive keratoplasty, refractive keratomileusis, epikeratophakia procedures, Low Vision Enhancement System (LVES), and eyeglass and contact lenses except the initial acquisition of one pair within the twelve months following cataract surgery, are not covered.

142. **Vitamins or Supplements.** Vitamins or nutrient supplements, except those that are prescription medications on an approved Formulary and are not available over the counter, are not covered. However, subject to all terms, conditions, exclusions and limitations of the Plan set forth in this Certificate, coverage is provided for medical foods and low protein modified food products for the treatment of phenylketonuria, galactosemia, organic acidemias, fatty acid and oxidative disorders, and disorders of amino acid metabolism as described in the Medical Benefits section for Medical Foods.

143. **Vocational Rehabilitation.** Vocational rehabilitation services, counseling and testing are not covered.

144. **War or Act of War.** That incurred as a result of war or any act of war, whether declared or undeclared, or any act of aggression, when the Covered Person is a member of the armed forces of any Country, or during

service by a Covered Person in the armed forces of any Country. This exclusion does not apply to any Covered Person who is not a member of the armed forces, and does not apply to victims of any act of war or aggression.

145. **Weight Control.** Medications prescribed, dispensed or used in any program of weight control, weight reduction, weight loss or other dietary control are not covered.

146. **Whole Body Computed Tomography.** Whole body computed tomography is not covered.

147. **Workers' Compensation.** The Plan will not cover any medical services or supplies for any injury, condition, or disease arising from any activities related to any employment for any Covered Person or that otherwise arises from a work-related injury or incident. The Plan will not make any payments even if: (a) no claim is tendered for benefits that may be available; and/or (b) no benefits are received under the Workers' Compensation, Defense Base Act, TRICARE, or other applicable laws and/or healthcare programs.

148. **Wound Treatment.** Blood derived growth factors are not covered.

Other Exclusions specific to this Plan:

1. **Smoking or Tobacco Cessation/or Caffeine Addiction.** Care and treatment for smoking cessation programs, including smoking deterrent products, unless Medically Necessary due to a severe active lung Illness such as emphysema or asthma or is required under the preventive care mandate of the Patient Protection and Affordable Care Act.

2. **Hazardous Pursuit, Hobby or Activity.** That are of an Injury or Sickness that results from engaging in a hazardous pursuit, hobby or activity. A pursuit, hobby or activity is hazardous if it involves or exposes an individual to risk of a degree or nature not customarily undertaken in the course of the Covered Person's customary occupation or if it involves leisure time activities commonly considered as involving unusual or exceptional risks, characterized by a constant threat of danger or risk of bodily harm **including but not limited to:** hang gliding, skydiving, bungee jumping, parasailing, use of all-terrain vehicles, rock climbing, use of explosives, automobile, motorcycle, aircraft, or speed boat racing, reckless operation of a vehicle or other machinery, and travel to countries with advisory warnings.

3. **Private Duty Nurses.** We will not cover private duty nurses.

4. **Infertility.** The plan will cover a basic diagnostic work-up to make an initial diagnosis of infertility. The plan will not cover any medications, procedures or other services for treatment of infertility. It does not matter whether the infertility service is diagnostic or therapeutic, it is still not covered. It does not matter whether the infertility service or treatment is by natural, artificial, mechanical, pharmacological, or other means, it is still not covered. Specific services that are not covered include, but are not limited to:
    a. Reversal of sterilization;
    b. Pre-implantation testing;
    c. Surrogate pregnancies;
    d. Medical treatment of infertility;
    e. Surgical treatment of infertility; and,
    f. In vitro fertilization.

    Note: The Plan will not pay for surgery that is done primarily for infertility treatment even when other disease or conditions that may be the underlying cause of the infertility are detected or treated during such surgery.

5. **Abortion.** The plan does not cover elective abortion, medical services, supplies or treatment the primary purpose of which is to cause an elective abortion. The plan does not cover any services, supplies or treatment provided as a result of such an abortion.

6. **Dependent Pregnancy.** Dependent pregnancy is not a covered benefit under this Plan.

Limitations to Benefits

Coverage is available for medical services or care as specified in the section titled Medical Benefits subject to the General Conditions for Payment, Pre-Authorization of Services and to all other applicable conditions, limitations and exclusions of the Plan.

1. **Ambulance.** Transportation by ground ambulance may limited to a maximum annual benefit amount. Transportation by air ambulance is limited to a maximum annual benefit amount and is subject to review for Medical Necessity. Consult the Schedule of Benefits for limitations.

2. **Auditory Brain Stem Implant.** One auditory brain stem implant per lifetime is covered for an individual twelve years of age and older with a diagnosis of Neurofibromatosis Type II (NF2) who has undergone removal of bilateral acoustic tumors.

3. **Biofeedback.** Biofeedback is covered only when it is Medically Necessary for muscle re-education of specific muscle groups, or for treating the pathological muscle abnormalities of spasticity, incapacitating muscle spasm, or weakness, and when more conventional treatments (heat, cold, exercise, and support) have not been successful. Pre-authorization is required. Biofeedback is medically appropriate when applied to the conditions reflected in the medical policies.

4. **Cochlear Implants.** Coverage for cochlear implants may be subject to a maximum lifetime benefit of one cochlear implant device, the surgical procedure, and one speech processor per Covered Person. Reimplantation of the same device is not covered. Pre-Authorization is required.

5. **Circumstances Beyond Our Control.** Services and other covered Benefits could be delayed or made impractical by circumstances not reasonably within our control, such as complete or partial destruction of facilities, war, riot, civil insurrection, labor disputes, and disability of a significant part of hospital or medical group personnel, or similar causes. If so, Network Providers will make a good faith effort to provide services and other Benefits covered hereunder. Neither any provider nor we shall have any other liability or obligation because of such delay or such failure to provide services or other Benefits.

6. **Dermatomal Somatosensory Evoked Potentials.** Pre-authorization is required for this service. Charges will be covered when it is Medically Necessary.

7. **Dynamic Orthotic Cranioplasty.** Dynamic orthotic cranioplasty charges will be covered when it is Medically Necessary. Pre-authorization is required.

8. **Electrotherapy and Electromagnetic Stimulators.** All treatment using electrotherapy and electromagnetic stimulators, including services and supplies used in conjunction with such stimulators, and complications resulting from such treatment, is covered only for conditions specified in our Medical Policies.

9. **Enhanced External Counterpulsation.** Enhanced external counterpulsation (EECP) is covered only for conditions specified in our Medical Policies.

10. **Genetic Counseling and Testing.** Genetic or genomic testing is often done on blood or tissue samples sent by your physician to a laboratory. *For genetic counseling or testing to be covered, it requires pre-authorization.*

Pre-authorization will only be given if the results of the genetic testing will affect choice of treatment or the outcome of treatment. This includes testing for mutations related to cancer and testing of tumors for mutations that may affect treatment. The Plan will not cover genetic or genomic testing to determine the likelihood of:

A. Developing a disease or condition; or
B. Disease or the presence of a disease in a relative; or
C. Passing an inheritable disease, for example, cystic fibrosis, or congenital abnormality to an offspring.

However, subject to all terms, conditions, exclusions and limitations set out in this Plan, genetic testing of the products of an amniocentesis to determine the presence of a disease or congenital anomaly in the fetus or genetic testing of an Covered Person's tissue to determine if the Covered Person has a specific disease (not to determine if the person is a carrier of a genetic abnormality), is covered if the test meets the medical necessity criteria. Any approved genetic testing must be preceded by genetic counseling. Note: this exclusion does not apply to the BRCA risk assessment and genetic counseling/testing requirement of the women's preventive care mandate of the Patient Protection and Affordable Care Act, which is covered under the Preventive Care benefit.

11. **Home Health Care.** Home health visits may be limited to a maximum number of visits per Covered Person per Plan. The home health care visit limitation and the costs sharing amounts are specified in the Schedule of Benefits. Pre-authorization is required.

12. **Hospice Services.** Hospice services may be limited to a maximum number of days of coverage per Covered Person. The hospice services day limitation and the cost sharing amounts are specified in the Schedule of Benefits. Pre-authorization is required.

13. **In Vitro Chemoresistance and Chemosensitivity Assays.** In Vitro chemoresistance and chemosensitivity assays for neoplastic disease, including, but no limited to, extreme drug resistance assays, histoculture drug response assay, or a fluorescent cytoprint assay are not covered, subject to Medical Policies.

14. **Lifetime Maximum.** Consult the Schedule of Benefits and this document for various lifetime maximum Benefits per Covered Person.

15. **Major Disaster or Epidemic.** If a major disaster or epidemic occurs, Network Physicians and Network Facilities will render medical services as is practical according to their best judgment within the limitation of available facilities and personnel. Neither any Network Provider nor we has any liability or obligation for delay or failure to provide or arrange any such services to the extent the disaster or epidemic creates unavailability of facilities or personnel.

16. **Medical Supplies.** Coverage of medical supplies is limited to a thirty-one (31)-day supply per month.

17. **Outpatient Rehabilitation Services.** Coverage for outpatient visits for physical, occupational, and speech therapy, audiology services, pulmonary rehabilitation, and chiropractic services are limited to a maximum number of visits per Covered Person per Plan Year as reflected in the Schedule of Benefits. Coverage for Cardiac Rehabilitation is limited to a maximum number of visits per Covered Person per Calendar Year as set out in the Schedule of Benefits.

18. **Prosthetic and orthotic devices and services.** The Plan does not cover replacement of a prosthetic or orthotic device or associated prosthetic or orthotic services more frequently than one (1) time every three (3) years unless Medically Necessary or indicated by other coverage criteria under this Certificate. However, the Plan will replace or repair a prosthetic or orthotic device if necessary due to anatomical changes or normal use, subject to co-payments, deductibles, and co-insurance as set out in the Schedule of Benefits.

19. **Refusal to Accept Treatment.** You may refuse to accept procedures or treatment recommended by Network Physicians for personal reasons. In such case, neither we nor any Network Physician or Provider shall have any further responsibility to provide care for the condition under treatment, unless you later recant the refusal and agree to follow the recommended treatment or procedure.

20. **Shoes and Shoe Inserts.** Custom molded and fitted shoes and shoe inserts are not covered except for a Covered Person with diabetes. Coverage for a Covered Person with diabetes for custom molded and fitted shoes and shoe inserts is subject to the following limitations:

    A. Two (2) pairs of custom molded and fitted shoes per year if the Covered Person is under 18 years of age and one (1) pair of custom molded and fitted shoes for a Covered Person 18 years of age or older; and

    B. Two (2) pairs of custom molded shoe inserts per year.

21. **Transplant Services.** Transplant services are subject to the following benefit maximums and limitations:

    A. Coverage for procurement and testing (per transplant) is limited to the amount reflected in your Schedule of Benefits;

    B. Lifetime maximum for an organ is limited to the amount reflected in your benefits summary.

    C. The Plan will not cover the transportation and/or lodging costs of the transplant donor, or individuals traveling with either the donor or the recipient. The Plan will not pay for artificial or non-human parts or organs or any services related to transplants using artificial or non-human parts or organs. Transportation and/or lodging costs of the transplant recipient are covered at the sole discretion and evaluation of the QualChoice Care Management Department.

    D. Coverage is limited to no more than two (2) transplants per Covered Person per lifetime. We cover re-transplantation, but a re-transplant is considered a transplant and counts toward the transplant limit of two (2);

    E. Expenses for drugs related to avoidance of rejection of a transplanted organ are subject to the lifetime transplant maximum as reflected in your Benefits Summary;

    F. Solid organ transplants of any kind are not covered for a Covered Person with a malignancy of any kind that is presently active, in partial remission, or in complete remission less than two (2) years. A solid organ transplant of any kind is not covered for a Covered Person that has had a malignancy removed or treated in the three (3) years prior to the proposed transplant. For purposes of this exclusion, malignancy includes a malignancy of the brain or meninges, head or neck, bronchus or lung, thyroid, parathyroid, thymus, pleura, esophagus, heart or pericardium, liver, stomach, small or large bowel, rectum, kidney, bladder, prostate, testicle, ovary, uterus, other organs associated with the genito-urinary tract, bones, muscle, nerves, blood vessels, leukemia, lymphoma, or melanoma. Exceptions to this exclusion are hepatocellular carcinoma under certain circumstances, basal or squamous cell carcinomas of the skin, absent lymphatic or distant metastasis.

    G. **Transplants that are not pre-authorized by are not covered.**

CLAIMS PROCEDURES AND PAYMENT OF CLAIMS

The procedures outlined below must be followed by Covered Persons to obtain payment of health benefits under this Plan. For the purposes of this section "claimant" shall mean any Covered Person or beneficiary submitting a claim to the Plan and thereby seeking to receive Plan benefits.

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

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

1. Obtain a Claim form from the Personnel Office, Human Resources Office or the Plan Administrator.

2. Complete the Employee portion of the form. ALL QUESTIONS MUST BE ANSWERED.

3. Have the Physician or Dentist complete the provider's portion of the form.

4. 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

5. Send the above to the Claims Administrator at this address:

QualChoice
12615 Chenal Parkway, Suite 300
Little Rock, Arkansas 72211
1-800-235-7111

Health Claims

All claims and questions regarding health claims should be directed to the Claims Administrator. The Plan Administrator shall be ultimately and finally responsible for adjudicating such claims and for providing full and fair review of the decision on such claims in accordance with the following provisions and with ERISA. Benefits under the Plan will be paid only if the Plan Administrator decides in its discretion that the Covered Person is entitled to them. The responsibility to process claims in accordance with the Plan Document may be delegated to the Claims Administrator; provided, however, that the Claims Administrator is not a fiduciary of the Plan and does not have the authority to make decisions involving the use of discretion.

Each Covered Person claiming benefits under the Plan shall be responsible for supplying, at such times and in such manner as the Plan Administrator in its sole discretion may require, written proof that the expenses were incurred or that the benefit is covered under the Plan. If the Plan Administrator in its sole discretion shall determine that the Covered Person has not Incurred a Covered Charge or that the benefit is not covered under the Plan, or if the Covered Person shall fail to furnish such proof as is requested, no benefits shall be payable under the Plan.

A call from a Provider who wants to know if an individual is covered under the Plan or if a certain procedure is

covered by the Plan, prior to providing treatment is not a "claim," since an actual claim for benefits is not being filed with the Plan. These are simply requests for information, and any response is not a guarantee of benefits, since payment of benefits is subject to all Plan provisions, limitations and exclusions. Once treatment is rendered, a Clean Claim must be filed with the Plan (which will be a "Post service Claim"). At that time, a determination will be made as to what benefits are payable under the Plan.

A claimant has the right to request a review of an Adverse Benefit Determination. 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 claims procedures properly, the claimant then has the right to request an independent external review. The external review procedures are described below.

The claims procedures are intended to provide a full and fair review. This means, among other things, that claims and appeals will be decided in a manner designed to ensure the independence and impartiality of the person involved in making these decisions.

Benefits will be payable to a Covered Person, or to a Provider that has accepted an Assignment of Benefits as consideration in full for services rendered.

According to Federal regulations which apply to the Plan, there are four (4) types of claims: Pre-service (Urgent and Non-urgent), Concurrent Care and Post service. However, as noted below, because of this Plan's design, there are no Pre-service Urgent Care Claims which may be filed with the Plan.

1. Pre-service Claims. A "Pre-service Claim" is a claim for a benefit under the Plan where the Plan conditions receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care. However, if the Plan does not require the Covered Person to obtain approval of a medical service prior to getting treatment, then there is no "Pre-service Claim." The Covered Person simply follows the Plan's procedures with respect to any notice which may be required after receipt of treatment, and files the claim as a Post-service Claim.

   A "Pre-service Urgent Care Claim" is any claim for medical care or treatment with respect to which the application of the time periods for making non urgent care determinations could seriously jeopardize the life or health of the Covered Person or the Covered Person's ability to regain maximum function, or, in the opinion of a Physician with knowledge of the Covered Person's medical condition, would subject the Participant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

   If a Covered Person needs medical care for a condition which could seriously jeopardize his or her life, obtain such care without delay, and communicate with the Plan as soon as reasonably possible.

   The Plan does not require the Covered Person to obtain approval of any urgent care or Emergency medical services or admissions prior to getting treatment for an urgent care or Emergency situation, so there are no "Pre-service Urgent Care Claims" under the Plan. The Covered Person simply follows the Plan's procedures with respect to any notice which may be required after receipt of treatment, and files the claim as a Post-service Claim.

   Pre-admission certification of a non-Emergency Hospital admission is a "claim" only to the extent of the determination made – that the type of procedure or condition warrants Inpatient confinement for a certain number of days. The rules regarding Pre-service Claims will apply to that determination only. Once a Covered Person has the treatment in question, the claim for benefits relating to that treatment will be treated as a Post-service Claim.

2. Concurrent Claims. A "Concurrent Claim" arises when the Plan has approved an on-going course of treatment to be provided over a period of time or number of treatments, and either:

   a. The Plan determines that the course of treatment should be reduced or terminated; or
   b. The Covered Person requests extension of the course of treatment beyond that which the Plan has approved.

   If the Plan does not require the Covered Person to obtain approval of a medical service prior to getting treatment, then there is no need to contact the Plan Administrator to request an extension of a course of treatment. The Covered Person simply follows the Plan's procedures with respect to any notice which may be required after receipt of treatment, and files the claim as a Post-service Claim.

3. Post-service Claims. A "Post-service Claim" is a claim for a benefit under the Plan after the services have been rendered.

When Claims Must Be Filed

Post-service health claims must be filed with the Claims Administrator within one hundred and eighty (180) days of the date charges for the service were Incurred. Benefits are based upon the Plan's provisions at the time the charges were incurred. Claims filed later than that date shall be denied.

a. it's not reasonably possible to submit the claim in that time; and
b. the claim is submitted within one year from the date incurred. This one year period will not apply when the person is not legally capable of submitting the claim.

A pre-service claim (including a concurrent claim that also is a pre-service claim) is considered to be filed when the request for approval of treatment or services is made and received by the Claims Administrator in accordance with the Plan's procedures.

Upon receipt of the required information, the claim will be deemed to be filed with the Plan. 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 as provided herein. This additional information must be received by the Claims Administrator within forty-five (45) days from receipt by the Participant of the request for additional information. Failure to do so may result in claims being declined or reduced.

Timing of Claim Decisions

The Plan Administrator shall notify the Covered Person, in accordance with the provisions set forth below, of any Adverse Benefit Determination (and, in the case of pre-service claims and concurrent claims, of decisions that a claim is payable in full) within the following timeframes:

1. Pre-service Urgent Care Claims:

   a. If the Covered Person has provided all of the necessary information, as soon as possible, taking into account the medical exigencies, but not later than seventy-two (72) hours after receipt of the claim.
   b. If the Covered Person has not provided all of the information needed to process the claim, then the Covered Person will be notified as to what specific information is needed as soon as possible, but not later than seventy-two (72) hours after receipt of the claim.
   c. The Covered Person will be notified of a determination of benefits as soon as possible, but not later than seventy-two (72) hours, taking into account the medical exigencies, after the earliest of:
      i. The Plan's receipt of the specified information; or
      ii. The end of the period afforded the Covered Person to provide the information.
   d. If there is an Adverse Benefit Determination, a request for an expedited appeal may be submitted orally or in writing by the Covered Person. All necessary information, including the Plan's benefit determination on review, may be transmitted between the Plan and the Covered Person by telephone, facsimile, or

other similarly expeditious method. Alternatively, the Covered Person may request an expedited review under the external review process.

2. Pre-service Non-urgent Care Claims:

   a. If the Covered Person has provided all of the information needed to process the claim, in a reasonable period of time appropriate to the medical circumstances, but not later than fifteen (15) days after receipt of the claim, unless an extension has been requested, then prior to the end of the fifteen (15) day extension period.
   b. If the Covered Person has not provided all of the information needed to process the claim, then the Covered Person will be notified as to what specific information is needed as soon as possible, but not later than five (5) days after receipt of the claim.

   The Covered Person will be notified of a determination of benefits in a reasonable period of time appropriate to the medical circumstances, either prior to the end of the extension period (if additional information was requested during the initial processing period), or by the date agreed to by the Plan Administrator and the Participant (if additional information was requested during the extension period).

3. Concurrent Claims:

   a. Plan Notice of Reduction or Termination. If the Plan Administrator is notifying the Covered Person of a reduction or termination of a course of treatment (other than by Plan amendment or termination), before the end of such period of time or number of treatments. The Covered Person will be notified sufficiently in advance of the reduction or termination to allow the Covered Person to appeal and obtain a determination on review of that Adverse Benefit Determination before the benefit is reduced or terminated. 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.
   b. Request by a Covered Person Involving Urgent Care. If the Plan Administrator receives a request from a Covered Person to extend the course of treatment beyond the period of time or number of treatments that is a claim involving urgent care, as soon as possible, taking into account the medical exigencies, but not later than seventy-two (72) hours after receipt of the claim, as long as the Covered Person makes the request at least seventy-two (72) hours prior to the expiration of the prescribed period of time or number of treatments. If the Covered Person submits the request with less than twenty-four (24) hours prior to the expiration of the prescribed period of time or number of treatments, the request will be treated as a claim involving urgent care and decided within the urgent care timeframe.
   c. Request by a Covered Person Involving Non-urgent Care. If the Plan Administrator receives a request from the Covered Person to extend the course of treatment beyond the period of time or number of treatments that is a claim not involving urgent care, the request will be treated as a new benefit claim and decided within the timeframe appropriate to the type of claim (either as a pre-service non-urgent claim or a post-service claim).
   d. Request by a Covered Person Involving Rescission. With respect to rescissions, the following timetable applies:
      i. Notification to Covered Person - thirty (30) days
      ii. Notification of Adverse Benefit Determination on appeal - thirty (30) days

4. Post-service Claims:

   a. If the Covered Person has provided all of the information needed to process the claim, in a reasonable period of time, but not later than thirty (30) days after receipt of the claim, unless an extension has been requested, then prior to the end of the fifteen (15) day extension period.

b. If the Covered Person has not provided all of the information needed to process the claim and additional information is requested during the initial processing period, then the Covered Person will be notified of a determination of benefits prior to the end of the extension period, unless additional information is requested during the extension period, then the Covered Person will be notified of the determination by a date agreed to by the Plan Administrator and the Covered Person.

   i. Extensions – Pre-service Urgent Care Claims. No extensions are available in connection with Pre-service urgent care claims.
   ii. Extensions – Pre-service Non-urgent Care Claims. This period may be extended by the Plan for up to fifteen (15) days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Covered Person, prior to the expiration of the initial fifteen (15) day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.
   iii. Extensions – Post-service Claims. This period may be extended by the Plan for up to fifteen (15) days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Covered Person, prior to the expiration of the initial thirty (30) day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.
   iv. Calculating Time Periods. The period of time within which a benefit determination is required to be made shall begin at the time a claim is deemed to be filed in accordance with the procedures of the Plan.

Notification of an Adverse Benefit Determination

The Plan Administrator shall provide a Covered Person with a notice, either in writing or electronically (or, in the case of pre-service urgent care claims, by telephone, facsimile or similar method, with written or electronic notice following within three (3) days), containing the following information:

1. Information sufficient to allow the Covered Person to identify the claim involved (including date of service, the healthcare Provider, the claim amount, if applicable, and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning);
2. A reference to the specific portion(s) of the Plan Document upon which a denial is based;
3. Specific reason(s) for a denial, including the denial code and its corresponding meaning, and a description of the Plan's standard, if any, that was used in denying the claim;
4. A description of any additional information necessary for the Covered Person to perfect the claim and an explanation of why such information is necessary;
5. A description of the Plan's review procedures and the time limits applicable to the procedures, including a statement of the Covered Person's right to bring a civil action under Section 502(a) of ERISA following an Adverse Benefit Determination on final review;
6. A statement that the Covered Person is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the Covered Person's claim for benefits;
7. The identity of any medical or vocational experts consulted in connection with a claim, even if the Plan did not rely upon their advice (or a statement that the identity of the expert will be provided, upon request);
8. Any rule, guideline, protocol or similar criterion that was relied upon in making the determination (or a statement that it was relied upon and that a copy will be provided to the Covered Person, free of charge, upon request);
9. In the case of denials based upon a medical judgment (such as whether the treatment is Medically Necessary or Experimental), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Covered Person's medical circumstances, or a statement that such explanation will be provided to the Covered Person, free of charge, upon request; and
10. In a claim involving urgent care, a description of the Plan's expedited review process.

Appeal of Adverse Benefit Determinations

Full and Fair Review of All Claims

In cases where a claim for benefits is denied, in whole or in part, and the Covered Person believes the claim has been denied wrongly, the Covered Person may appeal the denial and review pertinent documents. The claims procedures of this Plan provide a Covered Person with a reasonable opportunity for a full and fair review of a claim and Adverse Benefit Determination. More specifically, the Plan provides:

1. Covered Persons at least one hundred and eighty (180) days following receipt of a notification of an initial Adverse Benefit Determination within which to appeal the determination;
2. Covered Persons the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;
3. Covered Persons the opportunity to review the Claim file and to present evidence and testimony as part of the internal claims and appeals process;
4. For a review that does not afford deference to the previous Adverse Benefit Determination and that is conducted by an appropriate named fiduciary of the Plan, who shall be neither the individual who made the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of such individual;
5. For a review that takes into account all comments, documents, records, and other information submitted by the Covered Person relating to the claim, without regard to whether such information was submitted or considered in the prior benefit determination;
6. That, in deciding an appeal of any Adverse Benefit Determination that is based in whole or in part upon a medical judgment, the Plan fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, who is neither an individual who was consulted in connection with the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of any such individual;
7. For the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claim, even if the Plan did not rely upon their advice; and
8. That a Covered Person will be provided, free of charge: (a) reasonable access to, and copies of, all documents, records, and other information relevant to the Covered Person's claim in possession of the Plan Administrator or Claims Administrator; (b) information regarding any voluntary appeals procedures offered by the Plan; (c) information regarding the Covered Person's right to an external review process; (d) any internal rule, guideline, protocol or other similar criterion relied upon, considered or generated in making the adverse determination; and (e) an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Covered Person's medical circumstances; and
9. That a Covered Person will be provided, free of charge, and sufficiently in advance of the date that the notice of Final Internal Adverse Benefit Determination is required, with new or additional evidence considered, relied upon, or generated by the Plan in connection with the Claim, as well as any new or additional rationale for a denial at the internal appeals stage, and a reasonable opportunity for the Covered Person to respond to such new evidence or rationale.

9.02B Requirements for Appeal

The Covered Person must file the appeal in writing (although oral appeals are permitted for pre service urgent care claims) within one hundred and eighty (180) days following receipt of the notice of an Adverse Benefit Determination. For pre-service urgent care claims, if the Covered Person chooses to orally appeal, the Covered Person may telephone:

QualChoice Health Plan Services, Inc.
12615 Chenal Parkway, Suite 300
Little Rock, Arkansas 72211
1-800-235-7111

To file an appeal in writing, the Covered Person's appeal must be addressed as follows and mailed or faxed as follows:

QualChoice Health Plan Services, Inc.
12615 Chenal Parkway, Suite 300
Little Rock, Arkansas 72211
1-800-235-7111

It shall be the responsibility of the Covered Person to submit proof that the claim for benefits is covered and payable under the provisions of the Plan. Any appeal must include:

1. The name of the Employee/Covered Person;
2. The Employee/Covered Person's social security number;
3. The group name or identification number;
4. All facts and theories supporting the claim for benefits. Failure to include any theories or facts in the appeal will result in their being deemed waived. In other words, the Covered Person will lose the right to raise factual arguments and theories which support this claim if the Participant fails to include them in the appeal;
5. A statement in clear and concise terms of the reason or reasons for disagreement with the handling of the claim; and
6. Any material or information that the Covered Person has which indicates that the Covered Person is entitled to benefits under the Plan.

If the Covered Person provides all of the required information, it may be that the expenses will be eligible for payment under the Plan.

Timing of Notification of Benefit Determination on Review
The Plan Administrator shall notify the Covered Person of the Plan's benefit determination on review within the following timeframes:

1. Pre-service Urgent Care Claims: As soon as possible, taking into account the medical exigencies, but not later than seventy-two (72) hours after receipt of the appeal;
2. Pre-service Non-urgent Care Claims: Within a reasonable period of time appropriate to the medical circumstances, but not later than thirty (30) days after receipt of the appeal;
3. Concurrent Claims: The response will be made in the appropriate time period based upon the type of claim: Pre-service Urgent, Pre-service Non-urgent or Post-service; and
4. Post-service Claims: Within a reasonable period of time, but not later than sixty (60) days after receipt of the appeal.

Calculating Time Periods. The period of time within which the Plan's determination is required to be made shall begin at the time an appeal is filed in accordance with the procedures of this Plan, without regard to whether all information necessary to make the determination accompanies the filing.

Manner and Content of Notification of Adverse Benefit Determination on Review
The Plan Administrator shall provide a Covered Person with notification, with respect to pre-service urgent care claims, by telephone, facsimile or similar method, and with respect to all other types of claims, in writing or electronically, of a Plan's Adverse Benefit Determination on review, setting forth:

1. Information sufficient to allow the Covered Person to identify the claim involved (including date of service, the healthcare Provider, the claim amount, if applicable, and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning);
2. A reference to the specific portion(s) of the plan provisions upon which a denial is based;

3. Specific reason(s) for a denial, including the denial code and its corresponding meaning, and a description of the Plan's standard, if any, that was used in denying the claim, and a discussion of the decision;
4. A description of any additional information necessary for the Covered Person to perfect the claim and an explanation of why such information is necessary;
5. A description of available internal appeals and external review processes, including information regarding how to initiate an appeal;
6. A description of the Plan's review procedures and the time limits applicable to the procedures. This description will include information on how to initiate the appeal and a statement of the Covered Person's right to bring a civil action under section 502(a) of ERISA following an Adverse Benefit Determination on final review;
7. A statement that the Covered Person is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Covered Person's claim for benefits;
8. The identity of any medical or vocational experts consulted in connection with a claim, even if the Plan did not rely upon their advice (or a statement that the identity of the expert will be provided, upon request);
9. Any rule, guideline, protocol or similar criterion that was relied upon, considered, or generated in making the determination will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol or similar criterion was relied upon in making the determination and a copy will be provided to the Covered Person free of charge, upon request;
10. In the case of denials based upon a medical judgment (such as whether the treatment is Medically Necessary or Experimental), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Covered Person's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided to the Covered Person, free of charge, upon request; and
11. The following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency."

Furnishing Documents in the Event of an Adverse Determination
In the case of an Adverse Benefit Determination on review, the Plan Administrator shall provide such access to, and copies of, documents, records, and other information described in the section relating to "Manner and Content of Notification of Adverse Benefit Determination on Review" as appropriate.

Decision on Review
If, for any reason, the Covered Person does not receive a written response to the appeal within the appropriate time period set forth above, the Covered Person may assume that the appeal has been denied. The decision by the Plan Administrator or other appropriate named fiduciary of the Plan on review will be final, binding and conclusive and will be afforded the maximum deference permitted by law. All claim review procedures provided for in the Plan must be exhausted before any legal action is brought.

External Review Process
The Federal external review process does not apply to a denial, reduction, termination, or a failure to provide payment for a benefit based on a determination that a participant or beneficiary fails to meet the requirements for eligibility under the terms of a group health plan.

The Federal external review process applies only to:

1. An Adverse Benefit Determination (including a Final Internal Adverse Benefit Determination) by a plan or issuer that involves medical judgment (including, but not limited to, those based on the plan's or issuer's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or its determination that a treatment is Experimental or Investigational), as determined by the external reviewer; and
2. A rescission of coverage (whether or not the rescission has any effect on any particular benefit at that time).

Standard external review

Standard external review is external review that is not considered expedited (as described in the "expedited external review" paragraph in this section).

1. Request for external review. The Plan will allow a claimant to file a request for an external review with the Plan if the request is filed within four (4) months after the date of receipt of a notice of an Adverse Benefit Determination or Final Internal Adverse Benefit Determination. If there is no corresponding date four months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth month following the receipt of the notice. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.

2. Preliminary review. Within five (5) business days following the date of receipt of the external review request, the Plan will complete a preliminary review of the request to determine whether:
    a. The claimant is or was covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the Plan at the time the health care item or service was provided;
    b. The Adverse Benefit Determination or the final Adverse Benefit Determination does not relate to the claimant's failure to meet the requirements for eligibility under the terms of the Plan (e.g., worker classification or similar determination);
    c. The claimant has exhausted the Plan's internal appeal process unless the claimant is not required to exhaust the internal appeals process under the interim final regulations;
    d. The claimant has provided all the information and forms required to process an external review. Within one (1) business day after completion of the preliminary review, the Plan will issue a notification in writing to the claimant. If the request is complete but not eligible for external review, such notification will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)). If the request is not complete, such notification will describe the information or materials needed to make the request complete and the Plan will allow a claimant to perfect the request for external review with the four-month filing period or within the 48 hour period following the receipt of the notification, whichever is later.

3. Referral to Independent Review Organization. The Plan will assign an independent review organization (IRO) that is accredited by URAC or by a similar nationally-recognized accrediting organization to conduct the external review. Moreover, the Plan will take action against bias and to ensure independence. Accordingly, the Plan will contract with (or direct the Claims Processor to contract with, on its behalf) at least three (3) IROs for assignments under the Plan and rotate claims assignments among them (or incorporate other independent unbiased method for selection of IROs, such as random selection). In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits.

4. Reversal of Plan's decision. Upon receipt of a notice of a final external review decision reversing the Adverse Benefit Determination or Final Internal Adverse Benefit Determination, the Plan will provide coverage or payment for the claim without delay, regardless of whether the plan intends to seek judicial review of the external review decision and unless or until there is a judicial decision otherwise.

Expedited external review

1. Request for expedited external review. The Plan will allow a claimant to make a request for an expedited external review with the Plan at the time the claimant receives:

a. An Adverse Benefit Determination if the Adverse Benefit Determination involves a medical condition of the claimant for which the timeframe for completion of a standard internal appeal under the interim final regulations would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function and the claimant has filed a request for an expedited internal appeal; or
b. A Final Internal Adverse Benefit Determination, if the claimant has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function, or if the Final Internal Adverse Benefit Determination concerns an 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.

2. Preliminary review. Immediately upon receipt of the request for expedited external review, the Plan will determine whether the request meets the reviewability requirements set forth above for standard external review. The Plan will immediately send a notice that meets the requirements set forth above for standard external review to the claimant of its eligibility determination.

3. Referral to Independent Review Organization. Upon a determination that a request is eligible for external review following the preliminary review, the Plan will assign an IRO pursuant to the requirements set forth above for standard review. The Plan will provide or transmit all necessary documents and information considered in making the Adverse Benefit Determination or Final Internal Adverse Benefit Determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method. The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the information or documents described above under the procedures for standard review. In reaching a decision, the assigned IRO will review the claim de novo and is not bound by any decisions or conclusions reached during the Plan's internal claims and appeals process.

4. Notice of final external review decision. The Plan's (or Claim Processor's) contract with the assigned IRO will require the IRO to provide notice of the final external review decision, in accordance with the requirements set forth above, as expeditiously as the claimant's medical condition or circumstances require, but in no event more than seventy-two (72) hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within forty-eight (48) hours after the date of providing that notice, the assigned IRO will provide written confirmation of the decision to the claimant and the Plan.

Deemed Exhaustion of Internal Claims Procedures and De Minimis

Exception to the Deemed Exhaustion Rule

A claimant will not be required to exhaust the internal claims and appeals procedures described above if the Plan fails to adhere to the claims procedures requirements. In such an instance, a claimant may proceed immediately to the External Review Program or make a claim in court. However, the internal claim and appeals procedures will not be deemed exhausted (meaning the claimant must adhere to them before participating in the External Review Program or brining a claim in court) in the event of a de minimis violation that does not cause, and is not likely to cause, prejudice or harm to the claimant as long as the Plan Administrator demonstrates that the violation was for good cause or due to matters beyond the control of the Plan, the violation occurred in the context of an ongoing, good faith exchange of information between the Plan and the claimant, and the violation is not reflective of a pattern or practice of non-compliance.

If a claimant believes the Plan Administrator has engaged in a violation of the claims procedures and would like to pursue an immediate review, the claimant, may request that the Plan provide a written explanation of the violation, including a description of the Plan's basis for asserting that the violation should not result in a "deemed exhaustion" of the claims procedures.

The Plan will respond to this request within ten (10) days. If the External Reviewer or a court rejects a request for immediate review because the Plan has met the requirements for the "de minimis" exception described above, the

Plan will provide the claimant with notice of an opportunity to resubmit and pursue an internal appeal of the claim.

Appointment of Authorized Representative
A Covered Person is permitted to appoint an authorized representative to act on his or her behalf with respect to a benefit claim or appeal of a denial. An Assignment of Benefits by a Covered Person to a Provider will not constitute appointment of that Provider as an authorized representative. To appoint such a representative, the Covered Person must complete a form which can be obtained from the Plan Administrator or the Claims Administrator. However, in connection with a claim involving Urgent Care, the Plan will permit a health care professional with knowledge of the Covered Person's medical condition to act as the Covered Person's authorized representative without completion of this form. In the event a Covered Person designates an authorized representative, all future communications from the Plan will be with the representative, rather than the Covered Person, unless the Covered Person directs the Plan Administrator, in writing, to the contrary.

Physical Examinations
The Plan reserves the right to have a Physician of its own choosing examine any Covered Person whose condition, Sickness or Injury is the basis of a claim. All such examinations shall be at the expense of the Plan. This right may be exercised when and as often as the Plan may reasonably require during the pendency of a claim. The Covered Person must comply with this requirement as a necessary condition to coverage.

Autopsy
The Plan reserves the right to have an autopsy performed upon any deceased Covered Person whose condition, Sickness, or Injury is the basis of a claim. This right may be exercised only where not prohibited by law.

Payment of Benefits
All benefits under this Plan are payable, in U.S. Dollars, to the covered Employee whose Sickness or Injury, or whose covered Dependent's Sickness or Injury, is the basis of a claim. In the event of the death or incapacity of a covered Employee and in the absence of written evidence to this Plan of the qualification of a guardian for his or her estate, this Plan may, in its sole discretion, make any and all such payments to the individual or Institution which, in the opinion of this Plan, is or was providing the care and support of such Employee.

Assignments
Benefits for medical expenses covered under this Plan may be assigned by a Covered Person to the Provider as consideration in full for services rendered; however, if those benefits are paid directly to the Employee, the Plan shall be deemed to have fulfilled its obligations with respect to such benefits. The Plan will not be responsible for determining whether any such assignment is valid. Payment of benefits which have been assigned will be made directly to the assignee unless a written request not to honor the assignment, signed by the covered Employee and the assignee, has been received before the proof of loss is submitted.

No Covered Person shall at any time, either during the time in which he or she is a Covered Person in the Plan, or following his or her termination as a Covered Person in any manner, have any right to assign his or her right to sue to recover benefits under the Plan, to enforce rights due under the Plan or to any other causes of action which he or she may have against the Plan or its fiduciaries.

A Provider which accepts an Assignment of Benefits, in accordance with this Plan as consideration in full for services rendered, is bound by the rules and provisions set forth within the terms of this document.

Recovery of Payments
Occasionally, benefits are paid more than once, are paid based upon improper billing or a misstatement in a proof of loss or enrollment information, are not paid according to the Plan's terms, conditions, limitations or exclusions, or should otherwise not have been paid by the Plan. As such this Plan may pay benefits that are later found to be greater than the Maximum Allowable Expense.
In this case, this Plan may recover the amount of the overpayment from the source to which it was paid, primary payers, or from the party on whose behalf the charge(s) were paid. As such, whenever the Plan pays benefits exceeding the amount of benefits payable under the terms of the Plan, the Plan Administrator has the right to

recover any such erroneous payment directly from the person or entity who received such payment and/or from other payers and/or the Covered Person or Dependent on whose behalf such payment was made.

A Covered Person, Dependent, Provider, another benefit plan, insurer, or any other person or entity who receives a payment exceeding the amount of benefits payable under the terms of the Plan or on whose behalf such payment was made, shall return or refund the amount of such erroneous payment to the Plan within thirty (30) days of discovery or demand. The Plan Administrator shall have no obligation to secure payment for the expense for which the erroneous payment was made or to which it was applied.

The person or entity receiving an erroneous payment may not apply such payment to another expense. The Plan Administrator shall have the sole discretion to choose who will repay the Plan for an erroneous payment and whether such payment shall be reimbursed in a lump sum. When a Covered Person or other entity does not comply with the provisions of this section, the Plan Administrator shall have the authority, in its sole discretion, to deny payment of any claims for benefits by the Covered Person and to deny or reduce future benefits payable (including payment of future benefits for other injuries or Illnesses) under the Plan by the amount due as reimbursement to the Plan. The Plan Administrator may also, in its sole discretion, deny or reduce future benefits (including future benefits for other injuries or Illnesses) under any other group benefits plan maintained by the Plan Sponsor. The reductions will equal the amount of the required reimbursement.

Providers and any other person or entity accepting payment from the Plan or to whom a right to benefits has been assigned, in consideration of services rendered, payments and/or rights, agrees to be bound by the terms of this Plan and agree to submit claims for reimbursement in strict accordance with their State's health care practice acts, ICD-10 or CPT standards, Medicare guidelines, HCPCS standards, or other standards approved by the Plan Administrator or insurer. Any payments made on claims for reimbursement not in accordance with the above provisions shall be repaid to the Plan within thirty (30) days of discovery or demand or incur prejudgment interest of 1.5% per month. If the Plan must bring an action against a Covered Person Provider or other person or entity to enforce the provisions of this section, then that Covered Person, Provider or other person or entity agrees to pay the Plan's attorneys' fees and costs, regardless of the action's outcome.

Further, Covered Persons and/or their Dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (Covered Persons) shall assign or be deemed to have assigned to the Plan their right to recover said payments made by the Plan, from any other party and/or recovery for which the Covered Person(s) are entitled, for or in relation to facility-acquired condition(s), Provider error(s), or damages arising from another party's act or omission for which the Plan has not already been refunded.

The Plan reserves the right to deduct from any benefits properly payable under this Plan the amount of any payment which has been made:

1. In error;
2. Pursuant to a misstatement contained in a proof of loss or a fraudulent act;
3. Pursuant to a misstatement made to obtain coverage under this Plan within two (2) years after the date such coverage commences;
4. With respect to an ineligible person;
5. In anticipation of obtaining a recovery if a Covered Person fails to comply with the Plan's Third Party Recovery, Subrogation and Reimbursement provisions; or
6. Pursuant to a claim for which benefits are recoverable under any policy or act of law providing for coverage for occupational Injury or Disease to the extent that such benefits are recovered. This provision (6) shall not be deemed to require the Plan to pay benefits under this Plan in any such instance.

The deduction may be made against any claim for benefits under this Plan by a Covered Person or by any of his covered Dependents if such payment is made with respect to the Covered Person or any person covered or asserting coverage as a Dependent of the Covered Person.

If the Plan seeks to recoup funds from a Provider, due to a claim being made in error, a claim being fraudulent on

the part of the Provider, and/or the claim that is the result of the Provider's misstatement, said Provider shall, as part of its assignment to benefits from the Plan, abstain from billing the Covered Person for any outstanding amount(s).

Medicaid Coverage

A Covered Person's eligibility for any State Medicaid benefits will not be taken into account in determining or making any payments for benefits to or on behalf of such Covered Person. Any such benefit payments will be subject to the State's right to reimbursement for benefits it has paid on behalf of the Covered Person, as required by the State Medicaid program; and the Plan will honor any Subrogation rights the State may have with respect to benefits which are payable under the Plan.

Limitation of Action

A claimant cannot bring any legal action against the Company or the Claims Administrator to recover reimbursement until ninety (90) days after the claimant has properly submitted a request for reimbursement as described in this section and all required reviews of the claimant's claim have been completed. If the claimant wants to bring a legal action against the Company or the Claims Administrator, he/she must do so within three (3) years from the expiration of the time period in which a request for reimbursement must be submitted or he/she loses any rights to bring such an action against the Company or the Claims Administrator.

A claimant cannot bring any legal action against the Company or the Claims Administrator for any other reason unless he/she first completes all the steps, in the appeal process described in this section. After completing that process, if he/she wants to bring a legal action against the Company or the Claims Administrator he/she must do so within three (3) years of the date he/she is notified of the final decision on the appeal or he/she will lose any rights to bring such an action against the Company or the Claims Administrator.

COORDINATION OF BENEFITS

This provision shall apply to all benefits provided under any section of this Plan.

Excess Insurance
If at the time of Injury, Sickness, Disease or disability there is available, or potentially available any Coverage (including but not limited to Coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of Coverage.

The Plan's benefits will be excess to, whenever possible:

1. Group or group-type plans, including franchise or blanket benefit plans.
2. Fully Insured 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.

Allowable Expenses shall mean the Usual and Customary charge for any Medically Necessary, Reasonable, and eligible item of expense, at least a portion of which is covered under a plan. When some Other Plan pays first in accordance with the Application to Benefit Determinations Section herein, this Plan's Allowable Expenses shall in no event exceed the Other Plan's Allowable Expenses. When some Other Plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered, in the amount that would be payable in accordance with the terms of the Plan shall be deemed to be the benefit. Benefits payable under any Other Plan include the benefits that would have been payable had claim been duly made therefore.

In the case of HMO (Health Maintenance Organization)or other in-network 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. Further, when an HMO or network plan is primary and the Covered Person does not use an HMO Provider or network, this plan will not consider as Allowable Expenses any charge that would have been covered by the HMO or network plan had the Covered Person used the services of an HMO or network provider.

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 any vehicle insurance, the Plan shall pay excess benefits only, without reimbursement for vehicle plan and/or policy Deductibles. This Plan shall always be considered secondary to such plans and/or policies. This applies to all forms of medical payments under vehicle plans and/or policies regardless of its name, title or classification.

Effect on Benefits

Application to Benefit Determinations
The plan that pays first according to the rules in the section entitled "Order of Benefit Determination" will pay as if there were no Other Plan involved. The secondary and subsequent plans will pay the balance due up to one hundred percent (100%) of the total Allowable Expenses. When there is a conflict in the rules, this Plan will never pay more than fifty percent (50%) of Allowable Expenses when paying secondary. Benefits will be coordinated on the basis of a Claim Determination Period.

When medical payments are available under automobile insurance, this Plan will pay excess benefits only, without reimbursement for automobile plan Deductibles. This Plan will always be considered the secondary carrier regardless of the individual's election under personal Injury protection (PIP) coverage with the automobile insurance carrier.

In certain instances, the benefits of the Other Plan will be ignored for the purposes of determining the benefits under this Plan. This is the case when:

1. The Other Plan would, according to its rules, determine its benefits after the benefits of this Plan have been determined; and
2. The rules in the section entitled "Order of Benefit Determination" would require this Plan to determine its benefits before the Other Plan.

Order of Benefit Determination
For the purposes of the section entitled "Application to Benefit Determinations," the rules establishing the order of benefit determination are:

1. A plan without a coordinating provision will always be the primary plan;

2. The benefit plan which covers a Covered Person as an employee who is neither laid-off nor retired are determined to be the primary payer, before the benefit plan which covers that Covered Person as an employee who is laid-off or retired. The benefit plan which covers a Covered Person as a dependent of an employee who is neither laid-off nor retired are determined to be the primary payer, before the benefit plan which covers a Covered Person as a dependent of an employee who is laid-off or retired. 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 will not apply.

3. The benefit plan which covers a Covered Person as an employee who is neither laid-off nor retired or a dependent of an employee who is neither laid-off nor retired will be primary to the plan which covers the Covered Person which covers the participant as a COBRA participant.

4. When a dependent child is covered and the parents are not separated or divorced, these rules apply:

    a. The benefit plan of the parent whose birthday that falls earlier in a year will be the primary payer and the other parent will be the secondary payer.
    b. If both parents have the same birthday, the benefit plan that has been in effective for the longer period of time will be the primary payer and the other payer will be secondary.

5. When a dependent child is covered and the parents are divorced or legally separated, these rules apply:

    a. When the parents are separated or divorced, and the parent with custody of the child has not remarried. The plan of the parent which has custody of the dependent child will be the primary payer and the other parent's plan will be the secondary payer.
    b. When the parents are divorced and the parent with custody of the child has remarried, the plan of the parent with custody of the dependent child will be the primary payer, the stepparent will be the secondary payer and the parent without custody will be considered last.
    c. **THIS RULE WILL OVER RIDE 5A & 5B WHEN IT APPLIES:** If there is a COURT DECREE that may state which parent of the dependent child is to be financially responsible for medical/health insurance of the dependent child. In this case, the benefit plan of that parent will be the primary payer.
    d. If the COURT DECREE state that the parents shall share joint custody, without stating which parent is to be primarily financially responsible for the medical/health insurance of the dependent child. The order of benefits for payment on the dependent child will follow rule 5A.
    e. For parents who were never married to each other, the rules above apply as long as paternity has been established.

6. If an adult dependent is listed as a dependent under a parent's and a spouse's plan, the plan that has covered the adult dependent for the longest period of time will be the primary payer and the other plan will be the secondary payer.

7. Medicare will pay primary, secondary or last to the extent stated in Federal Law. The Covered Person and spouse must enroll in Medicare Part A and B.

    a. Medicare would be the primary payer if the employee was eligible due to age or disability.
    b. Medicare would be the secondary payer if the spouse is a dependent of a full time employee and the dependent spouse is the Covered Person that has Medicare Part A and B.
    c. A Covered Person or the Covered Person's spouse eligible for Medicare based solely on End Stage Renal Disease (ESRD), in entitled to have this plan pay primary for the first thirty (30) months beginning with the date of the diagnosis of End Stage Renal Disease (ESRD).

8. If a Covered Person is under a disability extension from a previous benefit plan, the previous benefit plan will pay primary and this plan will pay secondary.

9. This 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
For the purpose of determining the applicability of and implementing the terms of this provision or any provision of similar purpose of any Other Plan, this Plan may, without the consent of or notice to any person, release to or obtain from any insurance company, or other organization or individual, any information with respect to any person, which the Plan deems to be necessary for such purposes. Any person claiming benefits under this Plan shall furnish to the Plan such information as may be necessary to implement this provision.

Facility of payment
Whenever payments which should have been made under this Plan in accordance with this provision have been made under any Other Plans, the Plan Administrator may, in its sole discretion, pay any organizations making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of this provision, and amounts so paid shall be deemed to be benefits paid under this Plan and, to the extent of such payments, this Plan shall be fully discharged from liability.

Right of recovery
In accordance with the Recovery of Payments provision, whenever payments have been made by this Plan with respect to Allowable Expenses in a total amount, at any time, in excess of the Maximum Amount of payment necessary at that time to satisfy the intent of this Article, the Plan shall have the right to recover such payments, to the extent of such excess, from any one or more of the following as this Plan shall determine: any person to or with respect to whom such payments were made, or such person’s legal representative, any insurance companies, or any other individuals or organizations which the Plan determines are responsible for payment of such Allowable Expenses, and any future benefits payable to the Covered Person or his or her Dependents. Please see the Recovery of Payments provision above for more details.

Exception to Medicaid. In accordance with ERISA, the Plan shall not take into consideration the fact that an individual is eligible for or is provided medical assistance through Medicaid when enrolling an individual in the Plan or making a determination about the payments for benefits received by a Covered Person under the Plan.

THIRD PARTY RECOVERY, SUBROGATION AND REIMBURSEMENT PROVISION

Payment Condition

1. The Plan, in its sole discretion, may elect to conditionally advance payment of benefits in those situations where an Injury, Sickness, Disease or disability is caused in whole or in part by, or results from the acts or omissions of Covered Persons and/or their Dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this section as "Covered Person(s)") or a third party, where any party besides the Plan may be responsible for expenses arising from an incident, and/or other funds are available, including but not limited to no-fault, uninsured motorist, underinsured motorist, medical payment provisions, third party assets, third party insurance, and/or guarantor(s) of a third party (collectively "Coverage").

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

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

4. If there is more than one party responsible for charges paid by the Plan, or may be responsible for charges paid by the Plan, the Plan will not be required to select a particular party from whom reimbursement is due. Furthermore, unallocated settlement funds meant to compensate multiple injured parties of which the Covered Person(s) is/are only one or a few, that unallocated settlement fund is considered designated as an "identifiable" fund from which the plan may seek reimbursement.

Subrogation

1. As a condition to participating in and receiving benefits under this Plan, the Covered Person(s) agrees to assign to the Plan the right to subrogate and pursue any and all claims, causes of action or rights that may arise against any person, corporation and/or entity and to any Coverage to which the Covered Person(s) is entitled, regardless of how classified or characterized, at the Plan's discretion.

2. If a Covered Person(s) receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the Plan to any claim, which any Covered Person(s) may have against any Coverage and/or party causing the Sickness or Injury to the extent of such conditional payment by the Plan plus reasonable costs of collection.

3. The Plan may, at its discretion, in its own name or in the name of the Covered Person(s) commence a proceeding or pursue a claim against any party or Coverage for the recovery of all damages to the full extent of the value of any such benefits or conditional payments advanced by the Plan.

4. If the Covered Person(s) fails to file a claim or pursue damages against:

    a. The responsible party, its insurer, or any other source on behalf of that party;

b. Any first party insurance through medical payment coverage, personal Injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
c. Any policy of insurance from any insurance company or guarantor of a third party;
d. Workers' compensation or other liability insurance company; or
e. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage;

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

Right of Reimbursement

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

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

3. The Plan's right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of the Covered Person(s), whether under the doctrines of causation, comparative fault or contributory negligence, or other similar doctrine in law. Accordingly, any lien reduction statutes, which attempt to apply such laws and reduce a subrogating Plan's recovery will not be applicable to the Plan and will not reduce the Plan's reimbursement rights.

4. These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgment of these rights is required by the Plan and signed by the Covered Person(s).

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

Excess Insurance

If at the time of Injury, Sickness, Disease or disability there is available, or potentially available any Coverage (including but not limited to Coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of Coverage, except as otherwise provided for under the Plan's Coordination of Benefits section.

The Plan's benefits shall be excess to:

1. The responsible party, its insurer, or any other source on behalf of that party;
2. Any first party insurance through medical payment coverage, personal Injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
3. Any policy of insurance from any insurance company or guarantor of a third party;

4. Workers' compensation or other liability insurance company; or
5. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

Separation of Funds

Benefits paid by the Plan, funds recovered by the Covered Person(s), and funds held in trust over which the Plan has an equitable lien exist separately from the property and estate of the Participant(s), such that the death of the Covered Person(s), or filing of bankruptcy by the Covered Person(s), will not affect the Plan's equitable lien, the funds over which the Plan has a lien, or the Plan's right to subrogation and reimbursement.

Wrongful Death

In the event that the Covered Person(s) dies as a result of his or her injuries and a wrongful death or survivor claim is asserted against a third party or any Coverage, the Plan's subrogation and reimbursement rights shall still apply, and the entity pursuing said claim shall honor and enforce these Plan rights and terms by which benefits are paid on behalf of the Covered Person(s) and all others that benefit from such payment.

Obligations

1. It is the Covered Person(s)' obligation at all times, both prior to and after payment of medical benefits by the Plan:
    a. To cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the Plan's rights;
    b. To provide the Plan with pertinent information regarding the Sickness, Disease, disability, or Injury, including accident reports, settlement information and any other requested additional information;
    c. To take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights;
    d. To do nothing to prejudice the Plan's rights of subrogation and reimbursement;
    e. To promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received; and
    f. To not settle or release, without the prior consent of the Plan, any claim to the extent that the Covered Person may have against any responsible party or Coverage.

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

3. The Plan's rights to reimbursement and/or subrogation are in no way dependent upon the Covered Person(s)' cooperation or adherence to these terms.

Offset

If timely repayment is not made, or the Covered Person and/or his/her attorney fails to comply with any of the requirements of the Plan, the Plan has the right, in addition to any other lawful means of recovery, to deduct the value of the Covered Person's amount owed to the Plan. To do this, the Plan may refuse payment of any future medical benefits and any funds or payments due under this Plan on behalf of the Covered Person(s) in an amount equivalent to any outstanding amounts owed by the Covered Person to the Plan.

Minor Status

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

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

Language Interpretation

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

Severability

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

Conditions Precedent to Coverage

The plan shall have no obligation whatsoever to pay medical benefits to a Covered Person, if a Covered Person refuses to cooperate with the plan's reimbursement and Subrogation rights or refuses to execute and deliver such papers as the plan may require in furtherance of its reimbursement and Subrogation rights. Further, in the event the Covered Person is a minor, the plan shall have no obligation to pay any medical benefits incurred on account of injury or sickness caused by a responsible Third Party until after the Covered Person or his authorized legal representative obtains valid court recognition and approval of the plan's 100%, first dollar reimbursement and Subrogation rights on all Recoveries, as well as approval for the execution of any papers necessary for the enforcement thereof, as described herein.

Defined Terms

"Covered Person" means anyone covered under the plan, including minor dependents.

"Recover", "Recovered", "Recovery", "Recoveries" means all monies paid to the Covered Person by way of judgment, settlement, or otherwise to compensate for all losses caused by the injury or sickness, whether or not said losses reflect medical charges covered by the plan. "Recoveries" further includes, but is not limited to, recoveries for medical expenses, attorneys' fees, cost and expenses, pain and suffering, loss of consortium, wrongful death, lost wages and any other recovery of any form of damages or compensation whatsoever.

"Refund" means repayment to the plan for medical benefits that has been paid for care and treatment of the injury or sickness.

"Subrogation" means the plan's right to pursue and place a lien upon the Covered Person claims for medical charges against the other person.

"Third Party" means any Third Party including another person or a business entity.

Recovery from another plan under which the Covered Person is covered

The right of a refund also applies when a Covered Person recovers under an uninsured motorist plan (which will be treated as Third Party coverage when reimbursement or Subrogation is in order), homeowner's plan, renter's plan, medical malpractice plan or any liability plan.

Rights of Plan Administrator

The plan administrator has a right to request reports on and approved of all settlements.

CONTINUATION COVERAGE RIGHTS UNDER COBRA

Under federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), certain Employees and their families covered under **Arkansas Higher Education Consortium Employee Benefit 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 Covered Persons 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.

The Plan Administrator is Arkansas Higher Education Consortium. COBRA continuation coverage for the Plan is administered by PrimePay, 1487 Dunwoody Drive, West Chester, PA 19380, 1-877-97-COBRA. Complete instructions on COBRA, as well as election forms and other information, will be provided by the Plan Administrator or its designee to Covered Persons who become Qualified Beneficiaries under COBRA.

What is COBRA continuation coverage? COBRA continuation coverage is the temporary extension of group health plan coverage that must be offered to certain Covered Persons 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.

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. A domestic partner is not a Qualified Beneficiary.

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).

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, 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 ("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.

What factors should be considered when determining to elect COBRA continuation coverage? You should take into account that a failure to continue your group health coverage will affect your rights under federal law. First, if you do not elect COBRA continuation coverage and pay the appropriate premiums for the maximum time available to you, you will lose the right to convert to an individual health insurance policy finally, you should take into account that you have special enrollment rights under federal law (HIPAA). You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your Spouse's employer) within 30 days after Plan coverage ends due to a Qualifying Event listed above.
You will also have the same special right at the end of COBRA continuation coverage if you get COBRA continuation coverage for the maximum time available to you.

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.

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 or its designee 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. enrollment of the employee in any part of Medicare.

IMPORTANT:

For the other Qualifying Events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you or someone on your behalf must notify the Plan Administrator or its designee in writing 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. You must send this notice to the Plan Sponsor.

NOTICE PROCEDURES:

Any notice that you provide must be ***in writing***. Oral notice, including notice by telephone, is not acceptable. You must mail, fax or hand-deliver your notice to the person, department or firm listed below, at the following address:

Arkansas Higher Education Consortium
P.O. Box 10
Melbourne, AR 72556

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

- the **name of the plan or plans** under which you lost or are losing coverage,
- 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**, your notice must include **a copy of the divorce decree or the legal separation agreement**.

Be aware that 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 you or your spouse or dependent children do 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 Plan Administrator or its designee, as applicable.

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 will terminate automatically 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.

5. The date, after the date of the election that the Qualified Beneficiary first enrolls in the Medicare program (either part A or part B, whichever occurs earlier).

6. 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 other than the covered Employee ends on the later of:

a. 36 months after the date the covered Employee becomes enrolled in the Medicare program; 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 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.

4. 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 the COBRA 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 the COBRA 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 will pay 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 120% of the required amount.

IF YOU HAVE QUESTIONS

If you have questions about your COBRA continuation coverage, you should contact the COBRA Administrator. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). 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 to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

RESPONSIBILITIES FOR PLAN ADMINISTRATION

PLAN ADMINISTRATOR. Arkansas Higher Education Consortium the Plan Administrator, also called the Plan Sponsor. It is to be administered by the Plan Administrator in accordance with the provisions of ERISA. An individual or committee may be appointed by Arkansas Higher Education Consortium 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 Arkansas Higher Education Consortium, shall appoint a new Plan Administrator as soon as reasonably possible.

The Plan is administered by the Plan Administrator. The Plan Administrator has retained the services of the Claims Administrator to provide certain claims processing and other technical services. Subject to the claims processing and other technical services delegated to the Claims Administrator, the Plan Administrator reserves the unilateral right and power to administer and to interpret, construe and construct the terms and provisions of the Plan, including without limitation, correcting any error or defect, supplying any omission, reconciling any inconsistency and making factual determinations.

The Plan is administered by the Plan Administrator within the purview of ERISA, and in accordance with these provisions. An individual or entity may be appointed by the Plan Sponsor to be Plan Administrator and serve at the convenience of the Plan Sponsor. If the Plan Administrator resigns, dies, is otherwise unable to perform, is dissolved, or is removed from the position, the Plan Sponsor 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 (including the determination of what services, supplies, care and treatments are Experimental), to decide disputes which may arise relative to a Covered Person's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator as to the facts related to any claim for benefits and the meaning and intent of any provision of the Plan, or its application to any claim, shall receive the maximum deference provided by law and will be final and binding on all interested parties. Benefits under this Plan will be paid only if the Plan Administrator decides, in its discretion, that the Covered Person is entitled to them.

If due to errors in drafting, any Plan provision does not accurately reflect its intended meaning, as demonstrated by prior interpretations or other evidence of intent, or as determined by the Plan Administrator in its sole and exclusive judgment, the provision shall be considered ambiguous and shall be interpreted by the Plan Administrator in a fashion consistent with its intent, as determined by the Plan Administrator. The Plan may be amended retroactively to cure any such ambiguity, notwithstanding anything in the Plan to the contrary.

The foregoing provisions of this Plan may not be invoked by any person to require the Plan to be interpreted in a manner which is inconsistent with its interpretations by the Plan Administrator. All actions taken and all determinations by the Plan Administrator shall be final and binding upon all persons claiming any interest under the Plan subject only to the claims appeal procedures of the Plan.

DUTIES OF THE PLAN ADMINISTRATOR.

1. To administer the Plan in accordance with its terms;
2. To determine all questions of eligibility, status and coverage under the Plan;
3. To interpret the Plan, including the authority to construe possible ambiguities, inconsistencies, omissions and disputed terms;
4. To make factual findings;
5. To decide disputes which may arise relative to a Covered Person's rights and/or availability of benefits;
6. To prescribe procedures for filing a claim for benefits, to review claim denials and appeals relating to them and to uphold or reverse such denials;
7. To keep and maintain the Plan documents and all other records pertaining to the Plan;

8. To appoint and supervise a Claims Administrator to pay claims;
9. To perform all necessary reporting as required by ERISA;
10. To establish and communicate procedures to determine whether a Medical Child Support Order is a QMCSO;
11. To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate; and
12. To perform each and every function necessary for or related to the Plan's administration.

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.

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

FIDUCIARY DUTIES. A fiduciary must carry out his or her duties and responsibilities for the purpose of providing benefits to the Employees and their Dependent(s), and defraying reasonable expenses of administering the Plan. These are duties which must be carried out:

1. with care, skill, prudence and diligence under the given circumstances that a prudent person, acting in a like capacity and familiar with such matters, would use in a similar situation;

2. by diversifying the investments of the Plan so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so; and

3. in accordance with the Plan documents to the extent that they agree with ERISA.

THE NAMED FIDUCIARY. A "named fiduciary" is the one named in the Plan. A named fiduciary can appoint others to carry out fiduciary responsibilities (other than as a trustee) under the Plan. These other persons become fiduciaries themselves and are responsible for their acts under the Plan. To the extent that the named fiduciary allocates its responsibility to other persons, the named fiduciary shall not be liable for any act or omission of such person unless either:

1. the named fiduciary has violated its stated duties under ERISA in appointing the fiduciary, establishing the procedures to appoint the fiduciary or continuing either the appointment or the procedures; or

2. the named fiduciary breached its fiduciary responsibility under Section 405(a) of ERISA.

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.

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.

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 Covered Person, the amount of overpayment may be deducted from future benefits payable.

AMENDING AND TERMINATING THE PLAN

The Plan Sponsor expects to maintain this Plan indefinitely; however, as the settlor of the Plan, the Plan Sponsor, through its directors and officers, may, in its sole discretion, at any time, 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).

Any such amendment, suspension or termination shall be enacted, if the Plan Sponsor is a corporation, by resolution of the Plan Sponsor's directors and officers, which shall be acted upon as provided in the Plan Sponsor's Articles of Incorporation or Bylaws, as applicable, and in accordance with applicable Federal and State law. Notice shall be provided as required by ERISA. In the event that the Plan Sponsor is a different type of entity, then such amendment, suspension or termination shall be taken and enacted in accordance with applicable Federal and State law and any applicable governing documents. In the event that the Plan Sponsor is a sole proprietorship, then such action shall be taken by the sole proprietor, in his or her own discretion.

If the Plan is terminated, the rights of the Covered Persons are limited to expenses Incurred before termination. All amendments to this Plan shall become effective as of a date established by the Plan Sponsor.

SUMMARY OF MATERIAL REDUCTION (SMR)

A Material Reduction generally means any modification that would be considered by the average participant to be an important reduction in covered services or benefits. Examples include reductions in benefits or increases in Deductibles or copayments.

The Plan Administrator shall notify all eligible Employees of any plan amendment considered a Material Reduction in covered services or benefits provided by the Plan as soon as administratively feasible after its adoption, but no later than sixty (60) days after the date of adoption of the reduction. Eligible Employees and beneficiaries must be furnished a summary of such reductions, and any changes so made shall be binding on each Covered Person. The sixty (60) day period for furnishing a summary of Material Reduction does not apply to any Employee covered by the Plan who would reasonably expect to receive a summary through other means within the next ninety (90) days.

Material Reduction disclosure provisions are subject to the requirements of ERISA and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and any related amendments.

SUMMARY OF MATERIAL MODIFICATION (SMM)

A Summary of Material Modifications reports changes in the information provided within the Summary Plan Description. Examples include a change to Deductibles, eligibility or the addition or deletion of coverage.

The Plan Administrator shall notify all covered Employees of any plan amendment considered a Summary of Material Modifications by the Plan as soon as administratively feasible after its adoption, but no later than within two hundred and ten (210) days after the close of the Plan Year in which the changes became effective.

Note: The Patient Protection and Affordable Care Act (PPACA) requires if a Plan's Material Modifications are not reflected in the Plan's most recent Summary of Benefits and Coverage (SBC) then the Plan must provide written notice to Covered Persons at least sixty (60) days before the effective date of the Material Modification.

MISUSE OF IDENTIFICATION CARD

If an Employee or covered Dependent permits any person who is not a Covered Person of the family unit to use any identification card issued, the Plan Sponsor may give Employee written notice that his (and his family's) coverage will be terminated at the end of thirty-one (31) days from the date written notice is given.

MISCELLANEOUS PROVISIONS

Applicable Law
This is a self-funded benefit plan coming within the purview of the Employee Retirement Income Security Act of 1974 ("ERISA"). The Plan is funded with Employee and/or Employer contributions. As such, when applicable, Federal law and jurisdiction preempt State law and jurisdiction.

Clerical Error/Delay
Clerical errors made on the records of the Plan and delays in making entries on such records shall not invalidate coverage nor cause coverage to be in force or to continue in force. Rather, the Effective Dates of coverage shall be determined solely in accordance with the provisions of this Plan regardless of whether any contributions with respect to Covered Persons have been made or have failed to be made because of such errors or delays. Upon discovery of any such error or delay, an equitable adjustment of any such contributions will be made.

Conformity With Applicable Laws
This Plan shall be deemed to automatically be amended to conform as required by any applicable law, regulation or the order or judgment of a court of competent jurisdiction governing provisions of this Plan, including, but not limited to, stated maximums, exclusions or limitations. In the event that any law, regulation or the order or judgment of a court of competent jurisdiction causes the Plan Administrator to pay claims which are otherwise limited or excluded under this Plan, such payments will be considered as being in accordance with the terms of this Plan Document. It is intended that the Plan will conform to the requirements of ERISA, as it applies to Employee welfare plans, as well as any other applicable law.

Fraud
The following actions by any Covered Person, or a Covered Person's knowledge of such actions being taken by another, constitute fraud and will result in immediate termination of all coverage under this Plan for the entire Family Unit of which the Covered Person is a member:

1. Attempting to submit a claim for benefits (which includes attempting to fill a prescription) for a person who is not a Covered Person of the Plan;
2. Attempting to file a claim for a Covered Person for services which were not rendered or Drugs or other items which were not provided;
3. Providing false or misleading information in connection with enrollment in the Plan; or
4. Providing any false or misleading information to the Plan.

Headings
The headings used in this Plan Document are used for convenience of reference only. Covered Persons are advised not to rely on any provision because of the heading.

No Waiver or Estoppel
No term, condition or provision of this Plan shall be deemed to have been waived, and there shall be no estoppel against the enforcement of any provision of this Plan, except by written instrument of the party charged with such waiver or estoppel. No such written waiver shall be deemed a continuing waiver unless specifically stated therein, and each such waiver shall operate only as to the specific term or condition waived and shall not constitute a waiver of such term or condition for the future or as to any act other than the one specifically waived.

Plan Contributions
The Plan Administrator shall, from time to time, evaluate the funding method of the Plan and determine the amount to be contributed by the Participating Employer and the amount to be contributed (if any) by each Covered Person.

The Plan Sponsor shall fund the Plan in a manner consistent with the provisions of the Internal Revenue Code, ERISA, and such other laws and regulations as shall be applicable to the end that the Plan shall be funded on a lawful and sound basis; but, to the extent permitted by governing law, the Plan Administrator shall be free to determine the manner and means of funding the Plan.

Notwithstanding any other provision of the Plan, the Plan Administrator's obligation to pay claims otherwise allowable under the terms of the Plan shall be limited to its obligation to make contributions to the Plan as set forth in the preceding paragraph. Payment of said claims in accordance with these procedures shall discharge completely the Company's obligation with respect to such payments.

In the event that the Company terminates the Plan, then as of the effective date of termination, the Employer and eligible Employees shall have no further obligation to make additional contributions to the Plan and the Plan shall have no obligation to pay claims Incurred after the termination date of the Plan.

Right to Receive and Release Information
For the purpose of determining the applicability of and implementing the terms of these benefits, the Plan Administrator may, without the consent of or notice to any person, release or obtain any information necessary to determine the acceptability of any applicant or Covered Person for benefits from this Plan. In so acting, the Plan Administrator shall be free from any liability that may arise with regard to such action. Any Covered Person claiming benefits under this Plan shall furnish to the Plan Administrator such information as may be necessary to implement this provision.

Written Notice
Any written notice required under this Plan which, as of the Effective Date, is in conflict with the law of any governmental body or agency which has jurisdiction over this Plan shall be interpreted to conform to the minimum requirements of such law.

Right of Recovery
In accordance with the Recovery of Payments provision , whenever payments have been made by this Plan in a total amount, at any time, in excess of the Maximum Amount of benefits payable under this Plan, the Plan shall have the right to recover such payments, to the extent of such excess, from any one or more of the following as this Plan shall determine: any person to or with respect to whom such payments were made, or such person's legal representative, any insurance companies, or any other individuals or organizations which the Plan determines are responsible for payment of such amount, and any future benefits payable to the Covered Person or his or her Dependents. See the Recovery of Payments provision for full details.

Statements
All statements made by the Company or by a Covered Person will, in the absence of fraud, be considered representations and not warranties, and no statements made for the purpose of obtaining benefits under this document will be used in any contest to avoid or reduce the benefits provided by the document unless contained in a written application for benefits and a copy of the instrument containing such representation is or has been furnished to the Covered Person.

Any Covered Person who knowingly and with intent to defraud the Plan, files a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any material fact, commits a fraudulent act. The Covered Person may be subject to prosecution by the United States Department of Labor. Fraudulently claiming benefits may be punishable by a substantial fine, imprisonment, or both.

Protection Against Creditors
No benefit payment under this Plan shall be subject in any way to alienation, sale, transfer, pledge, attachment, garnishment, execution or encumbrance of any kind, and any attempt to accomplish the same shall be void. If the Plan Administrator shall find that such an attempt has been made with respect to any payment due or to become due to any Covered Person, the Plan Administrator in its sole discretion may terminate the interest of such Covered Person or former Covered Person in such payment.

And in such case the Plan Administrator shall apply the amount of such payment to or for the benefit of such Covered Person or former Covered Person, his/her spouse, parent, adult Child, guardian of a minor Child, brother or sister, or other relative of a dependent of such Covered Person or former Covered Person, as the Plan Administrator may determine, and any such application shall be a complete discharge of all liability with respect to such benefit payment. However, at the discretion of the Plan Administrator, benefit payments may be assigned to health care Providers.

CERTAIN PLAN PARTICIPANTS RIGHTS UNDER ERISA

Covered Persons in this Plan are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA specifies that all Covered Persons shall be entitled to:

Examine, without charge, at the Plan Administrator's office, all Plan documents and copies of all documents governing the Plan, including a copy of the latest annual report (form 5500 series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.

Continue health care coverage for a Covered Person, Spouse, or other dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event. Employees or dependents may have to pay for such coverage.

Review this summary plan description and the documents governing the Plan or the rules governing COBRA continuation coverage rights.

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

Under ERISA, there are steps a Covered Person can take to enforce the above rights. For instance, if a Covered Person requests a copy of Plan documents or the latest annual report from the Plan and does not receive them within 30 days, he or she may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and to pay the Covered Person up to $110 a day until he or she receives the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If the Covered Person has a claim for benefits which is denied or ignored, in whole or in part, the Covered Person may file suit in state or federal court.

In addition, if a Covered Person disagrees with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, he or she may file suit in federal court.

In addition to creating rights for Covered Persons, ERISA imposes obligations upon the individuals who are responsible for the operation of the Plan. The individuals who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of the Covered Persons and their beneficiaries. No one, including the Employer or any other person, may fire a Covered Person or otherwise discriminate against a Covered Person in any way to prevent the Covered Person from obtaining benefits under the Plan or from exercising his or her rights under ERISA.

If it should happen that the Plan fiduciaries misuse the Plan's money, or if a Covered Person is discriminated against for asserting his or her rights, he or she may seek assistance from the U.S. Department of Labor, or may file suit in a federal court. The court will decide who should pay court costs and legal fees. If the Covered Person is successful, the court may order the person sued to pay these costs and fees. If the Covered Person loses, the court may order him or her to pay these costs and fees, for example, if it finds the claim or suit to be frivolous.

If the Covered Person has any questions about the Plan, he or she should contact the Plan Administrator. If the Covered Person has any questions about this statement or his or her rights under ERISA, including COBRA or the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, that Covered Person should contact either the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) or visit the EBSA website at www.dol.gov/ebsa/. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

HIPAA PRIVACY

The Plan provides each Covered Person with a separate Notice of Privacy Practices. This Notice describes how the Plan uses and discloses your personal health information. It also describes certain rights you have regarding this information. Additional copies of our Notice of Privacy Practices are available by calling [1-501-228-7111].

Definitions

- **Breach** means an unauthorized acquisition, access, use or disclosure of Protected Health Information ("PHI") or Electronic Protected Health Information ("ePHI") that violates the HIPAA Privacy Rule and that compromises the security or privacy of the information.
- **Protected Health Information ("PHI")** means individually identifiable health information, as defined by HIPAA, that is created or received by us and that relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and that identifies the individual or for which there is a reasonable basis to believe the information can be used to identify the individual. PHI includes information of persons living or deceased.

Commitment to Protecting Health Information

The Plan will comply with the Standards for Privacy of Individually Identifiable Health Information (i.e., the "Privacy Rule") set forth by the U.S. Department of Health and Human Services ("HHS") pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Such standards control the dissemination of "protected health information" ("PHI") of Covered Persons. Privacy Standards will be implemented and enforced in the offices of the Employer and Plan Sponsor and any other entity that may assist in the operation of the Plan.

The Plan is required by law to take reasonable steps to ensure the privacy of the Covered Person's PHI, and inform him/her about:

1. The Plan's disclosures and uses of PHI;
2. The Covered Person's privacy rights with respect to his/her PHI;
3. The Plan's duties with respect to his/her PHI;
4. The Covered Person's right to file a complaint with the Plan and with the Secretary of HHS; and
5. The person or office to contact for further information about the Plan's privacy practices.

Within this provision capitalized terms may be used, but not otherwise defined. These terms shall have the same meaning as those terms set forth in 45 CFR Sections 160.103 and 164.501. Any HIPAA regulation modifications altering a defined HIPAA term or regulatory citation shall be deemed incorporated into this provision.

How Health Information May be Used and Disclosed

In general, the Privacy Rules permit the Plan to use and disclose, the minimum necessary amount, an individual's PHI, without obtaining authorization, only if the use or disclosure is:

1. To carry out Payment of benefits;
2. For Health Care Operations;
3. For Treatment purposes; or
4. If the use or disclosure falls within one of the limited circumstances described in the rules (e.g., the disclosure is required by law or for public health activities).

Disclosure of PHI to the Plan Sponsor for Plan Administration Purposes

In order that the Plan Sponsor may receive and use PHI for plan administration purposes, the Plan Sponsor agrees to:

1. Not use or further disclose PHI other than as permitted or required by the Plan documents or as required by law (as defined in the Privacy Standards);
2. Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan, agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;
3. Establish safeguards for information, including security systems for data processing and storage;
4. Maintain the confidentiality of all PHI, unless an individual gives specific consent or authorization to disclose such data or unless the data is used for health care payment or Plan operations;
5. Receive PHI, in the absence of an individual's express authorization, only to carry out Plan administration functions;
6. Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or Employee benefit plan of the Plan Sponsor, except pursuant to an authorization which meets the requirements of the Privacy Standards;
7. Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor becomes aware;
8. Make available PHI in accordance with section 164.524 of the Privacy Standards (45 CFR 164.524);
9. Make available PHI for amendment and incorporate any amendments to PHI in accordance with section 164.526 of the Privacy Standards (45 CFR 164.526);
10. Make available the information required to provide an accounting of disclosures in accordance with section 164.528 of the Privacy Standards (45 CFR 164.528);
11. Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services ("HHS"), or any other officer or Employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the Plan with part 164, subpart E, of the Privacy Standards (45 CFR 164.500 et seq);
12. Report to the Plan any inconsistent uses or disclosures of PHI of which the Plan Sponsor becomes aware;
13. Train Employees in privacy protection requirements and appoint a privacy compliance coordinator responsible for such protections;
14. If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made, 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 PHI infeasible; and
15. Ensure that adequate separation between the Plan and the Plan Sponsor, as required in section 164.504(f)(2)(iii) of the Privacy Standards (45 CFR 164.504(f)(2)(iii)), is established as follows:
    a. The following Employees, or classes of Employees, or other persons under control of the Plan Sponsor, shall be given access to the PHI to be disclosed:
        (i) Privacy Officer: The access to and use of PHI by the individuals described above shall be restricted to the plan administration functions that the Plan Sponsor performs for the Plan.

b. In the event any of the individuals described above do not comply with the provisions of the Plan documents relating to use and disclosure of PHI, the Plan Administrator shall impose reasonable sanctions as necessary, in its discretion, to ensure that no further non-compliance occurs. The Plan Administrator will promptly report such violation or non-compliance to the Plan, and will cooperate with the Plan to correct violation or non-compliance and to impose appropriate disciplinary action or sanctions. Such sanctions shall be imposed progressively (for example, an oral warning, a written warning, time off without pay and termination), if appropriate, and shall be imposed so that they are commensurate with the severity of the violation.

Disclosure of Summary Health Information to the Plan Sponsor

The Plan may disclose PHI to the Plan Sponsor of the group health plan for purposes of plan administration or pursuant to an authorization request signed by the Covered Person. The Plan may use or disclose "summary health information" to the Plan Sponsor for obtaining premium bids or modifying, amending, or terminating the group health plan.

Disclosure of Certain Enrollment Information to the Plan Sponsor

Pursuant to section 164.504(f)(1)(iii) of the Privacy Standards (45 CFR 164.504(f)(1)(iii)), the Plan may disclose to the Plan Sponsor information on whether an individual is participating in the Plan or is enrolled in or has un-enrolled from a health insurance issuer or health maintenance organization offered by the Plan to the Plan Sponsor.

Disclosure of PHI to Obtain Stop-loss or Excess Loss Coverage

The Plan Sponsor may hereby authorize and direct the Plan, through the Plan Administrator or the Claims Administrator, to disclose PHI to stop-loss carriers, excess loss carriers or managing general underwriters ("MGUs") for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage related to benefit claims under the Plan. Such disclosures shall be made in accordance with the Privacy Standards.

Other Disclosures and Uses of PHI:

Primary Uses and Disclosures of PHI

1. Treatment, Payment and Health Care Operations: The Plan has the right to use and disclose a Covered Person's PHI for all activities as included within the definitions of Treatment, Payment, and Health Care Operations and pursuant to the HIPAA Privacy Rule;
2. Business Associates: The Plan contracts with individuals and entities (Business Associates) to perform various functions on its behalf. In performance of these functions or to provide services, Business Associates will receive, create, maintain, use, or disclose PHI, but only after the Plan and the Business Associate agree in writing to contract terms requiring the Business Associate to appropriately safeguard the Covered Person's information; and
3. Other Covered Entities: The Plan may disclose PHI to assist health care Providers in connection with their treatment or payment activities or to assist other covered entities in connection with payment activities and certain health care operations. For example, the Plan may disclose PHI to a health care Provider when needed by the Provider to render treatment to a Covered Person, and the Plan may disclose PHI to another covered entity to conduct health care operations. The Plan may also disclose or share PHI with other insurance carriers (such as Medicare, etc.) in order to coordinate benefits, if a Covered Person has coverage through another carrier.

Other Possible Uses and Disclosures of PHI

1. Required by Law: The Plan may use or disclose PHI when required by law, provided the use or disclosure complies with and is limited to the relevant requirements of such law;
2. Public Health and Safety: The Plan may use or disclose PHI when permitted for purposes of public health activities, including disclosures to:
    a. A public health authority or other appropriate government authority authorized by law to receive reports of Child abuse or neglect;
    b. Report reactions to medications or problems with products or devices regulated by the Federal Food and Drug Administration or other activities related to quality, safety, or effectiveness of FDA-regulated products or activities;
    c. Locate and notify persons of recalls of products they may be using; and
    d. A person who may have been exposed to a communicable Disease or may otherwise be at risk of contracting or spreading a Disease or condition, if authorized by law;
3. The Plan may disclose PHI to a government authority, except for reports of Child abuse or neglect, when required or authorized by law, or with the Covered Person's agreement, if the Plan reasonably believes he/she to be a victim of abuse, neglect, or domestic violence. In such case, the Plan will promptly inform the Covered Person that such a disclosure has been or will be made unless the Plan believes that informing him/her would place him/her at risk of serious harm (but only to someone in a position to help prevent the threat). Disclosure generally may be made to a minor's parents or other representatives although there may be circumstances under Federal or State law when the parents or other representatives may not be given access to the minor's PHI;
4. Health Oversight Activities: The Plan may disclose PHI to a health oversight agency for oversight activities authorized by law. This includes civil, administrative or criminal investigations; inspections; claim audits; licensure or disciplinary actions; and other activities necessary for appropriate oversight of a health care system, government health care program, and compliance with certain laws;
5. Lawsuits and Disputes: The Plan may disclose PHI when required for judicial or administrative proceedings. For example, the Covered Person's PHI may be disclosed in response to a subpoena, discovery requests, or other required legal processes when the Plan is given satisfactory assurances that the requesting party has made a good faith attempt to advise the Covered Person of the request or to obtain an order protecting such information, and done in accordance with specified procedural safeguards;
6. Law Enforcement: The Plan may disclose PHI to a law enforcement official when required for law enforcement purposes concerning identifying or locating a suspect, fugitive, material witness or missing person. Under certain circumstances, the Plan may disclose the Covered Person's PHI in response to a law enforcement official's request if he/she is, or are suspected to be, a victim of a crime and if it believes in good faith that the PHI constitutes evidence of criminal conduct that occurred on the Sponsor's or Plan's premises;
7. Decedents: The Plan may disclose PHI to family members or others involved in decedent's care or payment for care, a coroner, funeral director or medical examiner for the purpose of identifying a deceased person, determining a cause of death or as necessary to carry out their duties as authorized by law. The decedent's health information ceases to be protected after the individual is deceased for fifty (50) years;
8. Research: The Plan may use or disclose PHI for research, subject to certain limited conditions;
9. To Avert a Serious Threat to Health or Safety: The Plan may disclose PHI in accordance with applicable law and standards of ethical conduct, if the Plan, in good faith, believes the use or disclosure is necessary to prevent or lessen a threat to health or safety of a person or to the public;
10. Workers' Compensation: The Plan may disclose PHI when authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law; and

11. Military and National Security: The Plan may disclose PHI to military authorities of armed forces personnel under certain circumstances. As authorized by law, the Plan may disclose PHI required for intelligence, counter-intelligence, and other national security activities to authorized Federal officials.

Required Disclosures of PHI

1. Disclosures to Covered Persons: The Plan is required to disclose to a Covered Person most of the PHI in a Designated Record Set when the Covered Person requests access to this information. The Plan will disclose a Covered Person's PHI to an individual who has been assigned as his/her representative and who has qualified for such designation in accordance with the relevant State law. Before disclosure to an individual qualified as a personal representative, the Plan must be given written supporting documentation establishing the basis of the personal representation.

   The Plan may elect not to treat the person as the Covered Person's personal representative if it has a reasonable belief that the Covered Person has been, or may be, subjected to domestic violence, abuse, or neglect by such person, it is not in the Covered Person's best interest to treat the person as his/her personal representative, or treating such person as his/her personal representative could endanger the Covered Person; and

2. Disclosures to the Secretary of the U.S. Dept. of Health and Human Services: The Plan is required to disclose the Covered Person's PHI to the Secretary of the U.S. Department of Health and Human Resources when the Secretary is investigating or determining the Plan's compliance with the HIPAA Privacy Rule.

Instances When Required Authorization Is Needed From Covered Persons Before Disclosing PHI

1. If the Plan maintains psychotherapy notes: Most uses and disclosures of psychotherapy notes;
2. Uses and disclosures for marketing;
3. Sale of PHI; and
4. Other uses and disclosures not described in this section can only be made with authorization from the Covered Person. The Covered Person may revoke this authorization at any time.

Covered Person's Rights

The Covered Person has the following rights regarding PHI about him/her:

1. Request Restrictions: The Covered Person has the right to request additional restrictions on the use or disclosure of PHI for treatment, payment, or health care operations. The Covered Person may request that the Plan restrict disclosures to family members, relatives, friends or other persons identified by him/her who are involved in his/her care or payment for his/her care. The Plan is not required to agree to these requested restrictions;
2. Right to Receive Confidential Communication: The Covered Person has the right to request that he/she receive communications regarding PHI in a certain manner or at a certain location. The request must be made in writing and how the Covered Person would like to be contacted. The Plan will accommodate all reasonable requests;
3. Right to Receive Notice of Privacy Practices: The Covered Person is entitled to receive a paper copy of the plan's Notice of Privacy Practices at any time. To obtain a paper copy, contact the Privacy Compliance Coordinator;

4. Accounting of Disclosures: The Covered Person has the right to request an accounting of disclosures the Plan has made of his/her PHI. The request must be made in writing and does not apply to disclosures for treatment, payment, health care operations, and certain other purposes. The Covered Person is entitled to such an accounting for the six (6) years prior to his/her request. Except as provided below, for each disclosure, the accounting will include: (a) the date of the disclosure, (b) the name of the entity or person who received the PHI and, if known, the address of such entity or person; (c) a description of the PHI disclosed, (d) a statement of the purpose of the disclosure that reasonably informs the Participant of the basis of the disclosure, and certain other information. If the Covered Person wishes to make a request, please contact the Privacy Compliance Coordinator;
5. Access: The Covered Person has the right to request the opportunity to look at or get copies of PHI maintained by the Plan about him/her in certain records maintained by the Plan. If the Covered Person requests copies, he/she may be charged a fee to cover the costs of copying, mailing, and other supplies. To inspect or copy PHI, or to have a copy of your PHI transmitted directly to another designated person, contact the Privacy Compliance Coordinator. A request to transmit PHI directly to another designated person must be in writing, signed by the Covered Person and the recipient must be clearly identified. The Plan must respond to the Covered Person's request within thirty (30) days (in some cases, the Plan can request a thirty (30) day extension). In very limited circumstances, the Plan may deny the Covered Person's request. If the Plan denies the request, the Covered Person may be entitled to a review of that denial;
6. Amendment: The Covered Person has the right to request that the Plan change or amend his/her PHI. The Plan reserves the right to require this request be in writing. Submit the request to the Privacy Compliance Coordinator. The Plan may deny the Covered Person's request in certain cases, including if it is not in writing or if he/she does not provide a reason for the request; and
7. Fundraising contacts: The Covered Person has the right to opt out of fundraising contacts.

Questions or Complaints

If the Covered Person wants more information about the Plan's privacy practices, has questions or concerns, or believes that the Plan may have violated his/her privacy rights, please contact the Plan using the following information. The Covered Person may submit a written complaint to the U.S. Department of Health and Human Services or with the Plan. The Plan will provide the Covered Person with the address to file his/her complaint with the U.S. Department of Health and Human Services upon request.

The Plan will not retaliate against the Covered Person for filing a complaint with the Plan or the U.S. Department of Health and Human Services

Contact Information

Arkansas Higher Education Consortium Privacy Official
Arkansas Higher Education Consortium
12615 Chenal Parkway, Suite 300
Little Rock, AR 72211

HIPAA SECURITY

Disclosure of Electronic Protected Health Information ("Electronic PHI") to the Plan Sponsor for Plan Administration Functions

STANDARDS FOR SECURITY OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION ("SECURITY RULE")

The Security Rule imposes regulations for maintaining the integrity, confidentiality and availability of protected health information that it creates, receives, maintains, or maintains electronically that is kept in electronic format (ePHI) as required under the Health Insurance Portability and Accountability Act (HIPAA).

Definitions

- **Electronic Protected Health Information (ePHI),** as defined in Section 160.103 of the Security Standards (45 C.F.R. 160.103), means individually identifiable health information transmitted or maintained in any electronic media.
- **Security Incidents,** as defined within Section 164.304 of the Security Standards (45 C.F.R. 164.304), means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operation in an information system.

Plan Sponsor Obligations

To enable the Plan Sponsor to receive and use Electronic PHI for Plan Administration Functions (as defined in 45 CFR §164.504(a)), the Plan Sponsor agrees to:

1. Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan;
2. Ensure that adequate separation between the Plan and the Plan Sponsor, as required in 45 CFR § 164.504(f)(2)(iii), is supported by reasonable and appropriate Security Measures;
3. Ensure that any agent, including a subcontractor, to whom the Plan Sponsor provides Electronic PHI created, received, maintained, or transmitted on behalf of the Plan, agrees to implement reasonable and appropriate administrative, physical, and technical safeguards to protect the confidentiality, integrity, and availability of the Electronic PHI and report to the Plan any security incident of which it becomes aware; and
4. Report to the Plan any security incident of which it becomes aware.

Notification Requirements in the Event of a Breach of Unsecured PHI

The required breach notifications are triggered upon the discovery of a breach of unsecured PHI. A breach is discovered as of the first day the breach is known, or reasonably should have been known.

When a breach of unsecured PHI is discovered, the Plan will:

1. Notify the Covered Person who's PHI has been, or is reasonably believed to have been, assessed, acquired, used, or disclosed as a result of the breach, in writing, without unreasonable delay and in no case later than sixty (60) calendar days after discovery of the breach. Breach Notification must be provided to individual by:
    a. Written notice by first-class mail to Covered Person (or next of kin) at last known address or, if specified by Covered Person, e-mail;

b. If Plan has insufficient or out-of-date contact information for the Covered Person, the Covered Person must be notified by a "substitute form;
c. If an urgent notice is required, Plan may contact the Covered Person by telephone.
    i. The Breach Notification will have the following content:
        1. Brief description of what happened, including date of breach and date discovered;
        2. Types of unsecured PHI involved (e.g., name, Social Security number, date of birth, home address, account number);
        3. Steps Covered Person should take to protect from potential harm;
        4. What the Plan is doing to investigate the breach, mitigate losses and protect against further breaches;

2. Notify the media if the breach affected more than five hundred (500) residents of a State or jurisdiction. Notice must be provided to prominent media outlets serving the State or jurisdiction without unreasonable delay and in no case later than sixty (60) calendar days after the date the breach was discovered;
3. Notify the HHS Secretary if the breach involves five hundred (500) or more individuals, contemporaneously with the notice to the affected individual and in the manner specified by HHS. If the breach involves less than five hundred (500) individuals, an internal log or other documentation of such breaches must be maintained and annually submitted to HHS within sixty (60) days after the end of each Calendar Year; and
4. When a Business Associate, which provides services for the Plan and comes in contact with PHI in connection with those services discovers a breach has occurred, that Business Associate will notify the Plan without unreasonable delay and in no case later than sixty (60) calendar days after discovery of a breach so that the affected Covered Person may be notified. To the extent possible, the Business Associate should identify each individual whose unsecured PHI has been, or is reasonably believed to have been, breached.

Any terms not otherwise defined in this section shall have the meanings set forth in the Security Standards.