

SERFF Tracking Number: CVKS-127837382 State: Arkansas
 Filing Company: Coventry Health and Life Insurance Company State Tracking Number: 50296
 Company Tracking Number: AR CERTIFICATE - REVISED
 TOI: H16G Group Health - Major Medical Sub-TOI: H16G.001A Any Size Group - PPO
 Product Name: AR Certificate of Coverage - Revised
 Project Name/Number: /

Filing at a Glance

Company: Coventry Health and Life Insurance Company

Product Name: AR Certificate of Coverage - Revised SERFF Tr Num: CVKS-127837382 State: Arkansas

TOI: H16G Group Health - Major Medical SERFF Status: Closed-Approved State Tr Num: 50296
 Sub-TOI: H16G.001A Any Size Group - PPO Co Tr Num: AR CERTIFICATE - REVISED State Status: Approved-Closed

Filing Type: Form

Reviewer(s): Donna Lambert
 Authors: Lisa Foos, Vanda Johnson, Paula Bostock
 Disposition Date: 12/05/2011

Date Submitted: 11/18/2011

Disposition Status: Approved

Implementation Date Requested: 01/01/2012

Implementation Date: 01/05/2012

State Filing Description:

General Information

Project Name:
 Project Number:
 Requested Filing Mode: Review & Approval
 Explanation for Combination/Other:
 Submission Type: Resubmission
 Group Market Size: Small and Large
 Overall Rate Impact:

Status of Filing in Domicile:
 Date Approved in Domicile:
 Domicile Status Comments:
 Market Type: Group
 Previous Filing Number: CVKS-127719618
 Group Market Type: Employer
 Filing Status Changed: 12/05/2011
 State Status Changed: 12/05/2011
 Created By: Lisa Foos
 Corresponding Filing Tracking Number:

Deemer Date:
 Submitted By: Lisa Foos
 PPACA: Not PPACA-Related
 PPACA Notes: null

Filing Description:

Certificate of Coverage for Group products (PPO) - Revisions since last review and approval on 11/7/2011 (CVKS-127719618)

Company and Contact

Filing Contact Information

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Lisa Foos, lfoos@phsystems.com
 8535 E. 21st St. N. 316-609-2564 [Phone]
 Wichita, KS 67206

Filing Company Information

Coventry Health and Life Insurance Company CoCode: 81973 State of Domicile: Delaware
 8320 Ward Parkway Group Code: 1137 Company Type: LAH
 Kansas City, MO 64114 Group Name: Coventry Health Care State ID Number:
 (866) 795-3995 ext. 4539[Phone] FEIN Number: 75-1296086

Filing Fees

Fee Required? Yes
 Fee Amount: \$50.00
 Retaliatory? No
 Fee Explanation: \$50/form
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Coventry Health and Life Insurance Company	\$50.00	11/18/2011	53899268

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Donna Lambert	12/05/2011	12/05/2011

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	Created By	Created On	Date Submitted	Responded By	Created On	Date Submitted
Pending Industry Response	Donna Lambert	11/30/2011	11/30/2011	Lisa Foos	12/05/2011	12/05/2011

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Disposition

Disposition Date: 12/05/2011

Implementation Date: 01/05/2012

Status: Approved

HHS Status: HHS Approved

State Review:

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved	Yes
Supporting Document	Application	Approved	Yes
Supporting Document	PPACA Uniform Compliance Summary	Approved	Yes
Supporting Document	Cover Letter	Approved	Yes
Form (<i>revised</i>)	AR Certificate of Coverage	Approved	Yes
Form	AR Certificate of Coverage	Replaced	Yes

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Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	11/30/2011
Submitted Date	11/30/2011
Respond By Date	12/30/2011

Dear Lisa Foos,

This will acknowledge receipt of the captioned filing. If you wish to use the same form numbers, you must add a revision date to them.

A.C.A. 23-79-109(1)-(5) sets forth the procedure by which filings may be deemed approved upon the expiration of certain time periods with no affirmative action by the commissioner. If the commissioner determines that additional information is needed to make a decision regarding approval, such request for information will be made to the company. The filing will not be considered complete until said additional information is received. The time periods set forth in this statute will not begin to run until the filing is complete.

Please feel free to contact me if you have questions.

Sincerely,

Donna Lambert

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Response Letter

Response Letter Status Submitted to State
 Response Letter Date 12/05/2011
 Submitted Date 12/05/2011

Dear Donna Lambert,

Comments:

Thank you for your response to this filing.

Response 1

Comments: I have updated the form number to reflect a revised date of 11.11. It is no longer the same form number as previously filed. It will replace the form number CHL-AR-COC-021-09.11.

Changed Items:

No Supporting Documents changed.

Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
AR Certificate of Coverage	CHL-AR-COC-021-11.11		Certificate	Revised	CVKS-127719618		CHL-AR-COC-021-11.11.pdf
Previous Version							
AR Certificate of Coverage	CHL-AR-COC-021-09.11		Certificate	Revised	CVKS-127719618		CHL-AR-COC-021-09.11.pdf

No Rate/Rule Schedule items changed.

Thank you for your attention to this filing.

Sincerely,

Lisa Foos, Paula Bostock, Vanda Johnson

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Form Schedule

Lead Form Number: CHL-AR-COC-021-09.11

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved 12/05/2011	CHL-AR- COC-021- 11.11	Certificate	AR Certificate of Coverage	Revised	Replaced Form #: CHL-AR-COC-021- 09.11 Previous Filing #: CVKS-127719618		CHL-AR- COC-021- 11.11.pdf



[LOGO]

PREFERRED PROVIDER ORGANIZATION (“PPO”)

*PPO products are underwritten by Coventry Health and Life Insurance Company
and administered by Coventry Health Care of Kansas, Inc.*

Arkansas

**THIS BENEFIT DOCUMENT AND ALL ATTACHED RIDERS
SHOULD BE READ IN THEIR ENTIRETY.**

You have the full freedom of choice in the selection of any duly licensed health care professional. This benefit document has provisions reducing the amount of Coverage You receive depending on which Physicians or other health care providers you use. Please consult this benefit document, the Schedule of Benefits and Provider Directory for more details. If you have any additional questions, please write or call us at:

Coventry Health & Life Insurance Company
[8320 Ward Parkway]
[Kansas City, MO 64114]
[(800) 969-3343]
[www.chckansas.com]

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Identification (ID) Card

Every individual receives an ID card. Carry Your ID card with You at all times, and present it every time You request or receive services. The ID card is needed for Providers to bill the Plan for charges other than Copayments, Coinsurance, and non-Covered Services. If You do not show Your ID card, the Providers cannot identify You as a participant of the Plan, and You may receive a bill for services. If Your ID card is missing, lost, or stolen, contact the Plan's Customer Service Department at [800-969-3343]; or through the website at [www.chckansas.com] to obtain a replacement. This information is also listed on Your ID card and in the Schedule of Important Numbers. If Your Dependents are Covered, You will receive an additional ID card for each Covered Dependent. Possession and use of an ID card is not an entitlement to Coverage. Coverage is subject to verification of eligibility and all the terms, conditions, limitations and exclusions set out in the Agreement.

How to Contact the Plan

Throughout this Agreement, You will find that the Plan encourages You to contact the Plan for further information. Whenever You have a question or concern regarding Covered Services or any required procedure, please contact the Plan at the telephone number or website on the back of Your ID card.

Telephone numbers and addresses to request review of denied claims, register Complaints, place requests for prior Authorization, and submit claims are listed in the Schedule of Important Telephone Numbers And Addresses included in this document.

Copayments, Coinsurance [and Deductibles]

You may be responsible for paying Copayments to Participating Providers at the time of service. The Provider may bill You at a later time for the Coinsurance amounts that are Your responsibility under the terms of the Plan as determined by the Allowed Amount. [You may be responsible for the difference between the actual billed charges of a Non-Participating Provider and the Allowed Amounts.] [You must meet the applicable Deductible, as described in Your Schedule of Benefits, before benefits will be payable to Providers on Your behalf.] Specific Copayments[, Deductible] and Coinsurance amounts are listed in the Schedule of Benefits.

[For Missouri-based Employer Groups, the Copayment and Coinsurance for a single service will not exceed fifty percent (50%) of the Plan's Allowed Amounts of providing a single Basic Health Service, nor in the annual aggregate more than twenty percent (20%) of the Allowed Amount of providing all Basic Health Services, which will not exceed two hundred percent (200%) of the total annual Premium.]

Prior Authorization

Prior Authorization is required for certain Covered Services as determined by the Plan. Coverage is subject to eligibility and benefits remaining at the time services are rendered. The Plan has the right to request and obtain whatever medical information it considers necessary to determine whether the service is Medically Necessary. You or the Participating Providers are required to obtain Prior Authorization for Covered Services. **You are responsible for verifying Prior Authorization has been obtained whenever You seek Covered Services from a Non-Participating Provider.** An up-to-date Prior Authorization List is available by contacting the Plan at the telephone number listed on Your ID card or by visiting the Plan's website.

Any new, additional or extended services not Covered under the original Authorization

USING YOUR BENEFITS

will be Covered only if a new Authorization is obtained. All services identified in this document are subject to all of the terms, conditions, exclusions and limitations of the Plan.

It is important to note that under the terms of the Plan, Prior Authorization only determines Medical Necessity and appropriateness. All other terms of the Plan are then applied. If the Plan Prior Authorizes Covered Services, the Plan shall not subsequently retract the Authorization after the Covered Services have been received, or reduce payment unless: (1) Such Authorization is based on a material misrepresentation or omission about Your health condition or the cause of the health condition; or (2) the Plan terminates before the health care services are provided; or (3) Your Coverage under the Plan terminates before the health care services are provided.

To find out the amount of the penalty applied for failure to obtain Prior Authorization, please see [the Prior Authorization List or] the Schedule of Benefits.

If You are admitted for emergency care to a Non-Participating Facility, or in the case of an unexpected length of stay after a Prior Authorized admission to a Non-Participating Facility, the Plan may request that You be transferred to a Participating Facility for continuation of care when it is not medically contraindicated. If You refuse to be transferred to a Participating Facility, [the Plan will not cover any services beyond the proposed date of transfer][coverage will be provided] [at the Non-Participating level] [for services received after the proposed date of transfer].

Health Services Rendered by Participating Providers

You have access to the services of a Participating Provider of Your choice within the Provider network for Covered Services, subject to the terms, conditions, exclusions and limitations of the Agreement. Participating Providers are contractually obligated to file all claims for You. Payment will be made directly to the Participating Provider for Covered Services.

It is Your responsibility to verify the participation status of Providers. You should not assume that a Provider, whom a Participating Provider may recommend, would always be another Participating Provider. To verify the status of the Provider, please contact the Customer Service Department or check the Plan's website.

Coverage for Services by Non-Participating Providers

A Non-Participating Provider may or may not complete and file the claim form for You. If not, You must submit a Claim form to the Plan. **If a Non-Participating claim form is not received from the Plan within fifteen (15) days after the Plan receives notice of a claim, You shall be deemed to have complied with the requirements of the Plan as to proof of loss upon submitting written proof covering the occurrence, character, and extent of loss, within the time fixed for filing a claim.** It is Your responsibility to provide any information that is necessary for the Plan to make a prompt and fair evaluation of Your claim. The Plan requests that You file the Non-Participating Provider claim within ninety (90) days from date of service. However, failure to file the claim within the ninety (90) day period shall not invalidate or reduce the claim, if it was not reasonably possible to provide notice or proof within the ninety (90) days. A claim will not be denied based upon the Your failure to submit a claim within the ninety (90) day period unless the failure operates to prejudice the rights of the Plan. [No claim will be paid if not received by the Plan within one (1) year] [and ninety (90) days] [after services are received, **except in the absence of**

legal capacity of the claimant.]

[Non-Participating Provider Fees

Payment for Covered Services provided by Non-Participating Providers is limited to the lesser of the billed charge or the Out-of-Network Rates listed below less applicable Copayments, Coinsurance and/or Deductibles. These rates are calculated as a multiple of the Medicare fee schedule for Physicians, Hospitals, outpatient facilities, ancillary Providers and other Providers. These rates may be adjusted from time to time.

If the amount You are charged for a Covered Service is equal to or less than the Out-of-Network Rate, the charge should be completely covered by Your Out of Network benefit, except for any Copayment, Coinsurance, and/or Deductible payments You are required to make. However, if the amount You are charged is in excess of the Out-of-Network Rate for a particular Covered Service, You will be responsible for paying any amounts in excess of the rates listed below, in addition to any applicable Copayment, Coinsurance, and/or Deductible payments.]

[Non-Participating Physician and Other Health Care Professional Fees

The Out-of-Network Rate is equivalent to 100% of the national average Medicare rate, based on the previous year's Resource Based Relative Value Scale (RBRVS) fee schedule for Physician and other health care professional services, as such services are defined in the American Medical Association's Current Procedural Terminology (CPT) manual. For Physician and other health care profession services not valued in RBRVS, other Medicare or nationally recognized schedules will be used. For CPT codes developed after the previous year, the rate will be calculated using the assigned Relative Value Units (RVU) and the previous year's Medicare conversion factor. Payment for immunizations and injectable drugs will be at 100% of the First Data Bank [Average Wholesale Price (AWP)]. Payment for anesthesia services will be 200% of the previous year national average Medicare rate per 15 minute increment. Payment for Durable Medical Equipment (DME), prosthetics, orthotics and supplies (DMEPOS) will be at the previous year's DMEPOS ceiling limit. Payment for Laboratory services will be at the previous year's Medicare Clinical Laboratory Fee Schedule. If there is no corresponding rate, as described above, for a particular service, the Plan shall provide payment at 50% of billed charges. The Plan reserves the right to apply proprietary payment guidelines, claim adjudication procedures and billing instructions in conjunction with the determination of the Out-of-Network Rates.]

[Non-Participating Facility Fees

The Out-of-Network Rate is equivalent to 100% of the Medicare base rate for facility charges. Payment for inpatient services will be based on Diagnosis Related Group (DRG) rates. Payment for outpatient services will be based on Ambulatory Payment Classification (APC) rates. Payment for services provided within an ambulatory surgical center will be based on Ambulatory Surgical Center (ASC) group rates. If there is no corresponding DRG, APC or ASC rate for a particular service, the Plan shall provide payment at 50% of billed charges. The Plan reserves the right to apply proprietary payment guidelines, claim adjudication procedures and billing instructions in conjunction with the determination of the Out-of-Network Rates.

Please note that Physician and Hospital charges typically are not regulated. Billed charges can vary tremendously from one Provider to the next, so please make sure You are aware of the billed charge for services You want to receive from Non-Participating Providers.]

USING YOUR BENEFITS

Second Opinion Policy

You may seek a second medical opinion or consultation from the Plan's Participating Providers. In the event the Plan does not employ or contract with another Physician with the expertise necessary to provide a second medical opinion, the Plan will arrange for a referral to a Provider with the necessary expertise.

Participating Provider Terminations

The Plan or a Participating Provider may end the relationship with the other party after having supplied notice under applicable law; therefore the Plan does not promise that any specific Participating Provider will be available to render services to You. [If a Participating Provider no longer participates with the Plan, the Plan will provide immediate notice to You and assist You in selecting another Participating Provider.] The Plan will provide You continuation of care up to ninety (90) days by a Provider who is terminated from the network in those cases where such continuation of care is Medically Necessary and in accordance with the dictates of medical prudence and where You have special circumstances such as a disability, a life-threatening condition or is in the third trimester of pregnancy. You will not be liable to the Provider for any amounts owed for medical care other than the applicable Copayments, Coinsurance and/or Deductible as specified in the Schedule of Benefits.

Provider Hold Harmless

Participating Providers agree that in no event, including but not limited to nonpayment by the Plan or intermediary, insolvency of the Plan or intermediary, or breach of this Agreement, shall the Participating Provider bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse against You or a person, other than the Plan or intermediary, acting on Your behalf for services provided pursuant to this Agreement. This Agreement shall not prohibit the Provider from collecting [Coinsurance, Deductibles or] Copayments, as specifically provided in this document, or fees for non-Covered Services delivered on a fee-for-service basis to You. The provider hold harmless provision shall not prohibit a Provider and You from agreeing to continue services solely at Your expense, as long as the Provider has clearly informed You that the Plan may not cover or continue to cover a specific service or services. Except as provided herein, this provision does not prohibit the Provider from pursuing any available legal remedy, including but not limited to, collecting from any insurance carrier providing You Coverage.

Plan Has Authority to Grant Coverage

Only Medically Necessary services are Covered under the Agreement. The fact that a Physician or other Provider has performed or prescribed a procedure or treatment, or the fact that it may be the only available treatment for an injury, illness or Substance Abuse, or Mental Illness does not mean that the procedure or treatment is Covered under the Agreement. The Plan shall have the right, subject to Your rights in this document, to interpret the benefits of this document and attached Riders, and other terms, conditions, limitations and exclusions set out in the Agreement in making factual determinations related to the Agreement, its benefits, and You; and in construing any disputed or ambiguous terms. In accordance with all applicable law, the Plan reserves the right at any time, to change, amend, interpret, modify, withdraw or add benefits to, or terminate this Plan. The Group will be given the proper written notice by means of Amendment or Endorsement prior to any termination or change in Coverage as required by applicable law. Any termination of the Agreement must be in accordance with the Termination of Coverage Section of this document. The Plan may, in certain circumstances, cover services that would otherwise not be Covered. The fact that the Plan does so in any particular case shall not in any way be deemed to require it to do so in other similar

cases.

[Payment to Public Entities

For Missouri-based Employer Groups, any benefits payable hereunder to You shall be payable with or without assignment from You to a public Hospital or clinic for services or supplies provided to You if a proper claim is submitted by the public Hospital or clinic. Payment to the public Hospital or clinic shall discharge the Plan from any and all obligations and liability to You to the extent of the benefits paid. In the event the Plan has already made payment on such charges to You prior to receipt of the claim from the public Hospital or clinic, the Plan will not be required to pay the claim to the public Hospital or clinic again.]

COVERED SERVICES

The Plan covers only those services and supplies that are (1) deemed Medically Necessary as well as not considered Experimental or Investigational, (2) Authorized, if required, (3) not expressly excluded in the list of Exclusions section, and (4) incurred while eligible for Coverage under the Plan. It is Your responsibility to verify whether a Covered Service requires Prior Authorization and should always reference the Authorization Requirements prior to receiving Covered Services. You should not assume that a Participating Provider has already obtained the Authorization. If a service is not specifically listed and not otherwise excluded, please contact the Plan to confirm whether the service is a Covered Service. Please note that the Covered Services are subject to all applicable provisions within this document, and any attached Schedule of Benefits, Riders, Amendments, or Endorsements.

Allergy

Coverage is provided for allergy testing, diagnosis, treatment, allergy serum, and the administration of injections.

Exclusions:

- Sublingual drops.
- Non-Physician services and expenses relating to an allergic condition including, but not limited to, installation of air filters, air purifiers, or air ventilation system cleaning.

Ambulance (air and ground)

For Emergency use, when transport by other means is not medically safe, and for non-Emergency transportation for the following:

- From a non-Participating Hospital to a Participating Hospital;
- To a Hospital that provides a higher level of care;
- To a more cost effective acute care Facility; or

When transportation is needed to a long term acute care or inpatient rehabilitation facility.

Exclusion:

Non-Emergency and non-medically appropriate ambulance services, regardless of who requested the services, including transport due to the absence of other transportation.

Blood and Blood Products Processing

Coverage is provided for administration, storage, and processing of blood and blood products in connection with Covered services.

Exclusions:

- Expenses related to personal blood storage, unless associated with a scheduled surgery.
- Fetal cord blood harvesting and storage.
- The cost of whole blood and blood products replacement to a blood bank.

Chemotherapy

Coverage is provided for standard chemotherapy, including, but not limited to, dose-intensive chemotherapy for the treatment of breast cancer.

Clinical Trials

Expenses associated with professional services, diagnostic laboratory and radiology tests, inpatient care, and administration of treatment and evaluation during the course of the treatment or a condition associated with a complication of the underlying disease or treatment, which are consistent with usual and customary patterns and standards of care incurred whenever You receive medical care associated with an approved clinical trial, and which would be covered if such items and services were provided other than in connection with an approved clinical trial.

Exclusions:

- The costs of the Investigational drugs or devices themselves, or the costs of any

COVERED SERVICES

non-medical services that might be required for You to receive the treatment or intervention.

- Transportation and/or lodging costs incurred while receiving such treatment.
- Any item or service that is provided solely to satisfy data collection and analysis needs and that is not used in Your clinical management.
- Health care services customarily provided by the research sponsors of a trial free of charge for any member in the trial.
- Experimental or Investigational treatment not related to a Clinical Trial as defined above.

Compression Sleeves and Stockings

Coverage is provided for [two (2) pair of] compression sleeves and [two (2) pair of] compression stockings per Benefit Period.

Dental/Oral Surgery Services

Benefits for oral surgical procedures of the jaw or gums will be covered for:

- Removal of tumors or cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth;
- Removal of symptomatic exostoses (bony growths) of the jaw and hard palate;
- Treatment of fractures and dislocations of the jaw and facial bones;
- Intraoral x-rays in connection with covered oral surgery; and
- General anesthetic for covered oral surgery.

Coverage is provided for diseases of the mouth, jaw and teeth related to radiation treatment, unless the condition is due to dental disease or of dental origin.

Limitations:

- Coverage is provided for anesthesia and hospital or ambulatory surgical facility charges for services performed in connection with dental procedures in a hospital or ambulatory surgical facility, if:
 - The provider treating the patient certifies that because of the patient's age or condition or problem, hospitalization or general anesthesia is required in order to safely and effectively perform the procedures; and the patient is:
 - A child under seven (7) years of age who is determined by two (2) dentists to require without delay necessary dental treatment in a hospital or ambulatory surgical center for a significantly complex dental condition;
 - A person with a diagnosed serious mental or physical condition; or
 - A person with a significant behavioral problem as determined by Your physician.
 - If a person is covered under both this Plan and a benefit plan that provides dental benefits, the health benefit plan that includes dental benefits is the primary payer.
- Services relating to the acute injury of sound, natural teeth caused directly by an accidental injury (not from biting or chewing) within a [six (6), twelve (12)] month consecutive period from the date of injury up to a maximum of \$1,000 of Allowed Amount(s). This benefit maximum does not apply to individuals under eighteen (18) years of age. A treatment plan must be submitted [within sixty (60) days of the injury] and approved by the Plan.

Exclusions:

- Upper and lower jaw bone surgery and dental implants (including that related to the temporomandibular and craniomandibular joint).
- Dental x-rays, supplies and appliances including occlusal splints.
- Orthodontia and related services.

COVERED SERVICES

- Oral surgery supplies required as part of an orthodontic treatment program, required for correction of an occlusal defect, encompassing orthognathic or prognathic surgical procedures, or removal of symptomatic bony impacted teeth.
- Treatment of teeth or structures directly supporting the teeth, whether the services are considered to be medical or dental in nature except as specified above.

Dermatological Services

Coverage is provided for the necessary removal of a skin lesion that interferes with normal body functions or is suspected to be malignant.

Dialysis

Coverage is provided for hemodialysis and peritoneal services provided by outpatient or inpatient facilities or at home. For home dialysis, equipment, supplies, and maintenance will be a Covered Service.

Diabetic Services

Diabetic services will be provided for individuals with gestational diabetes, Type I diabetes, and Type II diabetes. Coverage includes Plan approved diabetic education classes, including self-management training used in connection with the treatment of diabetes; foot care, including medical or surgical treatment of onychomycosis (nail fungus); an annual diabetic retinal eye examination; and [one (1) pair of] orthopedic shoes and [two (2) pair] associated shoe inserts [per Benefit Period] for those individuals with demonstrated peripheral neuropathy.

Limitation:

Diabetic equipment and supplies, including disposable insulin syringes, glucose meters, glucose strips, and lancets are Covered under the pharmacy Rider. If a pharmacy Rider is not purchased, Coverage for this benefit will be provided under the medical benefit.

Dietician Counseling

Coverage [for up to four (4) visits per Benefit Period] is provided when rendered by a registered dietician.

Disposable Medical Supplies

Specific disposable medical supplies are covered when prescribed by Your Physician. Covered disposable supplies are limited to:

- Inhaler supplies (aero chamber masks, spacers and peak flow meters)
- Ostomy supplies (appliance pouches, skin care agents, support belts);
- Open wound supplies (gauze pads, wound packing strips, ABD pads);
- Supplies used in conjunction with covered Durable Medical Equipment (except for diabetic supplies);
- Tracheostomy supplies;
- Urinary supplies limited to catheters, bags and related supplies; and
- Venous access catheter supplies (alcohol pads, benzoin, OP site).

Durable Medical Equipment (DME)

DME is medical equipment which can withstand repeated use and is not disposable, is used to serve a medical purpose, is generally not useful to a person in the absence of an illness or injury, and is appropriate for use in the home. Medically Necessary, non-disposable accessories that are commonly associated with the use of a Covered piece of DME will be considered DME.

Coverage is provided when determined to be necessary and reasonable for the treatment of an illness or injury, or to improve the functioning of a malformed body part.

Limitations:

- Coverage for repair, replacement or duplicate equipment is provided only when

COVERED SERVICES

required due to anatomical change and/or reasonable wear and tear. All maintenance and repairs that result from misuse are Your responsibility.

- Benefits are provided for one wheelchair or scooter and for repairs of that unit.

Exclusions:

- Electronically controlled heating and cooling compression therapy devices (such as polar ice packs, Ice Man Cool Therapy, or Cryo-cuff);
- Home traction units;
- Preventive or routine maintenance due to normal wear and tear or negligence of items You own;
- Replacement for changes due to obesity; and
- Personal comfort items, including breast pumps, air conditioners, humidifiers and dehumidifiers, even though prescribed by a Physician, unless defined as a Covered Service.

Emergency Services

Coverage will be provided for Emergency Services if the symptoms You present and records by the attending Physician indicate that an Emergency Medical Condition exists; or for Emergency Services necessary to provide You with a medical examination and stabilizing treatment, regardless whether Prior Authorization was obtained to provide those services. Services provided by a Hospital emergency department for non-Emergency Medical Conditions are not covered.

[In situations where You require Emergency Services and have no control over when or where such services are rendered, You will not be responsible for the difference between the Provider's billed charges and Allowed Amount(s).]

Eye Glasses and Corrective Lenses

Coverage will be provided for the first pair of [eyeglasses or] corrective lenses following cataract or cornea transplant surgery [up to a maximum of \$150] or one (1) pair of contact lenses; or one (1) pair of sclera shells intended for use as corneal bandages or for medically-diagnosed eye diseases approved by Our Medical Director. [Benefits are limited to the amount available for a basic (standard) frame which meet the minimum specifications for the corrective lens(es), the cost of basic frames shall not exceed [\$100-\$500].]

Family Planning

Covered Services are limited to:

- Office visits, medical evaluation, and counseling;
- Testing required to establish the etiology of male infertility, which is limited to sperm counts and/or semen analysis; scrotal ultrasound; prostate ultrasound, biopsy, and cystoscopy;
- Testing required to establish the etiology of female infertility, which is limited to hysterosalpingogram, diagnostic laparoscopy, and endometrial biopsy;
- [Surgical correction of physiological abnormalities causing infertility;]
- [Contraceptive implants, diaphragms, and IUDs (including their insertion and removal). Contraceptive supplies and devices obtained at a pharmacy are only covered through a pharmacy Rider]; and
- [Sterilization procedures (vasectomy or tubal ligation).]

Exclusions:

- Fee associated with donors;
- Collection or storage of sperm;
- Those services related to conception through artificial means including, but not

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limited to, artificial insemination (IUI), in-vitro fertilization (IVF), gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT) and similar procedures;

- Injectable drugs for stimulation of ovaries or treatment of infertility and associated office visits, injections, laboratory, and other testing, including those provided in any Physician's office setting;
- Embryo transplants;
- Reversal of voluntarily induced sterilization;
- Expenses of surrogate motherhood;
- Selective reduction;
- Any experimental procedure;
- Office visits, laboratory, x-ray and other testing associated with any Non-Covered Service;
- [Surgical correction of physiological abnormalities causing infertility;]
- [Contraceptive implants, diaphragms, and IUDs (including their insertion and removal)]; and
- [Sterilization procedures (vasectomy or tubal ligation)]

For maternity care coverage, reference the Maternity Care section of this document and Schedule of Benefits.

Foot Care

Coverage for routine foot care provided by a Physician, including the paring and removing of corns and calluses or trimming of nails, will only be provided for the treatment of a person who, due to a demonstrated medical condition, is unable to perform such activity.

Exclusions:

- Foot care in connection with corns, calluses, flat feet, fallen arches or chronic foot strain.
- Medical or surgical treatment of onychomycosis (nail fungus) except persons with circulatory impairment or as described in the Diabetic Services section.

Genetic Studies

Coverage is provided for genetic counseling and tests only when required for diagnosis or treatment of genetic abnormalities where historical evidence suggests a potential for such abnormalities and the testing will alter the outcome of treatment.

Exclusions:

- Genetic testing when performed primarily for screening purposes.
- Genetic testing when performed primarily for purposes of embryonic pre-selection.

Hearing Screenings

Coverage is provided for a hearing screening to determine hearing loss.

Exclusion:

Services and associated expenses for the examination for prescribing and fitting hearing aids, hearing therapy and any related diagnostic hearing tests.

Home Health Care Services

Home health services will be provided as indicated in the Schedule of Benefits if You require skilled care and are homebound due to a disabling condition, are unable to receive medical care on an ambulatory outpatient basis, and do not require confinement in a Hospital or other Participating Facility. In order to receive the Network level of benefits, Home health services must be provided by an accredited Participating home health agency. Home health services include:

- Periodic and intermittent diagnostic and therapeutic services which can only be performed by professional nurses and other Participating Health Professionals if the

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services are ordered by a Physician; and

- Consumable medical supplies and DME administered or used by such persons in the course of services rendered during such visits.

Limitations:

- Physical, occupational and speech therapy are subject to the benefit limitations and Copayments as described in the Rehabilitation Services section of this document and the Schedule of Benefits.
- Intravenous and injectable medications are subject to the benefits as described in the Therapeutic Injections and IV Infusions section of this document and the Schedule of Benefits.
- Home services to help meet personal, family, or domestic needs, including but not limited to eating, bathing, grooming, toileting, dressing, transferring or other custodial or self-care activities and private duty nursing, whether or not required by a Physician. This exclusion does not apply to wheelchairs, walkers, canes and crutches.

Hospice

Coverage is provided for hospice care rendered by a Provider for treatment of the terminally ill when ordered by a Physician. Care through a hospice program includes supportive care involving the evaluation of the emotional, social and environmental circumstances related to or resulting from the illness, including the services of a skilled nurse, physical or occupational therapist, home health aide, social worker, or chaplain; and guidance and assistance during the illness for the purpose of preparing You and Your family for a terminal illness.

Infertility Treatment

Coverage is provided for You or Your Spouse the patient's oocytes are fertilized with the sperm of the patient's spouse, and

- a history of unexplained infertility of at least two (2) years' duration; or
- the infertility is associated with one or more of the following medical conditions:
 - Endometriosis;
 - Exposure in utero to Diethylstilbestrol, commonly known as DES;
 - Blockage of or removal of one or both fallopian tubes (lateral or bilateral salpingectomy) not a result of voluntary sterilization; or
 - Abnormal male factors contributing to the infertility, and
- when performed at a medical facility, licensed or certified by the Arkansas Department of Health, those performed at a facility certified by the Arkansas Department of Health which conform to the American College of Obstetricians and Gynecologists' guidelines for in vitro fertilization clinics, or those performed at a facility certified by the Arkansas Department of Health which meet the American Fertility Society's minimal standards for programs of in vitro fertilization;
- unable to obtain successful pregnancy through any less costly applicable infertility treatment for which coverage is available under the policy.

Cryopreservation, the procedure whereby embryos are frozen for late implantation, shall be included as an in vitro fertilization procedure.

Inpatient Hospital Care

Inpatient Hospital and Facility services will be covered for evaluation or treatment of conditions that cannot be adequately treated on an outpatient basis. Coverage includes Semi-private accommodations and associated professional and ancillary services. Certain services rendered during a Your confinement may be subject to separate benefit

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restrictions and/or Copayments as described in the Schedule of Benefits.

Exclusion:

Private inpatient room, unless Medically Necessary or if a Semi-private room is unavailable.

Maternity Services

Maternity-related Covered Services are treated as any other illness. Hospital Coverage for the mother and her newborn child includes forty-eight (48) hours of post-natal maternity care for vaginal delivery and ninety-six (96) hours of post-natal maternity care for cesarean delivery. The Plan may authorize a shorter hospital stay if the attending provider, after consulting with the mother, approves discharging earlier than 48 hours (or 96 hours as applicable). The discharge shall be made in accordance with the most current version of the "Guidelines for Perinatal Care", or similar guidelines. Inpatient Hospital services may be subject to Your Responsibility as defined in the Schedule of Benefits.

Exclusions:

- Delivery in the home setting.
- Services provided by a doula (labor aide) [or lactation consultant] and parenting, pre-natal or birthing classes.
- Amniocentesis, ultrasound or any other procedures requested solely for sex determination of a fetus, unless Medically Necessary to determine the existence of a sex-linked genetic disorder.
- All services and supplies relating to the conception and pregnancy of a person acting as a surrogate mother.
- Medical and Hospital care and costs for the infant child of a Dependent.

Mental Health and Substance Abuse

Covered benefits under this section are those specified in the most current Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association (DSM) or the Plan's utilization policies when more generous. Benefits under this section are only covered if such treatment is rendered by a licensed Provider who has the legal authority to diagnose and treat mental illness or substance abuse. In order to receive the Network level of benefits, You should visit Your family Physician or a Participating Provider for outpatient treatment. You may also visit a Non-Participating Provider and receive the Non-Network level of benefits.

Inpatient treatment in a Hospital or Residential Treatment Facility, including the services of mental health professionals, is subject to the applicable Hospital Inpatient Deductible, Copayment and/or Coinsurance as listed in the Schedule of Benefits. Outpatient treatment, including treatment through partial or full-Day Program Services, is subject to the applicable Deductible, Copayment and/or Coinsurance for services provided by Specialty Physicians as listed in the Schedule of Benefits. Medical services in conjunction with Mental Health or Substance Abuse treatment are subject to the applicable benefit defined on the Schedule of Benefits.

Exclusion:

Mental illness and/or chemical dependency services for the following: 1) services utilizing methadone treatment as maintenance, LAAM (1-Alpha-Acetyl-Methadol), cyclazocine, or their equivalent; except where methadone or its equivalent is used as medically prescribed treatment in a federally approved detoxification program for drug abuse; and 2) services and treatment provided in connection with or to comply with involuntary commitments, police detentions and other similar arrangements.

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Orthotic Appliances

Orthotic appliances correct or support a defect of a body form or function. Coverage is provided for the purchase of orthotic appliances following the onset or initial diagnosis of the condition for which the device is required. Coverage is provided for orthotic appliances, splints and braces, including necessary adjustments to shoes to accommodate braces. Shoe inserts will be Covered only if You have diabetes with demonstrated peripheral neuropathy OR the insert is needed for a shoe that is part of a brace.

Exclusions:

- The replacement costs for any otherwise Covered appliance for changes due to obesity;
- Routine maintenance due to normal wear and tear or negligence of items You own;
- Foot or shoe inserts, arch pads, or insoles whether custom-made or prefabricated;
- Cranial (head) remodeling bands or any such service or supply for the treatment of positional non-synostotic plagiocephaly and other protective head gear.

Outpatient and Physician Office Services

Coverage will be provided for those services requested or directed by the Plan or a Physician to be provided on an outpatient basis, including:

- Diagnostic and/or treatment services.
- Lab services.
- Diagnostic and therapeutic radiology services.
- Health evaluations.
- Administered drugs, medications, biologicals, and fluids which have been approved by the FDA, have a National Drug Code, and are administered under the supervision of a Physician.
- Services which can be appropriately provided on an outpatient basis such as certain surgical procedures, which can include anesthesia, recovery room services, ambulatory surgical centers and Hospital outpatient surgical centers.
- Physician services, including office visits, Hospital visits, consultations, and interpretation of tests.

Exclusions:

- Physical examinations or testing, vaccinations, immunizations or treatments strictly for the purposes of employment, insurance or government licenses, pilot licensing, and court-ordered forensic or custodial evaluations.
- Charges for completion of insurance Claim forms, specialty reports, and physical exam forms.
- Origination site fees and technical component fees associated with telehealth.

PKU or any other Amino and Organic Acid Inherited Disease Formula/Food

Coverage is provided for formula and/or food used for PKU or any other amino and organic acid inherited disease that is recommended by a Provider as determined by the Plan to be Medically Necessary.

Limitation:

Enteral pumps and supplies will be covered only when the above criteria are met.

Exclusion:

The cost of outpatient Enteral tube feedings or formula and supplies are not covered except when used for PKU or any other amino and organic acid inherited disease, except as defined as a Covered Service, regardless of whether it is the sole source of nutrition.

Preventive Services

If received from a Participating Provider, Coverage for the following services will be

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provided at in a manner consistent with Section 2713 of Federal H.R. 3590. Coverage for these services will be provided once annually, unless otherwise specified below:

- Items or services with an “A” or “B” rating from the United States Preventive Services Task Force;
- Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control Prevention (ACIP-CDC);
- Preventive care and screenings for infants, children, and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration;
- Additional preventive care and screenings for women (including pap smears, breast cancer screening, mammography screenings, and osteoporosis screenings) not described in the first bullet; and
- Prostate cancer screening for men age forty (40) and older.

A complete list of the covered preventive services, including any age limitations, is available on Our website at [www.chckansas.com] or will be mailed to You upon request. You may request the list by calling the Customer Services number on Your ID card.

Please note:

- A preventive care service is designed to prevent or detect an illness, disease, or condition before the occurrence of the condition. This can include office visits, patient education, immunizations, and diagnostic testing. Preventive care services are performed before a disease is diagnosed and in the absence of symptoms. Services that are related to or in follow-up of an established illness, disease, condition and/or for a symptom are not part of a preventive care service.
- If a covered preventive service is provided during an office visit, it must either be billed separately from the office visit or be the primary purpose of the office visit in order to be covered under this benefit. If the preventive service is not billed separately and the primary purpose of the visit is not to provide the preventive service, then the applicable Copayments, Coinsurance and/or Deductible will apply to the office visit.

In order to receive the Network level of benefits, You should visit Your family Physician or a Participating OB/GYN specialist for the annual well-woman exam or may visit a Participating urologist for the annual well-man exam. You may also visit another provider and receive the Non-Network level of benefits.

Exclusions:

- Physical examinations or testing, vaccinations, immunizations or treatments strictly for the purposes of employment, insurance or government licenses, pilot licensing, and court-ordered forensic or custodial evaluations.
- Charges for completion of insurance Claim forms, specialty reports, and physical exam forms.
- Costs associated with immunizations for travel.

Prosthetic Devices

Prosthetic devices aid body functioning or replace a limb or body part and can be either internally or externally placed. Coverage is provided for the purchase of prosthetic devices following the onset or initial diagnosis of the condition for which the device is required. For prosthetic device placements requiring a temporary and then a permanent

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placement only one (1) temporary device will be Covered. Coverage is provided for prosthetic devices, including but not limited to, purchase of artificial limbs, bone anchored hearing aids, breasts, cochlear implants, and eyes, which meet the minimum requirements or specifications which are Medically Necessary for treatment, limited to the basic functional device which will restore the lost body function or part. Coverage is provided for external prosthetic devices that are used in lieu of surgery for breast reconstruction due to a mastectomy.

Coverage will be provided for replacement of prosthetic devices, which become non-functional and non-repairable due to: (1) A change in Your physiological condition; (2) Irreparable wear or deterioration from day-to-day usage over time of the device; or (3) The condition of the device requires repairs and the cost of such repairs would be greater than the cost of a replacement device. Prosthetics will be replaced for documented growth in a Dependent child requiring replacement.

Polishing and resurfacing of eye prosthetics are Covered on a yearly basis.

Exclusions:

- Those repairs or replacement costs for any otherwise Covered device, including replacement for changes due to obesity.
- Routine maintenance due to normal wear and tear or negligence of items You own.
- Electronic or computerized prosthetic limbs.
- Eyeglasses and contact lenses, except as described as a Covered Service.
- Hearing aids, except as above; digital and programmable hearing devices; hair pieces, prosthesis and styling; dental plates, bridges, braces, or any dental prostheses.

Reconstructive Surgery

Reconstructive procedures are those services that are performed when the primary purpose of the procedure is either to treat a medical condition or to improve or restore physiologic function for an organ or body part. Procedures and services which are related to psychological consequences or socially avoidant behavior as a result of injury, illness or congenital or developmental anomaly do not classify surgery or other procedures as a reconstructive procedure.

Coverage is provided for reconstructive treatment or surgery only under the following circumstances:

- Correction or repair of an accidental injury even if a cosmetic effect occurs.
- Correction or repair of a body part to improve/restore impairments of bodily function resulting from disease, injury, or previous therapeutic processes.
- Correction or repair of congenital abnormalities and hereditary complications or conditions are limited to:
 - Improving/restoring impairments of bodily function such as cleft lip or palate;
 - Birthmarks on head or neck;
 - Webbed fingers or toes; and
 - Supernumerary digits or toes.
- Removal of leaking breast implants, not including implant replacement.
- Services required by the Women's Health and Cancer Rights Act of 1998, including breast prostheses and treatment of complications, are provided in the same manner and at the same level as those for any other Covered Service and will be provided in a manner determined in consultation with You and the treating Physician

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including:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses and physical complications from all stages of the mastectomy, including lymphedema; and
- Two (2) bras per Benefit Period will also be covered following the mastectomy.

Exclusions:

- Elective or voluntary enhancement procedures, services, or medications for sexual performance, athletic performance, cosmetic purposes, anti-aging, or mental performance including, but not limited to: Botox, Restylane, growth hormone, testosterone, hair removal or hair transplant.
- Cosmetic therapies or surgical procedures primarily to restore or alter the appearance including, but not limited to: surgical excision or reformation of any sagging skin on any part of the body such as eyelids, face, neck, abdomen, arms, legs or buttocks; alabrasion; chemosurgery; laser surgery or other skin abrasion procedures related to removal of scars, tattoos, or actinic/acne changes.
- Services performed in connection with the enlargement, reduction, implantation or change in appearance of a portion of the body such as breasts, face, lips, jaw, chin, nose, ears or genitals (i.e. labia reduction).
- Treatment of gynecomastia.

Rehabilitation Services and Supplies

Rehabilitative services are designed to restore normal physical functions following injuries, surgeries, or acute medical conditions and are Covered when they are expected to resulting significant improvement in the patient's condition.

Services include physical, occupational, speech therapies, spinal manipulations, and cardiac and pulmonary rehabilitation. Authorization or referral may be required, please review the Prior Authorization list at the end of this document.

Spinal manipulation services are covered for the manual treatment used to influence joint and neurophysiological function.

Limitation:

Rehabilitation services are covered only if they are expected to result in significant improvement in Your condition. The Plan will determine whether significant improvement has, or is likely to occur based on the medical information received from Your Physician.

Exclusions:

- Therapy in which the goal is maintenance, rather than significant improvement.
- Convalescent or custodial care.
- Vocational rehabilitation including, but not limited to, employment counseling and training.
- Cognitive therapy including, but not limited to: behavioral training, educational testing and therapy, dyslexia testing and treatment, learning disabilities and/or mental retardation testing and treatment.
- Developmental therapy, unless a congenital condition is the underlying cause for the delay.
- Athletic evaluation and training.
- Services that federal or state laws require be made available through a child's

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school district pursuant to an Individual Education Plan (IEP).

- Speech therapy or voice training when prescribed for stuttering or hoarseness.
- Spinal treatment to treat a condition unrelated to alignment of the vertebral column.

Therapeutic Injections and IV Infusions

Therapeutic injections and IV infusions are those prescription medications given by injection or IV infusion (specifically excluding blood) by a duly-licensed Provider or injected by the individual. Coverage is provided for Injectable and Self-Injectable medications when FDA-approved, medically appropriate subject to the Plan's formulary list and substitute Coverage by therapeutically interchangeable drugs, according to clinical guidelines used by the Plan.

Limitation:

Growth hormone therapy is only covered for those individuals under 18 years of age who meet the criteria for Coverage and who have been appropriately diagnosed with a growth hormone deficiency or pituitary disorder according to clinical guidelines used by the Plan.

Exclusions:

- Any drug, medicine or medication prescribed in doses exceeding the manufacturer-recommended maximum dose documented in the package insert that is approved by the FDA. This exclusion shall not apply to a drug, medicine or medication dose that is referenced in one of the standard reference compendia or in generally accepted peer-reviewed medical literature.
- Self-Injectable Prescription Drugs are drugs that are commonly and customarily administered by the individual according to clinical guidelines used by the Plan. Any Self-Injectable medication that is covered by a pharmacy Rider is excluded from the medical benefit.

Transplants

Services related to Medically Necessary organ transplants are Covered when approved by the Plan, performed at a Designated Transplant Network Facility and You are the recipient.

[Donor screening tests are Covered when performed at a Designated Transplant Network Facility.

If not Covered by any other source, the cost of any care, including complications up to 90 days, arising from an organ donation by a non-participant when You are the recipient will be Covered for the duration of Your Agreement when approved by the Plan.]

Coverage shall include the treatment of breast cancer by autologous bone marrow transplants or stem cell transplants when performed pursuant to nationally accepted peer review protocols utilized by breast cancer treatment centers experienced in autologous bone marrow transplants or stem cell transplants.

[If You reside more than [fifty (50) - one hundred-fifty (150)] miles from the transplant facility, reimbursement for travel will be Covered.] [Travel expenses may include the lodging for You and a companion.] Lodging and meal costs incurred by You and a companion [is Covered in accordance with the Plan's utilization policy and procedure.][for a period beginning twenty-four (24) hours prior to admission for the transplant procedure and forty-eight (48) hours after Your discharge are also covered. Lodging and meal costs are subject to a [\$100-\$250] per day limitation. Transportation,

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lodging and meal costs shall not exceed a maximum benefit of [\$2,000 - \$5,000] per transplant.]

Exclusions:

- Any associated expenses, including complications, arising from an organ donation when You are the donor [and the recipient is not Covered under the Plan].
- Any associated expenses involving temporary or permanent mechanical or animal organs.
- Reimbursement for organ harvesting.

Urgent Care Services

A condition that requires urgent care is an unexpected illness or injury that is not life-threatening but requires prompt medical attention. Examples of urgent care conditions include sprains, lacerations and severe abdominal pain.

Vision Services

Coverage is provided for eye examination including medical history; evaluation of visual acuity; external examination of the eye; binocular measure; ophthalmoscopic examination; medication for dilating pupils and desensitizing the eyes for tonometry; summary and findings, a determination as to the need for correction of visual acuity, prescribing lenses, if needed.

Exclusions:

- Corrective contact lens fitting.
- Surgical treatment for the correction of a refractive error, including but not limited to: radial keratotomy, LASIK, or refractive lensectomy with intraocular lens implant.
- Other vision care services, including but not limited to: visual analysis testing, vision therapy, training related to muscular imbalance of the eye or eye exercises.
- Vision hardware (i.e. frames) unless covered under a Vision Rider.

The following items are excluded from Coverage:

- Any service or supply that is provided by a Provider **not** in accordance with the Plan's utilization management policies and procedures, except that Emergency Services shall be Covered in accordance with the terms and conditions set forth in this Agreement.
- Any service or supply that is not Medically Necessary.
- Any service or supply that is not a Covered Service or that is directly or indirectly a result of receiving a non-Covered Service and subsequent complications which may occur.
- Procedures and treatments that the Plan determines and defines to be Experimental or Investigational.
- Court-ordered services including forensic or custodial evaluations; evaluations and diagnostic tests ordered or requested in connection with criminal or legal actions; damages in any kind of personal injury action, divorce, child custody, paternity, severance of parental rights, or child visitation proceedings; or services that are a condition of probation, parole or diversion agreements.
- Those services otherwise Covered under the Agreement related to a specific condition when You have refused to comply with, or have terminated the scheduled service or treatment against the advice of a Provider.
- Those services otherwise Covered under the Agreement, but rendered after the date Coverage under the Agreement terminates, including services for medical conditions arising prior to the date individual Coverage under the Agreement terminates. This exclusion does not apply to services described in the Inpatient on the Effective Date provision.
- Those services rendered outside the scope of a Participating or Non-Participating Provider's license, rendered by a Provider with the same legal residence as You, or rendered by a person who is a member of Your family, including spouse, brother, sister, parent, stepparent, child or step-child.
- Any portion of a Claim that the Plan determines to be incorrectly or inappropriately billed by a Physician, Facility or Hospital. This includes, but is not limited to: unbundling of procedural services, office visits that take place within a global period, and inappropriate modifier use.

Specifically excluded services include, but are not limited to, the following:

Abortion	Services related to elective abortions unless covered under an attached Rider. An elective abortion is a termination of pregnancy for any reason other than a spontaneous abortion (miscarriage) or to prevent the death of the individual upon whom the abortion is being performed.
Alternative Therapies	All charges related to complementary/alternative medicine including, but not limited to: sensory integrative techniques, music therapy, guided imagery, therapeutic touch, aroma therapy, acupuncture, acupressure, hydro-massage, hypnotherapy, hypnosis, massage therapy, Vax-D therapy, reflexology, cranio-sacral therapy, and therapy for the development of cognitive skills to improve attention, memory or problem solving, including compensatory training.
Apparel	Items of wearing apparel including, but not limited to TENS unit sleeves, except as specified in the Covered Services section.
Augmentative Communication Devices	Devices including but not limited to, those used to assist hearing impaired, or physically or developmentally disabled individuals.
Autopsy	Those services and associated expenses related to the performance of autopsies, unless requested by the Plan, to the extent that payment for such services is, by law, Covered by any governmental agency as a primary plan.
[Biofeedback]	Any expenses related to biofeedback.]

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Chelation Therapy	Chelation therapy except for acute arsenic, gold, mercury or lead poisoning.
Counseling	Expenses related to religious counseling, marital/relationship counseling, vocational or employment counseling, and sex therapy.
Custodial Care	Domiciliary care, convalescent care, residential care, respite care or rest care. This includes care that assists You in the Activities of Daily Living like walking, getting in and out of bed, bathing, dressing, feeding and using the toilet; preparation of special diets and supervision of medication that is usually self-administered whether or not required by a Physician.
Duplicate Benefits	Benefits of this document will not duplicate benefits provided under Federal, State or local laws, regulations or programs. Examples of such programs are: Medicare, CHAMPUS, Tricare and services in any veteran's Facility when the services are eligible for coverage by the government. This document will provide coverage on a primary or secondary basis as required by state or federal law. This exclusion does not apply to Medicaid. This exclusion applies whether or not You choose to waive Your rights to these services.
Eligible Expenses	Any otherwise eligible expenses that exceed the maximum allowance or benefit limit.
Food	Food or food supplements regardless of whether it is the sole source of nutrition except as provided under for in the Covered Services Section.
Foreign travel	Care, treatment or supplies received outside of the U.S. if travel is primarily for the purpose of obtaining medical services.
Fraud	Any service(s) rendered and/or billed by a Provider through intentional misrepresentation of material fact or fraud.
Halfway House	Services rendered or billed by a school or halfway house.
Hair analysis	Those services related to the analysis of hair unless used as a diagnostic tool to determine poisoning.
Health Club Membership	Any costs of enrollment in a health, athletic or similar club.
Household Equipment and Fixtures	Purchase or rental of household equipment including, but not limited to: fitness equipment, air purifiers, central or unit air conditioners, humidifiers, dehumidifiers, water purifiers, hot tubs, hypo-allergenic pillows, pools, power assist chairs, mattresses or waterbeds, car seats, strollers, shower chairs, commodes, breast pumps, bedwetting alarms, prenatal cradles, electronic communication devices, braces and supports needed for employment, and modifications to Your home or vehicle.
Illegal Acts	Injuries incurred while You are in the commission or attempted commission of a felony, except when the injury is the result of You being a victim of domestic violence.
Immunizations	Those immunizations for travel, employment or education unless otherwise Covered

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under the Covered Services Section.

Medical-Legal	Services rendered primarily for the purpose of medical-legal reasons including, but not limited to, a Provider/patient contract to determine and monitor compliance with prescribed drug treatment, or for the purpose of Provider malpractice protection, that lack medical necessity as defined by this document. This does not include monitoring for therapeutic medication levels, which are deemed Medically Necessary.
Military Health Services	Those services for treatment of military service-related disabilities when You are legally entitled to other Coverage and for which facilities are reasonably available to You; or those services for any otherwise Eligible Employee or Dependent who is on active military duty except as required by the Uniformed Services Employment and Reemployment Rights Act.
Miscellaneous Service Charges	Miscellaneous service charges including, but not limited to, consultations performed through use of telephone, fax, or email communication; case management team conferences; consultations with family members; charges for failure to keep a scheduled appointment (unless the scheduled appointment was for a Mental Health service); or any late payment charge.
No Legal Obligation to Pay	Services are excluded for injuries and illnesses for which the Plan has no legal obligation to pay (e.g., free clinics, free government programs, court-ordered care, expenses for which a voluntary contribution is requested) or for that portion of any charge which would not be made but for the availability of benefits from the Plan, or for work-related injuries and illness. Health services and supplies furnished under or as part of a study, grant, or research program.
Non-Medical Ancillary Services	Non-medical ancillary services including, but not limited to: legal services, social rehabilitation, vocational rehabilitation, work reintegration training, work hardening or conditioning, behavioral training, sleep therapy, educational testing, training, or therapy, unless approved by the Plan as part of treatment for severe head injury or stroke, or as specified in the Covered Services section.
Non-Prescription Drugs and Medications	Over-the-counter drugs and medications incidental to outpatient care and Urgent Care Services are excluded unless specifically stated as Covered in the Covered Services Section or as specifically provided in an optional Pharmacy Rider.
Nutritional-Based Therapy	Nutritional-based therapies except for treatment of PKU and for nutritional deficiencies due to short bowel syndrome and HIV. Oral supplements and/or enteral feedings, either by mouth or by tube, are also excluded regardless of whether it is the sole source of nutrition except as provided for under PKU or any other Amino and Organic Acid Inherited Disease Food/Formula.
Nutritional Supplements	Vitamins, minerals, nutritional supplements, medical foods, breast milk and formulas, or special diet foods whether or not required by a Physician except as required to be covered by law.
Obesity Services	Those services and associated expenses for procedures intended primarily for the treatment of obesity and morbid obesity including, but not limited to, gastric bypasses,

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gastric balloons, stomach stapling, jejuna bypasses, wiring of the jaw, removal of excess skin, including pannus, and services of a similar nature. Services and associated expenses for weight loss programs, nutritional supplements, appetite suppressants, and supplies of a similar nature.

Over-the-Counter Supplies

ACE wraps, batteries, elastic supports, finger splints, orthotics, and braces; also over-the-counter (OTC) products not requiring a prescription to be dispensed (e.g., aspirin, antacids, cervical collars and pillows, lumbar-sacral supports, back braces, ankle supports, positioning wedges/pillows, herbal products, oxygen, medicated soaps, food supplements, therabands, and bandages) are excluded unless specifically stated as Covered in the Covered Services Section or as specifically provided in an optional pharmacy Rider.

Pain Management

Costs associated with commercial pain management programs.

Personal Comfort and Convenience

Services or items for the Provider's or Your convenience including items or services such as home laboratory testing, television, telephone, barber or beauty service, guest service and similar incidental services and supplies.

Prescription Drugs and Medications

Prescription and non-prescription drugs and medications that require a prescription and are dispensed at a Pharmacy for outpatient treatment, except as specifically Covered in the Covered Services Section or as specifically provided in an optional pharmacy Rider to the Agreement.

Private Duty Nursing

Private duty nursing services, whether or not required by a Physician; nursing care on a full-time basis in Your home; or home health aides.

Rebating

Any service(s) rendered where You receive monetary or in-kind enticement, incentive, rebate or kickback of any kind from a Provider(s) or agent(s) of a Provider(s).

Replacement Items

Costs associated with the replacement of items that are damaged, lost, or stolen.

Sex Transformation Services

Services and associated expenses for sex transformation operations regardless of any diagnosis of gender role disorientation or psychosexual orientation, including any treatment or studies related to sex transformation. Also excluded is hormonal support for sex transformation.

Sexual Dysfunction

Any device, implant or self-administered prescription medication for the treatment of sexual dysfunction, including erectile dysfunction, impotence and anorgasmy.

Sports Related Services

Those services or devices used specifically as safety items or to affect performance primarily in sports-related activities, and all expenses related to physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation including braces, supports and orthotics.

TMJ and MPDS

Services related to the diagnosis and treatment of temporomandibular joint disease (TMJ) and Myofascial Pain Dysfunction Syndrome (MPDS) unless covered by an attached Rider.

EXCLUSIONS

Third Party Liability	Services for which a third party has liability (by whatever terminology used-including such benefits mandated by law). Note: This exclusion is only applicable in the event that ERISA is held to preempt the anti-subrogation provisions of Missouri law.
[Tobacco Cessation	Those services and supplies for tobacco cessation programs and treatment of nicotine addiction.]
Travel or Transportation Expenses	Transportation, food, and lodging expenses even though prescribed by a Participating Provider, except as specified in the Covered Services Section.
War or act of war	Services received as a result of war or any act of war when You are outside of the continental United States, whether declared or undeclared or caused during service in the armed forces of any country.
Workers compensation	Payment for services or supplies for an illness or injury eligible for, or Covered by, any Federal, State or local Government Workers' Compensation Act, occupational disease law or other legislation of similar program.

ELIGIBILITY, ENROLLMENT AND EFFECTIVE DATES

Eligibility

Employee Eligibility

To be eligible as a Subscriber, You must:

- Be an Eligible Employee of the Group; and
- Complete and submit to the Plan such applications or forms that the Plan may reasonably request.

Dependent Eligibility

To be eligible to be enrolled under this Agreement as a Dependent, an individual must:

- Be the lawful spouse of the Subscriber or be a child of the Subscriber or the Subscriber's spouse including:
 - Children up to their twenty-sixth (26) birthday who are either the birth children of the Subscriber or the Subscriber's spouse or legally adopted by or placed for adoption with the Subscriber or Subscriber's spouse;
 - Children up to their twenty-sixth (26) birthday for whom the Subscriber or the Subscriber's spouse is required to provide health care Coverage pursuant to a Qualified Medical Child Support Order;
 - Children up to their twenty-sixth (26) birthday for whom the Subscriber or the Subscriber's spouse is the court-appointed legal guardian;
 - Coverage will be extended for children age twenty-six (26) who meet the Eligibility requirements, are mentally or physically incapable of earning a living and who are chiefly dependent upon the Subscriber or the Subscriber's Spouse for support and maintenance, provided that: the onset of such incapacity occurred before age twenty-six (26), proof of such incapacity is furnished to the Plan by the Subscriber upon enrollment of the Dependent child or at the onset of the Dependent child's incapacity prior to reaching the limiting age and annually thereafter;

[Notwithstanding the above, a common law spouse qualifies as a spouse under this Agreement only if his or her spousal status is affirmed by a court of competent jurisdiction.]

[Retirees

When eligible under the Agreement, a Retiree or Retiree's spouse who is eligible to be Covered under Medicare (Title XVIII of the Social Security Act as amended) shall enroll in Medicare Part A and B coverage on the later of the date he or she is first eligible for Medicare or the Effective Date of this Agreement in order to be eligible or continue Coverage under this Agreement.]

Change of Group's Eligibility Rules

In order to be eligible for Coverage under this health benefit plan, individuals must meet specific Group eligibility requirements. So long as this Agreement is in effect, any change in the Group's eligibility requirements must be approved in advance by the Plan.

Enrollment

Persons Not Eligible to Enroll

A person who fails to meet the eligibility requirements specified in this Agreement shall not be eligible to enroll or continue enrollment with the Plan for Coverage under this Agreement.

A person whose Coverage under this Agreement was previously terminated due to a violation of a material provision of this Agreement shall not be eligible to enroll with the Plan for Coverage under this Agreement.

ELIGIBILITY, ENROLLMENT AND EFFECTIVE DATES

No person who meets the eligibility requirements will be refused enrollment in the Plan due to a pre-existing health condition, including pregnancy.

Enrollment in the Plan

All individuals meeting the eligibility requirements may enroll with the Plan for Coverage under this Agreement during the Group Enrollment Period or a Special Enrollment Period.

Any new employee may enroll with the Plan for Coverage under this Agreement within thirty-one (31) days after becoming eligible. If the employee fails to submit an Employee Enrollment/Change Form for purposes of enrolling with the Plan for Coverage under this Agreement within thirty-one (31) days after becoming eligible, he or she is not eligible to enroll until the next Group Enrollment Period unless there is a special enrollment.

Eligible Employees or their Dependents who do not enroll during an initial eligibility period, or within thirty-one (31) days of first becoming eligible for Coverage under this Agreement are not eligible to enroll until the next Group Enrollment Period, unless they are eligible to enroll as a special enrollee, as described below.

Late Enrollees

Late Enrollees are not eligible to enroll except during the next Group Enrollment Period, or during a Special Enrollment Period.

Effective Dates

During Group Enrollment Period: An Eligible Employee or Retiree, and their Eligible Dependent(s), who enroll during a Group Enrollment Period shall be Covered under this Agreement as of the date stated therein.

Newly Eligible Employees: An Eligible Employee, including a newly hired employee, and their eligible Dependent(s), shall be Covered under this Agreement as of the date that he or she first becomes eligible for Coverage, according to the terms of the Agreement, so long as the Plan receives the employee's completed Employee Enrollment/Change Form within thirty-one (31) days of becoming eligible for Coverage.

Special Enrollment

[In the case of marriage, not later than the first day of the first month beginning after the completed Employee Enrollment/Change Form is received by the Plan.] [In all other instances,] Coverage shall become effective the day of the qualifying event.

An Employee of a Group and their Dependents who fail to enroll during the Special Dependent Enrollment Period or the Group Enrollment Period will not be permitted to enroll until the next Group Enrollment Period.

Non-Participating Eligible Employee

An Eligible Employee who is eligible but has not yet enrolled may enroll, within thirty-one (31) days from the date of marriage or upon the birth, adoption or placement for adoption of his or her child (even if the child does not enroll). A child who becomes a Dependent of a non-enrolled Eligible Employee as a result of marriage, birth, adoption or placement for adoption may enroll within thirty-one (31) days of that event, but only if the non-enrolled Eligible Employee is eligible for enrollment and enrolls at the same time.

Non-Participating Spouse.

Your Spouse may enroll within thirty-one (31) days of marriage to You, or upon the birth, adoption or placement for adoption of his or her child (even if the new child does not

ELIGIBILITY, ENROLLMENT AND EFFECTIVE DATES

enroll).

Newborn Enrollment

A newborn child born to the Policy Holder or the Policy Holder's Covered Spouse may be Covered for the treatment of Injury or Illness, including medically diagnosed congenital defects, birth abnormalities, prematurity and routine nursery care, for the first five (5) days from the date of birth or until the mother is discharged, whichever is earlier. For Coverage to continue beyond the first five (5) days, an Application agreement to enroll the newborn must be received within ninety (90) days from the date of birth, and subject to all eligibility requirements.

New Dependents Due to Adoption

A child who becomes a Dependent as a result of adoption or placement for adoption, may enroll within sixty (60) days from the date of adoption or placement for adoption.

Qualified Medical Child Support Order (QMCSO)

Dependents eligible for Coverage as a result of a Qualified Medical Child Support Order (QMCSO) shall be Covered as of the date specified in the order or the date on which the Plan qualifies the order, whichever is earlier. The Group and the Plan, pursuant to specifications of federal and state law, must qualify Medical Child Support Orders. The procedures for qualification require the Subscriber to timely submit the Medical Child Support Order to the Group for initial qualification or rejection. The Group will forward the order to the Plan for qualification or rejection. The Plan shall provide notice of the decision to all parties identified in the order. If the order is qualified, an Identification Card and COC will be issued to the Alternate Recipient. In addition, a Subscriber, a state agency, or an Alternate Recipient may enroll a Dependent child pursuant to the terms of a valid QMCSO. A child who is eligible for Coverage pursuant to a QMCSO may not enroll Dependents for Coverage under the Plan.

Dependent Coverage under the Plan is subject to payment of the required contribution by the Subscriber, if any contribution is required. In the case of a child who is eligible for Coverage pursuant to a QMCSO, payment of the required contribution is to be made for such child, by the custodial parent or legal guardian of such child, or by a state agency. The Plan will notify the Group of the amount of the required total Premium payable to the Plan. Upon agreement by the Plan and the Group, the parties may change the required Premium contribution of Subscribers.

Enrollment Pursuant to Termination of Medicaid or SCHIP Coverage

Subject to the conditions set forth below, an employee who is eligible but not enrolled, or the Dependents of such Eligible Employee, if eligible but not enrolled, may enroll in this Plan if either of the following two conditions is satisfied.

Termination of Medicaid or SCHIP Coverage: The Eligible Employee or Dependent may enroll if the Eligible Employee or Dependent is covered under a Medicaid plan under Title XIX of the Social Security Act, or under the State Children's Health Insurance Program (SCHIP) under Title XXI of the Social Security Act, and coverage of the Eligible Employee or Dependent under either the Medicaid or SCHIP plan is terminated as a result of loss of eligibility under such plan.

Eligibility for Employment Assistance Under Medicaid or SCHIP: The Eligible Employee or Dependent may enroll if the Eligible Employee or Dependent becomes eligible for premium or other assistance with respect to coverage under this Health Plan, pursuant to a Medicaid plan or SCHIP plan (including any waiver or demonstration product conducted under or related to such Medicaid or SCHIP plan).

ELIGIBILITY, ENROLLMENT AND EFFECTIVE DATES

Required Length of Special Enrollment Notification: An Eligible Employee and/or his or her Dependents must request special enrollment in writing no later than sixty (60) days from the date of termination of the Medicaid/SCHIP eligibility or the date the Eligible Employee or Dependent is determined to be eligible for the premium assistance.

Effective Date of Coverage: Coverage shall become effective on the first day of the month following the month in which the Plan received the request for Special Enrollment.

Notification of Change in Status

A Covered employee must notify the Plan of any changes in status or the status of any Dependent within thirty-one (31) days after the date of the qualifying event. This notification must be submitted on a written Employee Enrollment/Change Form to the Plan. Events qualifying as a change in status include, but are not limited to, changes in address, employment, divorce, marriage, dependency status, Medicare eligibility or coverage by another payer. The Plan should be notified within a reasonable time of the death of any Covered individual. Termination of the COC shall be without prejudice to any continuous loss which commenced while the COC was in force, but the extension of benefits beyond the period the COC was in force may be predicated upon the continuous injury or illness of the insured, limited to discharge or replacement of the COC.

Inpatient on the Effective Date

If You are Covered under an extension of benefits provision pursuant to state law or from a prior plan, services or supplies that are Covered, or required to be Covered, under an extension of benefits provision under the prior plan will be Covered under this Agreement subject to the Agreement's Coordination of Benefits Section.

TERMINATION OF COVERAGE

Termination of Coverage	Your Coverage shall terminate, upon the date specified by the Group, if any one of the following events occurs:
<i>Loss of Eligibility</i>	You no longer meet the eligibility requirements set forth in this Agreement; provided, however that this requirement may not apply to a Dependent child of a Subscriber, when Coverage is required to comply with a QMCSO. Loss of eligibility may also occur upon termination of the Subscriber from Employment; Your entering active military service; divorce or legal separation from the Subscriber; or when a Dependent child reaches the limiting age.
<i>Retire</i>	You are retired or pensioned, unless the Employer has included Retirees or those pensioned as eligible as referenced in this Agreement.
<i>Death</i>	The death of the Subscriber. Coverage for Dependents will terminate on the last day of the period for which payments have been made by or on behalf of the Subscriber, subject to the Continuation of Coverage section of this document.
<i>Non-Payment</i>	You fail to pay premiums required for Hospital or medical services. NOTE: In the event that the Plan has not received payment of premium at the end of the thirty-one (31) days notice period (and any grace period, if applicable), You will be retroactively terminated to the date Covered by Your last paid premium. You will be responsible for the value of services rendered during the thirty-one (31) days notice period (and any grace period, if applicable).
<i>Non-Compliance</i>	You fail to pay supplemental charges. You may have Your Coverage terminated for nonpayment of Copayments, Deductible and/or Coinsurance to the Provider under the following conditions: (1) the Provider has initiated collection efforts within sixty (60) days after the Plan is notified that copayment is due; and (2) the enrollee has received written notice from the Plan stating the disenrollment will occur unless arrangements for payment of the Copayments, Deductible and/or Coinsurance are made within [ten (10) working days, thirty-one (31) days] after receipt of the notice.
<i>Misrepresentation</i>	You abuse services or facilities. You may have Your Coverage restricted or canceled by the Plan in the event You abuse services or facilities. Knowingly misrepresenting or giving false information on any enrollment application form which is material to the Plan's acceptance of such application. The validity of the policy shall not be contested, except for non-payment of premiums, after the Plan has been in force for two years from the date of issue, and no initial statement You make regarding insurability shall be used as a reason for disenrollment after the Plan has been in force for two years from the date of issue.
<i>Criminal Behavior</i>	You participate in criminal behavior, including but not limited to threatening or perpetrating violent acts against the Plan, a Provider, or an employee of the Plan or a Provider. In this instance, Coverage for the Subscriber and all Dependents will be terminated.
Termination of Coverage without Notice	Your Coverage shall immediately terminate if any one of the following events occurs: <ul style="list-style-type: none">▪ Termination or non-renewal of the Agreement by the Group.▪ The Plan receives written notice from the Group instructing the Plan to terminate Your Coverage.▪ You select alternative Coverage in a health benefit plan offered by the Group.▪ You participate in fraudulent or criminal behavior, including but not limited to:<ul style="list-style-type: none">• Performing an act or practice that constitutes fraud or intentionally misrepresenting material facts including using Your identification card to obtain goods or services which are not prescribed or ordered for You or to which You

TERMINATION OF COVERAGE

are otherwise not legally entitled. In this instance, Coverage for the Subscriber and all Dependents will be terminated.

- Allowing any other person to use Your identification card to obtain services. If a Dependent allows any other person to use his/her identification card to obtain services, the Coverage of the Dependent who allowed the misuse of the card will be terminated. If the Subscriber allows any other person to use his/her identification card to obtain services, the Coverage of the Subscriber and his/her Dependents will be terminated.

Effect of Termination

If Your Coverage under this Agreement is terminated under this Section, all rights to receive Covered Services shall cease as of the date of termination.

Identification cards are the property of the Plan and, upon request, shall be returned to Us within thirty-one (31) days of the termination of Your Coverage. Identification cards are for purposes of identification only and do not guarantee eligibility to receive Covered Services.

Your Coverage cannot be terminated on the basis of the status of Your health or the exercise of Your rights under the Plan's Claims and Appeal procedures. The Plan may not terminate an Agreement solely for the purpose of effecting the disenrollment of an individual for either of these reasons.

Any monthly payments received on Your behalf for Coverage beyond the effective date of termination will be refunded by the Plan. In addition, the Plan may recover the contracted charges for Covered Services received after the termination of Coverage from You or the Provider, plus its cost to recover such charges, including attorneys' fees.

Under certain circumstances, You may be eligible for continuation of Coverage benefits or to convert to another policy as described in the Continuation of Coverage Section.

Discontinuation of Coverage

If the Plan decides to discontinue offering Coverage under the Agreement, You will receive a written notice of discontinuation at least ninety (90) days before the date the Coverage will be discontinued. Your Group will be offered the opportunity, on a guaranteed issue basis, to purchase for You any other coverage offered by the Plan. If the Plan elects to discontinue offering all health insurance coverage in the group market, You will receive a written notice of discontinuation at least one hundred and eighty (180) days before the date the coverage will be discontinued.

Certificates of Creditable Coverage

At the time coverage terminates, You are entitled to receive a certificate verifying the type of coverage, the date of any waiting periods, and the date any Creditable Coverage began and ended.

CONTINUATION OF COVERAGE/CONVERSION

In some cases, You can choose to continue group Coverage for a period of time. In such a case, conversion coverage would be available after group Coverage ends.

Continuation Coverage under Arkansas State Law

You are entitled to continue Your Hospital, surgical or major medical coverage under the Group Policy, including coverage for Your eligible dependents, if such coverage would otherwise terminate because employment or membership ends. Such continuation is subject to the following terms and conditions:

- You have been Covered for at least a three (3) month period before termination;
- You were not terminated for cause as permitted by the group master contract;
- The discontinued group Coverage was not replaced with similar group Coverage within thirty-one (31) days;
- You are not and do not become eligible for Medicare Coverage; and
- You are not eligible for any other Hospital, Physician and/or major medical Coverage for individuals in a group.

Continuation need not include dental, vision care or prescription drug benefits or any other Benefits provided under this Policy in addition to its Hospital, surgical or major medical Benefits, but continuation must include maternity Benefits if those Benefits are provided under the Group Policy.

Notification Requirements and Election Period

You do both of the following within ten (10) days of the date coverage would otherwise terminate:

- Request such continuation in writing.
- Pay the Employer Group, on a monthly basis, the amount of contribution required to continue coverage. Such Premium contribution shall not be more than the Group rate of the insurance being continued on the due date of each payment; but, if any Benefits are omitted (such as dental, vision care, and prescription drug), such Premium contribution shall be reduced accordingly.

The Enrolling Group must notify You, in writing, of its duties under this subdivision not later than the date on which coverage would otherwise terminate.

Terminating Events for Continuation Coverage Under Arkansas State Law

Continuation coverage under this Policy will end on the earliest of the following dates:

- The date four (4) months after the date Your Coverage under this COC would have terminated because of termination of employment;
- If You fail to make timely payment of a required Premium contribution, the end of the period for which contributions were made;
- The date this COC is terminated or, in the case of a Subscriber, the date the Employer Group terminates participation under the Agreement. However, if the Coverage ceasing by reason of termination is replaced by similar coverage under another Group Agreement, then You shall have the right to become covered under that other policy for the balance of the period that:
 - You would have remained covered under this COC in accordance with the conditions of this section;
 - The minimum level of Benefits to be provided by the other Agreement shall be the applicable level of Benefits of the prior policy reduced by any Benefits payable under that prior policy; and
 - The prior Group Agreement shall continue to provide Benefits to the extent of its accrued liabilities and extensions of benefits as if the replacement had not occurred.

CONTINUATION OF COVERAGE/CONVERSION

Individual Conversion Coverage

If Your coverage terminates for one of the reasons described below, You may apply for conversion coverage without furnishing evidence of insurability.

- Reasons for termination:
- The Subscriber is retired or pensioned;
- You cease to be eligible as a Subscriber or Enrolled Dependent;
- Continuation coverage ends;
- The entire Agreement ends and is not replaced.

A converted Policy need not be made available if termination occurred for any of the following reasons:

- You failed to make timely payment of any required contribution, or were terminated for Fraud or Misrepresentation;
- The Group Agreement terminated or a Group's participation terminated, and the insurance is replaced by similar coverage under another Agreement within thirty-one (31) days of the date of termination.

Application and payment of the initial Premium must be made within thirty (30) days after coverage ends under this COC. Conversion coverage will be issued in accordance with the terms and conditions in effect at the time of application. Conversion coverage may be substantially different from coverage provided under this policy.

The converted policy shall cover You and Your dependents who were covered by this COC on the date of termination of insurance. At the option of the Plan, a separate converted policy may be issued to cover any Dependent.

We are not required to issue a converted Policy covering any person if such person is or could be covered by Medicare. Furthermore, We shall not be required to issue a converted Policy covering any person if:

- Such person is or could be covered for similar benefits by another policy; such person is or could be covered for similar Benefits under any arrangement of coverage for individuals in a Group, whether insured or uninsured; or similar benefits are provided for or available to such person, by reasons of state or Federal law; and

The benefits under sources of the kind referred to above for such person, or benefits provided or available under sources of the kind referred to above for such person, together with the converted policy's benefits would result in over-insurance according to the insurer's standards for over-insurance.

CLAIMS AND APPEAL PROCEDURES

You may occasionally encounter situations where the performance of the Plan does not meet expectations. When this occurs, You or Your Authorized Representative may call or write the Plan to file a complaint or an appeal. We will provide You a full and fair review of Claims decisions and Appeal decisions as required under ERISA. If You receive Your health benefits coverage through any arrangement that is not subject to ERISA, You have the same Claims and Appeal rights as a matter of contract. Please note that benefits are paid only if the services provided are Medically Necessary and are Covered Services under this Agreement.

Definitions

Administrative Appeal

For the purposes of this section, the following terms and their definitions will apply:

An Appeal of a decision that has not been issued for medical necessity or medical appropriateness, but is administrative in nature, for example, appealing a Copayment, Coinsurance, or exclusion associated with a Covered Service.

Adverse Benefit Determination

A denial of a request for service or a failure to provide or make payment in whole or in part for a benefit. An Adverse Benefit Determination may be based in whole or in part on a medical judgment and may also include:

- Any reduction or termination of a benefit;
- The failure to cover services because they are determined to be Experimental or Investigational;
- The failure to cover services because they are determined to not be Medically Necessary or medically appropriate;
- The failure to cover services because they are cosmetic;
- The failure, reduction, or termination regarding the availability and/or delivery of health care services;
- The failure, reduction, or termination regarding claims payment, handling or reimbursement for health care services;
- The failure, reduction, or termination regarding terms of the contractual relationship between You and the Plan; and/or
- Rescission of coverage.

Appeal

An Appeal is a request by You or Your Authorized Representative for consideration of an Adverse Benefit Determination of a service request or benefit that You believe You are entitled to receive.

Claim for Benefits or Claim(s)

A request for a service or payment of a service You make in accordance with the Plan's procedure for filing Claims. A Claim includes urgent care Claims, Pre-Service Claims and Post-Service Claims. A Claim must have sufficient information upon which to base a decision regarding benefits according to all of the provisions of this document.

Claim Eligible for External Review

(1) In the case other than an Emergency Medical Condition, a Claim for a proposed or delivered health care service which would otherwise be covered under this Certificate but for which You have received an Adverse Decision following a second level Appeal due to the fact that the service is not or was not Medically Necessary, or the health care treatment has been determined by the Plan to be Experimental or Investigational, and the denial leaves You with a financial obligation or prevents You from receiving the requested services, or (2) in case of an Emergency Medical Condition, a Claim for which an initial Adverse Decision by the Plan that a proposed health care service, which would otherwise be covered under this Certificate, is not Medically Necessary or the health care treatment has been determined by the Plan to be Experimental or Investigational and the denial would leave You with a financial obligation or prevent You from receiving the requested service.

Complaint

Any dissatisfaction expressed by You or Your Authorized Representative regarding a Plan issue.

CLAIMS AND APPEAL PROCEDURES

<i>Expedited Appeal</i>	An Appeal that may be requested either orally or in writing if You feel Your condition requires Urgent Care.
<i>External Review</i>	The review of an Adverse Decision by an external review organization, which conducts independent External Reviews of Adverse Decisions pursuant to a contract with the Department of Insurance.
<i>Inquiry</i>	Any question from You or Your Authorized Representative that is not a Pre-Service Appeal, a Post-Service Appeal or an Urgent Care Appeal, or Complaint.
<i>Medical Necessity Appeal</i>	An Appeal of a determination by the Plan or its designated utilization review organization that is based in whole or in part on a medical judgment that includes an admission, availability of care, continued stay or other service which has been reviewed and, based on the information provided, does not meet the Plan's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness and payment for the service is denied, reduced or terminated
<i>Post-Service Appeal</i>	An appeal for which an Adverse Benefit Determination has been rendered for a service that has already been provided.
<i>Pre-Service Appeal</i>	An appeal for which an Adverse Benefit Determination has been rendered for a service that has not yet been provided and requires Prior Authorization. Routine inquiries about Coverage information do not constitute Pre-Service Claims.
<i>Urgent Care</i>	Care for a condition when a delay in receiving such care could seriously jeopardize Your life or health or Your ability to regain maximum function or, in the opinion of a Physician with knowledge of Your condition, would subject You to severe pain that could not be adequately managed without care or treatment that is the subject of the Claim. In determining whether a Claim involves urgent care, the Plan must apply the judgment of a prudent layperson who possesses an average knowledge of health and medicine. However, if a Physician with knowledge of Your medical condition determines a Claim involves urgent care, the Claim must be treated as an Urgent Care Claim.
<i>Urgent Care Appeal</i>	An Appeal for which a requested service requires prior authorization, an Adverse Benefit Determination has been rendered, the requested service has not been provided, and the application of non-urgent care Appeal time frames could seriously jeopardize: (a) the life or health of You or Your unborn child; or (b) Your ability to regain maximum function. In determining whether an Appeal involves urgent care, the Plan must apply the judgment of a prudent layperson who possesses an average knowledge of health and medicine.
<i>Urgent Care Claim</i>	A request for a Claims decision regarding Urgent Care.

Complaints

A Complaint is a verbal expression of dissatisfaction that may be resolved on an informal basis. Complaints may be expressed by telephone or in person and are handled by Our Customer Service Department. The Customer Service Department may involve one or more staff members of the Plan or Providers of health care before making a determination. The objective is to review all the facts and to handle the Complaint as quickly and as courteously as possible.

Written Complaints will be acknowledged in writing by the Plan within five (5) working days after receipt of the Complaint. The Plan will conduct an investigation within twenty (20) working days after receipt of the respective Complaint, unless the investigation cannot be completed within this time. If the investigation cannot be completed within the 20-day timeframe, You will be notified in writing by the 20th working day of the specific reasons for the delay, and the investigation will be completed within 30 working days thereafter. You will be notified of the resolution within five (5) working days after the

CLAIMS AND APPEAL PROCEDURES

investigation of the respective Complaint is completed. Within fifteen (15) working days after the investigation of the respective Complaint is completed, the person, if other than You, who submitted the Complaint will be notified.

The address and telephone numbers for Complaints are:

[P.O. Box 7109
London, KY 40742
Telephone: (800) 969-3343]

Process for Submitting an Appeal

You or Your Authorized Representative has the right to obtain, without charge, copies of the documents, relating to the Adverse Decision, including the name of the utilization review organization used to review the Claim and may Appeal an Adverse Decision from an initial Claims decision by:

- submitting the Appeal in writing to [8320 Ward Parkway, Kansas City, MO 64114] to the attention of the appeals committee;
- sending a fax to [816-769-2408]; or
- [sending an e-mail to][KCCompliance@cvty.com].

If You believe Your health would be seriously harmed by waiting for a decision under the standard timeframes set forth below, You may make an oral request for an Expedited Appeal by calling the Customer Services Department at the number on Your ID card.

Appeals should include:

- Your name and ID number.
- Specific information relating to and reason for the Appeal.
- Your expectation for resolution.
- Copies of medical records or other documentation that You wish to be considered in the Appeal.

All levels of the appeals process will be handled by individuals not involved in a previous determination. Appeals involving clinical issues will be reviewed by a practitioner in the same or a similar specialty that typically manages the medical condition, procedure or treatment in question. If time permits, You may be referred for a second opinion.

Appeal of Adverse Decisions

A decision on the Appeal will be made as quickly as the situation demands but in no event later than the time frames set forth below:

Action	Urgent Care Claim	Pre-Service Claim	Post-Service Claim
Time to File Appeal (from the date of the receipt of notification of the initial Adverse Decision)	180 days	180 days	180 days
Appeal Decision (from the date the Appeal is received by the Plan)	36 hours*	15 days*	20 working days*

*The time frames listed are those required by ERISA. You may voluntarily agree to provide the Plan additional time within which to make a decision.

In the case of an Urgent Care Appeal, You and/or Your Authorized Representative will

CLAIMS AND APPEAL PROCEDURES

be notified verbally and will be provided a follow-up written notice within 36 hours of receipt of the First Level Appeal request.

You will be notified in writing within five (5) working days of receipt of the Appeal request. We will complete Our investigation and will notify You of the resolution within five (5) working days after the respective Appeal is completed. Within fifteen (15) working days after the investigation of the respective Appeal is completed, the person, if other than You, who submitted the Appeal will be notified.

Right to Waive a Second Level of Appeal

If You have received an Adverse Decision following a first level Appeal due to the fact that the service is not or was not Medically Necessary, or the health care treatment has been determined by the Plan to be Experimental or Investigational, and the denial leaves You with a financial obligation or prevents You from receiving the requested services, You may voluntarily waive Your right to the Second Level Appeal and proceed directly to pursuing an External Review. You must notify the Plan in writing of Your decision to waive Your Second Level Appeal. By waiving Your Second Level Appeal, You exhaust all available internal appeal procedures.

Procedure for Pursuing an External Review

Participants of Arkansas-based revenue groups will have the right to request an External Review from the Arkansas Insurance Department. You have the right to request an External Review after a final Adverse Decision has been rendered, or when You have not received a final Adverse Decision within sixty (60) days of seeking such review, unless the delay was requested by You for eligible Claims as defined in the Claims Eligible for External Review section. We will notify You in writing regarding a final Adverse Decision and of the opportunity to request an External Review.

Within one-hundred twenty (120) days of receipt of the notice of the final Adverse Decision, You, the treating Provider acting on Your behalf with written authorization from You, or Your legally authorized designee, must make a written request for an External Review to [Us] [the Arkansas Insurance Department].

[For the purpose of pursuing an External Review, the definition of Emergency Medical Condition includes the following: 1) A medical condition where the timeframe for completion of a standard external review would seriously jeopardize Your ability to regain maximum function; or 2) A medical condition for which coverage has been denied on a determination that the recommended or requested health care service or treatment is experimental or investigational, if Your treating physician certifies, in writing, that the recommended or requested health care service or treatment for the medical condition would be significantly less effective if not promptly initiated.]

The right to External Review shall not be construed to change the terms of Coverage under this document. In no event shall more than one (1) External Review be available during the same year for any request arising out of the same set of facts. You may not pursue, either concurrently or sequentially, an External Review under both state and federal law. You shall have the option of designating which External Review process will be utilized. [The decision of the external review organization may be reviewed directly by the district court at the request of either You or the Plan. The review by the district court shall be de novo.]

If We fail to strictly adhere to all internal appeal procedure requirements as prescribed

CLAIMS AND APPEAL PROCEDURES

by state or federal law, You shall be deemed to have exhausted the internal claims and appeals process regardless of whether We assert Our substantial compliance with the appeal procedure or any error We committed was minimal.

You may contact your respective the Insurance Department at anytime by mail or telephone: Arkansas Department of Insurance, 1200 West Third Street, Little Rock, AR 72201, (501) 371 2600 or (800) 282-9134, and fax at (501) 371-2618, or via email at Insurance.Consumers@arkansas.gov.

ERISA Rights

If You are a participant or beneficiary of an employee welfare benefit plan under ERISA, You may have the right to bring a civil action under ERISA Section 502(a). Please see the Employer-sponsored benefit plan's Summary Plan Document for a complete statement of any ERISA rights You may have.

UTILIZATION REVIEW POLICY AND PROCEDURES

Utilization Review Circumstances

Utilization review is performed under the following circumstances:

Prospective or Pre-Service Review – Conducting utilization review for the purpose of Prior Authorization is called Prospective or Pre-Service Review. Services include, but are not limited to, elective inpatient admission and outpatient surgeries that require Prior Authorization.

Concurrent Care Review – Review that occurs at the time care is rendered. When You are hospitalized or Confined to a Skilled Nursing Facility, concurrent review is conducted on site or by telephone with the utilization review department at each facility.

Retrospective or Post-Service Review – Retrospective or post-service review is utilization review that takes place for medical services that have not been Prior Authorized by the Plan, after the services have been provided.

Toll Free Telephone Number – The toll free telephone number of the utilization review department is listed in the Plan's Schedule of Important Telephone Numbers and Addresses.

Timing of Utilization Review Decisions

The time-frame for making utilization review decisions and notifying You is as follows:

Prospective or Pre-Service Review

Two (2) business days from the date that the Plan receives all necessary information. In the event that the Plan does not receive all necessary information in fourteen (14) calendar days after the request for services, a decision will be made based on the information received. In the case of a determination to certify an admission, procedure or service, the Plan shall notify the provider rendering the service by telephone within twenty-four (24) hours of making the initial certification, and provide You and the Provider written or electronic confirmation of the telephone notification within two (2) working days of making the initial certification.

Concurrent Care Review

Determination regarding an extended stay or additional services will be made within one (1) business day from the date that the Plan receives all necessary information. The service shall be continued without liability to You until You have been notified of the determination. The Plan shall notify by telephone the Provider rendering the service within one (1) working day of making the determination, and provide You and the Provider written or electronic confirmation within one working day after the telephone notification. The written notification shall include the number of extended days or next review date, the new total number of days or services approved, and the date of admission or initiation of services.

Retrospective or Post-Service Review

Thirty (30) calendar days from the date that the Plan receives the request for determination. The Plan shall provide You written notice of determination within ten (10) working days of making the determination.

Notification

In the case of an adverse determination for an initial determination and/or concurrent review determination, the Plan shall notify by telephone the Provider rendering the service within twenty-four (24) hours of making the adverse determination, and provide You and the Provider written or electronic notification within one (1) working day of the telephone notification.

Reconsideration

You have the right to request reconsideration of any adverse determination involving a

UTILIZATION REVIEW POLICY AND PROCEDURES

prospective or pre-service review as well as any concurrent care review determination.

Such reconsideration shall occur within one (1) working day of the receipt of the request and shall be conducted between the Provider rendering the service and the reviewer who made the adverse determination or a clinical peer designated by the reviewer if the reviewer who made the adverse determination is not available within one (1) working day.

Right to Appeal

You also have the right to an expedited or standard Appeal. Please see the Claims and Appeal Procedures Section of this document for the time frames for Appeals. Reconsideration is not a prerequisite to any Appeal.

Denial of Claims

The Plan's Medical Director shall make decisions regarding the denial of Coverage when related to Medical Necessity. Notices of claim denials shall include information regarding the basis of the decision and further Appeal rights.

Technology Assessment

The Plan uses a technology assessment review process to evaluate the appropriate use and Coverage for new medical technologies or new applications of existing technologies, including but not limited to, medical procedures, drugs and drug therapies, and devices.

The process includes review of current published authoritative medical and scientific information pertaining to the proposed technology. Information will be obtained from such sources as, applicable medical and scientific journals, medical databases, specialty medical societies, applicable government publications, the Plan Medical Directors, Pharmacy Department, and specialists, researchers, or institutions that specialize in the condition involved as needed.

The following factors will be considered when evaluating the proposed technology:

- The technology must have final approval from the appropriate regulatory bodies.
- The scientific evidence must permit conclusions concerning the effect of the technology on health outcomes.
- The technology must improve the net health outcome; and must be as beneficial as any established alternatives.

To use a technique before it has been adequately tested and established may pose a risk to Your safety or require the use of substantial resources with no reasonable likelihood of benefit from treatment.

This process has been established to make Our determinations for Coverage based on a scientifically and medically sound process that will appropriately identify and distinguish those procedures, drugs and devices that have not yet been proven to be sufficiently safe and effective.

To prevent exposure to unwarranted risk and ensure the effective use of medical resources, the Plan excludes Coverage for new technology procedures, drugs and devices that are deemed by Us to be Experimental or Investigational.

Case Management

Case management is a program conducted by the Plan that:

- Identifies cases involving a patient in a clinical situation that presents either the

UTILIZATION REVIEW POLICY AND PROCEDURES

potential for catastrophic Claims or a utilization pattern that exceeds the norm.

- Assesses the appropriateness of the level of patient care and the setting in which it is received.
- Develops, introduces and implements viable alternate treatment plans for such cases that maintain or enhance the quality of patient care through discussion and agreement with You or Your legal representative, Provider(s), and the Plan.

This treatment plan may include both Covered Services and Non-Covered Services. Payment of benefits for such services or supplies shall be subject to the terms and provisions of this document.

COORDINATION OF BENEFITS

This coordination of benefits (COB) provision applies when You have health care coverage under more than one plan. "Plan" is defined below. The order of benefit determination rules listed below determine which plan will pay as the primary plan. The primary plan pays first without regard to the possibility that another plan may cover some expenses. A secondary plan pays after the primary plan and may reduce the benefits it pays so that payments from all group plans do not exceed 100% of the Plan's total allowable expense.

COB Definitions

- Plan*
- A "plan" is any of the following that provides benefits or services for medical or dental care or treatment. However, if separate contracts are used to provide coordinated coverage for participants of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.
- "Plan" includes: group insurance, closed panel or other forms of group or group-type coverage (whether insured or uninsured); hospital indemnity benefits in excess of \$200 per day; school accident-type coverage; medical care components of group long-term care contracts, such as skilled nursing care; and Medicare or other governmental benefits, as permitted by law.
 - "Plan" does not include: group or group-type accident only coverage; individual or family insurance; closed panel or other individual coverage; amounts of hospital indemnity insurance of \$200 or less per day; benefits for non-medical components of group long-term care policies; group and individual "no fault" contracts and group or group-type traditional automobile "fault" contracts; Medicare supplement policies, Medicaid policies and coverage under other governmental plans, unless permitted by law.
 - Each contract for coverage is a separate plan. If a plan has two (2) parts and COB rules apply only to one (1) of the two (2), each of the parts is treated as a separate plan.
 - The order of benefit determination rules determine whether this plan is a "primary plan" or "secondary plan" when compared to another plan covering the person.
 - When this plan is primary, its benefits are determined before those on any other plan and without considering any of the other plan's benefits. When this plan is secondary, its benefits are determined after those of another plan and may be reduced because of the primary plan's benefits.

Allowable Expense

- A health care service or expense, including deductibles and copayments, that is covered at least in part by any of the plans covering the person. When a plan provides benefits in the form of services (for example a HMO) the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense or service that is not covered by any of the plans is not an allowable expense. The following are examples of expenses or services that are not allowable expenses:
- If a covered person is confined in a private Hospital room, the difference between the cost of a semi-private room in the Hospital and the private room (unless the patient's stay in a private Hospital room is Medically Necessary in terms of generally accepted medical practice, or one of the plans routinely provides coverage for Hospital private rooms) is not an allowable expense.
 - If a person is covered by two (2) or more plans that compute their benefit payments on the basis of usual and customary fees, any amount in excess of the highest of the usual and customary fees for a specific benefit is not an allowable expense.
 - If a person is covered by two (2) or more plans that provide benefits or services on the basis of negotiated fees, or if one plan calculates its benefits or services on the basis of usual and customary fees and the other plan provides its benefits or

COORDINATION OF BENEFITS

services on the basis of negotiated fees, any amount in the excess of the highest of the fees is not an allowable expense.

- The amount a benefit is reduced by the primary plan because a covered person does not comply with the plan provisions. Examples of these provisions are second surgical opinions, pre-certification of admissions, and preferred Provider organizations.

Claim Determination Period

A calendar year; however, it does not include any part of a year during which the participant has no Coverage under this plan or before the date this COB provision or similar provision takes effect.

Closed Panel Plan

A plan that provides health benefits to covered persons primarily in the form of services through a panel of Providers that have contracted with or are employed by the plan, and that limits or excludes benefits for services provided by other Providers, except in the case of emergency or referral by a panel member.

Custodial Parent

A parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

ADEA Employer

An employer which is subject to the U.S. Age Discrimination in Employment Act (ADEA), and has twenty (20) or more Employees each working day in twenty (20) or more calendar weeks during the current or preceding Benefit Period.

Medicare Benefits

Benefits for services and supplies which You receive or are entitled to receive under Medicare Parts A or B.

Order of Benefit Determination Rules

When two (2) or more plans pay benefits, the rules for determining the order of payment are as follows:

1. The primary plan pays or provides its benefits as if the secondary plan or plans did not exist.
2. A plan that does not contain a COB provision that is consistent with this regulation is always primary. There is one exception: coverage that is obtained by virtue of membership in a group that is designed to supplement a part of basic package of benefits provided by a contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel to provide out-of-network benefits.
3. A plan may consider the benefits paid or provided by another plan in determining its benefits only when it is secondary to that other plan.
4. The first of the following rules that describes which plan pays its benefits before another plan is the rule to use.
 - **Non-Dependent or Dependent.** The plan that covers the person other than as a Dependent, (e.g. as an Employee, Participant, Subscriber or Retiree) is primary and the plan that covers the person as a Dependent is secondary. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a Dependent; and primary to the plan covering the person as other than a Dependent (e.g. a retired Employee); then the order of benefits between the two plans is reversed so that the plan covering the person as an Employee, Participant or Subscriber, or Retiree is secondary and the other plan is primary.
 - **Child Covered Under More Than One Plan.** The order of benefits when a child is covered by more than one plan is:
 - o The primary plan is the plan of the parent whose birthday is earlier in the

COORDINATION OF BENEFITS

year if:

- the parents are married;
 - the parents are not separated (whether or not they ever have been married); or
 - a court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.
 - If both parents have the same birthday, the plan that has covered either of the parents longer is primary.
- o If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with financial responsibility has no coverage for the child's health care services or expenses, but the parent's spouse does, the spouse's plan is primary. This rule applies to Claim determination periods or plan years commencing after the plan is given notice of the court decree.
- o If the parents are not married, or are separated (whether or not they ever have been married) or are divorced, the order of benefits is:
- the plan of the custodial parent;
 - the plan of the spouse of the custodial parent;
 - the plan of the non-custodial parent; and then
 - the plan of the spouse of the non-custodial parent.
- **Active or Inactive Employee.** The plan that covers a person as an Employee, who is neither laid off nor retired, is primary. The same would hold true if a person is a Dependent of a person covered as a Retiree and an Employee. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored. Coverage provided to an individual as a retired worker or as a Dependent of an actively working spouse will be determined under the rule labeled Non-Dependent or Dependent.
 - **Continuation Coverage.** If a person whose Coverage is provided under a right of continuation provided by federal or state law also is covered under another plan, the plan covering the person as an Employee, Participant or Subscriber, or Retiree (or as that person's Dependent) is primary, and the continuation coverage is secondary. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.
 - **Longer or Shorter Length of Coverage.** The plan that covered the person as an Employee, Participant, Subscriber or Retiree longer is primary.

If the preceding rules do not determine the primary plan, the allowable expenses shall be shared equally between the plans meeting the definition of plan under this regulation.

Effect on the Benefits of this Plan

When this plan is secondary, it may reduce its benefits on a Claim so that the total benefits paid or provided by all plans are not more than 100% of the total allowable expenses. The difference between the benefit payments that this plan would have paid had this plan been the primary plan, and the benefit payments that the plan actually paid or provided shall be recorded as a benefit reserve for You or Your Covered Dependent and used by the plan to pay any allowable expenses, not otherwise paid during the claim determination period. As each Claim is submitted, this plan will:

COORDINATION OF BENEFITS

- Determine its obligation to pay or provide benefits under its contract.
- Determine whether a benefit reserve has been recorded.
- Determine whether there are any unpaid allowable expenses.
- The benefits of the secondary plan will be reduced, so that they and the benefits payable under the other plans do not total more than 100% of the allowable expenses. When the benefits of this plan are reduced as described, each benefit is reduced in proportion and is charged against any applicable benefit limits or maximums. This plan will not pay more as secondary than it would have paid had it been primary.

If a covered person is enrolled in two (2) or more closed panel plans and if, for any reason, including the provision of service by a non-panel Provider, benefits are not payable by one closed panel plan, COB shall not apply between that plan and the other closed panel plan.

Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this plan and other plans. The Plan may get the facts it needs from, or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under this plan and other plans covering the person claiming benefits. The Plan need not tell, or get the consent of, any person to do this. Each person claiming benefits under this plan must give the Plan any facts it needs to apply those rules and determine benefits payable.

Facility of Payment

A payment made under another plan may include an amount that should have been paid under this plan. If it does, the Plan may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under this plan. The Plan will not have to pay that amount again. The term “payment made” includes providing benefits in the form of services, in which case “payment made” means reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the amount of the payments made by the Plan is more than it should have paid under this COB provision, it may recover the excess within twelve (12) months from one or more persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The “amount of the payments made” includes the reasonable cash value of any benefits provided in the form of services.

Coordination with Medicare

This Provision applies when You have Coverage under this document and are eligible for hospital insurance under Medicare Part A (whether or not You have applied or are enrolled for Medicare Benefits.) This Provision applies before any other COB provision of the policy.

If, in accordance with the following rules, the Plan has primary responsibility for Your Claims, then the Plan pays benefits first. If, in accordance with the following rules, the Plan has secondary responsibility for Your Claims; first Medicare benefits are determined or paid and then the Plan’s benefits are paid. However, for services payable under both plans the combined Medicare Benefits and the Plan’s benefits will not exceed 100% of total allowable expenses.

COORDINATION OF BENEFITS

Rules for Determining Order of Benefits

Subscriber: We have primary responsibility for Claims if the Subscriber is eligible for Medicare Part A or B, and the Subscriber is actively employed by an ADEA employer who pays all or part of the Agreement's premium. We have secondary responsibility for Claims when a Subscriber is eligible for Medicare Part A or B, and is not actively employed by an ADEA employer who pays all or part of the Group Contract's premium.

Dependent: We have primary responsibility for a Dependent's Claim if the Dependent is eligible for Medicare Part A or B, and the Subscriber is actively employed by an ADEA employer who pays all or part of the Agreement's premium. We have secondary responsibility for a Dependent's Claims when he or she is eligible for Medicare Part A or B, and the Subscriber is not actively employed by an ADEA employer who pays all or part of the Agreement's premium.

Persons with End-Stage Renal Disease: We have primary responsibility for the Claims for You for up to thirty (30) months from the date You begin a regular course of renal dialysis or You could be entitled to Medicare after receiving a kidney transplant. Medicare benefits are secondary only for that portion of the thirty (30) month period remaining after You become eligible for Medicare. Thereafter, Medicare benefits are primary, and the Plan's benefits are secondary.

Persons under Non-ADEA employer plans: We have secondary responsibility for Your Claims if the employer under the Agreement is not an ADEA employer.

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Applicability	The provisions of this Agreement shall apply equally to the Subscriber and Dependents and all the benefits and provisions made available to You shall be available to Your Dependents.
Governing Law	This Plan is delivered and governed by the laws of the State of Arkansas.
Limitation of Action	You must exhaust the Plan's Claims and Appeals Procedure prior to pursuing legal action, (in a court or other government tribunal). No action at law or in equity shall be brought to recover under the Policy prior to the expiration of sixty (60) days after written proof of loss has been furnished in accordance with the requirements of the Plan. No such action shall be brought after the expiration of five (5) years after the time written proof of loss is required to be furnished.
Nontransferable	No person other than You is entitled to receive health care service Coverage or other benefits to be furnished by the Plan under this Agreement. Such right to health care service Coverage or other benefits is not transferable.
Relationship Among Parties Affected by Agreement	<p>The relationship between the Plan and Participating Providers is that of independent contractors. Participating Providers are not agents or employees of the Plan, nor is the Plan or any employee of the Plan an employee or agent of Participating Providers. Participating Providers shall maintain the Provider-patient relationship with You and are solely responsible to You for all Participating Provider services.</p> <p>Neither the Employer Group nor You are agents or representatives of the Plan, and neither shall be liable for any acts or omissions of the Plan for the performance of services under this Agreement.</p>
Contractual Relationships	<p>The Plan agrees with the Group to provide You Coverage for services, subject to the terms, conditions, exclusions and limitations of the Agreement. The Agreement is issued on the basis of the Group's Group Master Contract. This document is issued on the basis of the Subscriber's enrollment in the Plan pursuant to the Agreement in place between the Plan and the Group, and the Group's payment to the Plan of the required Premium. The Plan has the right to increase Premium rates, provided the Group is given thirty-one (31) days advance written notice.</p> <p>The Agreement between the Plan and the Group may require that the Subscriber contribute to the required Premiums. Information regarding the Premium and any portion of the Premium cost that You must pay can be obtained from the Group.</p> <p>This document is fully incorporated into the Agreement, and any direct conflict between this document and the Agreement will be resolved according to the terms that are most favorable to You. This document will be provided to the Group by the Plan for distribution to all Covered individuals.</p>
The Plan is Not Employer	The Plan shall not be deemed or construed as an employer for any purpose with respect to the administration or provision of benefits under the Group's benefit plan. The Plan shall not be responsible for fulfilling any duties or obligations of an employer with respect to the Group's benefit plan.

GENERAL PROVISIONS

Reservations and Alternatives

The Plan reserves the right to contract with other corporations, associations, partnerships, or individuals for the furnishing and rendering of any of the services or benefits described herein. The identity of the service providers and the nature of the services provided may be changed from time to time and without prior notice to or approval by You or the Group. You must cooperate with those persons or entities in the performance of their responsibilities.

Severability

In the event that any provision of this Agreement is held to be invalid or unenforceable for any reason, the invalidity or unenforceability of that provision shall not affect the remainder of this Agreement, which shall continue in full force and effect in accordance with its remaining terms.

Valid Amendment

No change in this Agreement shall be valid unless approved by an Officer of the Plan, and evidenced by endorsement on this Agreement and/or by Amendment to this Agreement. Such Amendments will be incorporated into this document. Amendments to this document are effective upon thirty-one (31) days written notice to You or the Group. No change will be made to this document unless made by an Amendment or a Rider that is issued by the Plan. No agent has authority to change this document or to waive any of its provisions.

Waiver

The failure of the Plan, the Group, or You to enforce any provision of this Agreement shall not be deemed or construed to be a waiver of the enforceability of such provision. Similarly, the failure to enforce any remedy arising from a default under the terms of this Agreement shall not be deemed or construed to be a waiver of such default.

Entire Agreement

This Agreement shall constitute the entire Agreement between the parties. All statements, in the absence of fraud, pertaining to Coverage under this Agreement that are made by You shall be deemed representations, but not warranties. No such statement which is made to effectuate Your Coverage shall be used in any context to void the Coverage, with respect to which such statement was made or to decrease benefits hereunder after the Coverage has been in force prior to the contest for a period of two (2) years during Your lifetime, or unless such statement is contained in a written application signed by You and a copy of such application has been furnished to You.

Participation in the Policies of the Plan

If You wish to participate in matters of the Plan's policies and operations, You may do so by submitting suggestions, in writing, to the Customer Service Department at the address located in the Schedule of Important Numbers. The Plan's Quality Improvement Committee will investigate the viability and appropriateness of the suggestion and recommend approval or disapproval to the Plan's policymaking body.

Records

You shall furnish the Plan with all medical information and proofs of previous Coverage that the Plan may reasonably require with regard to any matters pertaining to this document in the event the Plan is unable to obtain this information directly from the Provider or insurer.

Providers rendering services to You and/or Your Dependents, are allowed by law, to disclose all facts pertaining to such services to Us upon request and in order to submit Claims on your behalf. The Plan agrees that such information and records will be

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considered confidential. The Plan and any of the Plan's designees shall have the right to release, and secondarily release any and all records concerning services which are necessary to implement and administer the terms of this document or for appropriate medical review or quality assessment.

ERISA	When Coverage under this document is purchased by the Group to provide benefits under a welfare plan governed by the ERISA 29 U.S.C. § 1001 et seq., the Plan is not the "Plan Administrator" or "Named Fiduciary" of the employer-sponsored welfare plan as those terms are used in ERISA. The Plan Administrator and Named Fiduciary is the Employer or Plan Sponsor.
Examination	In the event of a question or dispute concerning Coverage for services, the Plan may reasonably require that a Participating Provider acceptable to the Plan examine You at the Plan's expense.
Clerical Error	Clerical error shall not deprive any individual of Coverage under this document or create a right to additional benefits.
Workers' Compensation	The Coverage provided under this document does not substitute for and does not affect any requirements for Coverage by Workers' Compensation Insurance.
Conformity with Statutes	Any provision of this document which, on its Effective Date, is in conflict with the requirements of statutes or regulations of the jurisdiction in which it is delivered, is hereby amended to conform to the minimum requirements of such statutes and regulations.
Non-Discrimination	In compliance with state and federal law, the Plan shall not discriminate on the basis of age, color, disability, gender, marital status, national origin, religion, sexual preference, genetic information, or public assistance status.
Provisions Relating to Medicaid Eligibility	<p>Payment for benefits will be made in accordance with assignment of rights made by You or on Your behalf, as required by a State plan for medical assistance approved under title XIX of the Social Security Act. To the extent that payment has been made under such State plan in any case in which the Plan has a legal liability under the Plan to make payment for such services, the Plan will pay for such services in accordance with any State law, provided that the State has acquired such rights to payment.</p> <p>The fact that a person is eligible for or provided medical assistance under a State plan for medical assistance approved under Title XIX of the Social Security Act shall not be taken into account in enrolling such person, or in determining or making benefit payments under the Plan.</p>
Policies and Procedures	The Plan may adopt policies, procedures, rules and interpretations to promote orderly and efficient administration of this Agreement.
Discretionary Authority	The Plan has the discretionary authority to interpret the Agreement in order to make eligibility and benefit determinations. The Plan also has the discretionary authority to make factual determinations as to whether any individual is entitled to receive any benefits under this Agreement. In no way shall this section limit any of Your rights as set

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forth in the Claims and Appeals section or any rights permitted under law.

Value Added Services

From time to time the Plan may offer to provide You access to discounts on health care related goods or services. While the Plan has arranged for access to these goods, services and/or third party provider discounts, the third party service providers are liable to You for the provision of such goods and/or services. The Plan is not responsible for the provision of such goods and/or services nor is it liable for the failure of the provision of the same. Further, the Plan is not liable to You for the negligent provision of such goods and/or services by third party service providers. These discounts are subject to modification or discontinuance without notice.

Applications and Statements

You shall complete and submit to the Plan such applications, or other forms or statements, as the Plan may reasonably request. The only statements You make that may be used in any legal action concerning this document issued hereunder are statements that are in writing. Any such written statement will be considered a representation and not a warranty.

Cooperation with Claims Investigation

You shall cooperate with the Plan in the benefit determination process and regarding the investigation of Claims relating to Covered Services, Coordination of Benefits, Medical Necessity determinations, utilization review and fraud and abuse functions. This duty to cooperate includes, but is not limited to, providing upon request by the Plan a written statement and/or testimony under oath regarding any Claim where Your name, identification or identity is utilized. Failure to cooperate may result in a delay in payment of the Covered Service(s) and/or denial of the Claim(s).

Federal and State Law Requirements

You shall provide the Plan with any information that is required for Us to comply with federal or state law requirements. Failure to provide the required information may result in a delay in payment of the Covered Service(s) and/or denial of the Claim(s).

Time Limit on Certain Defenses

Except for fraud, no statement shall be used to deny Your Claim after two (2) years. The two (2) years start from the date of Your application for submission of evidence for reinstatement.

No claim for loss incurred or disability (as defined in this document) commencing after two (2) years from the date of issue of this Agreement shall be reduced or denied on the ground that a disease or physical condition not excluded from Coverage by name or specific description effective on the date of loss has existed prior to the effective date of Coverage of this Agreement.

GLOSSARY

Any capitalized terms listed in this Section shall have the meaning set forth below whenever the capitalized term is used in this Agreement.

Activities of Daily Living	Activities You usually do during a normal day including but not limited to bathing, dressing, eating, grooming, maintaining continence, toileting, transferring, and mobility.
Agreement	The Certificate of Coverage and any Amendments, the Employee Enrollment/Change Form, applicable Riders, Provider Directory, and the Schedule of Benefits together form the Agreement.
Allowed Amount(s)	The maximum monetary amount the Plan calculates for Covered Services, either in accordance with the Participating Provider's contract or the Non-Participating Provider Fee Schedule, when rendered to individuals and/or authorized by the Plan.
Alternate Facility	<p>A duly-licensed non-Hospital health care facility or an attached facility designated as such by a Hospital which provides one or more of the following services on an outpatient basis pursuant to the law of the jurisdiction in which treatment is received, including without limitation:</p> <ul style="list-style-type: none">▪ Scheduled surgical services;▪ Emergency services;▪ Urgent Care Services;▪ Prescheduled rehabilitative services;▪ Laboratory or diagnostic services;▪ Inpatient or outpatient Mental Illness services or Substance Abuse services.
Alternate Recipient	The child or children identified in the medical child support order as being eligible to receive health care Coverage pursuant to the medical child support order.
Amendment or Endorsement	Any attached written description of additional or alternative provisions to the Agreement and/or this document. Amendments or Endorsements are effective only when Authorized in writing by the Plan and are subject to all conditions, limitations and exclusions of the Agreement except for those which are specifically amended.
Ancillary Provider	A Provider who is not licensed as a Physician or a Hospital.
Authorized Representative	An Authorized Representative is an individual authorized in writing or verbally by You or by state law to act on Your behalf in requesting a health care service, obtaining claim payment or during the Appeal process. A Provider may act on Your behalf with Your expressed consent, or without Your expressed consent when it involves an Urgent Care claim or Appeal. An Authorized Representative does not constitute designation of a personal representative for HIPAA privacy purposes.
Benefit Period	The period of time (typically twelve (12) months) during which certain Allowed Amount(s) for Covered Services are accumulated for purposes of determining Coverage provisions, such as, but not limited to, satisfaction of out-of-pocket maximums and benefit limits. Refer to Your Schedule of Benefits to determine the applicable Benefit Period.
Benefit Period Maximum	A maximum dollar amount, or maximum number of days, visits or sessions for which

GLOSSARY

Covered Services are provided for You in any one year. Once a Benefit Period Maximum is met, no more Covered Services will be provided during the same year.

Certificate of Coverage (COC)	This document which sets forth the essential features of and benefits to which You are entitled, including exclusions, limitations on benefits and requirements to receive benefits.
COBRA	The Consolidated Omnibus Budget Reconciliation Act of 1986. This federal law requires employers with group health plans to offer participants and beneficiaries the opportunity to purchase the continuation of health care coverage for a limited period of time after the occurrence of a qualifying event, which is usually the termination of employment. The law applies to private employers with twenty (20) or more Employees.
Coinsurance	Cost-sharing arrangement in which You pay a specified percentage of the cost for a Covered Service.
Coinsurance Maximum	The annual limit of Your coinsurance payments for Covered Services, as specified in the Schedule of Benefits.
Confinement and Confined	An uninterrupted stay following formal admission to a Hospital, an Alternate Facility or Skilled Nursing Facility.
Copayment	Cost-sharing arrangement in which You pay a specified dollar amount as Your share of the cost for a Covered Service.
Coverage or Covered	The benefits provided under this document for Covered Services rendered to You, subject to the terms, conditions, exclusions, and limitations of this document.
Covered Services	The services or supplies provided to You for which the Plan will make payment, as described in the Agreement.
Custodial Care	Care is considered custodial when it is primarily for the purpose of helping You with Activities of Daily Living or meeting personal needs and can be provided safely and reasonably by people without professional skills or training. This term includes such other care that is provided to You who, in the opinion of the Medical Director, has reached the maximum level of recovery. This term also includes services to an institutionalized individual, who cannot reasonably be expected to live outside of an institution. Examples of Custodial Care include, but are not limited to; respite care and home care which is or which could be provided by family members or private duty caregivers; and vacation or resort facilities that incorporate recreational therapy or rest cures.
Day Program Services	A structured, intensive day or evening treatment or partial hospitalization program, certified by the department of mental health or accredited by a nationally recognized organization.
Deductible	The dollar amount of medical expenses for Covered Services that You are responsible for paying annually before benefits subject to the Deductible are payable under this Agreement.

Dependent	A person defined in the Agreement who is eligible to receive Covered Services (usually the spouse or child of a Subscriber).
Designated Transplant Network Facility	A Hospital appointed as a Designated Transplant Network Facility by the Plan, to render Medically Necessary and medically appropriate services for Covered transplants. You may request a listing that may be amended from time to time, of Designated Transplant Network Facilities from the Customer Service Department listed in the Schedule of Important Numbers.
Designated Transplant Network Physician	A Physician appointed as a Designated Transplant Network Physician by the Plan, who has entered into an agreement with a Designated Transplant Network Facility to render Medically Necessary and medically appropriate services for Covered transplants.
Effective Date	The date of Coverage as determined by the Group and agreed to by the Plan, as set forth in the Agreement.
Eligible Employee	A person defined by an employer as gainfully working and eligible for benefits offered through the Group.
Emergency Medical Condition and Medical Emergency	<p>The sudden and, at the time, unexpected onset of a health condition that manifests itself by symptoms of sufficient severity that would lead a prudent layperson, possessing an average knowledge of health and medicine, to believe that immediate medical care is required, which may include, but shall not be limited to:</p> <ul style="list-style-type: none">▪ Placing Your health in significant jeopardy;▪ Serious impairment to a bodily function;▪ Serious dysfunction of any bodily organ or part;▪ Inadequately controlled pain; or▪ With respect to a pregnant woman who is having contractions:<ul style="list-style-type: none">○ That there is inadequate time to effect a safe transfer to another Hospital before delivery; or○ That the transfer to another Hospital may pose a threat to the health or safety of the woman or unborn child. <p>Some examples of an Emergency Medical Condition include, but are not limited to: broken bone; chest pain; seizures or convulsions; severe or unusual bleeding; severe burns; suspected poisoning; trouble breathing; and vaginal bleeding during pregnancy. You may seek medical attention from a Hospital, Physician's office or some other Emergency facility.</p>
Emergency Services	Ambulance services and other Health Care Services rendered or required to evaluate and treat an Emergency Medical Condition, as directed or ordered by a Physician, subject to the exclusions and other provisions set out in this document.
Employee Enrollment/Change Form	Your application for enrollment in the Plan.
ERISA	The Employee Retirement Income Security Act of 1974, as amended. ERISA is a federal law that applies to employer sponsored health benefit plans if the employer is not a government entity or a church organization.

Experimental or Investigational	<p>A health product or service is deemed Experimental or Investigational if one or more of the following criteria are met:</p> <ul style="list-style-type: none">▪ Any drug not approved for use by the FDA; any FDA approved drug prescribed for an off-label use whose effectiveness is unproven based on clinical evidence reported in Peer-Reviewed Medical Literature; or, any drug that is classified as IND (investigational new drug) by the FDA. As used herein, off-label prescribing means prescribing prescription drugs for treatments other than those stated in the labeling approved by the FDA.▪ Any health product or service that is subject to Institutional Review Board (IRB) review or approval;▪ Any health product or service that is the subject of a clinical trial that meets criteria for Phase I, II, III, or IV as set forth by FDA regulations, except as otherwise covered under the Clinical Trial benefit;▪ Any health product or service whose effectiveness is unproven based on clinical evidence reported in Peer-Reviewed Medical Literature.
Grace Period	<p>The thirty-one (31) days immediately following the last day of the preceding Coverage month. If the Grace Period expires on a weekend, the Grace Period will be extended to the first business day thereafter.</p>
Group	<p>The employer or other legally constituted group with whom the Agreement is made.</p>
Group Effective Date	<p>The date that is specified in the Group master contract as the Effective Date of this Agreement.</p>
Group Enrollment Period	<p>The period of time during which Employees and their Dependents may enroll with the Plan. An initial enrollment period shall be no less favorable than a period beginning on the Employee's date of initial eligibility and ending 31 days thereafter.</p>
HIPAA	<p>The Health Insurance Portability and Accountability Act of 1996 and its administrative regulations.</p>
Home Health Agency	<p>An organization that meets all of these tests: (a) its main function is to provide home health care services and supplies; (b) it is federally certified as a home health care agency; and (c) it is licensed by the state in which it is located, if licensing is required.</p>
Hospital	<p>An institution, operated pursuant to law, which: (a) is operated for the medical treatment of sick and/or injured persons as inpatients; and (b) has twenty-four (24) hour nursing services on duty or on call. For the purpose of this definition, a facility that is primarily a place for rest, Custodial Care or care of the aged, a nursing home, convalescent home, or similar institution is not a Hospital.</p>
Late Enrollees	<p>Individuals who fail to enroll with the Plan for Coverage under the Agreement during the initial enrollment period when they first become eligible for Coverage as described in the Enrollment and Eligibility Section of this document. This term does not include individuals who enroll under a Special Enrollment Period; an employee of an employer which offers multiple health benefit plans, who elects a different health benefit plan during an open enrollment period; or a spouse or minor child who is eligible for</p>

Coverage due to a court order. An individual who declined Coverage in writing due to being covered under another group policy, is not a Late Enrollee if Coverage is requested within [thirty-one (31), sixty three (63)] days of losing that Coverage.

Maintenance Therapy

A treatment plan that seeks to prevent disease, promote health and prolong and enhance the quality of life, or therapy that is performed to maintain or prevent deterioration of a chronic condition.

Medical Director

The Physician specified by the Plan, or his or her designee, and appropriately licensed in the practice of medicine in accordance with state law, who is responsible for medical oversight programs, including but not limited to Prior Authorization programs.

Medically Necessary/Medical Necessity

Those services, supplies, equipment and facility charges that are not expressly excluded under this Agreement and are:

- Medically appropriate, so that expected health benefits (such as, but not limited to, increased life expectancy, improved functional capacity, prevention of complications, relief of pain) materially exceed the expected health risks;
- Necessary to meet Your basic health needs as a minimum requirement;
- Necessary to meet Your health needs, improve physiological function and required for a reason other than improving appearance;
- Rendered in the most cost-efficient manner and setting appropriate for the delivery of the health service without compromising the quality of care;
- Consistent in type, frequency and duration of treatment with scientifically-based guidelines of national medical research, professional medical specialty organizations or governmental agencies that are generally accepted as national authorities on the services, supplies, equipment or facilities for which Coverage is requested;
- Consistent with the diagnosis of the condition at issue;
- Required for reasons other than Your comfort or the comfort and convenience of Your Physician; and
- Not Experimental or Investigational as determined by the Plan under the Plan's Experimental Procedures Determination Policy.

Officer

The person holding the office of President and/or CEO or his or her designee.

Out-of-Pocket Maximum

The annual limit of Your payments for Covered Services, as specified in the Schedule of Benefits.

Participating Provider

A Provider who has a contractual arrangement with the Plan for the provision of Covered Services to individuals.

Peer-Reviewed Medical Literature

A phrase defined by two elements:

- It refers to the requirement that medical literature on a topic is only considered relevant if it is a scientific study, which has been published in the English language (mostly American) medical literature only after review by academic experts for structure of study and validity of conclusions, prior to acceptance for publication; and
- Based on a methodology used by certain authoritative bodies (including The National Cancer Institute PDQ Guidelines for Cancer Treatment and the

International Consensus Conference on Bone Marrow Transplantation), the medical literature is graded for its quality using a 2-by-2 grid based on two parameters: strength of the evidence and effectiveness. Strength of evidence is graded from the highest level of evidence to the lowest, as follows:

Level 1: Randomized, controlled trial

Level 2: Cohort/Case Control Study

Level 3: Systematic Literature Review

Level 4: Large consecutive case series

Level 5: Small consecutive case series

Level 6: Textbook chapters (opinion of a respected authority)

Level 7: Case report

Effectiveness is evaluated using 4 measurements: (1) Is the proposed treatment harmful or beneficial? (2) Do the results favor the study (experimental) group or the control group? (3) Is the outcome considered statistically weak or strong? (4) Is the study design weak or strong?

After evaluating the peer-reviewed medical literature according to the methodology described above, a conclusion is drawn that the preponderance of evidence favors the proposed new technology as being proven (and therefore standard of care), or conversely unproven (i.e. investigational/experimental).

Physician/Practitioner

Anyone qualified and licensed to practice medicine and surgery by the state in which services are rendered who has the Degree of Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) Physician also means Doctors of Dentistry, Chiropractic, Optometry and Podiatry when they are acting within the scope of their license.

By use of this term, the Plan recognizes and accepts, to the extent of the Plan's obligation under the Agreement, other practitioners of medical care and treatment when the services performed are within the lawful scope of the practitioner's license and are provided pursuant to applicable laws. This includes APRNs and duly licensed psychologists and specialist social workers.

Plan

Coventry Health and Life Insurance Company.

Premium

The monthly fee required from each Group on behalf of each Subscriber and each enrolled Dependent in accordance with the terms of the Agreement.

Preventive Services

The services set forth in Section 2713(a)(1) of the federal Public Health Service Act. A list of the preventive services covered is available on the website [www.chckansas.com] or will be mailed to You upon request.

Prior Authorization

The process of obtaining approval for receiving specific health care services prior to those services being rendered. The process includes determination of eligibility, determination of Covered Services, determination of Medical Necessity, and implications about the use of Participating and Non-Participating Providers. Authorization does not guarantee payment if You are not eligible for Covered Services at the time the service is provided.

Provider

A Physician, Hospital, Home Health Agency, or Ancillary Provider or other duly licensed

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	health care facility or practitioner, certified or otherwise authorized to furnish health care services pursuant to the law of the jurisdiction in which care or treatment is received.
Provider Directory	A listing of Participating Providers. Please be aware that the information in the directory is subject to change and will be updated at least annually.
Public Entity	A publicly supported medical facility providing care, treatment and supplies to injured or sick individuals through a program or agency owned and operated by a state or county government. This may include but is not limited to entities such as a county hospital or county health clinic.
Residential Treatment Facility	A facility licensed by the applicable state or approved by the Joint Commission on Accreditation of Health Care Organizations. The Residential Treatment Facility may be a general community Hospital with approved mental health beds, a psychiatric Hospital, a facility for the chemically dependent, or a Community Mental Health Center.
Residential Treatment Program	A program certified by the department of mental health involving residential care and structured, intensive treatment.
Retiree	A former Eligible Employee of the Group who meets the Group's definition of retired employees to whom the Group offers Coverage under the Agreement.
Rider	An Amendment that provides additional Covered Services and is attached to the Agreement. Services provided by a Rider may be subject to payment of additional Premiums.
Schedule Of Benefits	A written document, incorporated by reference into this document, that summarizes benefits and includes, but is not limited to, cost sharing amounts and limitations.
Semi-private Accommodations	A room with two (2) or more beds in a Hospital. The difference in cost between Semi-private Accommodations and private accommodations is Covered only when private accommodations are Medically Necessary.
Service Area	The geographic area served by the Plan and approved by the State Department of Insurance. The Plan's Service Area is subject to change from time to time. [Please refer to Section 12 for a description of the Service Area.]
Skilled Nursing Facility (SNF)	A facility certified by Medicare to provide inpatient skilled nursing care, rehabilitation services or other related services. The term "Skilled Nursing Facility" does not include a convalescent nursing home, rest facility, or facility for the aged that furnishes primarily Custodial Care, including training in Activities of Daily Living.
Special Enrollment Period	The period after the regular Group Enrollment Period during which an individual is allowed to enroll for Coverage subject to the terms of this document.
Specialty Care Physician/Specialist	A Physician who is not a Primary Care Physician and provides medical services to individuals concentrated in a specific medical area of expertise.
Subscriber	An Employee of a Group who meets the eligibility requirements as specified in this

document or the Agreement.

Substance Abuse	The psychological or physiological dependence upon and abuse of drugs, including alcohol, characterized by drug tolerance or withdrawal and impairment of social or occupational role functioning or both.
Total Disability	Your inability, because of sickness or injury, to perform the substantial and material duties of Your regular occupation, or Your inability to engage in employment or occupation for which You are or become qualified by reason of education, training, or experience. For an unemployed Dependent, Total Disability means Your complete inability to engage in most of the normal activities of a person of like age and gender. The disability, for Subscriber or Dependent, may require regular care and attendance by a Physician who is someone other than an immediate family member.
Utilization Review	A set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures, or settings. Techniques may include ambulatory review, prospective review, second opinion, Prior Authorization, concurrent review, case management, and discharge planning or retrospective review. Utilization review shall not include elective requests for clarification of Coverage.
Waiting Period	A time interval as defined by the Group starting from the Employee's date of hire to the Effective Date. [For small Groups, no Waiting Period shall be greater the ninety (90) days and shall permit Coverage to become effective no later than the first day of the month immediately following completion of the Waiting Period.]
We, Us or Our	Coventry Health and Life Insurance Company.
You or Your	An individual covered under this document.

SCHEDULE OF IMPORTANT TELEPHONE NUMBERS AND ADDRESSES

[Customer Services/Claims Coventry Health Care of Kansas, Inc.
Customer Service
PO Box 7109
London, KY 40742
(800) 969-3343
(866) 320-0697 (within Wichita)
(866) 285-1864 TDD
www.chckansas.com]

[Prior Authorization Coventry Health Care of Kansas, Inc.
Customer Service
PO Box 7109
London, KY 40742
(800) 969-3343
(866) 320-0697 (within Wichita)
(866) 285-1864 TDD]

[Appeals Attn: Appeals Department
8320 Ward Parkway
Kansas City, MO 64114]

[MH Net Behavioral Health PO Box 209010
Austin, TX 78720
(866) 607-5970
www.chckansas.com]

**Arkansas Insurance
Department** [1200 West Third Street
Little Rock, AR 72201,
(501) 371 2600
(800) 282-9134;
(501) 371-2618 (fax)
Insurance.Consumers@arkansas.gov]

SERFF Tracking Number: CVKS-127837382 State: Arkansas
 Filing Company: Coventry Health and Life Insurance Company State Tracking Number: 50296
 Company Tracking Number: AR CERTIFICATE - REVISED
 TOI: H16G Group Health - Major Medical Sub-TOI: H16G.001A Any Size Group - PPO
 Product Name: AR Certificate of Coverage - Revised
 Project Name/Number: /

Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification	Approved	12/05/2011
Comments:		
Attachment: AR Flesch Certification.pdf		

	Item Status:	Status Date:
Bypassed - Item: Application	Approved	12/05/2011
Bypass Reason: Not Applicable to this filing		
Comments:		

	Item Status:	Status Date:
Bypassed - Item: PPACA Uniform Compliance Summary	Approved	12/05/2011
Bypass Reason: Not Applicable to this filing		
Comments:		

	Item Status:	Status Date:
Satisfied - Item: Cover Letter	Approved	12/05/2011
Comments: This document replaces the document with the same form number approved on 11/7/11 under SERFF Tracking #CVKS-127719618. The document has been revised due to comments we've received from Departments of Insurance in other states we operate in. The revised sections are highlighted for ease of reference.		

All forms contain bracketed variables around the address, phone, and website information. This is intended to be modifiable as necessary, should this product be administered by another Coventry Health Care company maintaining Arkansas licensure.

This form contains policy language with in brackets. This is not variable language and will either remain or be deleted in

SERFF Tracking Number: CVKS-127837382 *State:* Arkansas
Filing Company: Coventry Health and Life Insurance Company *State Tracking Number:* 50296
Company Tracking Number: AR CERTIFICATE - REVISED
TOI: H16G Group Health - Major Medical *Sub-TOI:* H16G.001A Any Size Group - PPO
Product Name: AR Certificate of Coverage - Revised
Project Name/Number: /

its entirety.

This document reflects administration by Coventry Health Care of Kansas, Inc. (utilization manager) and underwritten by Coventry Health & Life Insurance Company.

Certification of Arkansas Mandated Coverage

Coventry recognizes the mandates Children's Preventive Health Care, Colorectal Cancer Screening, and Prostate Cancer Screening. These are now part of PPACA regulation and as such defined accordingly.

Coventry recognizes the mandate for In-Vitro Fertilization. AR 23-85-137, and Rule 1 indicate this benefit to treated as similar to Maternity coverage.

Mandated offerings for Hospice, Mammogram, out-patient service, and psychological examiners have been adapted to standard coverage and subject to the coverage, exclusions, and scope of the Certificate like any other service.

Coverage acknowledges the mandate of coverage for Breast Reconstruction/Mastectomy, Dental Anesthesia, Diabetic Supplies/Education, Prescription and Contraceptive drugs, PKU, Loss or Impairment of Speech or Hearing, Newborn coverage, Off-Label Drug Use, and Orthotic and Prosthetic Devices and certifies that each are, if not specifically defined in the Certificate, are administered in accordance with the mandate.

If you have any questions, please feel free to contact me at 316-609-2564.

Sincerely,
Lisa Foos

SERFF Tracking Number: CVKS-127837382 State: Arkansas
 Filing Company: Coventry Health and Life Insurance Company State Tracking Number: 50296
 Company Tracking Number: AR CERTIFICATE - REVISED
 TOI: H16G Group Health - Major Medical Sub-TOI: H16G.001A Any Size Group - PPO
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Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date:	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
11/18/2011	Form	AR Certificate of Coverage	12/05/2011	CHL-AR-COC-021-09.11.pdf (Superseded)



[LOGO]

PREFERRED PROVIDER ORGANIZATION (“PPO”)

*PPO products are underwritten by Coventry Health and Life Insurance Company
and administered by Coventry Health Care of Kansas, Inc.*

Arkansas

**THIS BENEFIT DOCUMENT AND ALL ATTACHED RIDERS
SHOULD BE READ IN THEIR ENTIRETY.**

You have the full freedom of choice in the selection of any duly licensed health care professional. This benefit document has provisions reducing the amount of Coverage You receive depending on which Physicians or other health care providers you use. Please consult this benefit document, the Schedule of Benefits and Provider Directory for more details. If you have any additional questions, please write or call us at:

Coventry Health & Life Insurance Company
[8320 Ward Parkway]
[Kansas City, MO 64114]
[(800) 969-3343]
[www.chckansas.com]

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USING YOUR BENEFITS

Identification (ID) Card

Every individual receives an ID card. Carry Your ID card with You at all times, and present it every time You request or receive services. The ID card is needed for Providers to bill the Plan for charges other than Copayments, Coinsurance, and non-Covered Services. If You do not show Your ID card, the Providers cannot identify You as a participant of the Plan, and You may receive a bill for services. If Your ID card is missing, lost, or stolen, contact the Plan's Customer Service Department at [800-969-3343]; or through the website at [www.chckansas.com] to obtain a replacement. This information is also listed on Your ID card and in the Schedule of Important Numbers. If Your Dependents are Covered, You will receive an additional ID card for each Covered Dependent. Possession and use of an ID card is not an entitlement to Coverage. Coverage is subject to verification of eligibility and all the terms, conditions, limitations and exclusions set out in the Agreement.

How to Contact the Plan

Throughout this Agreement, You will find that the Plan encourages You to contact the Plan for further information. Whenever You have a question or concern regarding Covered Services or any required procedure, please contact the Plan at the telephone number or website on the back of Your ID card.

Telephone numbers and addresses to request review of denied claims, register Complaints, place requests for prior Authorization, and submit claims are listed in the Schedule of Important Telephone Numbers And Addresses included in this document.

Copayments, Coinsurance [and Deductibles]

You may be responsible for paying Copayments to Participating Providers at the time of service. The Provider may bill You at a later time for the Coinsurance amounts that are Your responsibility under the terms of the Plan as determined by the Allowed Amount. [You may be responsible for the difference between the actual billed charges of a Non-Participating Provider and the Allowed Amounts.] [You must meet the applicable Deductible, as described in Your Schedule of Benefits, before benefits will be payable to Providers on Your behalf.] Specific Copayments[, Deductible] and Coinsurance amounts are listed in the Schedule of Benefits.

[For Missouri-based Employer Groups, the Copayment and Coinsurance for a single service will not exceed fifty percent (50%) of the Plan's Allowed Amounts of providing a single Basic Health Service, nor in the annual aggregate more than twenty percent (20%) of the Allowed Amount of providing all Basic Health Services, which will not exceed two hundred percent (200%) of the total annual Premium.]

Prior Authorization

Prior Authorization is required for certain Covered Services as determined by the Plan. Coverage is subject to eligibility and benefits remaining at the time services are rendered. The Plan has the right to request and obtain whatever medical information it considers necessary to determine whether the service is Medically Necessary. You or the Participating Providers are required to obtain Prior Authorization for Covered Services. **You are responsible for verifying Prior Authorization has been obtained whenever You seek Covered Services from a Non-Participating Provider.** An up-to-date Prior Authorization List is available by contacting the Plan at the telephone number listed on Your ID card or by visiting the Plan's website.

USING YOUR BENEFITS

Any new, additional or extended services not Covered under the original Authorization will be Covered only if a new Authorization is obtained. All services identified in this document are subject to all of the terms, conditions, exclusions and limitations of the Plan.

It is important to note that under the terms of the Plan, Prior Authorization only determines Medical Necessity and appropriateness. All other terms of the Plan are then applied. If the Plan Prior Authorizes Covered Services, the Plan shall not subsequently retract the Authorization after the Covered Services have been received, or reduce payment unless: (1) Such Authorization is based on a material misrepresentation or omission about Your health condition or the cause of the health condition; or (2) the Plan terminates before the health care services are provided; or (3) Your Coverage under the Plan terminates before the health care services are provided.

To find out the amount of the penalty applied for failure to obtain Prior Authorization, please see [the Prior Authorization List or] the Schedule of Benefits.

If You are admitted for emergency care to a Non-Participating Facility, or in the case of an unexpected length of stay after a Prior Authorized admission to a Non-Participating Facility, the Plan may request that You be transferred to a Participating Facility for continuation of care when it is not medically contraindicated. If You refuse to be transferred to a Participating Facility, [the Plan will not cover any services beyond the proposed date of transfer][coverage will be provided] [at the Non-Participating level] [for services received after the proposed date of transfer].

Health Services Rendered by Participating Providers

You have access to the services of a Participating Provider of Your choice within the Provider network for Covered Services, subject to the terms, conditions, exclusions and limitations of the Agreement. Participating Providers are contractually obligated to file all claims for You. Payment will be made directly to the Participating Provider for Covered Services.

It is Your responsibility to verify the participation status of Providers. You should not assume that a Provider, whom a Participating Provider may recommend, would always be another Participating Provider. To verify the status of the Provider, please contact the Customer Service Department or check the Plan's website.

Coverage for Services by Non-Participating Providers

A Non-Participating Provider may or may not complete and file the claim form for You. If not, You must submit a Claim form to the Plan. **If a Non-Participating claim form is not received from the Plan within fifteen (15) days after the Plan receives notice of a claim, You shall be deemed to have complied with the requirements of the Plan as to proof of loss upon submitting written proof covering the occurrence, character, and extent of loss, within the time fixed for filing a claim.** It is Your responsibility to provide any information that is necessary for the Plan to make a prompt and fair evaluation of Your claim. The Plan requests that You file the Non-Participating Provider claim within ninety (90) days from date of service. However, failure to file the claim within the ninety (90) day period shall not invalidate or reduce the claim, if it was not reasonably possible to provide notice or proof within the ninety (90) days. A claim will not be denied based upon the Your failure to submit a claim within the ninety (90) day period unless the failure operates to

USING YOUR BENEFITS

prejudice the rights of the Plan. [No claim will be paid if not received by the Plan within one (1) year] [and ninety (90) days] [after services are received, **except in the absence of legal capacity of the claimant.**]

[Non-Participating Provider Fees

Payment for Covered Services provided by Non-Participating Providers is limited to the lesser of the billed charge or the Out-of-Network Rates listed below less applicable Copayments, Coinsurance and/or Deductibles. These rates are calculated as a multiple of the Medicare fee schedule for Physicians, Hospitals, outpatient facilities, ancillary Providers and other Providers. These rates may be adjusted from time to time.

If the amount You are charged for a Covered Service is equal to or less than the Out-of-Network Rate, the charge should be completely covered by Your Out of Network benefit, except for any Copayment, Coinsurance, and/or Deductible payments You are required to make. However, if the amount You are charged is in excess of the Out-of-Network Rate for a particular Covered Service, You will be responsible for paying any amounts in excess of the rates listed below, in addition to any applicable Copayment, Coinsurance, and/or Deductible payments.]

[Non-Participating Physician and Other Health Care Professional Fees

The Out-of-Network Rate is equivalent to 100% of the national average Medicare rate, based on the previous year's Resource Based Relative Value Scale (RBRVS) fee schedule for Physician and other health care professional services, as such services are defined in the American Medical Association's Current Procedural Terminology (CPT) manual. For Physician and other health care profession services not valued in RBRVS, other Medicare or nationally recognized schedules will be used. For CPT codes developed after the previous year, the rate will be calculated using the assigned Relative Value Units (RVU) and the previous year's Medicare conversion factor. Payment for immunizations and injectable drugs will be at 100% of the First Data Bank [Average Wholesale Price (AWP)]. Payment for anesthesia services will be 200% of the previous year national average Medicare rate per 15 minute increment. Payment for Durable Medical Equipment (DME), prosthetics, orthotics and supplies (DMEPOS) will be at the previous year's DMEPOS ceiling limit. Payment for Laboratory services will be at the previous year's Medicare Clinical Laboratory Fee Schedule. If there is no corresponding rate, as described above, for a particular service, the Plan shall provide payment at 50% of billed charges. The Plan reserves the right to apply proprietary payment guidelines, claim adjudication procedures and billing instructions in conjunction with the determination of the Out-of-Network Rates.]

[Non-Participating Facility Fees

The Out-of-Network Rate is equivalent to 100% of the Medicare base rate for facility charges. Payment for inpatient services will be based on Diagnosis Related Group (DRG) rates. Payment for outpatient services will be based on Ambulatory Payment Classification (APC) rates. Payment for services provided within an ambulatory surgical center will be based on Ambulatory Surgical Center (ASC) group rates. If there is no corresponding DRG, APC or ASC rate for a particular service, the Plan shall provide payment at 50% of billed charges. The Plan reserves the right to apply proprietary payment guidelines, claim adjudication procedures and billing instructions in conjunction with the determination of the Out-of-Network Rates.

Please note that Physician and Hospital charges typically are not regulated. Billed charges can vary tremendously from one Provider to the next, so please make sure You

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are aware of the billed charge for services You want to receive from Non-Participating Providers.]

Second Opinion Policy

You may seek a second medical opinion or consultation from the Plan's Participating Providers. In the event the Plan does not employ or contract with another Physician with the expertise necessary to provide a second medical opinion, the Plan will arrange for a referral to a Provider with the necessary expertise.

Participating Provider Terminations

The Plan or a Participating Provider may end the relationship with the other party after having supplied notice under applicable law; therefore the Plan does not promise that any specific Participating Provider will be available to render services to You. [If a Participating Provider no longer participates with the Plan, the Plan will provide immediate notice to You and assist You in selecting another Participating Provider.] The Plan will provide You continuation of care up to ninety (90) days by a Provider who is terminated from the network in those cases where such continuation of care is Medically Necessary and in accordance with the dictates of medical prudence and where You have special circumstances such as a disability, a life-threatening condition or is in the third trimester of pregnancy. You will not be liable to the Provider for any amounts owed for medical care other than the applicable Copayments, Coinsurance and/or Deductible as specified in the Schedule of Benefits.

Provider Hold Harmless

Participating Providers agree that in no event, including but not limited to nonpayment by the Plan or intermediary, insolvency of the Plan or intermediary, or breach of this Agreement, shall the Participating Provider bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse against You or a person, other than the Plan or intermediary, acting on Your behalf for services provided pursuant to this Agreement. This Agreement shall not prohibit the Provider from collecting [Coinsurance, Deductibles or] Copayments, as specifically provided in this document, or fees for non-Covered Services delivered on a fee-for-service basis to You. The provider hold harmless provision shall not prohibit a Provider and You from agreeing to continue services solely at Your expense, as long as the Provider has clearly informed You that the Plan may not cover or continue to cover a specific service or services. Except as provided herein, this provision does not prohibit the Provider from pursuing any available legal remedy, including but not limited to, collecting from any insurance carrier providing You Coverage.

Plan Has Authority to Grant Coverage

Only Medically Necessary services are Covered under the Agreement. The fact that a Physician or other Provider has performed or prescribed a procedure or treatment, or the fact that it may be the only available treatment for an injury, illness or Substance Abuse, or Mental Illness does not mean that the procedure or treatment is Covered under the Agreement. The Plan shall have the right, subject to Your rights in this document, to interpret the benefits of this document and attached Riders, and other terms, conditions, limitations and exclusions set out in the Agreement in making factual determinations related to the Agreement, its benefits, and You; and in construing any disputed or ambiguous terms. In accordance with all applicable law, the Plan reserves the right at any time, to change, amend, interpret, modify, withdraw or add benefits to, or terminate this Plan. The Group will be given the proper written notice by means of Amendment or Endorsement prior to any termination or change in Coverage as required by applicable

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law. Any termination of the Agreement must be in accordance with the Termination of Coverage Section of this document. The Plan may, in certain circumstances, cover services that would otherwise not be Covered. The fact that the Plan does so in any particular case shall not in any way be deemed to require it to do so in other similar cases.

[Payment to Public Entities

For Missouri-based Employer Groups, any benefits payable hereunder to You shall be payable with or without assignment from You to a public Hospital or clinic for services or supplies provided to You if a proper claim is submitted by the public Hospital or clinic. Payment to the public Hospital or clinic shall discharge the Plan from any and all obligations and liability to You to the extent of the benefits paid. In the event the Plan has already made payment on such charges to You prior to receipt of the claim from the public Hospital or clinic, the Plan will not be required to pay the claim to the public Hospital or clinic again.]

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The Plan covers only those services and supplies that are (1) deemed Medically Necessary as well as not considered Experimental or Investigational, (2) Authorized, if required, (3) not expressly excluded in the list of Exclusions section, and (4) incurred while eligible for Coverage under the Plan. It is Your responsibility to verify whether a Covered Service requires Prior Authorization and should always reference the Authorization Requirements prior to receiving Covered Services. You should not assume that a Participating Provider has already obtained the Authorization. If a service is not specifically listed and not otherwise excluded, please contact the Plan to confirm whether the service is a Covered Service. Please note that the Covered Services are subject to all applicable provisions within this document, and any attached Schedule of Benefits, Riders, Amendments, or Endorsements.

Allergy

Coverage is provided for allergy testing, diagnosis, treatment, allergy serum, and the administration of injections.

Exclusions:

- Sublingual drops.
- Non-Physician services and expenses relating to an allergic condition including, but not limited to, installation of air filters, air purifiers, or air ventilation system cleaning.

Ambulance (air and ground)

For Emergency use, when transport by other means is not medically safe, and for non-Emergency transportation for the following:

- From a non-Participating Hospital to a Participating Hospital;
- To a Hospital that provides a higher level of care;
- To a more cost effective acute care Facility; or

When transportation is needed to a long term acute care or inpatient rehabilitation facility.

Exclusion:

Non-Emergency and non-medically appropriate ambulance services, regardless of who requested the services, including transport due to the absence of other transportation.

Blood and Blood Products Processing

Coverage is provided for administration, storage, and processing of blood and blood products in connection with Covered services.

Exclusions:

- Expenses related to personal blood storage, unless associated with a scheduled surgery.
- Fetal cord blood harvesting and storage.
- The cost of whole blood and blood products replacement to a blood bank.

Chemotherapy

Coverage is provided for standard chemotherapy, including, but not limited to, dose-intensive chemotherapy for the treatment of breast cancer.

Clinical Trials

Expenses associated with professional services, diagnostic laboratory and radiology tests, inpatient care, and administration of treatment and evaluation during the course of the treatment or a condition associated with a complication of the underlying disease or treatment, which are consistent with usual and customary patterns and standards of care incurred whenever You receive medical care associated with an approved clinical trial, and which would be covered if such items and services were provided other than in connection with an approved clinical trial.

Exclusions:

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- The costs of the Investigational drugs or devices themselves, or the costs of any non-medical services that might be required for You to receive the treatment or intervention.
- Transportation and/or lodging costs incurred while receiving such treatment.
- Any item or service that is provided solely to satisfy data collection and analysis needs and that is not used in Your clinical management.
- Health care services customarily provided by the research sponsors of a trial free of charge for any member in the trial.
- Experimental or Investigational treatment not related to a Clinical Trial as defined above.

Compression Sleeves and Stockings

Coverage is provided for [two (2) pair of] compression sleeves and [two (2) pair of] compression stockings per Benefit Period.

Dental/Oral Surgery Services

Benefits for oral surgical procedures of the jaw or gums will be covered for:

- Removal of tumors or cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth;
- Removal of symptomatic exostoses (bony growths) of the jaw and hard palate;
- Treatment of fractures and dislocations of the jaw and facial bones;
- Intraoral x-rays in connection with covered oral surgery; and
- General anesthetic for covered oral surgery.

Coverage is provided for diseases of the mouth, jaw and teeth related to radiation treatment, unless the condition is due to dental disease or of dental origin.

Limitations:

- Coverage is provided for anesthesia and hospital or ambulatory surgical facility charges for services performed in connection with dental procedures in a hospital or ambulatory surgical facility, if:
 - The provider treating the patient certifies that because of the patient's age or condition or problem, hospitalization or general anesthesia is required in order to safely and effectively perform the procedures; and the patient is:
 - A child under seven (7) years of age who is determined by two (2) dentists to require without delay necessary dental treatment in a hospital or ambulatory surgical center for a significantly complex dental condition;
 - A person with a diagnosed serious mental or physical condition; or
 - A person with a significant behavioral problem as determined by Your physician.
 - If a person is covered under both this Plan and a benefit plan that provides dental benefits, the health benefit plan that includes dental benefits is the primary payer.
- Services relating to the acute injury of sound, natural teeth caused directly by an accidental injury (not from biting or chewing) within a [six (6), twelve (12)] month consecutive period from the date of injury up to a maximum of \$1,000 of Allowed Amount(s). This benefit maximum does not apply to individuals under eighteen (18) years of age. A treatment plan must be submitted [within sixty (60) days of the injury] and approved by the Plan.

Exclusions:

- Upper and lower jaw bone surgery and dental implants (including that related to the temporomandibular and craniomandibular joint).

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- Dental x-rays, supplies and appliances including occlusal splints.
- Orthodontia and related services.
- Oral surgery supplies required as part of an orthodontic treatment program, required for correction of an occlusal defect, encompassing orthognathic or prognathic surgical procedures, or removal of symptomatic bony impacted teeth.
- Treatment of teeth or structures directly supporting the teeth, whether the services are considered to be medical or dental in nature except as specified above.

Dermatological Services

Coverage is provided for the necessary removal of a skin lesion that interferes with normal body functions or is suspected to be malignant.

Dialysis

Coverage is provided for hemodialysis and peritoneal services provided by outpatient or inpatient facilities or at home. For home dialysis, equipment, supplies, and maintenance will be a Covered Service.

Diabetic Services

Diabetic services will be provided for individuals with gestational diabetes, Type I diabetes, and Type II diabetes. Coverage includes Plan approved diabetic education classes, including self-management training used in connection with the treatment of diabetes; foot care, including medical or surgical treatment of onychomycosis (nail fungus); an annual diabetic retinal eye examination; and [one (1) pair of] orthopedic shoes and [two (2) pair] associated shoe inserts [per Benefit Period] for those individuals with demonstrated peripheral neuropathy.

Limitation:

Diabetic equipment and supplies, including disposable insulin syringes, glucose meters, glucose strips, and lancets are Covered under the pharmacy Rider. If a pharmacy Rider is not purchased, Coverage for this benefit will be provided under the medical benefit.

Dietician Counseling

Coverage [for up to four (4) visits per Benefit Period] is provided when rendered by a registered dietician.

Disposable Medical Supplies

Specific disposable medical supplies are covered when prescribed by Your Physician. Covered disposable supplies are limited to:

- Inhaler supplies (aero chamber masks, spacers and peak flow meters)
- Ostomy supplies (appliance pouches, skin care agents, support belts);
- Open wound supplies (gauze pads, wound packing strips, ABD pads);
- Supplies used in conjunction with covered Durable Medical Equipment (except for diabetic supplies);
- Tracheostomy supplies;
- Urinary supplies limited to catheters, bags and related supplies; and
- Venous access catheter supplies (alcohol pads, benzoin, OP site).

Durable Medical Equipment (DME)

DME is medical equipment which can withstand repeated use and is not disposable, is used to serve a medical purpose, is generally not useful to a person in the absence of an illness or injury, and is appropriate for use in the home. Medically Necessary, non-disposable accessories that are commonly associated with the use of a Covered piece of DME will be considered DME.

Coverage is provided when determined to be necessary and reasonable for the

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treatment of an illness or injury, or to improve the functioning of a malformed body part.

Limitations:

- Coverage for repair, replacement or duplicate equipment is provided only when required due to anatomical change and/or reasonable wear and tear. All maintenance and repairs that result from misuse are Your responsibility.
- Benefits are provided for one wheelchair or scooter and for repairs of that unit.

Exclusions:

- Electronically controlled heating and cooling compression therapy devices (such as polar ice packs, Ice Man Cool Therapy, or Cryo-cuff);
- Home traction units;
- Preventive or routine maintenance due to normal wear and tear or negligence of items You own;
- Replacement for changes due to obesity; and
- Personal comfort items, including breast pumps, air conditioners, humidifiers and dehumidifiers, even though prescribed by a Physician, unless defined as a Covered Service.

Emergency Services

Coverage will be provided for Emergency Services if the symptoms You present and records by the attending Physician indicate that an Emergency Medical Condition exists; or for Emergency Services necessary to provide You with a medical examination and stabilizing treatment, regardless whether Prior Authorization was obtained to provide those services. Services provided by a Hospital emergency department for non-Emergency Medical Conditions are not covered.

[In situations where You require Emergency Services and have no control over when or where such services are rendered, You will not be responsible for the difference between the Provider's billed charges and Allowed Amount(s).]

Eye Glasses and Corrective Lenses

Coverage will be provided for the first pair of [eyeglasses or] corrective lenses following cataract or cornea transplant surgery [up to a maximum of \$150] or one (1) pair of contact lenses; or one (1) pair of sclera shells intended for use as corneal bandages or for medically-diagnosed eye diseases approved by Our Medical Director. [Benefits are limited to the amount available for a basic (standard) frame which meet the minimum specifications for the corrective lens(es), the cost of basic frames shall not exceed [\$100-\$500].]

Family Planning

Covered Services are limited to:

- Office visits, medical evaluation, and counseling;
- Testing required to establish the etiology of male infertility, which is limited to sperm counts and/or semen analysis; scrotal ultrasound; prostate ultrasound, biopsy, and cystoscopy;
- Testing required to establish the etiology of female infertility, which is limited to hysterosalpingogram, diagnostic laparoscopy, and endometrial biopsy;
- [Surgical correction of physiological abnormalities causing infertility;]
- [Contraceptive implants, diaphragms, and IUDs (including their insertion and removal). Contraceptive supplies and devices obtained at a pharmacy are only covered through a pharmacy Rider]; and
- [Sterilization procedures (vasectomy or tubal ligation).]

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Exclusions:

- Fee associated with donors;
- Collection or storage of sperm;
- Those services related to conception through artificial means including, but not limited to, artificial insemination (IUI), in-vitro fertilization (IVF), gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT) and similar procedures;
- Injectable drugs for stimulation of ovaries or treatment of infertility and associated office visits, injections, laboratory, and other testing, including those provided in any Physician's office setting;
- Embryo transplants;
- Reversal of voluntarily induced sterilization;
- Expenses of surrogate motherhood;
- Selective reduction;
- Any experimental procedure;
- Office visits, laboratory, x-ray and other testing associated with any Non-Covered Service;
- [Surgical correction of physiological abnormalities causing infertility;]
- [Contraceptive implants, diaphragms, and IUDs (including their insertion and removal)]; and
- [Sterilization procedures (vasectomy or tubal ligation)]

For maternity care coverage, reference the Maternity Care section of this document and Schedule of Benefits.

Foot Care

Coverage for routine foot care provided by a Physician, including the paring and removing of corns and calluses or trimming of nails, will only be provided for the treatment of a person who, due to a demonstrated medical condition, is unable to perform such activity.

Exclusions:

- Foot care in connection with corns, calluses, flat feet, fallen arches or chronic foot strain.
- Medical or surgical treatment of onychomycosis (nail fungus) except persons with circulatory impairment or as described in the Diabetic Services section.

Genetic Studies

Coverage is provided for genetic counseling and tests only when required for diagnosis or treatment of genetic abnormalities where historical evidence suggests a potential for such abnormalities and the testing will alter the outcome of treatment.

Exclusions:

- Genetic testing when performed primarily for screening purposes.
- Genetic testing when performed primarily for purposes of embryonic pre-selection.

Hearing Screenings

Coverage is provided for a hearing screening to determine hearing loss.

Exclusion:

Services and associated expenses for the examination for prescribing and fitting hearing aids, hearing therapy and any related diagnostic hearing tests.

Home Health Care Services

Home health services will be provided as indicated in the Schedule of Benefits if You require skilled care and are homebound due to a disabling condition, are unable to receive medical care on an ambulatory outpatient basis, and do not require confinement

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in a Hospital or other Participating Facility. In order to receive the Network level of benefits, Home health services must be provided by an accredited Participating home health agency. Home health services include:

- Periodic and intermittent diagnostic and therapeutic services which can only be performed by professional nurses and other Participating Health Professionals if the services are ordered by a Physician; and
- Consumable medical supplies and DME administered or used by such persons in the course of services rendered during such visits.

Limitations:

- Physical, occupational and speech therapy are subject to the benefit limitations and Copayments as described in the Rehabilitation Services section of this document and the Schedule of Benefits.
- Intravenous and injectable medications are subject to the benefits as described in the Therapeutic Injections and IV Infusions section of this document and the Schedule of Benefits.
- Home services to help meet personal, family, or domestic needs, including but not limited to eating, bathing, grooming, toileting, dressing, transferring or other custodial or self-care activities and private duty nursing, whether or not required by a Physician. This exclusion does not apply to wheelchairs, walkers, canes and crutches.

Hospice

Coverage is provided for hospice care rendered by a Provider for treatment of the terminally ill when ordered by a Physician. Care through a hospice program includes supportive care involving the evaluation of the emotional, social and environmental circumstances related to or resulting from the illness, including the services of a skilled nurse, physical or occupational therapist, home health aide, social worker, or chaplain; and guidance and assistance during the illness for the purpose of preparing You and Your family for a terminal illness.

Infertility Treatment

Coverage is provided for You or Your Spouse the patient's oocytes are fertilized with the sperm of the patient's spouse, and

- a history of unexplained infertility of at least two (2) years' duration; or
- the infertility is associated with one or more of the following medical conditions:
 - Endometriosis;
 - Exposure in utero to Diethylstilbestrol, commonly known as DES;
 - Blockage of or removal of one or both fallopian tubes (lateral or bilateral salpingectomy) not a result of voluntary sterilization; or
 - Abnormal male factors contributing to the infertility, and
- when performed at a medical facility, licensed or certified by the Arkansas Department of Health, those performed at a facility certified by the Arkansas Department of Health which conform to the American College of Obstetricians and Gynecologists' guidelines for in vitro fertilization clinics, or those performed at a facility certified by the Arkansas Department of Health which meet the American Fertility Society's minimal standards for programs of in vitro fertilization;
- unable to obtain successful pregnancy through any less costly applicable infertility treatment for which coverage is available under the policy.

Cryopreservation, the procedure whereby embryos are frozen for late implantation, shall

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be included as an in vitro fertilization procedure.

Inpatient Hospital Care

Inpatient Hospital and Facility services will be covered for evaluation or treatment of conditions that cannot be adequately treated on an outpatient basis. Coverage includes Semi-private accommodations and associated professional and ancillary services. Certain services rendered during a Your confinement may be subject to separate benefit restrictions and/or Copayments as described in the Schedule of Benefits.

Exclusion:

Private inpatient room, unless Medically Necessary or if a Semi-private room is unavailable.

Maternity Services

Maternity-related Covered Services are treated as any other illness. Hospital Coverage for the mother and her newborn child includes forty-eight (48) hours of post-natal maternity care for vaginal delivery and ninety-six (96) hours of post-natal maternity care for cesarean delivery. The Plan may authorize a shorter hospital stay if the attending provider, after consulting with the mother, approves discharging earlier than 48 hours (or 96 hours as applicable). The discharge shall be made in accordance with the most current version of the "Guidelines for Perinatal Care", or similar guidelines. Inpatient Hospital services may be subject to Your Responsibility as defined in the Schedule of Benefits.

Exclusions:

- Delivery in the home setting.
- Services provided by a doula (labor aide) [or lactation consultant] and parenting, pre-natal or birthing classes.
- Amniocentesis, ultrasound or any other procedures requested solely for sex determination of a fetus, unless Medically Necessary to determine the existence of a sex-linked genetic disorder.
- All services and supplies relating to the conception and pregnancy of a person acting as a surrogate mother.
- Medical and Hospital care and costs for the infant child of a Dependent.

Mental Health and Substance Abuse

Covered benefits under this section are those specified in the most current Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association (DSM) or the Plan's utilization policies when more generous. Benefits under this section are only covered if such treatment is rendered by a licensed Provider who has the legal authority to diagnose and treat mental illness or substance abuse. In order to receive the Network level of benefits, You should visit Your family Physician or a Participating Provider for outpatient treatment. You may also visit a Non-Participating Provider and receive the Non-Network level of benefits.

Inpatient treatment in a Hospital or Residential Treatment Facility, including the services of mental health professionals, is subject to the applicable Hospital Inpatient Deductible, Copayment and/or Coinsurance as listed in the Schedule of Benefits. Outpatient treatment, including treatment through partial or full-Day Program Services, is subject to the applicable Deductible, Copayment and/or Coinsurance for services provided by Specialty Physicians as listed in the Schedule of Benefits. Medical services in conjunction with Mental Health or Substance Abuse treatment are subject to the applicable benefit defined on the Schedule of Benefits.

Exclusion:

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Mental illness and/or chemical dependency services for the following: 1) services utilizing methadone treatment as maintenance, LAAM (1-Alpha-Acetyl-Methadol), cyclazocine, or their equivalent; except where methadone or its equivalent is used as medically prescribed treatment in a federally approved detoxification program for drug abuse; and 2) services and treatment provided in connection with or to comply with involuntary commitments, police detentions and other similar arrangements.

Orthotic Appliances

Orthotic appliances correct or support a defect of a body form or function. Coverage is provided for the purchase of orthotic appliances following the onset or initial diagnosis of the condition for which the device is required. Coverage is provided for orthotic appliances, splints and braces, including necessary adjustments to shoes to accommodate braces. Shoe inserts will be Covered only if You have diabetes with demonstrated peripheral neuropathy OR the insert is needed for a shoe that is part of a brace.

Exclusions:

- The replacement costs for any otherwise Covered appliance for changes due to obesity;
- Routine maintenance due to normal wear and tear or negligence of items You own;
- Foot or shoe inserts, arch pads, or insoles whether custom-made or prefabricated;
- Cranial (head) remodeling bands or any such service or supply for the treatment of positional non-synostotic plagiocephaly and other protective head gear.

Outpatient and Physician Office Services

Coverage will be provided for those services requested or directed by the Plan or a Physician to be provided on an outpatient basis, including:

- Diagnostic and/or treatment services.
- Lab services.
- Diagnostic and therapeutic radiology services.
- Health evaluations.
- Administered drugs, medications, biologicals, and fluids which have been approved by the FDA, have a National Drug Code, and are administered under the supervision of a Physician.
- Services which can be appropriately provided on an outpatient basis such as certain surgical procedures, which can include anesthesia, recovery room services, ambulatory surgical centers and Hospital outpatient surgical centers.
- Physician services, including office visits, Hospital visits, consultations, and interpretation of tests.

Exclusions:

- Physical examinations or testing, vaccinations, immunizations or treatments strictly for the purposes of employment, insurance or government licenses, pilot licensing, and court-ordered forensic or custodial evaluations.
- Charges for completion of insurance Claim forms, specialty reports, and physical exam forms.
- Origination site fees and technical component fees associated with telehealth.

PKU or any other Amino and Organic Acid Inherited Disease Formula/Food

Coverage is provided for formula and/or food used for PKU or any other amino and organic acid inherited disease that is recommended by a Provider as determined by the Plan to be Medically Necessary.

Limitation:

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Enteral pumps and supplies will be covered only when the above criteria are met.

Exclusion:

The cost of outpatient Enteral tube feedings or formula and supplies are not covered except when used for PKU or any other amino and organic acid inherited disease, except as defined as a Covered Service, regardless of whether it is the sole source of nutrition.

Preventive Services

If received from a Participating Provider, Coverage for the following services will be provided at in a manner consistent with Section 2713 of Federal H.R. 3590. Coverage for these services will be provided once annually, unless otherwise specified below:

- Items or services with an “A” or “B” rating from the United States Preventive Services Task Force;
- Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control Prevention (ACIP-CDC);
- Preventive care and screenings for infants, children, and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration;
- Additional preventive care and screenings for women (including pap smears, breast cancer screening, mammography screenings, and osteoporosis screenings) not described in the first bullet; and
- Prostate cancer screening for men age forty (40) and older.

A complete list of the covered preventive services, including any age limitations, is available on Our website at [www.chckansas.com] or will be mailed to You upon request. You may request the list by calling the Customer Services number on Your ID card.

Please note:

- A preventive care service is designed to prevent or detect an illness, disease, or condition before the occurrence of the condition. This can include office visits, patient education, immunizations, and diagnostic testing. Preventive care services are performed before a disease is diagnosed and in the absence of symptoms. Services that are related to or in follow-up of an established illness, disease, condition and/or for a symptom are not part of a preventive care service.
- If a covered preventive service is provided during an office visit, it must either be billed separately from the office visit or be the primary purpose of the office visit in order to be covered under this benefit. If the preventive service is not billed separately and the primary purpose of the visit is not to provide the preventive service, then the applicable Copayments, Coinsurance and/or Deductible will apply to the office visit.

In order to receive the Network level of benefits, You should visit Your family Physician or a Participating OB/GYN specialist for the annual well-woman exam or may visit a Participating urologist for the annual well-man exam. You may also visit another provider and receive the Non-Network level of benefits.

Exclusions:

- Physical examinations or testing, vaccinations, immunizations or treatments strictly for the purposes of employment, insurance or government licenses, pilot licensing,

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and court-ordered forensic or custodial evaluations.

- Charges for completion of insurance Claim forms, specialty reports, and physical exam forms.
- Costs associated with immunizations for travel.

Prosthetic Devices

Prosthetic devices aid body functioning or replace a limb or body part and can be either internally or externally placed. Coverage is provided for the purchase of prosthetic devices following the onset or initial diagnosis of the condition for which the device is required. For prosthetic device placements requiring a temporary and then a permanent placement only one (1) temporary device will be Covered. Coverage is provided for prosthetic devices, including but not limited to, purchase of artificial limbs, bone anchored hearing aids, breasts, cochlear implants, and eyes, which meet the minimum requirements or specifications which are Medically Necessary for treatment, limited to the basic functional device which will restore the lost body function or part. Coverage is provided for external prosthetic devices that are used in lieu of surgery for breast reconstruction due to a mastectomy.

Coverage will be provided for replacement of prosthetic devices, which become non-functional and non-repairable due to: (1) A change in Your physiological condition; (2) Irreparable wear or deterioration from day-to-day usage over time of the device; or (3) The condition of the device requires repairs and the cost of such repairs would be greater than the cost of a replacement device. Prosthetics will be replaced for documented growth in a Dependent child requiring replacement.

Polishing and resurfacing of eye prosthetics are Covered on a yearly basis.

Exclusions:

- Those repairs or replacement costs for any otherwise Covered device, including replacement for changes due to obesity.
- Routine maintenance due to normal wear and tear or negligence of items You own.
- Electronic or computerized prosthetic limbs.
- Eyeglasses and contact lenses, except as described as a Covered Service.
- Hearing aids, except as above; digital and programmable hearing devices; hair pieces, prosthesis and styling; dental plates, bridges, braces, or any dental prostheses.

Reconstructive Surgery

Reconstructive procedures are those services that are performed when the primary purpose of the procedure is either to treat a medical condition or to improve or restore physiologic function for an organ or body part. Procedures and services which are related to psychological consequences or socially avoidant behavior as a result of injury, illness or congenital or developmental anomaly do not classify surgery or other procedures as a reconstructive procedure.

Coverage is provided for reconstructive treatment or surgery only under the following circumstances:

- Correction or repair of an accidental injury even if a cosmetic effect occurs.
- Correction or repair of a body part to improve/restore impairments of bodily function resulting from disease, injury, or previous therapeutic processes.
- Correction or repair of congenital abnormalities and hereditary complications or

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conditions are limited to:

- Improving/restoring impairments of bodily function such as cleft lip or palate;
 - Birthmarks on head or neck;
 - Webbed fingers or toes; and
 - Supernumerary digits or toes.
- Removal of leaking breast implants, not including implant replacement.
 - Services required by the Women's Health and Cancer Rights Act of 1998, including breast prostheses and treatment of complications, are provided in the same manner and at the same level as those for any other Covered Service and will be provided in a manner determined in consultation with You and the treating Physician including:
 - Reconstruction of the breast on which the mastectomy was performed;
 - Surgery and reconstruction of the other breast to produce a symmetrical appearance;
 - Prostheses and physical complications from all stages of the mastectomy, including lymphedema; and
 - Two (2) bras per Benefit Period will also be covered following the mastectomy.

Exclusions:

- Elective or voluntary enhancement procedures, services, or medications for sexual performance, athletic performance, cosmetic purposes, anti-aging, or mental performance including, but not limited to: Botox, Restylane, growth hormone, testosterone, hair removal or hair transplant.
- Cosmetic therapies or surgical procedures primarily to restore or alter the appearance including, but not limited to: surgical excision or reformation of any sagging skin on any part of the body such as eyelids, face, neck, abdomen, arms, legs or buttocks; alabrasion; chemosurgery; laser surgery or other skin abrasion procedures related to removal of scars, tattoos, or actinic/acne changes.
- Services performed in connection with the enlargement, reduction, implantation or change in appearance of a portion of the body such as breasts, face, lips, jaw, chin, nose, ears or genitals (i.e. labia reduction).
- Treatment of gynecomastia.

Rehabilitation Services and Supplies

Rehabilitative services are designed to restore normal physical functions following injuries, surgeries, or acute medical conditions and are Covered when they are expected to resulting significant improvement in the patient's condition.

Services include physical, occupational, speech therapies, spinal manipulations, and cardiac and pulmonary rehabilitation. Authorization or referral may be required, please review the Prior Authorization list at the end of this document.

Spinal manipulation services are covered for the manual treatment used to influence joint and neurophysiological function.

Limitation:

Rehabilitation services are covered only if they are expected to result in significant improvement in Your condition. The Plan will determine whether significant improvement has, or is likely to occur based on the medical information received from Your Physician.

Exclusions:

COVERED SERVICES

- Therapy in which the goal is maintenance, rather than significant improvement.
- Convalescent or custodial care.
- Vocational rehabilitation including, but not limited to, employment counseling and training.
- Cognitive therapy including, but not limited to: behavioral training, educational testing and therapy, dyslexia testing and treatment, learning disabilities and/or mental retardation testing and treatment.
- Developmental therapy, unless a congenital condition is the underlying cause for the delay.
- Athletic evaluation and training.
- Services that federal or state laws require be made available through a child's school district pursuant to an Individual Education Plan (IEP).
- Speech therapy or voice training when prescribed for stuttering or hoarseness.
- Spinal treatment to treat a condition unrelated to alignment of the vertebral column.

Therapeutic Injections and IV Infusions

Therapeutic injections and IV infusions are those prescription medications given by injection or IV infusion (specifically excluding blood) by a duly-licensed Provider or injected by the individual. Coverage is provided for Injectable and Self-Injectable medications when FDA-approved, medically appropriate subject to the Plan's formulary list and substitute Coverage by therapeutically interchangeable drugs, according to clinical guidelines used by the Plan.

Limitation:

Growth hormone therapy is only covered for those individuals under 18 years of age who meet the criteria for Coverage and who have been appropriately diagnosed with a growth hormone deficiency or pituitary disorder according to clinical guidelines used by the Plan.

Exclusions:

- Any drug, medicine or medication prescribed in doses exceeding the manufacturer-recommended maximum dose documented in the package insert that is approved by the FDA. This exclusion shall not apply to a drug, medicine or medication dose that is referenced in one of the standard reference compendia or in generally accepted peer-reviewed medical literature.
- Self-Injectable Prescription Drugs are drugs that are commonly and customarily administered by the individual according to clinical guidelines used by the Plan. Any Self-Injectable medication that is covered by a pharmacy Rider is excluded from the medical benefit.

Transplants

Services related to Medically Necessary organ transplants are Covered when approved by the Plan, performed at a Designated Transplant Network Facility and You are the recipient.

[Donor screening tests are Covered when performed at a Designated Transplant Network Facility.

If not Covered by any other source, the cost of any care, including complications up to 90 days, arising from an organ donation by a non-participant when You are the recipient will be Covered for the duration of Your Agreement when approved by the Plan.]

COVERED SERVICES

Coverage shall include the treatment of breast cancer by autologous bone marrow transplants or stem cell transplants when performed pursuant to nationally accepted peer review protocols utilized by breast cancer treatment centers experienced in autologous bone marrow transplants or stem cell transplants.

[If You reside more than [fifty (50) - one hundred-fifty (150)] miles from the transplant facility, reimbursement for travel will be Covered.] [Travel expenses may include the lodging for You and a companion.] Lodging and meal costs incurred by You and a companion [is Covered in accordance with the Plan's utilization policy and procedure.][for a period beginning twenty-four (24) hours prior to admission for the transplant procedure and forty-eight (48) hours after Your discharge are also covered. Lodging and meal costs are subject to a [\$100-\$250] per day limitation. Transportation, lodging and meal costs shall not exceed a maximum benefit of [\$2,000 - \$5,000] per transplant.]

Exclusions:

- Any associated expenses, including complications, arising from an organ donation when You are the donor [and the recipient is not Covered under the Plan].
- Any associated expenses involving temporary or permanent mechanical or animal organs.
- Reimbursement for organ harvesting.

Urgent Care Services

A condition that requires urgent care is an unexpected illness or injury that is not life-threatening but requires prompt medical attention. Examples of urgent care conditions include sprains, lacerations and severe abdominal pain.

Vision Services

Coverage is provided for eye examination including medical history; evaluation of visual acuity; external examination of the eye; binocular measure; ophthalmoscopic examination; medication for dilating pupils and desensitizing the eyes for tonometry; summary and findings, a determination as to the need for correction of visual acuity, prescribing lenses, if needed.

Exclusions:

- Corrective contact lens fitting.
- Surgical treatment for the correction of a refractive error, including but not limited to: radial keratotomy, LASIK, or refractive lensectomy with intraocular lens implant.
- Other vision care services, including but not limited to: visual analysis testing, vision therapy, training related to muscular imbalance of the eye or eye exercises.
- Vision hardware (i.e. frames) unless covered under a Vision Rider.

EXCLUSIONS

The following items are excluded from Coverage:

- Any service or supply that is provided by a Provider **not** in accordance with the Plan's utilization management policies and procedures, except that Emergency Services shall be Covered in accordance with the terms and conditions set forth in this Agreement.
- Any service or supply that is not Medically Necessary.
- Any service or supply that is not a Covered Service or that is directly or indirectly a result of receiving a non-Covered Service and subsequent complications which may occur.
- Procedures and treatments that the Plan determines and defines to be Experimental or Investigational.
- Court-ordered services including forensic or custodial evaluations; evaluations and diagnostic tests ordered or requested in connection with criminal or legal actions; damages in any kind of personal injury action, divorce, child custody, paternity, severance of parental rights, or child visitation proceedings; or services that are a condition of probation, parole or diversion agreements.
- Those services otherwise Covered under the Agreement related to a specific condition when You have refused to comply with, or have terminated the scheduled service or treatment against the advice of a Provider.
- Those services otherwise Covered under the Agreement, but rendered after the date Coverage under the Agreement terminates, including services for medical conditions arising prior to the date individual Coverage under the Agreement terminates. This exclusion does not apply to services described in the Inpatient on the Effective Date provision.
- Those services rendered outside the scope of a Participating or Non-Participating Provider's license, rendered by a Provider with the same legal residence as You, or rendered by a person who is a member of Your family, including spouse, brother, sister, parent, stepparent, child or step-child.
- Any portion of a Claim that the Plan determines to be incorrectly or inappropriately billed by a Physician, Facility or Hospital. This includes, but is not limited to: unbundling of procedural services, office visits that take place within a global period, and inappropriate modifier use.

Specifically excluded services include, but are not limited to, the following:

Abortion	Services related to elective abortions unless covered under an attached Rider. An elective abortion is a termination of pregnancy for any reason other than a spontaneous abortion (miscarriage) or to prevent the death of the individual upon whom the abortion is being performed.
Alternative Therapies	All charges related to complementary/alternative medicine including, but not limited to: sensory integrative techniques, music therapy, guided imagery, therapeutic touch, aroma therapy, acupuncture, acupressure, hydro-massage, hypnotherapy, hypnosis, massage therapy, Vax-D therapy, reflexology, cranio-sacral therapy, and therapy for the development of cognitive skills to improve attention, memory or problem solving, including compensatory training.
Apparel	Items of wearing apparel including, but not limited to TENS unit sleeves, except as specified in the Covered Services section.
Augmentative Communication Devices	Devices including but not limited to, those used to assist hearing impaired, or physically or developmentally disabled individuals.
Autopsy	Those services and associated expenses related to the performance of autopsies, unless requested by the Plan, to the extent that payment for such services is, by law, Covered by any governmental agency as a primary plan.

EXCLUSIONS

[Biofeedback]	Any expenses related to biofeedback.]
Chelation Therapy	Chelation therapy except for acute arsenic, gold, mercury or lead poisoning.
Counseling	Expenses related to religious counseling, marital/relationship counseling, vocational or employment counseling, and sex therapy.
Custodial Care	Domiciliary care, convalescent care, residential care, respite care or rest care. This includes care that assists You in the Activities of Daily Living like walking, getting in and out of bed, bathing, dressing, feeding and using the toilet; preparation of special diets and supervision of medication that is usually self-administered whether or not required by a Physician.
Duplicate Benefits	Benefits of this document will not duplicate benefits provided under Federal, State or local laws, regulations or programs. Examples of such programs are: Medicare, CHAMPUS, Tricare and services in any veteran's Facility when the services are eligible for coverage by the government. This document will provide coverage on a primary or secondary basis as required by state or federal law. This exclusion does not apply to Medicaid. This exclusion applies whether or not You choose to waive Your rights to these services.
Eligible Expenses	Any otherwise eligible expenses that exceed the maximum allowance or benefit limit.
Food	Food or food supplements regardless of whether it is the sole source of nutrition except as provided under for in the Covered Services Section.
Foreign travel	Care, treatment or supplies received outside of the U.S. if travel is primarily for the purpose of obtaining medical services.
Fraud	Any service(s) rendered and/or billed by a Provider through intentional misrepresentation of material fact or fraud.
Halfway House	Services rendered or billed by a school or halfway house.
Hair analysis	Those services related to the analysis of hair unless used as a diagnostic tool to determine poisoning.
Health Club Membership	Any costs of enrollment in a health, athletic or similar club.
Household Equipment and Fixtures	Purchase or rental of household equipment including, but not limited to: fitness equipment, air purifiers, central or unit air conditioners, humidifiers, dehumidifiers, water purifiers, hot tubs, hypo-allergenic pillows, pools, power assist chairs, mattresses or waterbeds, car seats, strollers, shower chairs, commodes, breast pumps, bedwetting alarms, prenatal cradles, electronic communication devices, braces and supports needed for employment, and modifications to Your home or vehicle.
Illegal Acts	Injuries incurred while You are in the commission or attempted commission of a felony, except when the injury is the result of You being a victim of domestic violence.

EXCLUSIONS

Immunizations	Those immunizations for travel, employment or education unless otherwise Covered under the Covered Services Section.
Medical-Legal	Services rendered primarily for the purpose of medical-legal reasons including, but not limited to, a Provider/patient contract to determine and monitor compliance with prescribed drug treatment, or for the purpose of Provider malpractice protection, that lack medical necessity as defined by this document. This does not include monitoring for therapeutic medication levels, which are deemed Medically Necessary.
Military Health Services	Those services for treatment of military service-related disabilities when You are legally entitled to other Coverage and for which facilities are reasonably available to You; or those services for any otherwise Eligible Employee or Dependent who is on active military duty except as required by the Uniformed Services Employment and Reemployment Rights Act.
Miscellaneous Service Charges	Miscellaneous service charges including, but not limited to, consultations performed through use of telephone, fax, or email communication; case management team conferences; consultations with family members; charges for failure to keep a scheduled appointment (unless the scheduled appointment was for a Mental Health service); or any late payment charge.
No Legal Obligation to Pay	Services are excluded for injuries and illnesses for which the Plan has no legal obligation to pay (e.g., free clinics, free government programs, court-ordered care, expenses for which a voluntary contribution is requested) or for that portion of any charge which would not be made but for the availability of benefits from the Plan, or for work-related injuries and Illness. Health services and supplies furnished under or as part of a study, grant, or research program.
Non-Medical Ancillary Services	Non-medical ancillary services including, but not limited to: legal services, social rehabilitation, vocational rehabilitation, work reintegration training, work hardening or conditioning, behavioral training, sleep therapy, educational testing, training, or therapy, unless approved by the Plan as part of treatment for severe head injury or stroke, or as specified in the Covered Services section.
Non-Prescription Drugs and Medications	Over-the-counter drugs and medications incidental to outpatient care and Urgent Care Services are excluded unless specifically stated as Covered in the Covered Services Section or as specifically provided in an optional Pharmacy Rider.
Nutritional-Based Therapy	Nutritional-based therapies except for treatment of PKU and for nutritional deficiencies due to short bowel syndrome and HIV. Oral supplements and/or enteral feedings, either by mouth or by tube, are also excluded regardless of whether it is the sole source of nutrition except as provided for under PKU or any other Amino and Organic Acid Inherited Disease Food/Formula.
Nutritional Supplements	Vitamins, minerals, nutritional supplements, medical foods, breast milk and formulas, or special diet foods whether or not required by a Physician except as required to be covered by law.

EXCLUSIONS

Obesity Services	Those services and associated expenses for procedures intended primarily for the treatment of obesity and morbid obesity including, but not limited to, gastric bypasses, gastric balloons, stomach stapling, jejuna bypasses, wiring of the jaw, removal of excess skin, including pannus, and services of a similar nature. Services and associated expenses for weight loss programs, nutritional supplements, appetite suppressants, and supplies of a similar nature.
Over-the-Counter Supplies	ACE wraps, batteries, elastic supports, finger splints, orthotics, and braces; also over-the-counter (OTC) products not requiring a prescription to be dispensed (e.g., aspirin, antacids, cervical collars and pillows, lumbar-sacral supports, back braces, ankle supports, positioning wedges/pillows, herbal products, oxygen, medicated soaps, food supplements, therabands, and bandages) are excluded unless specifically stated as Covered in the Covered Services Section or as specifically provided in an optional pharmacy Rider.
Pain Management	Costs associated with commercial pain management programs.
Personal Comfort and Convenience	Services or items for the Provider's or Your convenience including items or services such as home laboratory testing, television, telephone, barber or beauty service, guest service and similar incidental services and supplies.
Prescription Drugs and Medications	Prescription and non-prescription drugs and medications that require a prescription and are dispensed at a Pharmacy for outpatient treatment, except as specifically Covered in the Covered Services Section or as specifically provided in an optional pharmacy Rider to the Agreement.
Private Duty Nursing	Private duty nursing services, whether or not required by a Physician; nursing care on a full-time basis in Your home; or home health aides.
Rebating	Any service(s) rendered where You receive monetary or in-kind enticement, incentive, rebate or kickback of any kind from a Provider(s) or agent(s) of a Provider(s).
Replacement Items	Costs associated with the replacement of items that are damaged, lost, or stolen.
Sex Transformation Services	Services and associated expenses for sex transformation operations regardless of any diagnosis of gender role disorientation or psychosexual orientation, including any treatment or studies related to sex transformation. Also excluded is hormonal support for sex transformation.
Sexual Dysfunction	Any device, implant or self-administered prescription medication for the treatment of sexual dysfunction, including erectile dysfunction, impotence and anorgasm.
Sports Related Services	Those services or devices used specifically as safety items or to affect performance primarily in sports-related activities, and all expenses related to physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation including braces, supports and orthotics.

EXCLUSIONS

TMJ and MPDS	Services related to the diagnosis and treatment of temporomandibular joint disease (TMJ) and Myofascial Pain Dysfunction Syndrome (MPDS) unless covered by an attached Rider.
Third Party Liability	Services for which a third party has liability (by whatever terminology used-including such benefits mandated by law). Note: This exclusion is only applicable in the event that ERISA is held to preempt the anti-subrogation provisions of Missouri law.
[Tobacco Cessation	Those services and supplies for tobacco cessation programs and treatment of nicotine addiction.]
Travel or Transportation Expenses	Transportation, food, and lodging expenses even though prescribed by a Participating Provider, except as specified in the Covered Services Section.
War or act of war	Services received as a result of war or any act of war when You are outside of the continental United States, whether declared or undeclared or caused during service in the armed forces of any country.
Workers compensation	Payment for services or supplies for an illness or injury eligible for, or Covered by, any Federal, State or local Government Workers' Compensation Act, occupational disease law or other legislation of similar program.

ELIGIBILITY, ENROLLMENT AND EFFECTIVE DATES

Eligibility

Employee Eligibility

To be eligible as a Subscriber, You must:

- Be an Eligible Employee of the Group; and
- Complete and submit to the Plan such applications or forms that the Plan may reasonably request.

Dependent Eligibility

To be eligible to be enrolled under this Agreement as a Dependent, an individual must:

- Be the lawful spouse of the Subscriber or be a child of the Subscriber or the Subscriber's spouse including:
 - Children up to their twenty-sixth (26) birthday who are either the birth children of the Subscriber or the Subscriber's spouse or legally adopted by or placed for adoption with the Subscriber or Subscriber's spouse;
 - Children up to their twenty-sixth (26) birthday for whom the Subscriber or the Subscriber's spouse is required to provide health care Coverage pursuant to a Qualified Medical Child Support Order;
 - Children up to their twenty-sixth (26) birthday for whom the Subscriber or the Subscriber's spouse is the court-appointed legal guardian;
 - Coverage will be extended for children age twenty-six (26) who meet the Eligibility requirements, are mentally or physically incapable of earning a living and who are chiefly dependent upon the Subscriber or the Subscriber's Spouse for support and maintenance, provided that: the onset of such incapacity occurred before age twenty-six (26), proof of such incapacity is furnished to the Plan by the Subscriber upon enrollment of the Dependent child or at the onset of the Dependent child's incapacity prior to reaching the limiting age and annually thereafter;

[Notwithstanding the above, a common law spouse qualifies as a spouse under this Agreement only if his or her spousal status is affirmed by a court of competent jurisdiction.]

[Retirees

When eligible under the Agreement, a Retiree or Retiree's spouse who is eligible to be Covered under Medicare (Title XVIII of the Social Security Act as amended) shall enroll in Medicare Part A and B coverage on the later of the date he or she is first eligible for Medicare or the Effective Date of this Agreement in order to be eligible or continue Coverage under this Agreement.]

Change of Group's Eligibility Rules

In order to be eligible for Coverage under this health benefit plan, individuals must meet specific Group eligibility requirements. So long as this Agreement is in effect, any change in the Group's eligibility requirements must be approved in advance by the Plan.

Enrollment

Persons Not Eligible to Enroll

A person who fails to meet the eligibility requirements specified in this Agreement shall not be eligible to enroll or continue enrollment with the Plan for Coverage under this Agreement.

A person whose Coverage under this Agreement was previously terminated due to a violation of a material provision of this Agreement shall not be eligible to enroll with the Plan for Coverage under this Agreement.

ELIGIBILITY, ENROLLMENT AND EFFECTIVE DATES

No person who meets the eligibility requirements will be refused enrollment in the Plan due to a pre-existing health condition, including pregnancy.

Enrollment in the Plan

All individuals meeting the eligibility requirements may enroll with the Plan for Coverage under this Agreement during the Group Enrollment Period or a Special Enrollment Period.

Any new employee may enroll with the Plan for Coverage under this Agreement within thirty-one (31) days after becoming eligible. If the employee fails to submit an Employee Enrollment/Change Form for purposes of enrolling with the Plan for Coverage under this Agreement within thirty-one (31) days after becoming eligible, he or she is not eligible to enroll until the next Group Enrollment Period unless there is a special enrollment.

Eligible Employees or their Dependents who do not enroll during an initial eligibility period, or within thirty-one (31) days of first becoming eligible for Coverage under this Agreement are not eligible to enroll until the next Group Enrollment Period, unless they are eligible to enroll as a special enrollee, as described below.

Late Enrollees

Late Enrollees are not eligible to enroll except during the next Group Enrollment Period, or during a Special Enrollment Period.

Effective Dates

During Group Enrollment Period: An Eligible Employee or Retiree, and their Eligible Dependent(s), who enroll during a Group Enrollment Period shall be Covered under this Agreement as of the date stated therein.

Newly Eligible Employees: An Eligible Employee, including a newly hired employee, and their eligible Dependent(s), shall be Covered under this Agreement as of the date that he or she first becomes eligible for Coverage, according to the terms of the Agreement, so long as the Plan receives the employee's completed Employee Enrollment/Change Form within thirty-one (31) days of becoming eligible for Coverage.

Special Enrollment

[In the case of marriage, not later than the first day of the first month beginning after the completed Employee Enrollment/Change Form is received by the Plan.] [In all other instances,] Coverage shall become effective the day of the qualifying event.

An Employee of a Group and their Dependents who fail to enroll during the Special Dependent Enrollment Period or the Group Enrollment Period will not be permitted to enroll until the next Group Enrollment Period.

Non-Participating Eligible Employee

An Eligible Employee who is eligible but has not yet enrolled may enroll, within thirty-one (31) days from the date of marriage or upon the birth, adoption or placement for adoption of his or her child (even if the child does not enroll). A child who becomes a Dependent of a non-enrolled Eligible Employee as a result of marriage, birth, adoption or placement for adoption may enroll within thirty-one (31) days of that event, but only if the non-enrolled Eligible Employee is eligible for enrollment and enrolls at the same time.

Non-Participating Spouse. CHL-AR-COC-021-09.11

Your Spouse may enroll within thirty-one (31) days of marriage to You, or upon the birth,

ELIGIBILITY, ENROLLMENT AND EFFECTIVE DATES

adoption or placement for adoption of his or her child (even if the new child does not enroll).

Newborn Enrollment

A newborn child born to the Policy Holder or the Policy Holder's Covered Spouse may be Covered for the treatment of Injury or Illness, including medically diagnosed congenital defects, birth abnormalities, prematurity and routine nursery care, for the first five (5) days from the date of birth or until the mother is discharged, whichever is earlier. For Coverage to continue beyond the first five (5) days, an Application agreement to enroll the newborn must be received within ninety (90) days from the date of birth, and subject to all eligibility requirements.

New Dependents Due to Adoption

A child who becomes a Dependent as a result of adoption or placement for adoption, may enroll within sixty (60) days from the date of adoption or placement for adoption.

Qualified Medical Child Support Order (QMCSO)

Dependents eligible for Coverage as a result of a Qualified Medical Child Support Order (QMCSO) shall be Covered as of the date specified in the order or the date on which the Plan qualifies the order, whichever is earlier. The Group and the Plan, pursuant to specifications of federal and state law, must qualify Medical Child Support Orders. The procedures for qualification require the Subscriber to timely submit the Medical Child Support Order to the Group for initial qualification or rejection. The Group will forward the order to the Plan for qualification or rejection. The Plan shall provide notice of the decision to all parties identified in the order. If the order is qualified, an Identification Card and COC will be issued to the Alternate Recipient. In addition, a Subscriber, a state agency, or an Alternate Recipient may enroll a Dependent child pursuant to the terms of a valid QMCSO. A child who is eligible for Coverage pursuant to a QMCSO may not enroll Dependents for Coverage under the Plan.

Dependent Coverage under the Plan is subject to payment of the required contribution by the Subscriber, if any contribution is required. In the case of a child who is eligible for Coverage pursuant to a QMCSO, payment of the required contribution is to be made for such child, by the custodial parent or legal guardian of such child, or by a state agency. The Plan will notify the Group of the amount of the required total Premium payable to the Plan. Upon agreement by the Plan and the Group, the parties may change the required Premium contribution of Subscribers.

Enrollment Pursuant to Termination of Medicaid or SCHIP Coverage

Subject to the conditions set forth below, an employee who is eligible but not enrolled, or the Dependents of such Eligible Employee, if eligible but not enrolled, may enroll in this Plan if either of the following two conditions is satisfied.

Termination of Medicaid or SCHIP Coverage: The Eligible Employee or Dependent may enroll if the Eligible Employee or Dependent is covered under a Medicaid plan under Title XIX of the Social Security Act, or under the State Children's Health Insurance Program (SCHIP) under Title XXI of the Social Security Act, and coverage of the Eligible Employee or Dependent under either the Medicaid or SCHIP plan is terminated as a result of loss of eligibility under such plan.

Eligibility for Employment Assistance Under Medicaid or SCHIP: The Eligible Employee or Dependent may enroll if the Eligible Employee or Dependent becomes eligible for premium or other assistance with respect to coverage under this Health Plan,

ELIGIBILITY, ENROLLMENT AND EFFECTIVE DATES

pursuant to a Medicaid plan or SCHIP plan (including any waiver or demonstration product conducted under or related to such Medicaid or SCHIP plan).

Required Length of Special Enrollment Notification: An Eligible Employee and/or his or her Dependents must request special enrollment in writing no later than sixty (60) days from the date of termination of the Medicaid/SCHIP eligibility or the date the Eligible Employee or Dependent is determined to be eligible for the premium assistance.

Effective Date of Coverage: Coverage shall become effective on the first day of the month following the month in which the Plan received the request for Special Enrollment.

Notification of Change in Status

A Covered employee must notify the Plan of any changes in status or the status of any Dependent within thirty-one (31) days after the date of the qualifying event. This notification must be submitted on a written Employee Enrollment/Change Form to the Plan. Events qualifying as a change in status include, but are not limited to, changes in address, employment, divorce, marriage, dependency status, Medicare eligibility or coverage by another payer. The Plan should be notified within a reasonable time of the death of any Covered individual. Termination of the COC shall be without prejudice to any continuous loss which commenced while the COC was in force, but the extension of benefits beyond the period the COC was in force may be predicated upon the continuous injury or illness of the insured, limited to discharge or replacement of the COC.

Inpatient on the Effective Date

If You are Covered under an extension of benefits provision pursuant to state law or from a prior plan, services or supplies that are Covered, or required to be Covered, under an extension of benefits provision under the prior plan will be Covered under this Agreement subject to the Agreement's Coordination of Benefits Section.

TERMINATION OF COVERAGE

Termination of Coverage	Your Coverage shall terminate, upon the date specified by the Group, if any one of the following events occurs:
<i>Loss of Eligibility</i>	You no longer meet the eligibility requirements set forth in this Agreement; provided, however that this requirement may not apply to a Dependent child of a Subscriber, when Coverage is required to comply with a QMCSO. Loss of eligibility may also occur upon termination of the Subscriber from Employment; Your entering active military service; divorce or legal separation from the Subscriber; or when a Dependent child reaches the limiting age.
<i>Retire</i>	You are retired or pensioned, unless the Employer has included Retirees or those pensioned as eligible as referenced in this Agreement.
<i>Death</i>	The death of the Subscriber. Coverage for Dependents will terminate on the last day of the period for which payments have been made by or on behalf of the Subscriber, subject to the Continuation of Coverage section of this document.
<i>Non-Payment</i>	You fail to pay premiums required for Hospital or medical services. NOTE: In the event that the Plan has not received payment of premium at the end of the thirty-one (31) days notice period (and any grace period, if applicable), You will be retroactively terminated to the date Covered by Your last paid premium. You will be responsible for the value of services rendered during the thirty-one (31) days notice period (and any grace period, if applicable).
<i>Non-Compliance</i>	You fail to pay supplemental charges. You may have Your Coverage terminated for nonpayment of Copayments, Deductible and/or Coinsurance to the Provider under the following conditions: (1) the Provider has initiated collection efforts within sixty (60) days after the Plan is notified that copayment is due; and (2) the enrollee has received written notice from the Plan stating the disenrollment will occur unless arrangements for payment of the Copayments, Deductible and/or Coinsurance are made within [ten (10) working days, thirty-one (31) days] after receipt of the notice.
<i>Misrepresentation</i>	You abuse services or facilities. You may have Your Coverage restricted or canceled by the Plan in the event You abuse services or facilities. Knowingly misrepresenting or giving false information on any enrollment application form which is material to the Plan's acceptance of such application. The validity of the policy shall not be contested, except for non-payment of premiums, after the Plan has been in force for two years from the date of issue, and no initial statement You make regarding insurability shall be used as a reason for disenrollment after the Plan has been in force for two years from the date of issue.
<i>Criminal Behavior</i>	You participate in criminal behavior, including but not limited to threatening or perpetrating violent acts against the Plan, a Provider, or an employee of the Plan or a Provider. In this instance, Coverage for the Subscriber and all Dependents will be terminated.
Termination of Coverage without Notice	Your Coverage shall immediately terminate if any one of the following events occurs: <ul style="list-style-type: none">▪ Termination or non-renewal of the Agreement by the Group.▪ The Plan receives written notice from the Group instructing the Plan to terminate Your Coverage.▪ You select alternative Coverage in a health benefit plan offered by the Group.▪ You participate in fraudulent or criminal behavior, including but not limited to:<ul style="list-style-type: none">• Performing an act or practice that constitutes fraud or intentionally misrepresenting material facts including using Your identification card to obtain

TERMINATION OF COVERAGE

goods or services which are not prescribed or ordered for You or to which You are otherwise not legally entitled. In this instance, Coverage for the Subscriber and all Dependents will be terminated.

- Allowing any other person to use Your identification card to obtain services. If a Dependent allows any other person to use his/her identification card to obtain services, the Coverage of the Dependent who allowed the misuse of the card will be terminated. If the Subscriber allows any other person to use his/her identification card to obtain services, the Coverage of the Subscriber and his/her Dependents will be terminated.

Effect of Termination

If Your Coverage under this Agreement is terminated under this Section, all rights to receive Covered Services shall cease as of the date of termination.

Identification cards are the property of the Plan and, upon request, shall be returned to Us within thirty-one (31) days of the termination of Your Coverage. Identification cards are for purposes of identification only and do not guarantee eligibility to receive Covered Services.

Your Coverage cannot be terminated on the basis of the status of Your health or the exercise of Your rights under the Plan's Claims and Appeal procedures. The Plan may not terminate an Agreement solely for the purpose of effecting the disenrollment of an individual for either of these reasons.

Any monthly payments received on Your behalf for Coverage beyond the effective date of termination will be refunded by the Plan. In addition, the Plan may recover the contracted charges for Covered Services received after the termination of Coverage from You or the Provider, plus its cost to recover such charges, including attorneys' fees.

Under certain circumstances, You may be eligible for continuation of Coverage benefits or to convert to another policy as described in the Continuation of Coverage Section.

Discontinuation of Coverage

If the Plan decides to discontinue offering Coverage under the Agreement, You will receive a written notice of discontinuation at least ninety (90) days before the date the Coverage will be discontinued. Your Group will be offered the opportunity, on a guaranteed issue basis, to purchase for You any other coverage offered by the Plan. If the Plan elects to discontinue offering all health insurance coverage in the group market, You will receive a written notice of discontinuation at least one hundred and eighty (180) days before the date the coverage will be discontinued.

Certificates of Creditable Coverage

At the time coverage terminates, You are entitled to receive a certificate verifying the type of coverage, the date of any waiting periods, and the date any Creditable Coverage began and ended.

CONTINUATION OF COVERAGE/CONVERSION

In some cases, You can choose to continue group Coverage for a period of time. In such a case, conversion coverage would be available after group Coverage ends.

Continuation Coverage under Arkansas State Law

You are entitled to continue Your Hospital, surgical or major medical coverage under the Group Policy, including coverage for Your eligible dependents, if such coverage would otherwise terminate because employment or membership ends. Such continuation is subject to the following terms and conditions:

- You have been Covered for at least a three (3) month period before termination;
- You were not terminated for cause as permitted by the group master contract;
- The discontinued group Coverage was not replaced with similar group Coverage within thirty-one (31) days;
- You are not and do not become eligible for Medicare Coverage; and
- You are not eligible for any other Hospital, Physician and/or major medical Coverage for individuals in a group.

Continuation need not include dental, vision care or prescription drug benefits or any other Benefits provided under this Policy in addition to its Hospital, surgical or major medical Benefits, but continuation must include maternity Benefits if those Benefits are provided under the Group Policy.

Notification Requirements and Election Period

You do both of the following within ten (10) days of the date coverage would otherwise terminate:

- Request such continuation in writing.
- Pay the Employer Group, on a monthly basis, the amount of contribution required to continue coverage. Such Premium contribution shall not be more than the Group rate of the insurance being continued on the due date of each payment; but, if any Benefits are omitted (such as dental, vision care, and prescription drug), such Premium contribution shall be reduced accordingly.

The Enrolling Group must notify You, in writing, of its duties under this subdivision not later than the date on which coverage would otherwise terminate.

Terminating Events for Continuation Coverage Under Arkansas State Law

Continuation coverage under this Policy will end on the earliest of the following dates:

- The date four (4) months after the date Your Coverage under this COC would have terminated because of termination of employment;
- If You fail to make timely payment of a required Premium contribution, the end of the period for which contributions were made;
- The date this COC is terminated or, in the case of a Subscriber, the date the Employer Group terminates participation under the Agreement. However, if the Coverage ceasing by reason of termination is replaced by similar coverage under another Group Agreement, then You shall have the right to become covered under that other policy for the balance of the period that:
 - You would have remained covered under this COC in accordance with the conditions of this section;
 - The minimum level of Benefits to be provided by the other Agreement shall be the applicable level of Benefits of the prior policy reduced by any Benefits payable under that prior policy; and
 - The prior Group Agreement shall continue to provide Benefits to the extent of its accrued liabilities and extensions of benefits as if the replacement had not

CONTINUATION OF COVERAGE/CONVERSION

occurred.

Individual Conversion Coverage

If Your coverage terminates for one of the reasons described below, You may apply for conversion coverage without furnishing evidence of insurability.

- Reasons for termination:
- The Subscriber is retired or pensioned;
- You cease to be eligible as a Subscriber or Enrolled Dependent;
- Continuation coverage ends;
- The entire Agreement ends and is not replaced.

A converted Policy need not be made available if termination occurred for any of the following reasons:

- You failed to make timely payment of any required contribution, or were terminated for Fraud or Misrepresentation;
- The Group Agreement terminated or a Group's participation terminated, and the insurance is replaced by similar coverage under another Agreement within thirty-one (31) days of the date of termination.

Application and payment of the initial Premium must be made within thirty (30) days after coverage ends under this COC. Conversion coverage will be issued in accordance with the terms and conditions in effect at the time of application. Conversion coverage may be substantially different from coverage provided under this policy.

The converted policy shall cover You and Your dependents who were covered by this COC on the date of termination of insurance. At the option of the Plan, a separate converted policy may be issued to cover any Dependent.

We are not required to issue a converted Policy covering any person if such person is or could be covered by Medicare. Furthermore, We shall not be required to issue a converted Policy covering any person if:

- Such person is or could be covered for similar benefits by another policy; such person is or could be covered for similar Benefits under any arrangement of coverage for individuals in a Group, whether insured or uninsured; or similar benefits are provided for or available to such person, by reasons of state or Federal law; and

The benefits under sources of the kind referred to above for such person, or benefits provided or available under sources of the kind referred to above for such person, together with the converted policy's benefits would result in over-insurance according to the insurer's standards for over-insurance.

CLAIMS AND APPEAL PROCEDURES

You may occasionally encounter situations where the performance of the Plan does not meet expectations. When this occurs, You or Your Authorized Representative may call or write the Plan to file a complaint or an appeal. We will provide You a full and fair review of Claims decisions and Appeal decisions as required under ERISA. If You receive Your health benefits coverage through any arrangement that is not subject to ERISA, You have the same Claims and Appeal rights as a matter of contract. Please note that benefits are paid only if the services provided are Medically Necessary and are Covered Services under this Agreement.

Definitions

Administrative Appeal

For the purposes of this section, the following terms and their definitions will apply:

An Appeal of a decision that has not been issued for medical necessity or medical appropriateness, but is administrative in nature, for example, appealing a Copayment, Coinsurance, or exclusion associated with a Covered Service.

Adverse Benefit Determination

A denial of a request for service or a failure to provide or make payment in whole or in part for a benefit. An Adverse Benefit Determination may be based in whole or in part on a medical judgment and may also include:

- Any reduction or termination of a benefit;
- The failure to cover services because they are determined to be Experimental or Investigational;
- The failure to cover services because they are determined to not be Medically Necessary or medically appropriate;
- The failure to cover services because they are cosmetic;
- The failure, reduction, or termination regarding the availability and/or delivery of health care services;
- The failure, reduction, or termination regarding claims payment, handling or reimbursement for health care services;
- The failure, reduction, or termination regarding terms of the contractual relationship between You and the Plan; and/or
- Rescission of coverage.

Appeal

An Appeal is a request by You or Your Authorized Representative for consideration of an Adverse Benefit Determination of a service request or benefit that You believe You are entitled to receive.

Claim for Benefits or Claim(s)

A request for a service or payment of a service You make in accordance with the Plan's procedure for filing Claims. A Claim includes urgent care Claims, Pre-Service Claims and Post-Service Claims. A Claim must have sufficient information upon which to base a decision regarding benefits according to all of the provisions of this document.

Claim Eligible for External Review

(1) In the case other than an Emergency Medical Condition, a Claim for a proposed or delivered health care service which would otherwise be covered under this Certificate but for which You have received an Adverse Decision following a second level Appeal due to the fact that the service is not or was not Medically Necessary, or the health care treatment has been determined by the Plan to be Experimental or Investigational, and the denial leaves You with a financial obligation or prevents You from receiving the requested services, or (2) in case of an Emergency Medical Condition, a Claim for which an initial Adverse Decision by the Plan that a proposed health care service, which would otherwise be covered under this Certificate, is not Medically Necessary or the health care treatment has been determined by the Plan to be Experimental or Investigational and the denial would leave You with a financial obligation or prevent You from receiving the requested service.

Complaint

Any dissatisfaction expressed by You or Your Authorized Representative regarding a

CLAIMS AND APPEAL PROCEDURES

	Plan issue.
<i>Expedited Appeal</i>	An Appeal that may be requested either orally or in writing if You feel Your condition requires Urgent Care.
<i>External Review</i>	The review of an Adverse Decision by an external review organization, which conducts independent External Reviews of Adverse Decisions pursuant to a contract with the Department of Insurance.
<i>Inquiry</i>	Any question from You or Your Authorized Representative that is not a Pre-Service Appeal, a Post-Service Appeal or an Urgent Care Appeal, or Complaint.
<i>Medical Necessity Appeal</i>	An Appeal of a determination by the Plan or its designated utilization review organization that is based in whole or in part on a medical judgment that includes an admission, availability of care, continued stay or other service which has been reviewed and, based on the information provided, does not meet the Plan's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness and payment for the service is denied, reduced or terminated
<i>Post-Service Appeal</i>	An appeal for which an Adverse Benefit Determination has been rendered for a service that has already been provided.
<i>Pre-Service Appeal</i>	An appeal for which an Adverse Benefit Determination has been rendered for a service that has not yet been provided and requires Prior Authorization. Routine inquiries about Coverage information do not constitute Pre-Service Claims.
<i>Urgent Care</i>	Care for a condition when a delay in receiving such care could seriously jeopardize Your life or health or Your ability to regain maximum function or, in the opinion of a Physician with knowledge of Your condition, would subject You to severe pain that could not be adequately managed without care or treatment that is the subject of the Claim. In determining whether a Claim involves urgent care, the Plan must apply the judgment of a prudent layperson who possesses an average knowledge of health and medicine. However, if a Physician with knowledge of Your medical condition determines a Claim involves urgent care, the Claim must be treated as an Urgent Care Claim.
<i>Urgent Care Appeal</i>	An Appeal for which a requested service requires prior authorization, an Adverse Benefit Determination has been rendered, the requested service has not been provided, and the application of non-urgent care Appeal time frames could seriously jeopardize: (a) the life or health of You or Your unborn child; or (b) Your ability to regain maximum function. In determining whether an Appeal involves urgent care, the Plan must apply the judgment of a prudent layperson who possesses an average knowledge of health and medicine.
<i>Urgent Care Claim</i>	A request for a Claims decision regarding Urgent Care.
Complaints	A Complaint is a verbal expression of dissatisfaction that may be resolved on an informal basis. Complaints may be expressed by telephone or in person and are handled by Our Customer Service Department. The Customer Service Department may involve one or more staff members of the Plan or Providers of health care before making a determination. The objective is to review all the facts and to handle the Complaint as quickly and as courteously as possible.

Written Complaints will be acknowledged in writing by the Plan within five (5) working days after receipt of the Complaint. The Plan will conduct an investigation within twenty (20) working days after receipt of the respective Complaint, unless the investigation cannot be completed within this time. If the investigation cannot be completed within the 20-day timeframe, You will be notified in writing by the 20th working day of the specific

CLAIMS AND APPEAL PROCEDURES

reasons for the delay, and the investigation will be completed within 30 working days thereafter. You will be notified of the resolution within five (5) working days after the investigation of the respective Complaint is completed. Within fifteen (15) working days after the investigation of the respective Complaint is completed, the person, if other than You, who submitted the Complaint will be notified.

The address and telephone numbers for Complaints are:

[P.O. Box 7109
London, KY 40742
Telephone: (800) 969-3343]

Process for Submitting an Appeal

You or Your Authorized Representative has the right to obtain, without charge, copies of the documents, relating to the Adverse Decision, including the name of the utilization review organization used to review the Claim and may Appeal an Adverse Decision from an initial Claims decision by:

- submitting the Appeal in writing to [8320 Ward Parkway, Kansas City, MO 64114] to the attention of the appeals committee;
- sending a fax to [816-769-2408]; or
- [sending an e-mail to][KCCompliance@cvtv.com].

If You believe Your health would be seriously harmed by waiting for a decision under the standard timeframes set forth below, You may make an oral request for an Expedited Appeal by calling the Customer Services Department at the number on Your ID card.

Appeals should include:

- Your name and ID number.
- Specific information relating to and reason for the Appeal.
- Your expectation for resolution.
- Copies of medical records or other documentation that You wish to be considered in the Appeal.

All levels of the appeals process will be handled by individuals not involved in a previous determination. Appeals involving clinical issues will be reviewed by a practitioner in the same or a similar specialty that typically manages the medical condition, procedure or treatment in question. If time permits, You may be referred for a second opinion.

Appeal of Adverse Decisions

A decision on the Appeal will be made as quickly as the situation demands but in no event later than the time frames set forth below:

Action	Urgent Care Claim	Pre-Service Claim	Post-Service Claim
Time to File Appeal (from the date of the receipt of notification of the initial Adverse Decision)	180 days	180 days	180 days
Appeal Decision (from the date the Appeal is received by the Plan)	36 hours*	15 days*	20 working days*

*The time frames listed are those required by ERISA. You may voluntarily agree to

CLAIMS AND APPEAL PROCEDURES

provide the Plan additional time within which to make a decision.

In the case of an Urgent Care Appeal, You and/or Your Authorized Representative will be notified verbally and will be provided a follow-up written notice within 36 hours of receipt of the First Level Appeal request.

You will be notified in writing within five (5) working days of receipt of the Appeal request. We will complete Our investigation and will notify You of the resolution within five (5) working days after the respective Appeal is completed. Within fifteen (15) working days after the investigation of the respective Appeal is completed, the person, if other than You, who submitted the Appeal will be notified.

Right to Waive a Second Level of Appeal

If You have received an Adverse Decision following a first level Appeal due to the fact that the service is not or was not Medically Necessary, or the health care treatment has been determined by the Plan to be Experimental or Investigational, and the denial leaves You with a financial obligation or prevents You from receiving the requested services, You may voluntarily waive Your right to the Second Level Appeal and proceed directly to pursuing an External Review. You must notify the Plan in writing of Your decision to waive Your Second Level Appeal. By waiving Your Second Level Appeal, You exhaust all available internal appeal procedures.

Procedure for Pursuing an External Review

Participants of Arkansas-based revenue groups will have the right to request an External Review from the Arkansas Insurance Department. You have the right to request an External Review after a final Adverse Decision has been rendered, or when You have not received a final Adverse Decision within sixty (60) days of seeking such review, unless the delay was requested by You for eligible Claims as defined in the Claims Eligible for External Review section. We will notify You in writing regarding a final Adverse Decision and of the opportunity to request an External Review.

Within one-hundred twenty (120) days of receipt of the notice of the final Adverse Decision, You, the treating Provider acting on Your behalf with written authorization from You, or Your legally authorized designee, must make a written request for an External Review to [Us] [the Arkansas Insurance Department].

[For the purpose of pursuing an External Review, the definition of Emergency Medical Condition includes the following: 1) A medical condition where the timeframe for completion of a standard external review would seriously jeopardize Your ability to regain maximum function; or 2) A medical condition for which coverage has been denied on a determination that the recommended or requested health care service or treatment is experimental or investigational, if Your treating physician certifies, in writing, that the recommended or requested health care service or treatment for the medical condition would be significantly less effective if not promptly initiated.]

The right to External Review shall not be construed to change the terms of Coverage under this document. In no event shall more than one (1) External Review be available during the same year for any request arising out of the same set of facts. You may not pursue, either concurrently or sequentially, an External Review under both state and federal law. You shall have the option of designating which External Review process will be utilized. [The decision of the external review organization may be reviewed directly

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by the district court at the request of either You or the Plan. The review by the district court shall be de novo.]

If We fail to strictly adhere to all internal appeal procedure requirements as prescribed by state or federal law, You shall be deemed to have exhausted the internal claims and appeals process regardless of whether We assert Our substantial compliance with the appeal procedure or any error We committed was minimal.

You may contact your respective the Insurance Department at anytime by mail or telephone: Arkansas Department of Insurance, 1200 West Third Street, Little Rock, AR 72201, (501) 371 2600 or (800) 282-9134, and fax at (501) 371-2618, or via email at Insurance.Consumers@arkansas.gov.

ERISA Rights

If You are a participant or beneficiary of an employee welfare benefit plan under ERISA, You may have the right to bring a civil action under ERISA Section 502(a). Please see the Employer-sponsored benefit plan's Summary Plan Document for a complete statement of any ERISA rights You may have.

UTILIZATION REVIEW POLICY AND PROCEDURES

Utilization Review Circumstances

Utilization review is performed under the following circumstances:

Prospective or Pre-Service Review – Conducting utilization review for the purpose of Prior Authorization is called Prospective or Pre-Service Review. Services include, but are not limited to, elective inpatient admission and outpatient surgeries that require Prior Authorization.

Concurrent Care Review – Review that occurs at the time care is rendered. When You are hospitalized or Confined to a Skilled Nursing Facility, concurrent review is conducted on site or by telephone with the utilization review department at each facility.

Retrospective or Post-Service Review – Retrospective or post-service review is utilization review that takes place for medical services that have not been Prior Authorized by the Plan, after the services have been provided.

Toll Free Telephone Number – The toll free telephone number of the utilization review department is listed in the Plan's Schedule of Important Telephone Numbers and Addresses.

Timing of Utilization Review Decisions

The time-frame for making utilization review decisions and notifying You is as follows:

Prospective or Pre-Service Review

Two (2) business days from the date that the Plan receives all necessary information. In the event that the Plan does not receive all necessary information in fourteen (14) calendar days after the request for services, a decision will be made based on the information received. In the case of a determination to certify an admission, procedure or service, the Plan shall notify the provider rendering the service by telephone within twenty-four (24) hours of making the initial certification, and provide You and the Provider written or electronic confirmation of the telephone notification within two (2) working days of making the initial certification.

Concurrent Care Review

Determination regarding an extended stay or additional services will be made within one (1) business day from the date that the Plan receives all necessary information. The service shall be continued without liability to You until You have been notified of the determination. The Plan shall notify by telephone the Provider rendering the service within one (1) working day of making the determination, and provide You and the Provider written or electronic confirmation within one working day after the telephone notification. The written notification shall include the number of extended days or next review date, the new total number of days or services approved, and the date of admission or initiation of services.

Retrospective or Post-Service Review

Thirty (30) calendar days from the date that the Plan receives the request for determination. The Plan shall provide You written notice of determination within ten (10) working days of making the determination.

Notification

In the case of an adverse determination for an initial determination and/or concurrent review determination, the Plan shall notify by telephone the Provider rendering the service within twenty-four (24) hours of making the adverse determination, and provide You and the Provider written or electronic notification within one (1) working day of the telephone notification.

UTILIZATION REVIEW POLICY AND PROCEDURES

Reconsideration

You have the right to request reconsideration of any adverse determination involving a prospective or pre-service review as well as any concurrent care review determination.

Such reconsideration shall occur within one (1) working day of the receipt of the request and shall be conducted between the Provider rendering the service and the reviewer who made the adverse determination or a clinical peer designated by the reviewer if the reviewer who made the adverse determination is not available within one (1) working day.

Right to Appeal

You also have the right to an expedited or standard Appeal. Please see the Claims and Appeal Procedures Section of this document for the time frames for Appeals. Reconsideration is not a prerequisite to any Appeal.

Denial of Claims

The Plan's Medical Director shall make decisions regarding the denial of Coverage when related to Medical Necessity. Notices of claim denials shall include information regarding the basis of the decision and further Appeal rights.

Technology Assessment

The Plan uses a technology assessment review process to evaluate the appropriate use and Coverage for new medical technologies or new applications of existing technologies, including but not limited to, medical procedures, drugs and drug therapies, and devices.

The process includes review of current published authoritative medical and scientific information pertaining to the proposed technology. Information will be obtained from such sources as, applicable medical and scientific journals, medical databases, specialty medical societies, applicable government publications, the Plan Medical Directors, Pharmacy Department, and specialists, researchers, or institutions that specialize in the condition involved as needed.

The following factors will be considered when evaluating the proposed technology:

- The technology must have final approval from the appropriate regulatory bodies.
- The scientific evidence must permit conclusions concerning the effect of the technology on health outcomes.
- The technology must improve the net health outcome; and must be as beneficial as any established alternatives.

To use a technique before it has been adequately tested and established may pose a risk to Your safety or require the use of substantial resources with no reasonable likelihood of benefit from treatment.

This process has been established to make Our determinations for Coverage based on a scientifically and medically sound process that will appropriately identify and distinguish those procedures, drugs and devices that have not yet been proven to be sufficiently safe and effective.

To prevent exposure to unwarranted risk and ensure the effective use of medical resources, the Plan excludes Coverage for new technology procedures, drugs and devices that are deemed by Us to be Experimental or Investigational.

UTILIZATION REVIEW POLICY AND PROCEDURES

Case Management

Case management is a program conducted by the Plan that:

- Identifies cases involving a patient in a clinical situation that presents either the potential for catastrophic Claims or a utilization pattern that exceeds the norm.
- Assesses the appropriateness of the level of patient care and the setting in which it is received.
- Develops, introduces and implements viable alternate treatment plans for such cases that maintain or enhance the quality of patient care through discussion and agreement with You or Your legal representative, Provider(s), and the Plan.

This treatment plan may include both Covered Services and Non-Covered Services. Payment of benefits for such services or supplies shall be subject to the terms and provisions of this document.

COORDINATION OF BENEFITS

This coordination of benefits (COB) provision applies when You have health care coverage under more than one plan. "Plan" is defined below. The order of benefit determination rules listed below determine which plan will pay as the primary plan. The primary plan pays first without regard to the possibility that another plan may cover some expenses. A secondary plan pays after the primary plan and may reduce the benefits it pays so that payments from all group plans do not exceed 100% of the Plan's total allowable expense.

COB Definitions

- Plan*
- A "plan" is any of the following that provides benefits or services for medical or dental care or treatment. However, if separate contracts are used to provide coordinated coverage for participants of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.
- "Plan" includes: group insurance, closed panel or other forms of group or group-type coverage (whether insured or uninsured); hospital indemnity benefits in excess of \$200 per day; school accident-type coverage; medical care components of group long-term care contracts, such as skilled nursing care; and Medicare or other governmental benefits, as permitted by law.
 - "Plan" does not include: group or group-type accident only coverage; individual or family insurance; closed panel or other individual coverage; amounts of hospital indemnity insurance of \$200 or less per day; benefits for non-medical components of group long-term care policies; group and individual "no fault" contracts and group or group-type traditional automobile "fault" contracts; Medicare supplement policies, Medicaid policies and coverage under other governmental plans, unless permitted by law.
 - Each contract for coverage is a separate plan. If a plan has two (2) parts and COB rules apply only to one (1) of the two (2), each of the parts is treated as a separate plan.
 - The order of benefit determination rules determine whether this plan is a "primary plan" or "secondary plan" when compared to another plan covering the person.
 - When this plan is primary, its benefits are determined before those on any other plan and without considering any of the other plan's benefits. When this plan is secondary, its benefits are determined after those of another plan and may be reduced because of the primary plan's benefits.

Allowable Expense

- A health care service or expense, including deductibles and copayments, that is covered at least in part by any of the plans covering the person. When a plan provides benefits in the form of services (for example a HMO) the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense or service that is not covered by any of the plans is not an allowable expense. The following are examples of expenses or services that are not allowable expenses:
- If a covered person is confined in a private Hospital room, the difference between the cost of a semi-private room in the Hospital and the private room (unless the patient's stay in a private Hospital room is Medically Necessary in terms of generally accepted medical practice, or one of the plans routinely provides coverage for Hospital private rooms) is not an allowable expense.
 - If a person is covered by two (2) or more plans that compute their benefit payments on the basis of usual and customary fees, any amount in excess of the highest of the usual and customary fees for a specific benefit is not an allowable expense.
 - If a person is covered by two (2) or more plans that provide benefits or services on the basis of negotiated fees, or if one plan calculates its benefits or services on the

COORDINATION OF BENEFITS

basis of usual and customary fees and the other plan provides its benefits or services on the basis of negotiated fees, any amount in the excess of the highest of the fees is not an allowable expense.

- The amount a benefit is reduced by the primary plan because a covered person does not comply with the plan provisions. Examples of these provisions are second surgical opinions, pre-certification of admissions, and preferred Provider organizations.

Claim Determination Period

A calendar year; however, it does not include any part of a year during which the participant has no Coverage under this plan or before the date this COB provision or similar provision takes effect.

Closed Panel Plan

A plan that provides health benefits to covered persons primarily in the form of services through a panel of Providers that have contracted with or are employed by the plan, and that limits or excludes benefits for services provided by other Providers, except in the case of emergency or referral by a panel member.

Custodial Parent

A parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

ADEA Employer

An employer which is subject to the U.S. Age Discrimination in Employment Act (ADEA), and has twenty (20) or more Employees each working day in twenty (20) or more calendar weeks during the current or preceding Benefit Period.

Medicare Benefits

Benefits for services and supplies which You receive or are entitled to receive under Medicare Parts A or B.

Order of Benefit Determination Rules

When two (2) or more plans pay benefits, the rules for determining the order of payment are as follows:

1. The primary plan pays or provides its benefits as if the secondary plan or plans did not exist.
2. A plan that does not contain a COB provision that is consistent with this regulation is always primary. There is one exception: coverage that is obtained by virtue of membership in a group that is designed to supplement a part of basic package of benefits provided by a contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel to provide out-of-network benefits.
3. A plan may consider the benefits paid or provided by another plan in determining its benefits only when it is secondary to that other plan.
4. The first of the following rules that describes which plan pays its benefits before another plan is the rule to use.
 - **Non-Dependent or Dependent.** The plan that covers the person other than as a Dependent, (e.g. as an Employee, Participant, Subscriber or Retiree) is primary and the plan that covers the person as a Dependent is secondary. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a Dependent; and primary to the plan covering the person as other than a Dependent (e.g. a retired Employee); then the order of benefits between the two plans is reversed so that the plan covering the person as an Employee, Participant or Subscriber, or Retiree is secondary and the other plan is primary.
 - **Child Covered Under More Than One Plan.** The order of benefits when a

COORDINATION OF BENEFITS

child is covered by more than one plan is:

- o The primary plan is the plan of the parent whose birthday is earlier in the year if:
 - the parents are married;
 - the parents are not separated (whether or not they ever have been married); or
 - a court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.
 - If both parents have the same birthday, the plan that has covered either of the parents longer is primary.
 - o If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with financial responsibility has no coverage for the child's health care services or expenses, but the parent's spouse does, the spouse's plan is primary. This rule applies to Claim determination periods or plan years commencing after the plan is given notice of the court decree.
 - o If the parents are not married, or are separated (whether or not they ever have been married) or are divorced, the order of benefits is:
 - the plan of the custodial parent;
 - the plan of the spouse of the custodial parent;
 - the plan of the non-custodial parent; and then
 - the plan of the spouse of the non-custodial parent.
 - **Active or Inactive Employee.** The plan that covers a person as an Employee, who is neither laid off nor retired, is primary. The same would hold true if a person is a Dependent of a person covered as a Retiree and an Employee. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored. Coverage provided to an individual as a retired worker or as a Dependent of an actively working spouse will be determined under the rule labeled Non-Dependent or Dependent.
 - **Continuation Coverage.** If a person whose Coverage is provided under a right of continuation provided by federal or state law also is covered under another plan, the plan covering the person as an Employee, Participant or Subscriber, or Retiree (or as that person's Dependent) is primary, and the continuation coverage is secondary. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.
 - **Longer or Shorter Length of Coverage.** The plan that covered the person as an Employee, Participant, Subscriber or Retiree longer is primary.
- If the preceding rules do not determine the primary plan, the allowable expenses shall be shared equally between the plans meeting the definition of plan under this regulation.

Effect on the Benefits of this Plan

When this plan is secondary, it may reduce its benefits on a Claim so that the total benefits paid or provided by all plans are not more than 100% of the total allowable expenses. The difference between the benefit payments that this plan would have paid had this plan been the primary plan, and the benefit payments that the plan actually paid

COORDINATION OF BENEFITS

or provided shall be recorded as a benefit reserve for You or Your Covered Dependent and used by the plan to pay any allowable expenses, not otherwise paid during the claim determination period. As each Claim is submitted, this plan will:

- Determine its obligation to pay or provide benefits under its contract.
- Determine whether a benefit reserve has been recorded.
- Determine whether there are any unpaid allowable expenses.
- The benefits of the secondary plan will be reduced, so that they and the benefits payable under the other plans do not total more than 100% of the allowable expenses. When the benefits of this plan are reduced as described, each benefit is reduced in proportion and is charged against any applicable benefit limits or maximums. This plan will not pay more as secondary than it would have paid had it been primary.

If a covered person is enrolled in two (2) or more closed panel plans and if, for any reason, including the provision of service by a non-panel Provider, benefits are not payable by one closed panel plan, COB shall not apply between that plan and the other closed panel plan.

Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this plan and other plans. The Plan may get the facts it needs from, or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under this plan and other plans covering the person claiming benefits. The Plan need not tell, or get the consent of, any person to do this. Each person claiming benefits under this plan must give the Plan any facts it needs to apply those rules and determine benefits payable.

Facility of Payment

A payment made under another plan may include an amount that should have been paid under this plan. If it does, the Plan may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under this plan. The Plan will not have to pay that amount again. The term “payment made” includes providing benefits in the form of services, in which case “payment made” means reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the amount of the payments made by the Plan is more than it should have paid under this COB provision, it may recover the excess within twelve (12) months from one or more persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The “amount of the payments made” includes the reasonable cash value of any benefits provided in the form of services.

Coordination with Medicare

This Provision applies when You have Coverage under this document and are eligible for hospital insurance under Medicare Part A (whether or not You have applied or are enrolled for Medicare Benefits.) This Provision applies before any other COB provision of the policy.

If, in accordance with the following rules, the Plan has primary responsibility for Your Claims, then the Plan pays benefits first. If, in accordance with the following rules, the Plan has secondary responsibility for Your Claims; first Medicare benefits are

COORDINATION OF BENEFITS

determined or paid and then the Plan's benefits are paid. However, for services payable under both plans the combined Medicare Benefits and the Plan's benefits will not exceed 100% of total allowable expenses.

Rules for Determining Order of Benefits

Subscriber: We have primary responsibility for Claims if the Subscriber is eligible for Medicare Part A or B, and the Subscriber is actively employed by an ADEA employer who pays all or part of the Agreement's premium. We have secondary responsibility for Claims when a Subscriber is eligible for Medicare Part A or B, and is not actively employed by an ADEA employer who pays all or part of the Group Contract's premium.

Dependent: We have primary responsibility for a Dependent's Claim if the Dependent is eligible for Medicare Part A or B, and the Subscriber is actively employed by an ADEA employer who pays all or part of the Agreement's premium. We have secondary responsibility for a Dependent's Claims when he or she is eligible for Medicare Part A or B, and the Subscriber is not actively employed by an ADEA employer who pays all or part of the Agreement's premium.

Persons with End-Stage Renal Disease: We have primary responsibility for the Claims for You for up to thirty (30) months from the date You begin a regular course of renal dialysis or You could be entitled to Medicare after receiving a kidney transplant. Medicare benefits are secondary only for that portion of the thirty (30) month period remaining after You become eligible for Medicare. Thereafter, Medicare benefits are primary, and the Plan's benefits are secondary.

Persons under Non-ADEA employer plans: We have secondary responsibility for Your Claims if the employer under the Agreement is not an ADEA employer.

GENERAL PROVISIONS

Applicability	The provisions of this Agreement shall apply equally to the Subscriber and Dependents and all the benefits and provisions made available to You shall be available to Your Dependents.
Governing Law	This Plan is delivered and governed by the laws of the State of Arkansas.
Limitation of Action	You must exhaust the Plan's Claims and Appeals Procedure prior to pursuing legal action, (in a court or other government tribunal). No action at law or in equity shall be brought to recover under the Policy prior to the expiration of sixty (60) days after written proof of loss has been furnished in accordance with the requirements of the Plan. No such action shall be brought after the expiration of five (5) years after the time written proof of loss is required to be furnished.
Nontransferable	No person other than You is entitled to receive health care service Coverage or other benefits to be furnished by the Plan under this Agreement. Such right to health care service Coverage or other benefits is not transferable.
Relationship Among Parties Affected by Agreement	<p>The relationship between the Plan and Participating Providers is that of independent contractors. Participating Providers are not agents or employees of the Plan, nor is the Plan or any employee of the Plan an employee or agent of Participating Providers. Participating Providers shall maintain the Provider-patient relationship with You and are solely responsible to You for all Participating Provider services.</p> <p>Neither the Employer Group nor You are agents or representatives of the Plan, and neither shall be liable for any acts or omissions of the Plan for the performance of services under this Agreement.</p>
Contractual Relationships	<p>The Plan agrees with the Group to provide You Coverage for services, subject to the terms, conditions, exclusions and limitations of the Agreement. The Agreement is issued on the basis of the Group's Group Master Contract. This document is issued on the basis of the Subscriber's enrollment in the Plan pursuant to the Agreement in place between the Plan and the Group, and the Group's payment to the Plan of the required Premium. The Plan has the right to increase Premium rates, provided the Group is given thirty-one (31) days advance written notice.</p> <p>The Agreement between the Plan and the Group may require that the Subscriber contribute to the required Premiums. Information regarding the Premium and any portion of the Premium cost that You must pay can be obtained from the Group.</p> <p>This document is fully incorporated into the Agreement, and any direct conflict between this document and the Agreement will be resolved according to the terms that are most favorable to You. This document will be provided to the Group by the Plan for distribution to all Covered individuals.</p>
The Plan is Not Employer	The Plan shall not be deemed or construed as an employer for any purpose with respect to the administration or provision of benefits under the Group's benefit plan. The Plan shall not be responsible for fulfilling any duties or obligations of an employer with

GENERAL PROVISIONS

respect to the Group's benefit plan.

Reservations and Alternatives

The Plan reserves the right to contract with other corporations, associations, partnerships, or individuals for the furnishing and rendering of any of the services or benefits described herein. The identity of the service providers and the nature of the services provided may be changed from time to time and without prior notice to or approval by You or the Group. You must cooperate with those persons or entities in the performance of their responsibilities.

Severability

In the event that any provision of this Agreement is held to be invalid or unenforceable for any reason, the invalidity or unenforceability of that provision shall not affect the remainder of this Agreement, which shall continue in full force and effect in accordance with its remaining terms.

Valid Amendment

No change in this Agreement shall be valid unless approved by an Officer of the Plan, and evidenced by endorsement on this Agreement and/or by Amendment to this Agreement. Such Amendments will be incorporated into this document. Amendments to this document are effective upon thirty-one (31) days written notice to You or the Group. No change will be made to this document unless made by an Amendment or a Rider that is issued by the Plan. No agent has authority to change this document or to waive any of its provisions.

Waiver

The failure of the Plan, the Group, or You to enforce any provision of this Agreement shall not be deemed or construed to be a waiver of the enforceability of such provision. Similarly, the failure to enforce any remedy arising from a default under the terms of this Agreement shall not be deemed or construed to be a waiver of such default.

Entire Agreement

This Agreement shall constitute the entire Agreement between the parties. All statements, in the absence of fraud, pertaining to Coverage under this Agreement that are made by You shall be deemed representations, but not warranties. No such statement which is made to effectuate Your Coverage shall be used in any context to void the Coverage, with respect to which such statement was made or to decrease benefits hereunder after the Coverage has been in force prior to the contest for a period of two (2) years during Your lifetime, or unless such statement is contained in a written application signed by You and a copy of such application has been furnished to You.

Participation in the Policies of the Plan

If You wish to participate in matters of the Plan's policies and operations, You may do so by submitting suggestions, in writing, to the Customer Service Department at the address located in the Schedule of Important Numbers. The Plan's Quality Improvement Committee will investigate the viability and appropriateness of the suggestion and recommend approval or disapproval to the Plan's policymaking body.

Records

You shall furnish the Plan with all medical information and proofs of previous Coverage that the Plan may reasonably require with regard to any matters pertaining to this document in the event the Plan is unable to obtain this information directly from the Provider or insurer.

Providers rendering services to You and/or Your Dependents, are allowed by law, to

GENERAL PROVISIONS

disclose all facts pertaining to such services to Us upon request and in order to submit Claims on your behalf. The Plan agrees that such information and records will be considered confidential. The Plan and any of the Plan's designees shall have the right to release, and secondarily release any and all records concerning services which are necessary to implement and administer the terms of this document or for appropriate medical review or quality assessment.

ERISA

When Coverage under this document is purchased by the Group to provide benefits under a welfare plan governed by the ERISA 29 U.S.C. § 1001 et seq., the Plan is not the "Plan Administrator" or "Named Fiduciary" of the employer-sponsored welfare plan as those terms are used in ERISA. The Plan Administrator and Named Fiduciary is the Employer or Plan Sponsor.

Examination

In the event of a question or dispute concerning Coverage for services, the Plan may reasonably require that a Participating Provider acceptable to the Plan examine You at the Plan's expense.

Clerical Error

Clerical error shall not deprive any individual of Coverage under this document or create a right to additional benefits.

Workers' Compensation

The Coverage provided under this document does not substitute for and does not affect any requirements for Coverage by Workers' Compensation Insurance.

Conformity with Statutes

Any provision of this document which, on its Effective Date, is in conflict with the requirements of statutes or regulations of the jurisdiction in which it is delivered, is hereby amended to conform to the minimum requirements of such statutes and regulations.

Non-Discrimination

In compliance with state and federal law, the Plan shall not discriminate on the basis of age, color, disability, gender, marital status, national origin, religion, sexual preference, genetic information, or public assistance status.

Provisions Relating to Medicaid Eligibility

Payment for benefits will be made in accordance with assignment of rights made by You or on Your behalf, as required by a State plan for medical assistance approved under title XIX of the Social Security Act. To the extent that payment has been made under such State plan in any case in which the Plan has a legal liability under the Plan to make payment for such services, the Plan will pay for such services in accordance with any State law, provided that the State has acquired such rights to payment.

The fact that a person is eligible for or provided medical assistance under a State plan for medical assistance approved under Title XIX of the Social Security Act shall not be taken into account in enrolling such person, or in determining or making benefit payments under the Plan.

Policies and Procedures

The Plan may adopt policies, procedures, rules and interpretations to promote orderly and efficient administration of this Agreement.

Discretionary Authority

The Plan has the discretionary authority to interpret the Agreement in order to make

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eligibility and benefit determinations. The Plan also has the discretionary authority to make factual determinations as to whether any individual is entitled to receive any benefits under this Agreement. In no way shall this section limit any of Your rights as set forth in the Claims and Appeals section or any rights permitted under law.

Value Added Services

From time to time the Plan may offer to provide You access to discounts on health care related goods or services. While the Plan has arranged for access to these goods, services and/or third party provider discounts, the third party service providers are liable to You for the provision of such goods and/or services. The Plan is not responsible for the provision of such goods and/or services nor is it liable for the failure of the provision of the same. Further, the Plan is not liable to You for the negligent provision of such goods and/or services by third party service providers. These discounts are subject to modification or discontinuance without notice.

Applications and Statements

You shall complete and submit to the Plan such applications, or other forms or statements, as the Plan may reasonably request. The only statements You make that may be used in any legal action concerning this document issued hereunder are statements that are in writing. Any such written statement will be considered a representation and not a warranty.

Cooperation with Claims Investigation

You shall cooperate with the Plan in the benefit determination process and regarding the investigation of Claims relating to Covered Services, Coordination of Benefits, Medical Necessity determinations, utilization review and fraud and abuse functions. This duty to cooperate includes, but is not limited to, providing upon request by the Plan a written statement and/or testimony under oath regarding any Claim where Your name, identification or identity is utilized. Failure to cooperate may result in a delay in payment of the Covered Service(s) and/or denial of the Claim(s).

Federal and State Law Requirements

You shall provide the Plan with any information that is required for Us to comply with federal or state law requirements. Failure to provide the required information may result in a delay in payment of the Covered Service(s) and/or denial of the Claim(s).

Time Limit on Certain Defenses

Except for fraud, no statement shall be used to deny Your Claim after two (2) years. The two (2) years start from the date of Your application for submission of evidence for reinstatement.

No claim for loss incurred or disability (as defined in this document) commencing after two (2) years from the date of issue of this Agreement shall be reduced or denied on the ground that a disease or physical condition not excluded from Coverage by name or specific description effective on the date of loss has existed prior to the effective date of Coverage of this Agreement.

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Any capitalized terms listed in this Section shall have the meaning set forth below whenever the capitalized term is used in this Agreement.

Activities of Daily Living	Activities You usually do during a normal day including but not limited to bathing, dressing, eating, grooming, maintaining continence, toileting, transferring, and mobility.
Agreement	The Certificate of Coverage and any Amendments, the Employee Enrollment/Change Form, applicable Riders, Provider Directory, and the Schedule of Benefits together form the Agreement.
Allowed Amount(s)	The maximum monetary amount the Plan calculates for Covered Services, either in accordance with the Participating Provider's contract or the Non-Participating Provider Fee Schedule, when rendered to individuals and/or authorized by the Plan.
Alternate Facility	<p>A duly-licensed non-Hospital health care facility or an attached facility designated as such by a Hospital which provides one or more of the following services on an outpatient basis pursuant to the law of the jurisdiction in which treatment is received, including without limitation:</p> <ul style="list-style-type: none">▪ Scheduled surgical services;▪ Emergency services;▪ Urgent Care Services;▪ Prescheduled rehabilitative services;▪ Laboratory or diagnostic services;▪ Inpatient or outpatient Mental Illness services or Substance Abuse services.
Alternate Recipient	The child or children identified in the medical child support order as being eligible to receive health care Coverage pursuant to the medical child support order.
Amendment or Endorsement	Any attached written description of additional or alternative provisions to the Agreement and/or this document. Amendments or Endorsements are effective only when Authorized in writing by the Plan and are subject to all conditions, limitations and exclusions of the Agreement except for those which are specifically amended.
Ancillary Provider	A Provider who is not licensed as a Physician or a Hospital.
Authorized Representative	An Authorized Representative is an individual authorized in writing or verbally by You or by state law to act on Your behalf in requesting a health care service, obtaining claim payment or during the Appeal process. A Provider may act on Your behalf with Your expressed consent, or without Your expressed consent when it involves an Urgent Care claim or Appeal. An Authorized Representative does not constitute designation of a personal representative for HIPAA privacy purposes.
Benefit Period	The period of time (typically twelve (12) months) during which certain Allowed Amount(s) for Covered Services are accumulated for purposes of determining Coverage provisions, such as, but not limited to, satisfaction of out-of-pocket maximums and benefit limits. Refer to Your Schedule of Benefits to determine the applicable Benefit Period.

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Benefit Period Maximum	A maximum dollar amount, or maximum number of days, visits or sessions for which Covered Services are provided for You in any one year. Once a Benefit Period Maximum is met, no more Covered Services will be provided during the same year.
Certificate of Coverage (COC)	This document which sets forth the essential features of and benefits to which You are entitled, including exclusions, limitations on benefits and requirements to receive benefits.
COBRA	The Consolidated Omnibus Budget Reconciliation Act of 1986. This federal law requires employers with group health plans to offer participants and beneficiaries the opportunity to purchase the continuation of health care coverage for a limited period of time after the occurrence of a qualifying event, which is usually the termination of employment. The law applies to private employers with twenty (20) or more Employees.
Coinsurance	Cost-sharing arrangement in which You pay a specified percentage of the cost for a Covered Service.
Coinsurance Maximum	The annual limit of Your coinsurance payments for Covered Services, as specified in the Schedule of Benefits.
Confinement and Confined	An uninterrupted stay following formal admission to a Hospital, an Alternate Facility or Skilled Nursing Facility.
Copayment	Cost-sharing arrangement in which You pay a specified dollar amount as Your share of the cost for a Covered Service.
Coverage or Covered	The benefits provided under this document for Covered Services rendered to You, subject to the terms, conditions, exclusions, and limitations of this document.
Covered Services	The services or supplies provided to You for which the Plan will make payment, as described in the Agreement.
Custodial Care	Care is considered custodial when it is primarily for the purpose of helping You with Activities of Daily Living or meeting personal needs and can be provided safely and reasonably by people without professional skills or training. This term includes such other care that is provided to You who, in the opinion of the Medical Director, has reached the maximum level of recovery. This term also includes services to an institutionalized individual, who cannot reasonably be expected to live outside of an institution. Examples of Custodial Care include, but are not limited to; respite care and home care which is or which could be provided by family members or private duty caregivers; and vacation or resort facilities that incorporate recreational therapy or rest cures.
Day Program Services	A structured, intensive day or evening treatment or partial hospitalization program, certified by the department of mental health or accredited by a nationally recognized organization.
Deductible	The dollar amount of medical expenses for Covered Services that You are responsible

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for paying annually before benefits subject to the Deductible are payable under this Agreement.

Dependent	A person defined in the Agreement who is eligible to receive Covered Services (usually the spouse or child of a Subscriber).
Designated Transplant Network Facility	A Hospital appointed as a Designated Transplant Network Facility by the Plan, to render Medically Necessary and medically appropriate services for Covered transplants. You may request a listing that may be amended from time to time, of Designated Transplant Network Facilities from the Customer Service Department listed in the Schedule of Important Numbers.
Designated Transplant Network Physician	A Physician appointed as a Designated Transplant Network Physician by the Plan, who has entered into an agreement with a Designated Transplant Network Facility to render Medically Necessary and medically appropriate services for Covered transplants.
Effective Date	The date of Coverage as determined by the Group and agreed to by the Plan, as set forth in the Agreement.
Eligible Employee	A person defined by an employer as gainfully working and eligible for benefits offered through the Group.
Emergency Medical Condition and Medical Emergency	<p>The sudden and, at the time, unexpected onset of a health condition that manifests itself by symptoms of sufficient severity that would lead a prudent layperson, possessing an average knowledge of health and medicine, to believe that immediate medical care is required, which may include, but shall not be limited to:</p> <ul style="list-style-type: none">▪ Placing Your health in significant jeopardy;▪ Serious impairment to a bodily function;▪ Serious dysfunction of any bodily organ or part;▪ Inadequately controlled pain; or▪ With respect to a pregnant woman who is having contractions:<ul style="list-style-type: none">○ That there is inadequate time to effect a safe transfer to another Hospital before delivery; or○ That the transfer to another Hospital may pose a threat to the health or safety of the woman or unborn child. <p>Some examples of an Emergency Medical Condition include, but are not limited to: broken bone; chest pain; seizures or convulsions; severe or unusual bleeding; severe burns; suspected poisoning; trouble breathing; and vaginal bleeding during pregnancy. You may seek medical attention from a Hospital, Physician's office or some other Emergency facility.</p>
Emergency Services	Ambulance services and other Health Care Services rendered or required to evaluate and treat an Emergency Medical Condition, as directed or ordered by a Physician, subject to the exclusions and other provisions set out in this document.
Employee Enrollment/Change Form	Your application for enrollment in the Plan.

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ERISA	The Employee Retirement Income Security Act of 1974, as amended. ERISA is a federal law that applies to employer sponsored health benefit plans if the employer is not a government entity or a church organization.
Experimental or Investigational	<p>A health product or service is deemed Experimental or Investigational if one or more of the following criteria are met:</p> <ul style="list-style-type: none">▪ Any drug not approved for use by the FDA; any FDA approved drug prescribed for an off-label use whose effectiveness is unproven based on clinical evidence reported in Peer-Reviewed Medical Literature; or, any drug that is classified as IND (investigational new drug) by the FDA. As used herein, off-label prescribing means prescribing prescription drugs for treatments other than those stated in the labeling approved by the FDA.▪ Any health product or service that is subject to Institutional Review Board (IRB) review or approval;▪ Any health product or service that is the subject of a clinical trial that meets criteria for Phase I, II, III, or IV as set forth by FDA regulations, except as otherwise covered under the Clinical Trial benefit;▪ Any health product or service whose effectiveness is unproven based on clinical evidence reported in Peer-Reviewed Medical Literature.
Grace Period	The thirty-one (31) days immediately following the last day of the preceding Coverage month. If the Grace Period expires on a weekend, the Grace Period will be extended to the first business day thereafter.
Group	The employer or other legally constituted group with whom the Agreement is made.
Group Effective Date	The date that is specified in the Group master contract as the Effective Date of this Agreement.
Group Enrollment Period	The period of time during which Employees and their Dependents may enroll with the Plan. An initial enrollment period shall be no less favorable than a period beginning on the Employee's date of initial eligibility and ending 31 days thereafter.
HIPAA	The Health Insurance Portability and Accountability Act of 1996 and its administrative regulations.
Home Health Agency	An organization that meets all of these tests: (a) its main function is to provide home health care services and supplies; (b) it is federally certified as a home health care agency; and (c) it is licensed by the state in which it is located, if licensing is required.
Hospital	An institution, operated pursuant to law, which: (a) is operated for the medical treatment of sick and/or injured persons as inpatients; and (b) has twenty-four (24) hour nursing services on duty or on call. For the purpose of this definition, a facility that is primarily a place for rest, Custodial Care or care of the aged, a nursing home, convalescent home, or similar institution is not a Hospital.
Late Enrollees	Individuals who fail to enroll with the Plan for Coverage under the Agreement during the initial enrollment period when they first become eligible for Coverage as described in the

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Enrollment and Eligibility Section of this document. This term does not include individuals who enroll under a Special Enrollment Period; an employee of an employer which offers multiple health benefit plans, who elects a different health benefit plan during an open enrollment period; or a spouse or minor child who is eligible for Coverage due to a court order. An individual who declined Coverage in writing due to being covered under another group policy, is not a Late Enrollee if Coverage is requested within [thirty-one (31), sixty three (63)] days of losing that Coverage.

Maintenance Therapy

A treatment plan that seeks to prevent disease, promote health and prolong and enhance the quality of life, or therapy that is performed to maintain or prevent deterioration of a chronic condition.

Medical Director

The Physician specified by the Plan, or his or her designee, and appropriately licensed in the practice of medicine in accordance with state law, who is responsible for medical oversight programs, including but not limited to Prior Authorization programs.

Medically Necessary/Medical Necessity

Those services, supplies, equipment and facility charges that are not expressly excluded under this Agreement and are:

- Medically appropriate, so that expected health benefits (such as, but not limited to, increased life expectancy, improved functional capacity, prevention of complications, relief of pain) materially exceed the expected health risks;
- Necessary to meet Your basic health needs as a minimum requirement;
- Necessary to meet Your health needs, improve physiological function and required for a reason other than improving appearance;
- Rendered in the most cost-efficient manner and setting appropriate for the delivery of the health service without compromising the quality of care;
- Consistent in type, frequency and duration of treatment with scientifically-based guidelines of national medical research, professional medical specialty organizations or governmental agencies that are generally accepted as national authorities on the services, supplies, equipment or facilities for which Coverage is requested;
- Consistent with the diagnosis of the condition at issue;
- Required for reasons other than Your comfort or the comfort and convenience of Your Physician; and
- Not Experimental or Investigational as determined by the Plan under the Plan's Experimental Procedures Determination Policy.

Officer

The person holding the office of President and/or CEO or his or her designee.

Out-of-Pocket Maximum

The annual limit of Your payments for Covered Services, as specified in the Schedule of Benefits.

Participating Provider

A Provider who has a contractual arrangement with the Plan for the provision of Covered Services to individuals.

Peer-Reviewed Medical Literature

A phrase defined by two elements:

- It refers to the requirement that medical literature on a topic is only considered relevant if it is a scientific study, which has been published in the English language

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(mostly American) medical literature only after review by academic experts for structure of study and validity of conclusions, prior to acceptance for publication; and

- Based on a methodology used by certain authoritative bodies (including The National Cancer Institute PDQ Guidelines for Cancer Treatment and the International Consensus Conference on Bone Marrow Transplantation), the medical literature is graded for its quality using a 2-by-2 grid based on two parameters: strength of the evidence and effectiveness. Strength of evidence is graded from the highest level of evidence to the lowest, as follows:

Level 1: Randomized, controlled trial

Level 2: Cohort/Case Control Study

Level 3: Systematic Literature Review

Level 4: Large consecutive case series

Level 5: Small consecutive case series

Level 6: Textbook chapters (opinion of a respected authority)

Level 7: Case report

Effectiveness is evaluated using 4 measurements: (1) Is the proposed treatment harmful or beneficial? (2) Do the results favor the study (experimental) group or the control group? (3) Is the outcome considered statistically weak or strong? (4) Is the study design weak or strong?

After evaluating the peer-reviewed medical literature according to the methodology described above, a conclusion is drawn that the preponderance of evidence favors the proposed new technology as being proven (and therefore standard of care), or conversely unproven (i.e. investigational/experimental).

Physician/Practitioner

Anyone qualified and licensed to practice medicine and surgery by the state in which services are rendered who has the Degree of Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) Physician also means Doctors of Dentistry, Chiropractic, Optometry and Podiatry when they are acting within the scope of their license.

By use of this term, the Plan recognizes and accepts, to the extent of the Plan's obligation under the Agreement, other practitioners of medical care and treatment when the services performed are within the lawful scope of the practitioner's license and are provided pursuant to applicable laws. This includes APRNs and duly licensed psychologists and specialist social workers.

Plan

Coventry Health and Life Insurance Company.

Premium

The monthly fee required from each Group on behalf of each Subscriber and each enrolled Dependent in accordance with the terms of the Agreement.

Preventive Services

The services set forth in Section 2713(a)(1) of the federal Public Health Service Act. A list of the preventive services covered is available on the website [www.chckansas.com] or will be mailed to You upon request.

Prior Authorization

The process of obtaining approval for receiving specific health care services prior to those services being rendered. The process includes determination of eligibility,

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determination of Covered Services, determination of Medical Necessity, and implications about the use of Participating and Non-Participating Providers. Authorization does not guarantee payment if You are not eligible for Covered Services at the time the service is provided.

Provider	A Physician, Hospital, Home Health Agency, or Ancillary Provider or other duly licensed health care facility or practitioner, certified or otherwise authorized to furnish health care services pursuant to the law of the jurisdiction in which care or treatment is received.
Provider Directory	A listing of Participating Providers. Please be aware that the information in the directory is subject to change and will be updated at least annually.
Public Entity	A publicly supported medical facility providing care, treatment and supplies to injured or sick individuals through a program or agency owned and operated by a state or county government. This may include but is not limited to entities such as a county hospital or county health clinic.
Residential Treatment Facility	A facility licensed by the applicable state or approved by the Joint Commission on Accreditation of Health Care Organizations. The Residential Treatment Facility may be a general community Hospital with approved mental health beds, a psychiatric Hospital, a facility for the chemically dependent, or a Community Mental Health Center.
Residential Treatment Program	A program certified by the department of mental health involving residential care and structured, intensive treatment.
Retiree	A former Eligible Employee of the Group who meets the Group's definition of retired employees to whom the Group offers Coverage under the Agreement.
Rider	An Amendment that provides additional Covered Services and is attached to the Agreement. Services provided by a Rider may be subject to payment of additional Premiums.
Schedule Of Benefits	A written document, incorporated by reference into this document, that summarizes benefits and includes, but is not limited to, cost sharing amounts and limitations.
Semi-private Accommodations	A room with two (2) or more beds in a Hospital. The difference in cost between Semi-private Accommodations and private accommodations is Covered only when private accommodations are Medically Necessary.
Service Area	The geographic area served by the Plan and approved by the State Department of Insurance. The Plan's Service Area is subject to change from time to time. [Please refer to Section 12 for a description of the Service Area.]
Skilled Nursing Facility (SNF)	A facility certified by Medicare to provide inpatient skilled nursing care, rehabilitation services or other related services. The term "Skilled Nursing Facility" does not include a convalescent nursing home, rest facility, or facility for the aged that furnishes primarily Custodial Care, including training in Activities of Daily Living.

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Special Enrollment Period	The period after the regular Group Enrollment Period during which an individual is allowed to enroll for Coverage subject to the terms of this document.
Specialty Care Physician/Specialist	A Physician who is not a Primary Care Physician and provides medical services to individuals concentrated in a specific medical area of expertise.
Subscriber	An Employee of a Group who meets the eligibility requirements as specified in this document or the Agreement.
Substance Abuse	The psychological or physiological dependence upon and abuse of drugs, including alcohol, characterized by drug tolerance or withdrawal and impairment of social or occupational role functioning or both.
Total Disability	Your inability, because of sickness or injury, to perform the substantial and material duties of Your regular occupation, or Your inability to engage in employment or occupation for which You are or become qualified by reason of education, training, or experience. For an unemployed Dependent, Total Disability means Your complete inability to engage in most of the normal activities of a person of like age and gender. The disability, for Subscriber or Dependent, may require regular care and attendance by a Physician who is someone other than an immediate family member.
Utilization Review	A set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures, or settings. Techniques may include ambulatory review, prospective review, second opinion, Prior Authorization, concurrent review, case management, and discharge planning or retrospective review. Utilization review shall not include elective requests for clarification of Coverage.
Waiting Period	A time interval as defined by the Group starting from the Employee's date of hire to the Effective Date. [For small Groups, no Waiting Period shall be greater the ninety (90) days and shall permit Coverage to become effective no later than the first day of the month immediately following completion of the Waiting Period.]
We, Us or Our	Coventry Health and Life Insurance Company.
You or Your	An individual covered under this document.

SCHEDULE OF IMPORTANT TELEPHONE NUMBERS AND ADDRESSES

[Customer Services/Claims Coventry Health Care of Kansas, Inc.
Customer Service
PO Box 7109
London, KY 40742
(800) 969-3343
(866) 320-0697 (within Wichita)
(866) 285-1864 TDD
www.chckansas.com]

[Prior Authorization Coventry Health Care of Kansas, Inc.
Customer Service
PO Box 7109
London, KY 40742
(800) 969-3343
(866) 320-0697 (within Wichita)
(866) 285-1864 TDD]

[Appeals Attn: Appeals Department
8320 Ward Parkway
Kansas City, MO 64114]

[MH Net Behavioral Health PO Box 209010
Austin, TX 78720
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