
**PLAN DOCUMENT AND
SUMMARY PLAN DESCRIPTION
FOR
SOUTHERN ARKANSAS UNIVERSITY
EMPLOYEE HEALTH PLAN**

TABLE OF CONTENTS

INTRODUCTION..... 1

ELIGIBILITY, FUNDING, EFFECTIVE DATE AND TERMINATION PROVISIONS 3

OPEN ENROLLMENT..... 11

SCHEDULE OF BENEFITS..... 12

MEDICAL BENEFITS..... 15

PLAN EXCLUSIONS, LIMITATIONS AND NON-COVERED SERVICES 26

COST MANAGEMENT SERVICES..... 32

DEFINED TERMS 35

PRESCRIPTION DRUG BENEFITS..... 43

HOW TO SUBMIT A CLAIM 46

COORDINATION OF BENEFITS 55

THIRD PARTY RECOVERY PROVISION..... 58

COBRA CONTINUATION OPTIONS 60

RESPONSIBILITIES FOR PLAN ADMINISTRATION 66

GENERAL PLAN INFORMATION 71

INTRODUCTION

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

Coverage under the Plan will take effect for an eligible Employee and designated Dependents when the Employee and such Dependents satisfy 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.

The Plan believes that it is a “grandfathered” health plan under the Patient Protection and Affordable Care Act (“the Affordable Care Act”). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that the Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost-sharing. However, grandfathered health plans must comply with certain other consumer protections under the Affordable Care Act, such as the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Administrator. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans. You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.

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

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

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, even if the expenses were incurred as a result of an accident, injury or disease that occurred, began, or existed while coverage was in force. An expense for a service or supply is incurred on the date the service or supply is furnished.

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

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

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

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

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

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

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

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

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

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

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

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

COBRA Continuation Options. 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 Participants' rights under the Plan.

ELIGIBILITY, FUNDING, EFFECTIVE DATE AND TERMINATION PROVISIONS

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

ELIGIBILITY

Eligible Classes of Employees. The following Classes of Employees are eligible for coverage under this plan:

- (1) Active Faculty. Faculty have a rank of professor, associate professor, assistant professor or instructor.
- (2) Classified Staff. Classified positions are a part of the Arkansas Uniform Classification System, are established by grade and titled by SAU.
- (3) Nonclassified Staff. Nonclassified staff are management positions or positions with specific professional educational requirements as defined by SAU.
- (4) Retired Employees of the Employer. A Retired faculty or staff member is someone who has had ten years of continuous service and who is at least 55 years of age. Retirees may elect early retirement at the end of a contract or fiscal year with the following health insurance options depending on age and years of service.

Each option ends at age 65, the current age for Medicare to begin. If this Medicare policy changes, the early retirement plan will be updated to reflect age changes in Medicare eligibility.

Option A: A retiree from age 55-61 may remain a member of the health insurance group until age 65 at the cost to the retiring faculty or staff member.

Option B: A retiree at age 62 or after (up to 65) may remain a member of the health insurance group, and the University will contribute to the health insurance plan of the retiree at an amount up to \$504.00 per month.

Option C: A retiree whose age (55-65) and years of service (minimum of 15) total 75 or more may remain a member of the health insurance group, and the University will contribute to the health insurance plan of the retiree at an amount up to \$504.00 per month.

With each of the above options, a retiree may continue to provide coverage for the spouse or other dependents at the retiree's expense (based on coverage at the time of retirement with the University's health insurance group) until the spouse reaches age 65. Other dependent coverage may be maintained as provided in the health insurance contract.

Eligibility Requirements for Employee Coverage. A person is eligible for Employee coverage from the first day that he or she is a Full-Time, Active Employee of the Employer. An Employee is considered to be Full-Time if he or she is a member of the eligible classes of employees described above.

Coverage will become effective on the first day of the next Calendar Month, following the date of hire.

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

- (1) A covered Employee's Spouse.

The term "Spouse" shall mean a person of the opposite sex who is the husband or wife of an Employee as a result of a marriage that is legally recognized in the state of Arkansas. The Plan Administrator may require documentation proving a legal marital relationship. For the purposes of this Plan, the phrase "legally married" does not include "common-law" marriages.

Domestic partners are not eligible for coverage as Dependents.

- (2) A covered Employee's child less than 26 years.

- (3) A covered Employee's child who reaches age 26 and is Totally Disabled, incapable of self-sustaining employment by reason of mental retardation or physical disability, provided:

- (a) such child is or was under the limiting age of dependency at the time of application for coverage in the Plan, or;

- (b) if not under such limiting age, has had continuous health plan coverage, i.e. no break in coverage greater than 63 days, at the time of application for coverage in the Plan.

The Plan Administrator may require, at reasonable intervals during the two years following the Dependent's 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.

Except for Dependents considered Totally Disabled, when a child reaches age 26, coverage will end on the last day of the child's birthday month.

The terms "child" or "children" shall include natural children, step-children, adopted children, or children placed with a covered Employee in anticipation of adoption.

If a covered Employee is the Legal Guardian of a child or children, these children may be enrolled in this Plan as covered Dependents.

The phrase "child placed with a covered Employee in anticipation of adoption" refers to a child whom the Employee 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 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.

Any child of a Plan Participant 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 dependency, including birth certificates, tax records or initiation of legal proceedings severing parental rights.

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 or a child qualifies or continues to qualify as a Dependent as defined by this Plan.

FUNDING

Cost of the Plan. Southern Arkansas University pays the entire cost of Employee coverage under this Plan. Southern Arkansas University shares the cost of 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. If the newborn child is not enrolled in this Plan on a timely basis, as defined in the section "Timely Enrollments" following this section, there will be no payment from the Plan and the covered parent will be responsible for all costs.

For coverage of Sickness or Injury, including Medically Necessary care and treatment of congenital defects, birth abnormalities or complications resulting from prematurity, the newborn child must be enrolled as a Dependent under this Plan within 30 days of the child's birth in order for non-routine coverage to take effect from the birth.

If the child is not enrolled within 30 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, initially or no later than 60 days, 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 Enrollees 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 Enrollee.

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

SPECIAL ENROLLMENT RIGHTS

Federal law provides Special Enrollment provisions under some circumstances. If an Employee is declining enrollment for himself or his dependents (including their 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 60 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 60 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 enrollee 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 otherwise eligible, but not enrolled in this Plan, may enroll if loss of eligibility for coverage is due to each 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.
 - (d) The Employee or Dependent requests enrollment in this Plan not later than 60 days after the date

of exhaustion of COBRA coverage or termination of non-COBRA coverage due to loss of eligibility or termination of employer contributions, as 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.

- (e) For purposes of these rules, a loss of eligibility occurs if:
- (i) The Employee or Dependent has a loss of eligibility on the earliest date a claim is denied that would meet or exceed a lifetime limit on all benefits.
 - (ii) 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 (ie: part-time employees).
 - (iii) 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.
 - (iv) 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).
 - (v) 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), 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.

(2) 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 60 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 60-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 date of the marriage;
 - (b) in the case of a Dependent's birth, as of the date of birth; or
 - (c) in the case of a Dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.
- (3) **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 of the calendar month following the date 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

For Plan Years that begin before January 1, 2015, Plan Participants who lose coverage under the Plan will receive a certificate that will show the period of Creditable Coverage under this Plan. The Plan maintains written procedures that explain how to request this certificate. Please contact the Plan Administrator for a copy of these procedures and further details. When coverage under this Plan stops, Plan Participants will

receive a certificate that will show the period of Creditable Coverage under this Plan. The Plan maintains written procedures that explain how to request this certificate. Please contact the Plan Administrator for further details.

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 COBRA Continuation Options):

- (1) The date the Plan is terminated.
- (2) The end of the month following the date on which the covered Employee ceases to be in one of the Eligible Classes. This includes death or termination of Active Employment of the covered Employee. (See the COBRA Continuation Options.)
- (3) The last day of the period for which the required contribution has been paid if the charge for the next period is not paid when due.
- (4) The date the covered Employee's Eligible Class is eliminated.

Continuation During Periods of Employer-Certified Disability, Leave of Absence or Layoff. A person may remain eligible for a limited time if Active, full-time work ceases due to disability, leave of absence or layoff. This continuance will end on the date determined by the Employer.

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

Continuation During Family and Medical Leave. Regardless of the established leave policies mentioned above, this Plan shall at all times comply with the Family and Medical Leave Act 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. A terminated Employee who is rehired will be treated as a new hire and be required to satisfy all Eligibility and Enrollment requirements.

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 under the following circumstances. These rights apply only to Employees and their Dependents covered under the Plan before leaving for military service.

- (1) The maximum period of coverage of a person 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 or employment and fails to do so.
- (2) A person who elects to continue health plan coverage may be required to 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.

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 COBRA Continuation Options):

- (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 COBRA Continuation Options.)
- (3) The date a covered Spouse loses coverage due to loss of dependency status. (See the COBRA Continuation Options.)
- (4) On the last day of the calendar month that a Dependent person ceases to be a Dependent as defined by the Plan. (See the COBRA Continuation Options.)
- (5) 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.

OPEN ENROLLMENT

Each year during the annual open enrollment period, Employees and their Dependents who are Late Enrollees will be able to enroll in the Plan.

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

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

SCHEDULE OF BENEFITS

MEDICAL BENEFITS

All benefits described in this Schedule are subject to the Claims Administrator's established Coverage Policy, Allowable Charge, and the benefit limits and exclusions described more fully herein including, but not limited to the determination that: care and treatment is Medically Necessary; 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.

Additional information about this option, as well as a list of In-Network Providers, will be given to Plan Participants and updated as needed.

Deductibles payable by Plan Participants, per Calendar Year

<u>Per Covered Person</u>	
In-Network Provider.....	\$575
Out-of-Network Provider	\$1,150
 <u>Per Family Unit</u>	
In-Network Provider.....	\$1,150
Out-of-Network Provider	\$2,300

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

Annual out-of-pocket amount, per Calendar Year

The Plan will pay the percentage of Covered Charges designated until the following Annual Out-of-Pocket Limits are reached, at which time the Plan will pay 100% of the remainder of Covered Charges for the rest of the Calendar Year unless stated otherwise.

<u>Per Covered Person</u>	
In-Network Provider.....	\$2,000
Out-of-Network Provider	\$8,000
 <u>Per Family Unit</u>	
In-Network Provider.....	\$4,000
Out-of-Network Provider	\$16,000

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

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

- Copayments
- Calendar Year Deductible
- Cost-containment penalties

HOSPITAL BENEFITS

Inpatient admissions require prenotification

Penalty for failure to prenotify \$200

Reimbursement rate

In-Network facility 80%, after deductible

Out-of-Network facility 60%, after deductible

Room and Board Limits

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

Emergency Room Services

Reimbursement rates for services sought for treatment of a medical emergency, as defined by the Plan.

In-Network and Out-of-Network copay, per occurrence \$100

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

- Emergency room copay will be waived if the patient is admitted to the hospital from the emergency room.

Reimbursement rates for non-emergency services.

In-Network copay, per occurrence \$100

In-Network reimbursement rate 80%, after deductible

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

PHYSICIAN BENEFITS

In-Network Physician Services

Reimbursement rate 80%, after deductible

Out-of-Network Physician Services

Reimbursement rate 60%, after deductible

OTHER BENEFIT LIMITATIONS AND MAXIMUMS

Ground and air ambulance services

Benefit limit, per trip \$5,000

Home health care

Calendar Year limit 50 visits

Hospice care

Calendar Year limit 180 days

Infertility treatment

Lifetime maximum \$15,000

Morbid Obesity treatment

Calendar Year maximum \$4,000

In-Network reimbursement rate 50%, after deductible

Out-of-Network reimbursement rate 30%, after deductible

Outpatient rehabilitation

Includes physical therapy, occupational therapy, speech therapy, cardiac rehabilitation and chiropractic services.
Calendar Year maximum..... 40 visits

Prosthetics and Orthotics

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

- Coverage includes custom-molded foot orthotics.
- Replacement orthotics are covered once every three years.

Routine Obstetrical Ultrasound

Limit, per pregnancy one ultrasound

Routine Preventive Care

In-Network and Out-of-Network reimbursement rate..... 100%, no deductible

- Routine Preventive Care includes vision exams, which are limited to one per Calendar Year.

Routine Preventive Colonoscopy

Benefit limitone colonoscopy every three years
In-Network reimbursement rate 80%, after deductible
Out-of-Network reimbursement rate 60%, after deductible

- Coverage is only available to individuals age 50 and older

Skilled Nursing

Calendar Year limit 100 days

SPECIAL IN-NETWORK EXCEPTIONS

- Non-contracted suppliers and specialists will be reimbursed at the In-Network level of benefits.
- If services are not available from an In-Network provider, Covered Charges will be reimbursed at the In-Network level of benefits.
- If services from an In-Network provider are not accessible, Covered Charges will be reimbursed at the In-Network level of benefits.
- Covered charges for emergency and accident services will be reimbursed at the In-Network level of benefits.
- Covered charges for inpatient or outpatient services rendered by an Out-of-Network anesthesiologist, pathologist or radiologist in connection with an In-Network facility will be paid at the In-Network level of benefits.

PRESCRIPTION DRUG CARD BENEFITS

The prescription drug card program is administered by the pharmacy benefits manager.

Copay, per 34-day supply from a retail pharmacy

Generic copay..... \$10
Preferred copay \$30
Non-preferred copay \$50

Copay, per 90-day supply from the mail order pharmacy

Generic copay..... \$20
Preferred copay \$60
Non-preferred copay \$100

MEDICAL BENEFITS

Medical Benefits apply when Covered Charges are incurred by a Covered Person 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.

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 any listed limit of the Plan.

ANNUAL OUT-OF-POCKET LIMIT

Covered Charges are payable at the percentages shown each Calendar Year until the Annual 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.

COVERED SERVICES AND BENEFITS

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

PLAN PARTICIPANTS ARE LIABLE FOR COPAYMENTS, DEDUCTIBLE, AND OUT-OF-POCKET AMOUNTS TO PHYSICIANS FOR SPECIFIED SERVICES AS SET FORTH BELOW AND AMOUNTS IN EXCESS OF ALLOWABLE CHARGES BILLED BY OUT-OF-NETWORK PROVIDERS.

The Copayment, Deductible, Out-of-Pocket Limit, and benefit limits are specified in the Schedule of Benefits. Copayment amounts are not applied to the Annual Out-of-Pocket Limit. Annual maximum benefit limits are based on the Calendar Year.

- (1) **Professional Services**, limited to one visit per day.
 - (a) **Primary Care Physician Office Visits.** Coverage is provided for the diagnosis and treatment of illness or injury when provided in the medical office of the Primary Care Physician. Plan Participant is responsible for the Deductible and Out-of-Pocket amount specified in the Schedule of Benefits, for each visit.

- (b) **Specialty Care Physician Office Visits.** Coverage is provided for the diagnosis and treatment of illness or injury when provided in the medical office of a Specialty Care Physician. Specialty Care Physician office visits are subject to the Deductible and Out-of-Pocket amount specified in the Schedule of Benefits.
 - (c) **Physician Hospital Visits.** Coverage is provided for services of Physicians for diagnosis, treatment and consultation while the Plan Participant is confined as an inpatient in the hospital for Medically Necessary Covered Services, subject to the Deductible and Out-of-Pocket amount specified in the Schedule of Benefits.
 - (d) **Physician Home Visits.** Coverage is provided for Medically Necessary home visits by Physicians when the nature of the illness or injury so indicates. Home visits are subject to the limitations specified in the Schedule of Benefits.
 - (e) **Other Physician Home Visits.** Care in the home by Health Care Professionals including but not limited to registered nurses, licensed practical nurses, physical therapists, inhalation therapists, speech and hearing therapists, and other licensed providers, is a covered benefit when ordered by a Physician, subject to the limitations specified in the Schedule of Benefits.
 - (f) Charges for **multiple surgical procedures** will be a covered expense subject to the following provisions:
 - (i) Coverage is provided for services of Physicians for surgery, either as an inpatient or outpatient. If coverage is provided for two or more surgical operations performed during the same surgical encounter or for bilateral procedures, payment for the secondary or subsequent procedure will be made at a reduced rate.
 - (ii) Payment for a covered assistant surgeon shall be limited to ~~one~~ a single Physician, qualified to act as an assistant for the surgical procedure. Covered Charges for assistant surgery services or minimum assistant surgery services will be paid at a reduced rate which will never exceed 20% of the surgeon's Allowable Charge.
- (2) **Wellness Health Services.** Subject to all terms, conditions, exclusions and limitations of this Plan Document, coverage is provided for preventive health services. Coverage is limited as specified in the Schedule of Benefits. The following are examples of preventive health services:
- (a) Well baby care for Plan Participants up to age 12 months and well child care over the age of 12 months.
 - (b) Immunizations.
 - (c) Pap smears for cervical cancer screening.
 - (d) Mammograms for breast cancer screening.
 - (e) Osteoporosis screening for women.
 - (f) Eye and hearing screenings for Plan Participant for the purpose of determining vision or hearing problems.
 - (g) Prostate-specific antigen test for detection of cancer is covered for male Plan Participants with a family history of prostate cancer.
 - (h) Periodic health assessments for adults, based on age, sex and medical history.

- (i) One routine vision examination is covered when obtained from an optometrist or ophthalmologist.
- (3) **Hospital Services.** Subject to all terms, conditions, exclusions and limitations of this Plan Document, coverage is provided for the following Hospital Services. The Plan Participant is responsible for the Deductible and Out-of-Pocket amount specified in the Schedule of Benefits.
- (a) **Inpatient Services.** Coverage is provided for the following inpatient services:
 - (i) Room and board, while confined.
 - (ii) Laboratory, x-ray and other diagnostic services.
 - (iii) Medications, biologicals and their administration.
 - (iv) Physician services.
 - (v) Surgical services, use of operating and delivery rooms and related facilities.
 - (vi) Anesthesia and oxygen services.
 - (vii) Radiation therapy, inhalation therapy, hemodialysis, and chemotherapy (See benefit information regarding high-dose chemotherapy and Allogeneic bone marrow transplantation which is found in this section).
 - (viii) Blood and blood plasma and their administration (See benefit information regarding Allogeneic bone marrow transplantation which is found in this section).
 - (ix) Equipment and medical supplies while receiving inpatient services except those equipment items that are specifically excluded herein.
 - (b) **Outpatient Services.** Coverage is provided for services of a hospital outpatient department or outpatient surgery center when Medically Necessary subject to the limitations specified in the Schedule of Benefits.
 - (i) Dialysis, Radiation therapy, Chemotherapy (See benefit information regarding high-dose chemotherapy and Allogeneic bone marrow transplantation which is found in this section).
 - (ii) Physical, occupational, cardiac rehabilitation, and speech therapy.
 - (iii) Outpatient surgery, anesthesia and use of facility.

- (c) **Outpatient Diagnostic Services (Laboratory and X-ray).** Subject to all terms, conditions, exclusions and limitations of this Plan Document, coverage is provided for laboratory and radiographic procedures, services and materials, including diagnostic x-rays, x-ray therapy, fluoroscopy, electrocardiograms, electroencephalograms, laboratory tests and therapeutic radiology services, subject to any limitations specified in the Schedule of Benefits.
- (4) **Maternity and Family Planning Services.** Subject to all terms, conditions, exclusions and limitations of this Plan Document, coverage is provided for Maternity and Family Planning Services, subject to any limitations specified in the Schedule of Benefits.
 - (a) **Maternity Care.** Coverage is provided for maternity care including pre and postnatal care; use of hospital delivery rooms and related facilities; use of newborn nursery and related facilities; special procedures as may be Medically Necessary. Routine obstetrical ultrasounds are limited to one per pregnancy.

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).

The Expectant Mother is encouraged to enroll in the Special Delivery Program by the 14th week of pregnancy. Special Delivery can be accessed by calling 1-800-742-6457. This program is designed to encourage the Covered Person to actively participate in obtaining comprehensive prenatal care. Services that are not normally offered, such as skilled nursing assessments or nursing assistant care in the home for conditions including pregnancy-induced hypertension, diabetes mellitus, and preterm labor, are covered through the Special Delivery program. The Special Delivery nurse can assist in coordinating home health care in lieu of hospitalization for those high-risk patients who the physician feels would benefit from this alternative care.

- (b) **Newborn Care in the Hospital.** Newborn Children of the Subscriber or Spouse will be covered from date of birth provided the Subscriber enrolls the newborn within the required time frame after the date of birth.

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

Charges for covered routine nursery care will be applied toward the Plan of the covered parent.

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

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

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

- (c) **Family Planning and Infertility Services.** Coverage is provided for the following family planning services:
- (i) Counseling and planning services for infertility when provided by Plan Physicians.
 - (ii) Infertility treatment. Medically Necessary testing and treatment of infertility, as determined by a Plan Physician.
 - (iii) Voluntary sterilizations (vasectomies and tubal ligations) are covered.
 - (iv) Medically Necessary pregnancy terminations are covered.
- (5) **Therapy Services.** Coverage is provided for inpatient and outpatient therapy services when performed or prescribed by a Physician. Such therapy services include physical and occupational therapy. Such therapy services shall include services provided for developmental delay, developmental speech or language disorder, developmental coordination disorder and mixed developmental disorder. Therapy services must be performed by an appropriate registered physical, occupational or speech-language therapist licensed by the appropriate State Licensing Board.
- (6) **Mental Health and Substance Abuse Services.** Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Plan Document, coverage is provided for Health Interventions to treat Mental Illness and Substance Abuse.

Psychiatrists (M.D.) and psychologists (Ph.D.) may bill the Plan directly. Other licensed mental health practitioners must be under the direction of and must bill the Plan through these professionals.

Outpatient Health Interventions

- (a) Coverage of Mental Illness and Substance Abuse Health Interventions during office visits and other forms of outpatient treatment, including partial or full-day program services is subject to the Deductible and Out-of-Pocket Limit set out in the Schedule of Benefits.
- (b) Coverage of office visits and other outpatient treatment sessions, beyond the eighth session in a Calendar Year, except for medication management treatment sessions is subject to Prior Approval from the Mental Health and Substance Abuse treatment management vendor. See the Prior Approval section, below.

Inpatient, Partial Hospitalization Program and Intensive Outpatient Program Health Interventions

- (a) Coverage for Inpatient Hospitalization, Partial Hospitalization Programs or Intensive Outpatient Programs for Mental Illness or Substance Abuse Health Interventions is subject to Prior Approval from the Mental Health and Substance Abuse treatment management vendor. See the Prior Approval section, below.
 - (i) Inpatient Hospitalization requires a patient to receive covered services 24 hours a day as an inpatient in a Hospital.
 - (ii) Partial Hospitalization Programs generally require the patient to receive covered services six to eight hours a day, five to seven days per week in a Hospital.
 - (iii) Intensive Outpatient Programs generally require the patient to receive covered services lasting two to four hours a day, three to five days per week in a Hospital.

- (b) Coverage is subject to the Deductible and Out-of-Pocket Limit set forth in the Schedule of Benefits.
- (c) **The treating facility must be a Hospital.** Treatment received at a Freestanding Residential Substance Abuse Treatment Center or at a Freestanding Psychiatric Residential Treatment Facility is not a covered benefit.

Prior Approval. Coverage for many Health Interventions for the treatment of Mental Illness and Substance Abuse are subject to Prior Approval from the Mental Health and Substance Abuse treatment management vendor. To request Prior Approval, the patient or family member must call the MH/SA telephone number on the back of the ID card. **Please note that Prior Approval does not guarantee payment or assure coverage; it means only that the information furnished at the time indicates that the proposed Health Intervention meets the established coverage criteria. All services, including any Health Interventions for the treatment of Mental Illness or Substance Abuse receiving Prior Approval may be limited or denied if, when the claims for the Health Intervention are received by the claims administrator, investigation shows that a benefit exclusion or limitation applies, that the Covered Person ceased to be eligible for benefits on the date services were provided, that coverage lapsed for non-payment of premium, that Out-of-Network limitations apply, or that any other basis for denial of the claim specified in this Plan Document exists.**

- (7) **Emergency Care Services.** Subject to all terms, conditions, exclusions and limitations of this Plan Document, coverage is provided for Emergency Care Services. When Emergency Services are needed the Plan Participant should seek care at the nearest facility. Emergency Care is subject to medical review.

Medical Emergency means a sudden onset of a condition with acute symptoms requiring immediate medical care and includes such conditions as heart attacks, cardiovascular accidents, poisonings, loss of consciousness or respiration, convulsions or other such acute medical conditions.

- (a) **Emergency Care.** Coverage is provided for Emergency Care as defined in this Plan Document. The Plan Participant is responsible for the Copayment specified in the Schedule of Benefits for each Emergency Care visit.
 - (b) **Observation Services.** Observation services are covered when ordered by a Physician. Observation Services ordered in conjunction with an emergency room visit are subject to the Emergency Care Copayment.
 - (c) **Follow-up Care.** Continuing or follow-up treatment for accidental injury or Emergency Care.
- (8) Coverage is provided for **Durable Medical Equipment (DME)** when prescribed by a Physician according to the guidelines specified below.
 - (a) Durable Medical Equipment is equipment which (1) can withstand repeated use; and (2) is primarily and customarily used to serve a medical purpose; and (3) generally is not useful to a person in the absence of an illness or injury; and (4) is appropriate for use in the home. Coverage for Durable Medical Equipment and Medical Supplies is provided when the Durable Medical Equipment is provided in accordance with Coverage Policy. Examples of Durable Medical Equipment include, but are not limited to, oxygen equipment, wheelchairs and crutches.
 - (b) Replacement of DME is covered only when necessitated by normal growth or when it exceeds its useful life. Maintenance and repairs resulting from misuse or abuse of DME are the responsibility of the Covered Person.
 - (c) When it is more cost effective, the Plan, in its discretion will purchase rather than lease equipment. In making such purchase, the Plan may deduct previous rental payments from its

purchase Allowance.

- (d) **Surgical dressings**, splints, casts and other devices used in the reduction of fractures and dislocations are covered.

(9) **Prosthetics and Orthotic Devices.**

- (a) The initial purchase, fitting and repair of fitted **prosthetic devices** which replace body parts.
- (b) The initial purchase, fitting and repair of **orthotic appliances** such as braces, splints or other appliances which are required for support for an injured or deformed part of the body as a result of a disabling congenital condition or an Injury or Sickness.

NOTE: Prosthetics and orthotic devices are subject to the DME and Medical Supply annual maximum of \$5,000.

(10) **Diabetes Management Services.** Subject to all terms, conditions, exclusions and limitations of this Plan Document, coverage is provided for Diabetes equipment and supplies and Diabetes Self-Management Training when prescribed by a Physician.

- (a) **Diabetes Equipment and Supplies.** Diabetic supplies are covered under the Prescription Drug Card Program. Podiatric appliances for prevention of complications associated with diabetes are covered under Medical benefits.
- (b) **Diabetes Self-Management Training** is covered when ordered by a Physician.

NOTE: Diabetic equipment and supplies including insulin pump and insulin pump supplies are not subject to the DME and medical supply annual maximum of \$5,000.

(11) **Ambulance Services.** Local Medically Necessary professional land or air **ambulance** service to a Hospital or Skilled Nursing Facility where necessary treatment can be provided. Billed charges for Medically Necessary ambulance services which do not result in transport to a medical facility are not covered.

(12) **Skilled Nursing Facility Services.** Subject to all terms, conditions, exclusions and limitations of the Plan Document, coverage is provided for Skilled Nursing Facilities when Medically Necessary.

- (a) Coverage is provided, subject to the limit stated in the Schedule of Benefits, if the Skilled Nursing Facility services are of a temporary nature and lead to rehabilitation and increased ability to function.
- (b) Plan Participants remaining in a Skilled Nursing Facility after discharge by the attending Physician, or after the maximum benefit period or period authorized by the attending Physician is reached, shall be liable for all subsequent costs incurred.

NOTE: Custodial care is not a covered benefit.

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

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

Please note:

- (a) Medical Supplies used for Home Health Services are not subject to the DME and medical supply annual maximum of \$5,000.
 - (b) DME equipment items and medical supplies for use with the DME equipment for Home Health Services are subject to the DME and medical supply annual maximum of \$5,000.
- (14) **Hospice Care.** Subject to all terms, conditions, exclusions and limitations of the Plan Document, coverage is provided for Hospice services when prescribed by a Physician. Coverage is limited as shown in the Schedule of Benefits.
- (15) **Dental Care Services.** Injury to or care of **mouth, teeth and gums.** Charges for Injury to or care of the mouth, teeth, gums and alveolar processes will be Covered Charges under Medical Benefits only if that care is for the following oral surgical procedures:
- Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth.
 - Emergency repair due to Injury to sound natural teeth.
 - Surgery needed to correct accidental injuries to the jaws, cheeks, lips, tongue, floor and roof of the mouth.
 - Excision of benign bony growths of the jaw and hard palate.
 - External incision and drainage of cellulitis.
 - Incision of sensory sinuses, salivary glands or ducts.
 - Removal of impacted teeth.
 - Reduction of dislocations and excision of temporomandibular joints (TMJs), limited as shown in the Schedule of Benefits.

No charge will be covered under Medical Benefits for dental and oral surgical procedures involving orthodontic care of the teeth, periodontal disease and preparing the mouth for the fitting of or continued use of dentures.

- (16) **Reconstructive Surgery.** Subject to all terms, conditions, exclusions and limitations of the Plan Document, coverage is provided for Reconstructive Surgery when Medically Necessary. The following services are covered.
- (a) Treatment provided for the correction of defects incurred in an accidental injury sustained by the Plan Participant while covered under this Plan Document or follow-up care for accidental injury that could not have been provided at an earlier date.
 - (b) Surgery performed on a child age 12 years and under for the correction of a cleft palate or hair lip, removal of a port-wine stain on the face, or correction of a congenital abnormality.
 - (c) Treatment provided when it is incidental to disease or for reconstructive surgery following neoplastic (cancer) surgery while the Plan Participant was covered under this Plan Document.
 - (d) In connection with a mastectomy resulting from cancer surgery, services for (a) reconstruction of the breast on which the cancer-related surgery was performed; (b) surgery to reconstruct the other breast to produce a symmetrical appearance; and (c) prostheses and services to correct physical complications for all stages of the mastectomy, including lymphedemas.

NOTE: Coverage for Reconstructive Surgery that could have been provided at an earlier date is not covered.

- (17) **Injectable Medications.** Coverage under Medical benefits is available for injectable medications while confined as an inpatient, or when provided and administered by a Physician in a clinic setting.
- (18) **Allergy Services.** Subject to all terms, conditions, exclusions and limitations of the Plan Document, coverage is provided for allergy services when deemed Medically Necessary. Services include allergy testing and evaluation, therapy, injections and serum.

- (19) **Organ Transplant Services.** Coverage is provided for human-to-human organ or tissue transplants in accordance with the following specific conditions:
- (a) Not all transplants are covered. There must be a specific Coverage Policy which allows benefits for the transplant in question, and the Covered Person must meet all of the required criteria necessary for coverage set forth in the Coverage Policy and in this Plan Document.
 - (b) Except for kidney and cornea transplants, coverage for transplant services requires Prior Approval from the Claims Administrator. A request for approval must be submitted to the Claims Administrator prior to receiving any transplant services, including transplant evaluation.
 - (c) The transplant benefit is subject to the deductible, coinsurance and any applicable copays or maximums specified in the Schedule of Benefits.
 - (d) Notwithstanding any other provisions, the Allowable Charge for an organ transplant, including any charge for the procurement of the organ, hospital services, physician services and associated costs, including costs of complications arising from the original procedure that occur within the Transplant Global Period, shall be limited to the lesser of (a) ninety percent (90%) of the billed charges or (b) the global payment determined as payment in full by a Blue Cross and Blue Shield Association Blue Distinction Centers for Transplant participating facility, if the Covered Person chooses to use that facility. If the Covered Person receives the transplant from a facility that is not in the Blue Distinction Centers for Transplant network, but is contracted with a local Blue Cross and/or Blue Shield Plan, the Allowable Charge shall be the price contracted by such Blue Cross and/or Blue Shield Plan. If the Covered Person receives the transplant from a facility that is not in the Blue Distinction Centers for Transplant network and does not contract with the local Blue Cross and/or Blue Shield plan, the Allowable Charge for the transplant services provided in the Transplant Global Period is eighty (80%) percent of the average usual and reasonable charge authorized by participating facilities in the Blue Distinction Centers for Transplant network located in the geographic region where the transplant is performed.
 - (e) Charges for obtaining donor organs or tissues are Covered Charges under the Plan when the recipient is a Covered Person. When the donor has medical coverage, his or her plan will pay first. The benefits under this Plan will be reduced by those payable under the donor's plan. Donor charges include those for evaluating the organ or tissue, removing the organ or tissue from the donor, and transportation of the organ or tissue from within the United States and Canada to the place where the transplant is to take place.
- (20) **Allogeneic bone marrow transplantation.** Allogeneic bone marrow transplantation and all related procedures (including High Dose Chemotherapy) designed to replace bone marrow or peripheral blood cells are not covered. The only instances in which services, supplies or drugs associated with allogeneic transplantation and related procedures will be covered are in the treatment of diseases of the bone marrow listed below when the specified donor match is used:
- (a) The following diseases when the acceptable donor matches patient at all six HLA antigens and the patient and donor cells are nonreactive in mixed leukocyte culture:
 - Aplastic anemia;
 - Wiskott-Aldrich syndrome;
 - Infantile malignant osteopetrosis (Albers-Schonberg syndrome or marble bone disease);
 - Homozygous beta-thalassemia (thalassemia major); or
 - Myelodysplastic Syndromes (including primary [e.g. idiopathic] and acquired [e.g. secondary to drug or toxin exposure] forms using 6 of 6 antigen matched, mixed lymphocyte culture negative, family member donor).
 - (b) Acceptable donor matches the patient at three or more of six HLA antigens; patient and donor

cells are nonreactive in mixed leukocyte culture, and the patient has severe combined immunodeficiency syndrome (e.g. adenosine deaminase deficiency and idiopathic deficiencies).

- (c) For the following malignancies in which the acceptable donor is related or unrelated to the patient with matches at all six HLA loci and patient and donor cells are nonreactive in mixed leukocyte culture:
- Non-Hodgkin's lymphoma, intermediate or high grade stage III or stage IV;
 - Hodgkin's disease, stage IIIA or IIIB, or stage IVA or IVB;
 - Neuroblastoma, stage III or stage IV; or
 - Chronic myelogenous blast leukemia in blast crisis or chronic phase.
- (d) The following diseases for patients in absence of HLA identical donor, if acceptable donor is related (haploidentical) to the patient with one or more antigen mismatches and the patient and donor cells are nonreactive in mixed leukocyte culture:
- Acute lymphocytic or nonlymphocytic (acute myelocytic) leukemic patients who are in first or subsequent remission, but at high risk for relapse. Factors associated with high risk for relapse are:
 - age greater than 15 years;
 - leukocyte count greater than 10×10^9 per liter;
 - extramedullary disease (especially central nervous system disease);
 - leukemic blast with chromosomal translocations; and
 - failure to achieve a complete remission within six weeks of the start of induction therapy.
 - Chronic myelogenous leukemia in chronic phase.
 - Multiple Myeloma in patients under the age of 55 years
 - when performed with an HLA-matched donor.

(21) **High dose chemotherapy.** High Dose Chemotherapy and all related procedures, including but not limited to autologous bone marrow transplantation, allogeneic bone marrow transplantation, stem cell rescue or similar treatment or procedures designed to replace or rejuvenate bone marrow or peripheral blood cells are not covered. Other than for allogeneic bone marrow transplantation, (Exclusion 3), the only instances in which drugs, services or supplies associated with High Dose Chemotherapy and related procedures will be covered are in the following limited circumstances:

- For a diagnosis of Non-Hodgkin's lymphoma, when classified as intermediate or high grade stage III, or stage IV; or
- For a diagnosis of Hodgkin's disease classified as stage IIIA, IIIB, IVA or IVB; or
- For a diagnosis of neuroblastoma, when classified as stage III or stage IV; or
- For a diagnosis of acute lymphocytic or non-lymphocytic leukemia following a first or any subsequent relapse; or
- For a diagnosis of testicular, mediastinal, retroperitoneal or ovarian germ cell tumors that are refractory to standard dose Chemotherapy with a U. S. Food and Drug Administration platinum compound. Refractory cases include (1) patients with advanced disease who fail to achieve a complete response to second-line therapy, and (2) patients with moderate or minimal extent disease who fail to achieve a complete response to third-line therapy. Disease extent (e.g., minimal, moderate, advanced) refers to germ cell tumor stage according to the Indiana University/Einhorn Classification; or
- For a diagnosis of breast cancer under the following conditions: (1) 10 or more positive nodes in the adjuvant setting; or (2) inflammatory breast cancer at the time of the diagnosis of the cancer; or (3) stage II or III metastatic breast cancer that has relapsed after first line therapy; or (4) stage II or III metastatic breast cancer that is known to be chemotherapy sensitive (partial or complete response to prior chemotherapy) and are at high risk of relapse. Such patients must have adequate marrow

- function with no evidence of marrow involvement of the disease.
- For a diagnosis of multiple myeloma in patients who meet the coverage criteria established by the Plan.
 - For children up to eighteen (18) years of age with pineoblastoma who have shown response to standard chemotherapy and whose disease is localized in the brain.
 - For children or young adults up to thirty-two (32) years of age with metastatic Ewing's sarcoma.

NOTE: In each of the cases outlined above, the following conditions must be satisfied in order for High Dose Chemotherapy to be a covered benefit:

- the patient's disease characteristics and treatment history suggest that the
 - probability of achieving a durable, complete remission are greater with High Dose
 - Chemotherapy compared to standard treatment or conventional dose
 - Chemotherapy; and
 - the patient does not have a concurrent condition which would seriously jeopardize
 - the achievement of a durable, complete remission with High Dose Chemotherapy.
- (22) **Morbid obesity** treatment coverage, including gastric bypass surgery or any other procedure performed for the purpose of weight loss, is subject to prior written approval from the Claims Administrator, acting on behalf of the Plan Administrator. Benefits for surgical procedures will be limited as described in the Schedule of Benefits.
- (23) **Genetic testing** is covered in accordance with established Coverage Policy.

PLAN EXCLUSIONS, LIMITATIONS AND NON-COVERED SERVICES

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

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

- (1) **Abortion.** Purely elective or voluntary abortions or pregnancy terminations are not covered. Medically Necessary pregnancy terminations are covered.
- (2) **Acupuncture.** Services related to acupuncture are not covered.
- (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) **Allogeneic bone marrow transplantation.** Allogeneic bone marrow transplantation and all related procedures (including High Dose Chemotherapy) designed to replace bone marrow or peripheral blood cells are not covered unless otherwise stated in the Medical Benefits Section.
- (5) **Appointments/medical records.** Charges resulting from the failure to keep a scheduled visit with a Physician or other Provider; or for completion of any insurance forms; or for acquisition of medical records are not covered.
- (6) **Behavior/conduct disorders.** Services provided for treatment of adolescent behavior or conduct disorders, oppositional disorders or neuroeducational testing are not covered.
- (7) **Bereavement services.** Medical social services and outpatient family counseling and/or therapy for bereavement, except if provided as Hospice Care, are not covered.
- (8) **Biofeedback.** Biofeedback and other forms of self-care or self-help training, and any related diagnostic testing are not covered for any diagnosis or medical condition.
- (9) **Chelation therapy.** Services or supplies provided as, or in conjunction with, chelation therapy, except for treatment of acute metal poisoning are not covered.
- (10) **Clinical Trials.** Services or supplies provided in connection with a phase I, II, III or IV clinical trial or any study to determine the maximum tolerated dose, toxicity, safety, efficacy, or efficacy as compared with a standard means of treatment or diagnosis of a drug, device or medical treatment or procedure are not covered. This exclusion will not apply to routine items and services that (a) would have been Covered Expenses had they not be incurred during an approved clinical trial, and (b) are provided during an approved clinical trial, as required and defined under PHSA Section 2709.
- (11) **Cochlear implants.** Services related to cochlear implants including diagnostic tests are not covered.
- (12) **Comfort items.** Private hospital rooms are covered only when Medically Necessary and authorized by the Physician. Personal or comfort items such as television, radio, telephone, guest meals, personal computer with or without assistive talking devices, automobile/van conversion or addition of patient lifts, hand controls, or wheel chair ramps, and home modifications such as overhead patient lifts and wheelchair ramps are not covered.
- (13) **Complications of non-covered treatments.** Care, services or treatment required as a result of complications from a treatment not covered under this Plan Document are not covered.
- (14) **Contraceptive devices.** Contraceptive devices including but not limited to IUD, subcutaneous

contraceptive implant, diaphragm, foams and jellies are not covered. All services or supplies related to or complications resulting from injectable contraceptives are not covered.

- (15) **Cosmetic services.** All services or procedures related to or complications resulting from Cosmetic Services are not covered.
- (16) **Court ordered or third party recommended treatment.** Services required or recommended by third parties, including physicals and/or vaccines/immunizations for employment, overseas travel, camp, marriage licensing, insurance, and services ordered by the court or arranged by law enforcement officials, unless otherwise covered by this Plan are not covered.
- (17) **Custodial Care.** Services or supplies for custodial, convalescent, domiciliary or support care and non-medical services to assist a Covered Person with activities of daily living are not covered.
- (18) **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.
- (19) **Delivery Charges.** Charges for shipping, packaging, handling or delivering Medications are not separately covered.
- (20) **Dental care.** Dental Implants, dental abutments, dental restorations, and services or supplies for dental care, except as provided in the Medical Benefits Section under Dental Care Services are not covered. Orthognathic surgery and Orthodontics and braces regardless of Plan Participant's age are not covered.
- (21) **Domestic Partners.** Domestic partners of the same sex or opposite sex are not covered.
- (22) **Donor services.** Services or supplies incident to organ and tissue transplant, or other procedures when the Plan Participant acts as the donor are not covered except for Autologous services. When the Plan Participant is the potential transplant recipient, expenses for testing of a donor who is found to be incompatible are not covered.
- (23) **Eating Disorders.** Anorexia, bulimia, and services related to eating disorders including long-term rehabilitative services are not covered.
- (24) **Electrotherapy stimulators.** All treatment using electrotherapy stimulators, services and supplies used in connection with treatment, and complications resulting from the treatment are not covered.
- (25) **Enteral Feedings.** Enteral tube feedings are not covered except when it is the sole source of nutrition.
- (26) **Excess charges.** The part of an expense for care and treatment of an Injury or Sickness that is in excess of the Allowable Charge is not covered.
- (27) **Exercise programs.** Exercise programs for treatment of any condition are not covered.
- (28) **Experimental/Investigational.** Any treatment, procedure, facility, equipment, drug, device or supply deemed to be Experimental or Investigational as defined in this Plan Document is not covered. Diagnostic procedures, services and supplies provided in connection with Experimental or Investigational studies or treatment are not covered.
- (29) **Eye care.** Refractive keratoplasty, epikeratophakia procedures, Low Vision Enhancement System (LVES), and eyeglasses and contact lenses (except the initial acquisition following cataract surgery) are not covered.
- (30) **Family planning and infertility services.** Any services or supplies provided for, in preparation for, or in conjunction with the following are not covered except as provided in the Medical Benefits Section.

- Elective or voluntary abortions; and complications for these procedures.
 - Infertility drugs.
 - Sterilization reversal (male or female).
 - Sexual dysfunction including sex therapy.
 - Surrogate mother services
- (31) **Foot care.** Services or supplies for treatment of flat feet or fallen arches, routine foot care such as hygiene care, removal of corns, warts or calluses, and toenail trimming, except when required for prevention of complications associated with diabetes are not covered.
- (32) **Foreign travel.** Care, treatment or supplies out of the United States if travel is for the sole purpose of obtaining medical services. Services received outside of the United States must be Medically Necessary to be considered eligible for coverage.
- (33) **Freestanding Residential Treatment Center.** Treatment received at a Freestanding Substance Abuse Residential Treatment Center or a Freestanding Psychiatric Residential Treatment Center is not covered.
- (34) **Genetic Testing.** Genetic Testing to determine the likelihood of developing a disease or condition, the likelihood of a disease or the presence of a disease in a relative, or the likelihood of passing an inheritable disease or congenital abnormality to an offspring, are not covered. Services for pre-implantation genetic diagnosis or treatment are not covered. However, 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 a Covered Person's tissue to determine if the person has a specific disease, is covered, subject to established coverage criteria.
- (35) **Hair loss.** Care and treatment for hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a Physician are not covered. Wigs following chemotherapy are covered.
- (36) **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.
- (37) **Hearing or talking aids.** Hearing aids or assistive talking devices including special computers are not covered.
- (38) **High dose chemotherapy.** High Dose Chemotherapy and all related procedures, including but not limited to autologous bone marrow transplantation, allogeneic bone marrow transplantation, stem cell rescue or similar treatment or procedures designed to replace or rejuvenate bone marrow or peripheral blood cells are not covered unless otherwise stated in the Medical Benefits Section.
- (39) **High frequency chest wall oscillators.** Any type of portable device including inflatable vests used to create an airflow within the lungs are not covered regardless of diagnosis.
- (40) **Hypnotherapy.** Hypnotherapy is not covered for any diagnosis or medical condition.
- (41) **Learning Disabilities.** Services or supplies provided for learning disabilities, i.e. reading disorder, alexia, developmental dyslexia, dyscalculia, spelling difficulty, applied behavior analysis and other learning difficulties, are not covered.

- (42) **Long term care.** Services or supplies furnished by an institution, which is primarily a place of rest or a place for the aged, residential long term care for mental health disorders, youth homes, or any similar institution are not covered.
- (43) **Marriage and Family Therapy.** Marriage and family therapy or counseling services are not covered.
- (44) **Midwives.** Services provided by midwives are not covered.
- (45) **Naturopath/Homeopath services.** Naturopathic or Homeopathic remedies for treatment of any condition are not covered.
- (46) **Non-Covered Services.** Services not specifically included as a benefit herein, complications related to non-Covered Services, services provided after exceeding the benefit maximum for specified services, and services for which the Plan Participant is not responsible for payment are not covered.
- (47) **Not Medically Necessary.** Services and supplies which are not Medically Necessary are not covered except for preventive health services for which coverage is otherwise specifically listed herein. Hospitalization that is extended for reasons other than medical necessity, e.g. lack of transportation, lack of caregiver at home, inclement weather, and other social reasons not justifying coverage for extended Hospital stay is not covered.
- (48) **Nutritional counseling services.** Dietary and Nutritional Counseling Services are not covered except in conjunction with Diabetic Self-Management Training, and for a nutritional assessment program provided in and by a Hospital.
- (49) **Nutritional supplements.** Regular formulas, special formulas, and food additives are not covered except for formulas necessary for the treatment of phenylketonuria (an inherited condition that may cause severe mental retardation), and other heritable diseases.
- (50) **Orthognathic services.** See exclusions for Dental Care and Reconstructive Surgery.
- (51) **Prescribed drugs and medications.** Medications obtained by prescription through a managed pharmacy program including any outpatient medications, take-home medications, medications administered in conjunction with home health services, and medications prescribed after exceeding any maximum allowable benefits are not covered. Medications administered outside a Physician's office except medications provided while confined as an inpatient are not covered.
- (52) **Private duty nursing.** Private duty nursing is not covered, except for outpatient private duty nursing when determined to be Medically Necessary and ordered by the Physician.
- (53) **Prosthetics and orthotic devices.** General orthotic devices, dental appliances, splints or bandages provided by a physician in a non-hospital setting or purchased "over the counter" for the support of strains and sprains; orthopedic shoes which are a separable part of a covered brace, elastic stockings, garter belts, specially ordered, custom made or built-up shoes, cast shoes, and shoe inserts designed to support the arch or effect changes in the foot alignment are not covered.
- (54) **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.
- (55) **Reconstructive Surgery.** All services or procedures related to or complications resulting from Reconstructive Surgery are not covered except as specified in the Medical Benefits Section. Reconstructive Surgery. Orthognathic procedures are not covered.
- (56) **Rehabilitative Treatment or Therapy.** Services or supplies for supportive or maintenance care, and non-medical services to assist a Plan Participant with activities of daily living are not covered. Services, supplies, or therapy provided for developmental delay, including learning disabilities, communication

delay, perceptual disorder, sensory deficit and motor dysfunctions is not covered except for services provided to improve or prevent deterioration of function in children under the age of 6.

- (57) **Relative giving services.** Professional services performed by a person who ordinarily resides in the covered Plan Participant's home, including self, or is related to the covered Plan Participant as a Spouse, parent, Child, brother or sister, grandparent and grandchild, whether the relationship is by blood or exists in law are not covered.
- (58) **Residential long term care facilities for mental health or eating disorders are not covered.** Youth homes, schools, therapeutic camps or any similar institution are not covered.
- (59) **Seasonal Affective Disorder (SAD).** Use of photo therapy or light therapy to treat seasonal affective disorder or depression is not covered.
- (60) **Self-Inflicted Injuries.** Services for intentional self-inflicted injuries, including drug overdose, whether sane or insane are not covered. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition
- (61) **Services outside of Service Area.** Services rendered outside of the PPO Service Area, the need for which could reasonably have been foreseen by the Plan Participant prior to leaving the Service Area are not covered. Maternity care is not covered outside the service area if after the 36th week of pregnancy.
- (62) **Sex changes/sex therapy.** Care, services or treatment for non-congenital transsexualism, gender dysphoria or sexual reassignment or change are not covered. This exclusion includes medications, implants, hormone therapy, surgery, medical or psychiatric treatment or other treatment of sexual dysfunction including Prescription Medications and sex therapy.
- (63) **Short stature syndrome.** Any services related to the treatment of short stature syndrome except for growth hormone deficiency.
- (64) **Sleep study centers.** Services provided by contracted sleep study centers are covered when ordered by a Physician. Services and supplies provided by or in connection with free-standing sleep study centers or sleep laboratories are not covered.
- (65) **Smoking cessation/Caffeine addiction.** Treatment of caffeine or nicotine addiction, smoking cessation prescription drug products, including, but not limited to, nicotine gum and nicotine patches are not covered.
- (66) **Supplies.** Medical Supplies regardless of where prescribed or purchased that are covered by the Drug Card Program are not covered.
- (67) **Telephone and Other Electronic Consultation.** Telephone calls or other forms of electronic consultation (e.g. e-mail, 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 Case Management with involved health care Providers are covered.
- (68) **Transplant procedures.** The following transplant procedures and services are not covered:
- Animal to human transplants.
 - Artificial or mechanical devices designed to replace human organs.
 - Services provided beyond the benefit maximums.
 - Organ transplants that are not Medically Necessary.
 - Organ transplants considered experimental or investigational.
 - Small bowel transplantation.

- Pancreas transplant not done simultaneously with kidney transplant with diabetic mellitus and End Stage Renal Disease.
 - Solid organ transplantation in patients for carcinoma except for liver transplants for patient with hepatoma confined to the liver.
- (69) **Travel or accommodations.** Travel or transportation as a treatment modality or to receive consultation treatment except emergency transportation and ambulance services are not covered.
- (70) **Unlicensed Provider.** Coverage is not provided for treatment, procedures or services received from any person or entity, including but not limited to Physicians, who is required to be licensed to perform the treatment, procedure or service, but (1) is not so licensed, or (2) has had his license suspended, revoked or otherwise terminated for any reason, or (3) has a license that does not include within its scope the treatment, procedure or service provided.
- (71) **Vocational rehabilitation.** Vocational rehabilitation services, vocational counseling, employment counseling or services to assist a Plan Participant in gaining employment are not covered.
- (72) **War.** Services or supplies provided for injuries sustained as a result of war, declared or undeclared, or any act of war; or while on active or reserve duty in the armed forces of any country or international authority are not covered.
- (73) **Weight Control.** Medications prescribed, dispensed or used for the treatment of obesity, or for use in any program of weight control, weight reduction, weight loss or dietary control are not covered.
- (74) **Workers Compensation.** Treatment of any compensable injury, as defined by the Workers' Compensation Law is not covered, regardless of whether or not the Plan Participant timely filed a claim for workers' compensation benefits.
- (75) **Limitations as a Result of Major Disaster or Epidemic.** In the event that due to circumstances not within the commercially allowable control of the Plan, including, but not limited to, a major disaster, epidemic, the complete or partial destruction of facilities, computer failures or viruses, riot, civil insurrection, disability of a significant part of the Provider Networks' personnel or similar causes, the rendering of Professional or Hospital Services covered under this Plan is delayed or rendered impractical, the Plan shall make a good faith effort to arrange for an alternative method of providing coverage. The Plan and Physicians shall incur no liability or obligation for delay, or failure to provide or arrange for services if such failure or delay is caused by such an event.

COST MANAGEMENT SERVICES

Prenotification Phone Number

Please refer to the Employee ID card for the Prenotification phone number.

The patient or family member must call this number to notify the utilization review vendor of inpatient Hospitalizations. This call must be made at least three days in advance of services being rendered or within 48 hours after an emergency.

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

PLEASE NOTE: Prior approval is required for an inpatient Hospitalization related to Mental Health or Substance Abuse Treatment. The patient or family member must call the Mental Health and Substance Abuse Treatment management vendor at the MH/SA phone number on the back of the Employee ID Card to obtain Prior Approval. (Please refer to the Medical Benefits Section for more information on Mental Health and Substance Abuse Prior Approval requirements.)

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 prenotification of non-emergency Inpatient Hospital admissions before Medical and/or Surgical services are provided.

The purpose of the program is alert the utilization review administrator of a patient's potential need for long-term and/or extensive care. 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 there is an **emergency** admission to the Medical Care Facility, the patient, patient's family member, Medical Care Facility or attending Physician must contact the utilization review administrator **within 48 hours** after the admission.

Setting The Utilization Review Program In Motion

The utilization review program is set in motion by a telephone call from the Covered Person. Contact the utilization review administrator **before** services are scheduled to be rendered with the following information:

- The name of the patient and relationship to the covered Employee
- The name, Social Security 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 diagnosis and/or type of surgery
- The proposed rendering of listed medical services

PREADMISSION TESTING SERVICE

Diagnostic lab tests and x-ray exams will be payable at standard Plan reimbursement levels when:

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

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

CASE MANAGEMENT

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

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

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

NOTICE OF PROVIDER INCENTIVES – HOW PAYMENT PROGRAMS FOR NETWORK PROVIDERS MAY AFFECT YOUR HEALTH CARE

The Plan has elected to participate in new health care provider payment initiatives that offer financial incentives – both potential rewards and possible penalties – to providers based on their ability to meet or exceed certain quality and cost targets or standards.

For example, a physician may be offered an incentive program in which the physician's performance of a particular kind of health care service, such as a hip or knee replacement surgery, is evaluated in terms of the average cost of the surgery when performed by the physician, as well as whether or how often the physician meets certain defined quality standards when performing such surgery. Under such an incentive program, the physician may be told that the incentive program target for average physician cost is, for example, \$5,000. The physician also may be informed of five or six quality indicators that the incentive program will require be confirmed in all or a high percentage of the physician's hip/knee surgical cases, in order to qualify for incentive payments.

Under such an incentive program, if the average cost for all hip and knee replacement surgeries performed by the physician during a defined review period (for example, 12 months) exceeds the program target average cost of \$5,000, the physician would be responsible for refunding a portion of such excess costs to insurers or self-funded

health benefit plans (such as your Plan). Such refunds for excess average costs might be recovered from the physician through what are known as “withholds,” whereby the insurer or self-funded health benefit plan would withhold a certain percentage from future claims payments otherwise due to the physician, until the excess cost amount is fully recovered. On the other hand, if the average costs for all hip and knee replacement surgeries performed by the physician during a defined review period was less than the program target average cost of \$5,000, the physician would qualify to receive additional incentive payments (sometimes called “bonus” payments) from the insurer or self-funded health benefit plan (including your Plan) as a reward for reducing the physician’s average cost for such surgeries.

The preceding is simply one example of a possible incentive program; there are very likely to be numerous other types of incentive programs focusing on different kinds of surgeries, medical treatments, or “episodes of care.” While the precise working or content of each incentive program may vary, the goal of all such incentive programs is the same: to give the provider financial incentives to control costs of services, as well as financial incentives to maintain certain quality standards. “Episodes of Care” is a term that refers to the grouping of certain sets of medical services that may be provided over an extended period of time into one “episode” for purposes of quality and cost evaluation. Hip and knee replacement surgeries are one such type of “episode of care,” but there are likely to be many others, which could focus on virtually any aspect of health care services, procedures, surgeries or treatments. Please note as well that although the example above refers to physician services and charges, the provider incentive programs in which the Plan has elected to participate may include other categories of providers, not just physicians. Also, you should be aware that any deductibles and coinsurance, or other Plan participant cost-sharing provisions of the Plan shall not apply in any manner to any incentive payments or withholds that result from participation in the incentive programs.

Should you have any concerns about whether your provider is participating in a provider incentive program, or how the potential for reward or penalty in that program might affect the provider’s provision of health care services to you, you should ask your treating provider or their administrative staff about such incentive program participation prior to receiving any health care services. Additional details on incentive programs in which the Plan participates as of a certain date can be obtained by writing to the Plan Administrator at P.O. Box 9403, Magnolia, Arkansas, 71754-9403. Please note that the types of provider incentive programs, or the specifics of such programs, including payment methods or methods of calculating potential rewards or penalties, may change from time to time, and could be changed quickly, as conditions in the health care or financing marketplace change. Accordingly, you may want to request updated information from your treating provider, or request it from the Plan, prior to undergoing a specific course of treatment.

DEFINED TERMS

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

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

Allowable Charge when used in connection with covered services or supplies delivered in Arkansas, will be the amount deemed by the Claims Administrator, in its sole discretion, to be reasonable. The customary allowance is the basic Allowable Charge. However, Allowable Charge may vary, given the facts of the case and the opinion of the Claims Administrator.

Allowable Charges for services or supplies received out of Arkansas may be determined by the local Blue Cross and Blue Shield Plan. Please note that all benefits under this Plan are subject to and shall be paid only by reference to the Allowable Charge 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 Charge. If services are rendered by a participating Provider, that 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 Charge.

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.

Annual Out-of-Pocket Limit means the maximum amount of coinsurance payments a Plan Participant is required to make in connection with Covered Services or supplies in a Calendar Year. Copayments and amounts a Plan Participant may have to pay in excess of contract benefit limits do not contribute to the Annual Out-of-Pocket Limit

Baseline shall mean the initial test results to which the results in future years will be compared in order to detect abnormalities.

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 a registered nurse (R.N.); 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.

Case Management means a process in which BlueAdvantage Administrators of Arkansas staff provides information and assistance to a Plan Participant and their treating Physician(s) about cost-effective treatment alternatives from which the Plan Participant and their Physician(s) may choose, including, where deemed appropriate by the Plan Participant's Physician, outpatient or home care settings

Chemotherapy means chemotherapy for the treatment of a malignant disease by chemical agents that affect the causative organism unfavorably. High Dose Chemotherapy is chemotherapy for malignant disease several times higher than the standard dose (as determined in recognized medical compendia) and which would automatically require the addition of drugs and procedures (e.g., Granulocyte Colony-Stimulating Factor, Granulocyte-Macrophage Colony-Stimulating Factor, re-infusion of stem cells, re-infusion of autologous bone marrow transplantation, or

allogeneic bone marrow transplantation) in any patient who received this high dose chemotherapy, to prevent life-threatening complications of the chemotherapy on the patient's own progenitor blood cells.

Child means a Subscriber's natural Child, legally adopted Child or Stepchild. "Child" also means a Child that has been placed with the Subscriber for adoption. "Child" also means a Child for whom the Subscriber must provide medical Child support pursuant to a court order or a Child for whom the Subscriber has been court appointed the guardian.

Coinsurance means the percentage of Allowable Charges for Covered Services for which the Plan Participant is responsible.

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

Contract Year means the twelve consecutive month period commencing on the Group Contract effective date and ending on the day before the anniversary of that effective date.

Controlled Substance means a Toxic Inhalant or a substance designated as a controlled substance in the Arkansas Code.

Copayment means the amount required to be paid to a Physician by or on behalf of a Plan Participant in connection with the services set forth in the Schedule of Benefits.

Cosmetic Services means any treatment or corrective surgical procedure performed to reshape structures of the body in order to alter the individual's appearance or to alter the manifestation of the aging process. Breast augmentation, mastopexy, breast reduction for cosmetic reasons, otoplasty, rhinoplasty, collagen injection and scar reversals are examples of Cosmetic Services. Cosmetic Services also includes any procedure required to correct complications caused by or arising from prior Cosmetic Services. Cosmetic Services do not include the following services in connection with a mastectomy resulting from cancer: (a) reconstruction of the breast on which the cancer-related surgery has been performed, and (b) surgery to reconstruct the other breast to produce a symmetrical appearance. The following procedures performed on a child age 12 years and under are not considered Cosmetic Services: correction of a cleft palate or hair lip, removal of a port-wine stain on the face, correction of a congenital abnormality.

Coverage Policy - With respect to certain drugs, treatments, 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 Person is an Employee or Dependent who is covered under this Plan.

Covered Services means services and benefits for which a Plan Participant is entitled to coverage under the terms of 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.

Creditable Coverage does not include coverage that was in place before a significant break of coverage of more than 63 days. With respect to the Trade Act of 2002, when determining whether a significant break in coverage has occurred, the period between the trade related coverage loss and the start of special second COBRA election period under the Trade Act, does not count.

Custodial Care means care comprised of services and supplies, including room and board and other institutional services, provided to a Plan Participant primarily to assist in activities of daily living and to maintain life and/or comfort with no reasonable expectation of cure or improvement of sickness or injury. "Custodial Care" is care which is not a necessary part of medical treatment for recovery, and shall include, but not be limited to, bathing, dressing, personal hygiene, transferring, eating, ambulating, assistance with drugs that are normally self-administered, and changing bandages or other dressings.

Diabetes Self-Management Training means instruction, including medical nutrition therapy relating to diet, caloric intake and diabetes management, excluding programs the primary purpose of which is weight reduction, which enables diabetic patients to understand the diabetic management process and daily management of diabetic therapy as a means of avoiding frequent hospitalizations and complications when the instruction is provided in accordance with a program in compliance with the National Standards for Diabetes Self-Management Education Program as developed by the American Diabetes Association.

Dietary and Nutritional Services means the education, counseling, or training of a Plan Participant (including printed material) regarding: (1) diet; (2) regulation or management of diet; or (3) the assessment or management of nutrition.

Disease Management means a coordinated, disease-specific educational program that seeks to provide access to information and benefit management for Plan Participants and providers regarding possible ways to reduce morbidity from preventable complications. Disease Management is not medical advice or services, nor a substitute for treatment, advice or services of the Plan Participant's treating physician(s).

Durable Medical Equipment means equipment which, in absence of illness or injury, is of no medical value to the Plan Participant including but not limited to oxygen equipment, manual wheelchairs, crutches, etc. and is provided as a result of Medical Necessity, not for the convenience of the Plan Participant or any other person.

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 Southern Arkansas University.

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.

Experimental/Investigational means any treatment, procedure, facility, equipment, drug, device or supply not accepted as standard medical treatment of the condition being treated or deemed to be experimental or investigational, under the criteria outlined below. The Plan shall have full discretion to determine whether a drug, device or medical treatment is experimental or investigational. Any drug, device or medical treatment may be deemed experimental or investigational, if:

- (1) the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and final regulatory approval for marketing has not been announced to the public at the time the drug or device is furnished; or
- (2) the drug, device, treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review and approval; or
- (3) Reliable Evidence (as defined below) shows that the drug, device or medical treatment or procedure is the subject of on-going phase I, II or III clinical trials or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis; or

- (4) Reliable Evidence (as defined below), regarding the drug, device or medical treatment or procedure shows that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or
- (5) Reliable Evidence (as defined below) shows that, at the time a claim is presented for coverage of any drug, device, or medical treatment or procedure, the evidence is inconclusive regarding its maximum tolerated dose, toxicity, safety, efficacy or efficacy as compared with the standard means of treatment. Evidence will be deemed inconclusive if reliable evidence (as defined below) shows no firm medical consensus or majority opinion either supports **or** denies use of the drug, device or medical treatment or procedure for a particular condition or disease; or
- (6) Reliable Evidence (as defined below) shows that the majority opinion among experts, as stated in the published authoritative literature, regarding the drug, device or medical treatment or procedure is that it should not be used as a first line therapy for a particular condition or disease; or
- (7) Reliable Evidence (as defined below) is that the drug, device or medical treatment or procedure is experimental or investigational or is not safe or effective.

“Reliable Evidence” shall mean only the following sources:

- (a) the patient’s medical records or other information from the treating Physician(s) or from a consultant(s) regarding the patient’s medical history, treatment or condition;
- (b) the written protocol(s) under which the drug, device, treatment or procedure is provided to the patient;
- (c) any consent document the patient has executed or will be asked to execute, in order to receive the drug, device, treatment or procedure;
- (d) published reports and articles in the authoritative medical and scientific literature, signed by or published in the name of a recognized medical expert, regarding the drug, device, treatment or procedure at issue as applied to the injury, illness or condition at issue;
- (e) the written protocol(s) used by another facility studying substantially the same drug, device, medical treatment or procedure; or
- (f) the written opinion of experts engaged to review the patient’s medical history, treatment and condition, and to advise on the toxicity, safety, efficacy or efficacy as compared with the standard means of treatment, of the drug, device, medical treatment or procedure at issue.

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

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 genes, gene products and inherited characteristics that may derive from an individual or a family member. This includes information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories and direct analysis of genes or chromosomes.

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

Home Health Agency means an organization, licensed by appropriate regulatory authority, which has entered into an agreement with the Plan to render home health services to Plan Participants.

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 means an organization or agency, licensed by appropriate regulatory authority and certified by Medicare as a supplier of Hospice Care, which has entered into an agreement with the Plan to render Hospice Care to Plan Participants.

Hospice Care means services provided for pain relief, symptom management and supportive services to terminally ill Plan Participants and their families.

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

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

Infertility means incapable of producing offspring.

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

In-Network refers to a provider who participates in the Preferred Provider Organization (PPO). Due to their nature, the Plan has classified certain services as "In-Network" provisions even though the provider or facility may not be a member of the PPO.

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 Enrollee means a Plan Participant 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.

Lifetime is a word that appears in this Plan in reference to benefit maximums and limitations. Lifetime is understood to mean while covered under this Plan. Under no circumstances does Lifetime mean during the lifetime of the Covered Person.

Marriage and Family Therapy means the provision of professional therapy services to individuals, families, or married couples, singly or in groups, and involves the professional application of family systems theories and techniques in the delivery of therapy services to those persons. The term includes the evaluation and treatment of cognitive, affective, behavioral, or relational dysfunction within the context of marriage or family systems.

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

Medical Director means a person trained and licensed as a medical doctor who works for the Plan to review medical issues and coverage policy related to claims or Covered Services.

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

Medically Necessary/Medical Necessity means services and/or supplies provided by a Physician required to identify or treat a Plan Participant's illness or injury and which are (1) consistent with the symptoms or diagnosis and treatment of the Plan Participant's condition, disease, ailment or injury; (2) appropriate with regard to standards of good medical practice; (3) not solely for the convenience of the Plan Participant, Provider; and (4) the most appropriate supply or level of service which can be safely provided to the Plan Participant. In the case of inpatient services, "medically necessary" further means that the Plan Participant's medical symptoms or conditions cannot be safely treated in an outpatient setting.

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

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

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

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

Non-diseased Tooth means a tooth that is whole or properly restored, and free of decay or of periodontal conditions.

Observation Services means services furnished by a Hospital on the Hospital's premises, including use of a bed and periodic monitoring by a Hospital's nursing or other staff, which are reasonable and necessary to evaluate an outpatient's condition or determine the need for a possible admission to the Hospital as an inpatient. Such services are covered only when provided by the order of a Physician.

Out-of-Area Services means those services a Plan Participant receives while outside the Service Area. Out-of-Area Services, which are Covered Services, that are Emergency Care or Urgent Care Services are covered at the In-Network benefit level. All other covered Out-of-Area Services are covered at the Out-of-Network benefit level.

Out-of-Network refers to a provider not participating in the PPO.

Outpatient Care means all care received including services, supplies and medications in a physicians office, outpatient surgery center, x-ray or laboratory facility, the Plan Participant's home, or at a Hospital where the member receives services but is not admitted to the Hospital.

Outpatient Therapy Visit means one unit of therapeutic service (usually one hour or less) provided by licensed Physician(s). An Outpatient Therapy Visit may include services provided by more than one provider and in the case of physical therapy, up to four modalities of treatment.

Partial Hospitalization means continuous treatment for Members who require care or support or both in a Hospital but who do not require 24-hour supervision. Services must be received by a Physician for at least 4 hours, but not more than 16 hours in any 24-hour period.

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

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

Plan means Southern Arkansas University Employee Health Plan, which is a benefits plan for certain employees of Southern Arkansas University and is described in this document.

Plan Administrator means the Employer.

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

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.

Preferred Provider means a facility or physician who has a written agreement to provide health care services and supplies to PPO Plan participants for a set fee.

Preferred Provider Organization or **PPO** means the PPO with which this Plan has contracted to provide medical care, services and supplies to Plan Participants.

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.

Primary Care Physician or "**PCP**" means the Plan Physician selected by the Plan Participant who is primarily responsible for providing, arranging and coordinating all aspects of the Plan Participant's health care.

Professional Services means those Medically Necessary Covered Services rendered by Physicians and other health care providers in accordance with this Plan.

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

Service Area is the State of Arkansas.

Sickness is an Illness, disease or Pregnancy.

Skilled Nursing Facility means a facility which provides inpatient skilled nursing care, rehabilitation services or other related health services. The term does not include a convalescent nursing home, rest facility or facility for the aged which furnishes primarily custodial care, including training in routines of daily living.

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

Total Disability (Totally Disabled) means: In the case of a Dependent person, 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.

Toxic Inhalant means a volatile chemical designated in the Arkansas Code.

Transplant Global Period means a period of time that begins on or prior to the day of the transplant procedure and extends for a number of days after the transplant procedure. The length of the Transplant Global Period varies, depending upon the type of transplant involved.

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

Waiting Period means the number of days established by the Group that must pass before a new employee who is an eligible Subscriber can commence coverage for benefits.

PRESCRIPTION DRUG BENEFITS

MANAGED PHARMACY PROGRAM

The Plan has contracted with the pharmacy benefits manager to provide Plan participants with prescription medication coverage. To use this benefit, plan participants should present their identification card to a participating pharmacy. Participants can obtain prescription medications for the Brand or Generic copayment subject to the terms, conditions and limitations outlined in this Plan Document.

COPAYMENT

Each Prescription is covered only after the Plan Participant pays the applicable Copayment to the Participating Pharmacy. Plan Participants will be charged one Copayment for each 34-day supply (three Copayments for a 100-day supply of Maintenance Medications).

When a Generic Medication is dispensed, the Generic Medication Copayment is required for each initial and refill Prescription. If there is no generic equivalent, or if the Physician indicates "dispense as written," the Plan Participant will pay the appropriate Preferred or Non-Preferred Brand Name Medication Copayment for each initial and refill Prescription.

If a Brand Name Medication is dispensed when a Generic Medication is available and the Physician has NOT indicated "dispense as written," the Copayment required is the appropriate Preferred or Non-Preferred Brand Name Medication Copayment.

If a drug is purchased from a participating pharmacy more than 30 days after the Covered Person's effective date of coverage under the Plan, the amount payable in excess of the copayment will be the ingredient cost and dispensing fee.

If a drug is purchased from a non-participating pharmacy, when the Covered Person's ID card is not used, it is not covered.

COVERED PRESCRIPTION DRUGS

- (1) All drugs, prescribed by a Physician that require a prescription either by Federal or state law (other than insulin) or any other drugs not covered under this Plan.
- (2) Diabetic supplies, insulin and syringes, when prescribed by a Physician.
- (3) Self-administered injectable drugs require prior authorization.
- (4) Coverage of any prescription medication is subject to the Formulary. Note: the Formulary is subject to change throughout the year as new medications, dosages or strengths are added to the market.

BENEFIT LIMITS

- (1) **Oral contraceptives** are covered and subject to a Preferred or Non-Preferred Brand Name Medication copay, dependent on the type of medication prescribed.
- (2) **Quantity- Versus-Time Edits.** Some medications have quantity limitations that are more restrictive than the plan's standard 34-day supply. These are medications that are appropriate for dispensing through an outpatient pharmacy, but because of their high cost and potential for misuse, should be monitored closely.

Often, physicians will write open-ended or “as needed” prescriptions for non-addictive pain treatments (such as the migraine-relief medications on this list). This allows the Plan Participant to decide how much of the prescription to have filled within their 34-day benefit period.

By regulating the quantity that can be obtained each time the prescription is filled and within each 30-day period, we can monitor those cases where the Plan Participant is getting a quantity that is greater than the manufacturer recommends. This is beneficial information for the prescribing physician and protects the plan’s financial risk.

- (3) **Prior Authorization.** Medications that are expensive, have a high risk for misuse, or whose effectiveness is limited to very specific indications are placed on the Prior Authorization list. Also on the list are medications which cause adverse or harmful reactions, or have been ineffective in the treatment of a particular disease or condition.

To obtain coverage for a medication that requires prior authorization, the prescribing physician should provide a letter of medical necessity or contact the customer service department at the number printed on the plan participant’s identification card. Once a determination is made, a letter will be sent to the plan participant announcing the decision.

Prior authorization requests and inquiries may be submitted to:

Prior Authorization coordination
P.O. Box 3688
Little Rock, AR 72203-3688
FAX: (501) 378-6647

EXPENSES NOT COVERED

The following medications and supplies are not covered:

- (1) Medications purchased from a non-Participating Pharmacy, except in an emergency situation.
- (2) Medications used or intended to be used in the treatment of a condition, sickness, disease, injury, or bodily malfunction which is not covered by the Plan, or for which benefits have been exhausted.
- (3) Medications for use or intended use of which would be illegal, abusive, or are not medically necessary.
- (4) Experimental or Prescription Medications labeled, “Caution: Limited by Federal Law to Investigational Use.”
- (5) Medications that are to be administered to the Covered Person by a physician or in a physician’s office.
- (6) Medications for which, normally (in professional practice), there is no charge.
- (7) Medications that do not require a prescription to purchase, over-the-counter medications (except insulin), which do not, by law, require a Prescription order from a physician.
- (8) Topical Vitamin A acid, retinoic acid, tretinoin or similar agents for individuals age 26 and above.
- (9) Medications dispensed for use by a Covered Person while such person is in a hospital, extended care facility, nursing home, convalescent or psychiatric facility or any institution; or any medication consumed or administered at the place where it is dispensed.
- (10) Immunization agents and vaccines.

- (11) Vitamins or food/nutrient supplements except prenatal vitamins and those which are Prescription Medications.
- (12) Medications obtained for weight control or smoking cessation.
- (13) Prescription medications obtained to sustain addiction or drug dependence.
- (14) Rogaine, minoxidil or any other drugs, medications, solutions or preparations used or intended for use in the treatment of hair loss, hair thinning or any related condition, whether to facilitate or promote hair growth or replace lost hair.
- (15) Medications obtained by unauthorized, fraudulent, or abusive use of the identification card.
- (16) Legend Medications that are not approved by the US Food and Drug Administration (FDA) for a particular use or purpose or when used for a purpose other than the purpose for which FDA approval is given.
- (17) Fluids, solutions, nutrients, or medications (including all additives and chemotherapy) used or intended to be used by intravenous or gastrointestinal (enteral) infusion.
- (18) Medications prescribed and dispensed for the treatment of obesity, or for use in any program of weight reduction, weight loss, or dietary control.
- (19) Medical supplies such as colostomy supplies, bandages, and similar items.
- (20) Injectable medications, unless Prior Approval is received from the Plan.
- (21) Devices or durable medical equipment of any type (even though such devices may require a prescription order), such as, but not limited to, contraceptive devices, therapeutic devices, artificial appliances, or similar devices.
- (22) Charges to administer or inject any medication.
- (23) Charges for delivering medications.
- (24) Compound Medications.
- (25) A prescription refill in excess of the quantity specified in the Prescription order, any Prescription refill dispensed after one year from the date of the prescription order, or any refill of a Prescription not authorized by a physician is not covered.
- (26) Non-formulary medications.

HOW TO SUBMIT A CLAIM

Benefits under this Plan shall be paid only if the Plan Administrator, in its discretion, interprets the Plan to provide such benefits to the Covered Person.

Claim for Benefits. "Claim for benefits" means (1) a request for payment for a service, supply, prescription drug, equipment or treatment covered by the Plan or (2) a request for prior approval for a service, supply, prescription drug, equipment or treatment covered by the Plan where the Plan conditions receipt of payment for such service, supply, prescription drug, equipment or treatment on approval in advance by the Claims Administrator.

Who Can Submit a Claim. A Covered Person, a Provider with an assignment of the claim that is approved by the Claims Administrator or a Covered Person's Authorized Representative may submit a claim. See section concerning the Authorized Representative.

The presentation of a prescription to a pharmacist in accordance with the terms of a Plan Managed Pharmacy Benefit Rider is not a claim for benefits under the terms of the Plan. However, a Covered Person may submit a claim if, upon such a presentation, the pharmacist informs the Covered Person that, because of the provisions of the Plan, the Plan will not provide benefits for the requested prescription medication.

Classifications of Claims. There are four general types of claims for benefits possible under the Plan. The type of claim involved affects the procedures for filing the claim and the timing of the benefit determination by the Claims Administrator.

- (1) **Post-Service Claims.** The most common claim involves post-service benefit determination. Such a claim results when a Covered Person obtains a medical service, prescription drug, supply, equipment or other treatment and then, in accordance with the terms of the Plan, the Covered Person or the Covered Person's Authorized Representative submits a claim for benefits to the Claims Administrator. Examples of post-service claims are claims involving physician office visits, maternity care, inpatient services and outpatient services.

You, your Provider or your Authorized Representative must submit written proof of any service, supply, prescription drug, equipment or other treatment within 180 days following the date on which such service, supply, prescription drug, equipment or treatment was received. In the case of a claim for inpatient services for multiple consecutive days, the written proof must be submitted no later than 180 days following your date of discharge for that single admission.

Post-Service Claims may be submitted electronically in accordance with the Claims Administrator's electronic claim filing procedures, or such claims may be mailed to BlueAdvantage Administrators of Arkansas, Post Office Box 1460, Little Rock, Arkansas 72203.

If the Claims Administrator is able to process your post-service claim without requesting additional information, it will notify you its claim determination within 30 days of the Claims Administrator's receipt of the claim.

If the Claims Administrator requires information reasonably necessary to determine whether or to what extent benefits are covered under the Plan, the Claims Administrator will suspend the claim and request the needed information. A Covered Person or their treating Provider should supply the Claims Administrator with the required information within a reasonable timeframe of the claim suspension. The timeframe will be determined by the Claims Administrator based on Plan timely filing limitations and plan year requirements. Contracted providers must abide by stipulations within their provider contract in providing requested information. The provider will be obligated to write-off their charges if he or she fails to provide the information accordingly.

- (2) **Pre-Service Claims.** A pre-service claim results if the terms of the Plan condition receipt of benefits on the Claims Administrator or Plan Administrator giving approval in advance of the Covered Person obtaining a requested medical service, drug, supply, or equipment that such medical service, drug, supply or equipment is Medically Necessary and not Experimental or Investigational. Examples of some Plan benefits requiring pre-service claims are typically claims involving organ transplants and certain high cost injectable medications. **Please note that prior approval does not guarantee payment or assure coverage; it means only that the information furnished to the Claims Administrator at the time indicates that the requested service, supply, prescription drug, equipment or treatment is Medically Necessary and not Experimental or Investigational. A pre-service claim receiving prior approval as a pre-service claim must still meet all other coverage terms, conditions and limitations. Coverage for any such pre-service claim receiving prior approval may still be limited or denied if, when, after the requested service, supply, prescription drug, equipment or treatment is completed and the Claims Administrator receives post-service claim(s), investigation shows that a benefit exclusion or limitation applies, that the Covered Person ceased to be eligible for benefits on the date services were provided, that coverage lapsed for non-payment of Employee contribution, that out-of-network limitations apply, or any other basis specified in the Plan applies to limit or exclude the claim.**

Pre-Service Claims should be submitted to the BlueAdvantage Administrators of Arkansas Medical Audit and Review Services, FAX (501) 378-6647 or mailed to Post Office Box 3688, Little Rock, Arkansas 72203.

If the Claims Administrator is able to process your pre-service claim without requesting additional information, it will notify you of its determination in a time appropriate for the medical exigencies, but in no case later than 15 days from the date it received the pre-service claim.

If the Claims Administrator requires information reasonably necessary to determine whether the requested medical service, drug, supply, or equipment is Medically Necessary and not Experimental or Investigational, the Claims Administrator will suspend the claim and request the needed information. If you or your treating Provider supplies the Claims Administrator the required information within ninety (90) days of the claim suspension, the Claims Administrator will notify you of its claim determination within 15 days after the Claims Administrator receives such information. If the Claims Administrator does not receive the required information within the 90-day period, the suspended claim will become a denied claim, subject to appeal. See Claim Review Procedure Subsection that follows.

After you have received the health intervention that was the subject of an approved pre-service claim, you must submit a post-service claim in accordance with Subsection.1. above.

- (3) **Claims Involving Urgent Care.** A claim involving urgent care is a pre-service claim (See Subsection 2 above) for which a health care professional with knowledge of the claimant's condition certifies that the processing of the claim in the time period for making a non-urgent claim determination (1) could seriously jeopardize the life or health of the claimant or the ability of the claimant to maintain or regain maximum function, or (2) would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

A claim involving urgent care must be submitted in writing via mail, facsimile, or e-mail in a format authorized by the Claims Administrator. **A claim involving urgent care must include the medical records pertinent to the urgent condition.**

If the Claims Administrator is able to process your claim involving urgent care without requesting additional information, it will notify you of its determination in a time appropriate for the medical exigencies, but in no case later than 72 hours from the date it received the pre-service claim.

If the Claims Administrator requires information reasonably necessary to determine whether the requested medical service, drug, supply, or equipment is Medically Necessary and not Experimental or Investigational, the Claims Administrator will notify your physician within 24 hours of receiving the

claim and request the needed information. If you or your treating Provider supplies Claims Administrator the required information within 48 hours, the Claims Administrator will notify you of its claim determination within 48 hours after the Claims Administrator receives such information. If the Claims Administrator does not receive the required information within the 48-hour period, the claim will be denied, subject to appeal. See Claim Review Procedure Subsection that follows.

If the urgent care claim is a request to extend previously approved benefits for ongoing treatment the Claims Administrator shall make a determination within 24 hours after receipt of the claim, provided the claim is received at least 24 hours prior to the expiration of the previously approved benefit.

Please note that approval of a claim involving urgent care does not guarantee payment or assure coverage; it means only that the information furnished to the Claims Administrator at the time indicates that requested service, supply, prescription drug, equipment or treatment is Medically Necessary and not Experimental or Investigational. A requested service, supply, prescription drug, equipment or treatment receiving prior approval as a claim involving urgent care, must still meet all other coverage terms, conditions, and limitations. Coverage for any such claim may still be limited or denied if, when the claimed intervention is completed and the Claims Administrator receives the post-service claim(s), investigation shows that a benefit exclusion or limitation applies, that the Covered Person ceased to be eligible for benefits on the date services were provided, that coverage lapsed for non-payment of premium, that out-of-network limitations apply, or any other basis specified in the Plan applies to limit or exclude the claim.

After you have received the health intervention that was the subject of a claim involving urgent care, you, your Provider or your Authorized Representative must submit a post-service claim in accordance with Subsection 1., above.

- (4) **Claims involving Ongoing Care or Concurrent Review.** The Claims Administrator's termination or reduction of a previously granted benefit under the Plan (other than by Plan amendment or termination) results in a claim involving ongoing care or concurrent review. The Claims Administrator shall give an explanation of the reduction or termination of a benefit to the Covered Person (See Explanation of Benefit Determination Subsection that follows.) with sufficient time prior to the termination or reduction to allow for an appeal (See Claim Review Procedure Subsection that follows.) to be completed before the termination or reduction takes place.

PREFERRED PAYMENT PLAN AND HOSPITAL REIMBURSEMENT PROGRAM PARTICIPATING PROVIDERS

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

Contact the Human Resources Office for a list of the participating providers or for more information about this Plan.

The Claim Process

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

Bills for Preferred Providers will be paid directly to the provider unless the provider requests payment be made directly to the Covered Person.

PREFERRED PROVIDER ORGANIZATION (PPO)

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

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

Contact the Human Resources Benefits Office for a list of the participating providers or for more information about this Plan.

The Claims Process

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

Bills for PPO Providers will be paid directly to the provider unless the provider requests payment be made directly to the Covered Person.

BLUECARD® PROGRAM

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

Typically, when accessing care outside the service area, a Covered Person will obtain care from healthcare providers that have a contractual agreement (i.e., are “participating providers”) with the local Blue Cross and/or Blue Shield Licensee in that other geographic area (“Host Blue”). In some instances, a Covered Person may obtain care from nonparticipating healthcare providers. The Health Plan’s practices for consideration of payment in both instances are described below.

- (1) BlueCard® Program.
 - (a) Under the BlueCard® Program, when a Covered Person accesses covered healthcare services within the geographic area served by a Host Blue, the Health Plan will remain responsible for fulfilling its contractual obligations. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating healthcare providers. Whenever a Covered Person accesses covered healthcare services outside the service area and the claim is processed through the BlueCard Program, the amount a Covered Person pays for covered healthcare services is calculated based on the lower of:
 - The billed covered charges for the covered services; or
 - The negotiated price that the Host Blue makes available to the Health Plan.
 - (b) Often, this “negotiated price” will be a simple discount that reflects an actual price that the Host Blue pays to the healthcare provider. Sometimes, it is an estimated price that takes into account special arrangements with the healthcare provider or provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of healthcare providers after taking into account the same types of transactions as with an estimated price.
 - (c) Estimated pricing and average pricing, going forward, also take into account adjustments to

correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price used for a Covered Person's claim because the adjustments will not be applied retroactively to claims already paid.

- (d) Laws in a small number of states may require the Host Blue to add a surcharge to the calculation. If any state laws mandate other liability calculation methods, including a surcharge, the Health Plan would then calculate the Covered Person's liability for any covered healthcare services according to applicable law.

(2) Non-Participating Healthcare Providers Outside the Service Area

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

ALL OTHER PROVIDERS

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

- Obtain a Claim form from the Personnel Office or the Plan Administrator.
- Complete the Employee portion of the form. ALL QUESTIONS MUST BE ANSWERED.
- Have the Physician complete the provider's portion of the form. For Plan reimbursements, attach bills for services rendered. ALL BILLS MUST SHOW:

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

Send the above to the Claims Administrator at this address:

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

WHEN CLAIMS SHOULD BE FILED

Claims should be filed with the Claims Administrator within 180 days from the date on which charges for the service were incurred. Benefits are based on the Plan's provisions at the time the charges were incurred. Claims filed later than that date may be declined or reduced unless it's not reasonably possible to submit the claim in that time.

In order to be a claim, the submission must comply with the filing and coding policies and procedures established by the Claims Administrator and given to your Provider. You may request a copy of the claim coding policies and procedures from the Claims Administrator or from your Provider. If the submission fails to comply with the claim filing or code policies or procedures, the Claims Administrator shall return the submission to the person that submitted it. If the claim involved is a pre-service claim, the submission shall be returned as soon as possible, but no later than 5 days (24 hours for a claim involving urgent care), and the Claims Administrator shall indicate on the returned submission the proper procedures to be followed.

The Claims Administrator will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested from the claimant. The Plan reserves the right to have a Plan Participant seek a second medical opinion.

EXPLANATION OF BENEFIT DETERMINATION.

Upon making a determination of a claim, the Claims Administrator will deliver to the Covered Person an Explanation of Benefit Determination containing the following information:

- (1) The specific reason or reasons for the determination;
- (2) Reference to the specific plan provision(s) on which the determination is based;
- (3) A description of any additional information necessary for the claim to be perfected and an explanation of why such information is necessary;
- (4) A description of the Plan's appeal process, see Section B below. If the claim involves urgent care, a description of the expedited appeals process, see Subsection 2 below;
- (5) If the determination was based in whole or in part on a Claims Administrator Coverage Policy an explanation of how to obtain a copy of the Coverage Policy at no cost;
- (6) A statement of your right to bring a legal action under section 502(a) of the Employee Retirement Income Security Act of 1974.

CLAIMS REVIEW PROCEDURE.

The Plan Participant will receive an Explanation of Benefits (EOB) explaining the claim determination, and if applicable, the reason or reasons for any denial or reduction of benefits. In cases where a claim for benefits payment is denied or reduced in whole or in part, the Plan Participant or the Authorized Representative may request an informal claim review.

In a situation where the determination, after informal review, remains adverse the Plan Participant or the Authorized Representative may request an appeal of the denial. The Plan Participant also has the right to initiate legal action subsequent to an appeal.

The following describes the informal review and appeals processes:

- (1) **Informal Claim Review.**
Requests for review may be submitted in writing, email, or by telephone to the Claims Administrator.

You should provide your name, Plan identification number and reference the specific claim(s) you want to have reviewed. Additional relevant documentation may also be provided to the Claims Administrator to assist in the review. A request for an informal claim review must be submitted within one hundred eighty (180) days after notice is received of the denial or reduction in benefits.*

A determination shall be rendered within a reasonable period of time, but notification of the determination will be provided not later than sixty (60) days after received.

If the review is in regard to a Pre-Service Claim, response will be provided within thirty (30) days of receipt.

If the review is in regard to an Urgent Care Pre-Service Claim, response will be provided within seventy-two (72) hours of receipt.

(2) Appeal.

You must submit your appeal to the Plan Administrator in writing and include your name, Plan identification number and reference the specific claim(s) you want to have reviewed. Appeals must be submitted within one hundred eighty (180) days after notice is received of the denial or reduction in benefits. However, an appeal related to a claim involving urgent care may be made orally. You may submit with your request for review any additional written comments, issues, documents, records and other information relating to your claim. Although the Plan Administrator will immediately commence consideration of an oral appeal, the Plan Administrator requires written confirmation of the appeal. *

The appeal will be reviewed by the Plan Administrator utilizing personnel with appropriate expertise who is neither the individual who denied the claim that is the subject of the appeal, nor the subordinate of such individual. The Plan Administrator shall conduct a complete review of all information relating to the claim and shall not afford deference to the initial claim determination in conducting the review.

When reviewing a claim in which the determination was based in whole or in part on medical judgment, including determinations with regard to whether a particular treatment is experimental, investigational, or not medically necessary or appropriate, the Plan Administrator shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. Such health care professional shall not be an individual that was consulted in the initial claim determination, nor the subordinate of such individual. The Plan Administrator shall, upon request, provide the identity of the health care professional(s) consulted in conducting the review, without regard to whether the health care professional's advice was relied upon in making the benefit determination.

A determination shall be rendered within a reasonable period of time, but notification of the determination will be provided not later than sixty (60) days after received.

If the review is in regard to a Pre-Service Claim, response will be provided within thirty (30) days of receipt.

If the review is in regard to an Urgent Care Pre-Service Claim, you or your Authorized Representative request an expedited review and a health care professional certifies that determination as a general pre-service claim would seriously jeopardize your life or health or your ability to regain maximum function, response will be provided within seventy-two (72) hours of receipt.

If the review is in regard to a Concurrent Care Claim, response will be provided within the timeframes as noted above, depending upon whether the claim is a post-service claim, a pre-service claim or a claim involving urgent care.

The Plan Administrator shall provide notice in a printed form and written in a manner calculated to be understood by the claimant. The notice shall include:

- (a)** The specific reason or reasons for the review determination.

- (b) Reference to the specific plan provision(s) on which the review determination is based.
- (c) A statement that the claimant 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 claimant's claim for benefits.

Relevant information includes:

- (i) Information relied upon in making the benefit determination.
 - (ii) Information submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record or other information was relied upon in making the benefit determination.
 - (iii) Information that demonstrates compliance with the terms of the Plan.
 - (iv) Information that constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for the diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.
- (d) A statement that any internal rule, guideline, protocol or other similar criterion relied upon by the Plan is available upon request and free of charge.
 - (e) A statement of your right to bring a legal action under Section 502(a) of the Employee Retirement Income Security Act of 1974.

Expedited Appeal Procedure. An appeal of a claim involving urgent care or of a claim involving ongoing care is conducted in accordance with this Plan provision. An expedited appeal may be submitted by telephone, followed by a written confirmation. The Plan Administrator will notify you and your treating health care professional of the determination of your expedited appeal within 72 hours after the Plan Administrator receives the expedited appeal.

* You and the treating health care professional are required to provide the Claims Administrator or the Plan Administrator, upon request, access to information necessary to make a determination. Such information should be provided not later than five (5) days after the date on which the request for information is received, or, in the case of a claim involving urgent care or concurrent review, at such earlier time as may be necessary to comply with the applicable timelines. Your failure to provide access to such information shall not remove the obligation of the Plan Administrator to make a determination, but the determination may be affected if such requested information is not provided.

AUTHORIZED REPRESENTATIVE

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

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

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

- (1) An individual designated by the Covered Person in writing in a form approved by the Claims Administrator;
- (2) The treating provider, if the claim is a claim involving urgent care, or if the Covered Person has designated the provider in writing in a form approved by the Claims Administrator;

- (3) A person holding the Covered Person's durable power of attorney;
- (4) If the Covered Person is incapacitated due to illness or injury, a person appointed as guardian to have care and custody of the Covered Person by a court of competent jurisdiction; or
- (5) If the Covered Person is a minor, the Covered Person's parent or legal guardian, unless the Claims Administrator is notified that the Covered Person's claim involves health care services where the consent of the Covered Person's parent or legal guardian is or was not required by law and the Covered Person shall represent himself or herself with respect to the claim.

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

Communication with Authorized Representative.

- (1) If the Authorized Representative represents the Covered Person because the Authorized Representative is the Covered Person's parent or legal guardian or attorney in fact under a durable power of attorney, the Claims Administrator shall send all correspondence, notices and benefit determinations in connection with the Covered Person's claim to the Authorized Representative.
- (2) If the Authorized Representative represents the Covered Person in connection with the submission of a pre-service claim, including a claim involving urgent care, or in connection with an appeal, the Claims Administrator shall send all correspondence, notices and benefit determinations in connection with the Covered Person's claim to the Authorized Representative.
- (3) If the Authorized Representative represents the Covered Person in connection with the submission of a post-service claim, the Claims Administrator will send all correspondence, notices and benefit determinations in connection with the Covered Person's claim to the Covered Person, but the Claims Administrator will provide copies of such correspondence to the Authorized Representative upon request.
- (4) The Covered Person understands that it will take the Claims Administrator at least thirty (30) days to notify all its personnel about the termination of the Covered Person's Authorized Representative and it is possible that the Claims Administrator may communicate information about the Covered Person to the Authorized Representative during this 30-day period.

COORDINATION OF BENEFITS

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

The plan that pays first according to the rules will pay as if there were no other plan involved. The secondary and subsequent plans will pay the balance up to each one's plan formula minus whatever the primary plan paid. This is called non-duplication of benefits. The total reimbursement will never be more than the amount that would have been paid if the secondary plan had been the primary plan -- 50% or 80% or 100% -- whatever it may be. The balance due, if any, is the responsibility of the Covered Person

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

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

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

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

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

Automobile limitations. When medical payments are available under vehicle insurance, the Plan shall pay excess benefits only, without reimbursement for vehicle plan deductibles. This Plan shall always be considered the secondary carrier regardless of the individual's election under PIP (personal injury protection) coverage with the auto carrier.

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

- (1) Plans that do not have a coordination provision, or one like it, will pay first. Plans with such a provision will be considered after those without one.
- (2) Plans with a coordination provision will pay their benefits up to the Allowable Charge:

- (a) The benefits of the plan which covers the person directly (that is, as an employee, Plan Participant or subscriber) ("Plan A") are determined before those of the plan which covers the person as a dependent ("Plan B").
- (b) The benefits of a benefit plan which covers a person as an Employee who is neither laid off nor retired are determined before those of a benefit plan which covers that person as a laid-off or Retired Employee. The benefits of a benefit plan which covers a person as a Dependent of an Employee who is neither laid off nor retired are determined before those of a benefit plan which covers a person as a Dependent of a laid off or Retired Employee. If the other benefit plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.
- (c) The benefits of a benefit plan which covers a person as an Employee who is neither laid off nor retired or a Dependent of an Employee who is neither laid off nor retired are determined before those of a plan which covers the person as a COBRA beneficiary.
- (d) When a child is covered as a Dependent and the parents are not separated or divorced, these rules will apply:
 - (i) The benefits of the benefit plan of the parent whose birthday falls earlier in a year are determined before those of the benefit plan of the parent whose birthday falls later in that year;
 - (ii) If both parents have the same birthday, the benefits of the benefit plan which has covered the patient for the longer time are determined before those of the benefit plan which covers the other parent.
- (e) When a child's parents are divorced or legally separated, these rules will apply:
 - (i) This rule applies when the parent with custody of the child has not remarried. The benefit plan of the parent with custody will be considered before the benefit plan of the parent without custody.
 - (ii) This rule applies when the parent with custody of the child has remarried. The benefit plan of the parent with custody will be considered first. The benefit plan of the stepparent that covers the child as a Dependent will be considered next. The benefit plan of the parent without custody will be considered last.
 - (iii) This rule will be in place of items (i) and (ii) above when it applies. A court decree may state which parent is financially responsible for medical and dental benefits of the child. In this case, the benefit plan of that parent will be considered before other plans that cover the child as a Dependent.
 - (iv) If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined above when a child is covered as a Dependent and the parents are not separated or divorced.
- (f) If there is still a conflict after these rules have been applied, the benefit plan which has covered the patient for the longer time will be considered first. When there is a conflict in coordination of benefit rules, the Plan will never pay more than 50% of allowable charges when paying secondary.

- (3) Medicare will pay primary, secondary or last to the extent stated in federal law. When Medicare is to be the primary payer, this Plan will base its payment upon benefits that would have been paid by Medicare under Parts A and B, regardless of whether or not the person was enrolled under both of these parts.
- (4) If a Plan Participant is under a disability extension from a previous benefit plan, that benefit plan will pay first and this Plan will pay second.

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

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

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

Right of recovery. This Plan may pay benefits that should be paid by another benefit plan. In this case this Plan may recover the amount paid from the other benefit plan or the Covered Person. That repayment will count as a valid payment under the other benefit plan.

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

THIRD PARTY RECOVERY PROVISION

Reimbursement

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

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

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

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

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

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

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

Subrogation

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

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

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

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

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

COBRA CONTINUATION OPTIONS

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

Complete instructions on COBRA, as well as election forms and other information, will be provided by the Plan Administrator or its designee to Plan Participants 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 Plan Participants and their eligible family members (called "Qualified Beneficiaries") at group rates. The right to COBRA continuation coverage is triggered by the occurrence of a life event that results in the loss of coverage under the terms of the Plan (the "Qualifying Event"). The coverage must be identical to the Plan coverage that the Qualified Beneficiary had immediately before the Qualifying Event, or if the coverage has been changed, the coverage must be identical to the coverage provided to similarly situated active employees who have not experienced a Qualifying Event (in other words, similarly situated non-COBRA beneficiaries).

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

- (1) Any individual who, on the day before a Qualifying Event, is covered under a Plan by virtue of being on that day either a covered Employee, the Spouse of a covered Employee, or a Dependent child of a covered Employee. If, however, an individual 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 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 not only common-law employees (whether part-time or full-time) but also 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., self-employed individuals, independent contractor, or corporate director).

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 group health coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a Qualifying Event 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 the 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, you can lose the right to avoid having pre-existing condition exclusions applied by other group health plans if there is more than a 63-day gap in health coverage and election of COBRA continuation coverage may help you avoid such a gap. Second, 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, which does not impose such pre-existing condition exclusions. 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 your group health 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 can elect COBRA continuation coverage under the Plan. The election period must begin not later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event and must not end before the date that is 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.

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

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 Human Resource office at the Employer's location of operation.

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 (but only after any applicable preexisting condition exclusions of that other plan have been exhausted or satisfied).

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

- (1) The last day of the applicable maximum coverage period.
- (2) The first day for which Timely Payment is not made to the Plan with respect to the Qualified Beneficiary.
- (3) The date upon which the Employer ceases to provide any group health plan (including a successor plan) to any employee.
- (4) The date, after the date of the election, that the Qualified Beneficiary first becomes covered under any other Plan that does not contain any exclusion or limitation with respect to any pre-existing condition, other than such an exclusion or limitation that does not apply to, or is satisfied by, the Qualified Beneficiary.
- (5) 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 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 Plan Sponsor.

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 Plan Sponsor.

Does the Plan require payment for COBRA continuation coverage? For any period of COBRA continuation coverage under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. Qualified beneficiaries will pay up to 102% of the applicable premium and up to 150% of the applicable premium for any expanded period of COBRA continuation coverage covering a disabled Qualified Beneficiary due to a disability extension. The Plan will terminate a Qualified Beneficiary's COBRA continuation

coverage as of the first day of any period for which timely payment is not made.

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

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

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

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

Must a qualified beneficiary be given the right to enroll in a conversion health plan at the end of the maximum coverage period for COBRA continuation coverage? If a Qualified Beneficiary's COBRA continuation coverage under a group health plan ends as a result of the expiration of the applicable maximum coverage period, the Plan will, during the 180-day period that ends on that expiration date, provide the Qualified Beneficiary with the option of enrolling under a conversion health plan if such an option is otherwise generally available to similarly situated non-COBRA beneficiaries under the Plan. If such a conversion option is not otherwise generally available, it need not be made available to Qualified Beneficiaries.

IF YOU HAVE QUESTIONS

If you have questions about your COBRA continuation coverage, you should contact the Plan Sponsor. 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. Southern Arkansas University Employee Health Plan is the benefit plan of AAA Company, 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 a committee may be appointed by Southern Arkansas University 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, Southern Arkansas University shall appoint a new Plan Administrator as soon as reasonably possible.

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

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

DUTIES OF THE PLAN ADMINISTRATOR.

- (1) To administer the Plan in accordance with its terms.
- (2) To interpret the Plan, including the right to remedy possible ambiguities, inconsistencies or omissions.
- (3) To decide disputes which may arise relative to a Plan Participant's rights.
- (4) To prescribe procedures for filing a claim for benefits and to review claim denials.
- (5) To keep and maintain the Plan documents and all other records pertaining to the Plan.
- (6) To appoint a Claims Administrator to pay claims.
- (7) To perform all necessary reporting as required by ERISA.
- (8) To establish and communicate procedures to determine whether a medical child support order is qualified under ERISA Sec. 609.
- (9) To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate.

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

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.

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

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

Bills for Non-preferred providers will be paid directly to the Covered Person and the Covered Person will be responsible for paying the provider.

HIPAA PRIVACY FIREWALL

The following summary establishes the circumstances under which the Plan may share a Plan participant's protected health information with the Plan Administrator (the Employer), and limits the uses and disclosures that the Plan Administrator may make of a Plan participant's protected health information. This is intended to establish the firewall protections required under the Health Insurance Portability and Accountability Act of 1996 and its attendant privacy regulations, 45 C.F.R. Parts 160 and 164, as amended (the "HIPAA Privacy Rules" or "Rules").

There are three circumstances under which the Plan may disclose a Plan participant's protected health information to the Plan Administrator.

First, the Plan may inform the Plan Administrator whether a Plan participant is enrolled in the Plan.

Second, the Plan may disclose summary health information to the Plan Administrator. The Plan Administrator must limit its use of that information to obtaining quotes from reinsurers or modifying, amending, or terminating the Plan. Summary health information is information that summarizes claims history, claims expenses, or types of claims without identifying the Plan participant.

Third, the Plan may disclose a Plan participant's protected health information to the Plan Administrator for Plan administrative purposes. This is because employees of the Plan Administrator perform many of the administrative functions necessary for the management and operation of the Plan.

CERTIFICATION OF FIREWALL AMENDMENT

The Plan Administrator hereby certifies to the Plan that the Plan's terms have been amended to incorporate the terms of this summary. The Plan Administrator has agreed to abide by the terms of this summary. The Plan's privacy notice also permits the Plan to disclose the Plan participant's protected health information to the Plan Administrator as described in this summary.

RESTRICTIONS ON USE OR DISCLOSURE OF PHI

Here are the restrictions that apply to the Plan Administrators use and disclosure of a Plan participant's protected health information.

- (1) The Plan Administrator will only use or disclose a Plan participant's protected health information for Plan administrative purposes, as required by law, or as permitted under the HIPAA Privacy Rules. See the Plan's privacy notice for more information about permitted uses and disclosures of protected health information under HIPAA.
- (2) If the Plan Administrator discloses any protected health information to any of its agents or subcontractors, the Plan Administrator will require the agent or subcontractor to keep Plan participants' protected health information as required by the HIPAA Privacy Rules.
- (3) The Plan Administrator will not use or disclose a Plan participant's protected health information for employment-related actions or decisions or in connection with any other benefit or benefit plan of the Plan Administrator.
- (4) The Plan Administrator will promptly report to the Plan any use or disclosure of a Plan participant's protected health information that is inconsistent with the uses or disclosures allowed in this summary.
- (5) The Plan Administrator will allow a Plan participant or the Plan to inspect and copy any protected health information about the Plan participant that is in the Plan Administrator's custody and control, as permitted or required by the HIPAA Privacy Rules, subject to certain exceptions recognized in the Rules.
- (6) The Plan Administrator will amend, or allow the Plan to amend, any portion of a Plan participant's protected health information to the extent permitted or required under the HIPAA Privacy Rules.
- (7) With respect to some types of disclosures for purposes other than payment or health care operations, the Plan Administrator will keep a disclosure log. The disclosure log will go back for six years (but not before April 14, 2003). Plan participants have a right to see the disclosure log. The Plan Administrator does not have to maintain the log if disclosures are for certain Plan related purposes, such as payment of benefits or health care operations, or if a Plan participant authorized the disclosures.
- (8) The Plan Administrator will make its internal practices, books, and records, relating to its use and disclosure of a Plan participant's protected health information available to the Plan and to the U.S. Department of Health and Human Services upon their request.
- (9) The Plan Administrator will, if feasible, return or destroy all of protected health information in the Plan Administrator's custody or control that the Plan Administrator has received from the Plan or from any business associate when the Plan Administrator no longer needs the protected health information to administer the Plan. If it is not feasible for the Plan Administrator to return or destroy protected health information, the Plan Administrator will limit the use or disclosure of any protected health information that it cannot feasibly return or destroy to those purposes that make return or destruction of the information infeasible.

DESIGNATION OF FIREWALL DEPARTMENT

The following classes of employees or other workforce members under the control of the Plan Administrator (sometimes referred to as the "Firewall Department" for HIPAA Privacy Rules purposes) are hereby designated in accordance with HIPAA Privacy Rules firewall provisions to be given access to protected health information for the purposes set forth in this document:

Employees assigned to and working in the Human Resources Department, including but not limited to all employees whose job duties require communication and interaction with the third party administrator for the group health plan regarding any plan administration, claims or eligibility-related matters.

The above designation includes every class of employees or other workforce members under the control of the Plan Administrator who may receive protected health information. If any of these employees or workforce members use or disclose protected health information in violation of the rules that are set out in this summary, the employees or workforce members will be subject to disciplinary action and sanctions, including the possibility of termination of employment. If the Plan Administrator becomes aware of any such violations, the Plan Administrator will promptly report the violation to the Plan and will cooperate with the Plan to correct the violation, to impose appropriate sanctions, and to mitigate any harmful effects to Plan participants.

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, due to a clerical error, an overpayment occurs in a Plan reimbursement amount, the Plan retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money. In the case of a Plan Participant, if it is requested, the amount of overpayment will be deducted from future benefits payable.

AMENDING AND TERMINATING THE PLAN

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

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

CERTAIN PLAN PARTICIPANTS RIGHTS UNDER ERISA

Plan Participants in this Plan are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA specifies that all Plan Participants 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 Pension and Welfare Benefits 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 Plan Participant, 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 Plan Document and the documents governing the Plan on the rules governing COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for Pre-Existing Conditions under this group health Plan, if an Employee or dependent has Creditable Coverage from another plan. The Employee or dependent should be provided a certificate of Creditable Coverage, free of charge, from the group health plan or health insurance issuer when coverage is lost under the plan, when a person becomes entitled to elect COBRA continuation coverage, when COBRA continuation coverage ceases, if a person requests it before losing coverage, or if a person requests it up to 24 months after losing coverage. Without evidence of Creditable Coverage, a Plan Participant may be subject to a Pre-Existing Conditions exclusion for 12 months (18 months for Late Enrollees) after the Enrollment Date of coverage.

If a Plan Participant's claim for a benefit is denied or ignored, in whole or in part, the participant 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 Plan Participant can take to enforce the above rights. For instance, if a Plan Participant 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 Plan Participant 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 Plan Participant has a claim for benefits which is denied or ignored, in whole or in part, the participant may file suit in state or federal court.

In addition, if a Plan Participant 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 Plan Participants, 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 Plan Participants and their beneficiaries. No one, including the Employer or any other person, may fire a Plan Participant or otherwise discriminate against a Plan Participant in any way to prevent the Plan Participant 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 Plan Participant 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 Plan Participant is successful, the court may order the person sued to pay these costs and fees. If the Plan Participant 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 Plan Participant has any questions about the Plan, he or she should contact the Plan Administrator. If the Plan Participant has any questions about this statement or his or her rights under ERISA or the Health Insurance Portability and Accountability Act (HIPAA), that Plan Participant should contact either the nearest area office of the Pension and Welfare Benefits Administration, U.S. Department of Labor listed in the telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, at 200 Constitution Avenue, N.W., Washington, DC 20210.

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.

PLAN NAME

Southern Arkansas University Employee Health Plan

PLAN NUMBER: 501

TAX ID NUMBER: 71-6007749

PLAN EFFECTIVE DATE: 07/01/2005

PLAN YEAR ENDS: 12/31

EMPLOYER INFORMATION

Southern Arkansas University
P.O. Box 9403
Magnolia, AR 71754-9403

PLAN ADMINISTRATOR

Vice President For Administration And General Council
Southern Arkansas University
P.O. Box 9403
Magnolia, AR 71754-9403

NAMED FIDUCIARY

Vice President For Administration And General Council
Southern Arkansas University
P.O. Box 9403
Magnolia, AR 71754-9403

AGENT FOR SERVICE OF LEGAL PROCESS

Vice President For Administration And General Council
Southern Arkansas University
P.O. Box 9403
Magnolia, AR 71754-9403

CLAIMS ADMINISTRATOR

BlueAdvantage Administrators of Arkansas
P.O. Box 1460
Little Rock, Arkansas 72203-1460
1-888-872-2531

BlueAdvantage Administrators of Arkansas is an independent licensee of the Blue Cross and Blue Shield Association. BlueAdvantage Administrators does not underwrite or assume any financial risk with respect to the claims liability of the Plan.

BY THIS AGREEMENT, Southern Arkansas University Employee Health Plan is hereby adopted as shown.

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

By _____
Southern Arkansas University

Date _____

Witness _____

Date _____

BY THIS AGREEMENT, Southern Arkansas University Employee Health Plan is hereby adopted as shown.

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

By Pogorelles
Southern Arkansas University

Date March 13, 2015

Witness Alan Davis

Date March 13, 2015

AMENDMENT ONE

To the

**SOUTHERN ARKANSAS UNIVERSITY
EMPLOYEE HEALTH PLAN**

BY THIS AGREEMENT, the Southern Arkansas University Employee Health Plan is hereby amended as follows, effective as of January 1, 2015.

In the COST MANAGEMENT Section, the Prenotification Phone Number Subsection and the Utilization Review Subsection are DELETED and REPLACED with the following language:

NOTIFICATION OF MEDICAL SERVICES

The Plan has a program designed to help insure that all Covered Persons receive necessary and appropriate health care while avoiding unnecessary expenses.

Please refer to the Employee ID card for the Prenotification Services phone number.

The responsible party must call the Prenotification Services telephone number on the ID card to provide notification of the following services before Medical and/or Surgical services are provided:

Inpatient Admissions

Emergency Inpatient Admissions (call must be made within 48 hours of Admission)

The purpose of the Prenotification program is to alert the Plan of a patient's potential need for long-term and/or extensive care. 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.

Failure to follow this procedure may reduce reimbursement received from the Plan.

Responsibility for Prenotification

The following table identifies services which require prenotification and who is responsible for providing prenotification.

Services requiring prenotification	Party Responsible for Notification if the Provider is In-Network	Party Responsible for Notification if the Provider is Out-of-Network*
Inpatient admissions, including emergency admissions	In-Network Hospital The In-Network Hospital is responsible for any penalty amounts incurred for failure to provide prenotification.	Covered Person Failure to provide prenotification will result in a \$200 reduction in benefits paid by the Plan. The Covered Person is responsible for reimbursing the provider for the penalty amount.

This Plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act. See Important Grandfather Status Notice Attached.

*Some out-of-network providers may have contracts with either the Claims Administrator or the Blue Cross and Blue Shield plan in the state where services were provided, which make them responsible for any penalty amounts incurred for failure to obtain precertification. The Covered Person may contact BlueAdvantage at the customer service telephone number listed on the ID card to determine if a specific out-of-network provider has this type of contract.

IN WITNESS WHEREOF, this Agreement has been executed on or as of the date first written below.

By: Reynolds
Employer

Alan Davis
Witness

9/3/2014
Date

9-3-14
Date

*This Plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act.
See Important Grandfather Status Notice Attached.*