

State: Arkansas **Filing Company:** HMO Partners, Inc. d/b/a Health Advantage
TOI/Sub-TOI: HOrg02G Group Health Organizations - Health Maintenance (HMO)/HOrg02G.002A Any Size Group - PPO
Product Name: 2013 General Amendments
Project Name/Number: Amendments/34-159,34-160,34-161,34-162,34-163,34-164,34-165,34-166,34-167,34-168 1/13

Filing at a Glance

Company: HMO Partners, Inc. d/b/a Health Advantage
 Product Name: 2013 General Amendments
 State: Arkansas
 TOI: HOrg02G Group Health Organizations - Health Maintenance (HMO)
 Sub-TOI: HOrg02G.002A Any Size Group - PPO
 Filing Type: Form
 Date Submitted: 11/15/2012
 SERFF Tr Num: HLAD-128772440
 SERFF Status: Closed-Approved-Closed
 State Tr Num:
 State Status: Approved-Closed
 Co Tr Num: 34-159

 Implementation: 01/01/2013
 Date Requested:
 Author(s): Christi Kittler, Yvonne McNaughton, Frank Sewall, Rita Thatcher, Evelyn Laney
 Reviewer(s): Rosalind Minor (primary)
 Disposition Date: 11/15/2012
 Disposition Status: Approved-Closed
 Implementation Date:

 State Filing Description:

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General Information

Project Name: Amendments	Status of Filing in Domicile: Pending
Project Number: 34-159,34-160,34-161,34-162,34-163,34-164,34-165,34-166,34-167,34-168 1/13	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments: Arkansas is state of domicile.
Explanation for Combination/Other:	Market Type: Group
Submission Type: New Submission	Group Market Size: Small and Large
Group Market Type: Employer	Overall Rate Impact:
Filing Status Changed: 11/15/2012	
State Status Changed: 11/15/2012	Deemer Date:
Created By: Evelyn Laney	Submitted By: Evelyn Laney
Corresponding Filing Tracking Number:	

PPACA: Not PPACA-Related

PPACA Notes: null

Include Exchange Intentions: No

Filing Description:

Attached please find forms 34-159,34-160,34-161,34-162,34-163,34-164,34-165,34-166,34-167,34-168 1/13 for your review and approval if indicated.

The following information describes the changes included in the amendment.

Dental Care and Orthodontic Services

Generally, dental care and orthodontic services are not covered under the Plan. However, we are amending the provision to allow coverage for dental services in connection with radiation treatment for cancer of the head or neck where appropriate.

Organ Transplant Services

We are amending Plan language to clarify that we cover high-dose or non-myeloablative chemotherapy, allogeneic or autologous stem or progenitor cell transplantation only when supported by the Company's Coverage Policies relative to such conditions. This does not represent a change in benefit but a clarification only.

Influenza Vaccinations

We are modifying the provisions surrounding influenza vaccinations to clarify that coverage is subject to the Plans allowance for intradermally administered (shots) influenza vaccinations without thimerasol. Thimerasol a mercury-containing organic compound that has been widely used as a preservative in many vaccines since the 1930s. This does not represent a change in benefit but a clarification only.

Electrotherapy and Electromagnetic Stimulators

The exclusion for electrotherapy stimulators is being amended to reflect new coverage for neuromuscular electrical stimulation (NMES) when supported by Coverage Policy.

Sleep Apnea, Portable Studies

Generally, portable sleep apnea studies are not covered. However, we are modifying the Plan language to provide coverage for certain portable sleep apnea studies when certain criteria are met.

Vision Enhancement

The exclusion for vision enhancements is being amended to reflect new coverage for Keratoprosthesis (corneal implant). It was previously excluded.

Allowance or Allowable Charge

We are amending the definition of Allowable Charge to clarify that we will pay each Current Procedural Terminology (CPT) code billed only one time. The CPT code is an all-inclusive, global payment that covers all elements of the service as described in the code and paid by the Health Plan. No further reimbursements are allowed. This does not represent a change

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in benefits.

There were several technical clarifications made within these Evidences of Coverage. Please refer to the amendment for these changes.

Also attached is a Flesch Reading Ease score certification signed by an officer of the company as required by Arkansas Code Annotated §23-80-206(d). I certify that the submission meets the provisions of Arkansas Insurance Department Rule & Regulation 19.

I further certify that the Life and Health Guaranty Association Notices required by Arkansas Insurance Department Rule & Regulation 49 and the consumer information notice required by Arkansas Code Annotated §23-79-138 are incorporated in the Evidences of Coverage to which this amendment is attached. Please feel free to contact me at 378-2165 with any questions you may have.

Company and Contact

Filing Contact Information

Evelyn Laney, Senior Compliance Analyst exlaney@arkbluecross.com
 320 West Capitol, Ste 211 501-378-2165 [Phone]
 Little Rock, AR 72201 501-378-2975 [FAX]

Filing Company Information

HMO Partners, Inc. d/b/a Health Advantage	CoCode: 95442	State of Domicile: Arkansas
320 West Capitol	Group Code:	Company Type:
Little Rock, AR 72203-8069	Group Name:	State ID Number: N/A
(501) 378-2967 ext. [Phone]	FEIN Number: 71-0747497	

Filing Fees

Fee Required?	Yes
Fee Amount:	\$500.00
Retaliatory?	No
Fee Explanation:	\$50.00 per form
Per Company:	No

Company	Amount	Date Processed	Transaction #
HMO Partners, Inc. d/b/a Health Advantage	\$500.00	11/15/2012	64933385

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	11/15/2012	11/15/2012

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Disposition

Disposition Date: 11/15/2012

Implementation Date:

Status: Approved-Closed

HHS Status: HHS Approved

State Review: Reviewed-No Actuary

Comment:

Rate data does NOT apply to filing.

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	Yes
Supporting Document	PPACA Uniform Compliance Summary	Approved-Closed	Yes
Form	Amendment	Approved-Closed	Yes
Form	Amendment	Approved-Closed	Yes
Form	Amendment	Approved-Closed	Yes
Form	Amendment	Approved-Closed	Yes
Form	Amendment	Approved-Closed	Yes
Form	Amendment	Approved-Closed	Yes
Form	Amendment	Approved-Closed	Yes
Form	Amendment	Approved-Closed	Yes
Form	Amendment	Approved-Closed	Yes
Form	Amendment	Approved-Closed	Yes
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Form Schedule

Lead Form Number: 34-159 1/13								
Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
1	Approved-Closed 11/15/2012	Amendment	34-159 1/13	CERA	Initial		40.600	34-159 1-13GenAmend(Non-Grandfathered).pdf
2	Approved-Closed 11/15/2012	Amendment	34-160 1/13	CERA	Initial		40.600	34-160 1-13GenAmend(Non-Grandfathered).pdf
3	Approved-Closed 11/15/2012	Amendment	34-161 1/13	CERA	Initial		40.600	34-161 1-13GenAmend(Non-Grandfathered).pdf
4	Approved-Closed 11/15/2012	Amendment	34-162 1/13	CERA	Initial		40.600	34-162 1-13GenAmend(Non-Grandfathered).pdf
5	Approved-Closed 11/15/2012	Amendment	34-163 1/13	CERA	Initial		40.600	34-163 1-13GenAmend(Non-Grandfathered).pdf
6	Approved-Closed 11/15/2012	Amendment	34-164 1/13	CERA	Initial		40.600	34-164 1-13GenAmend(Grandfathered).pdf

State: Arkansas **Filing Company:** HMO Partners, Inc. d/b/a Health Advantage
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Lead Form Number: 34-159 1/13								
Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
7	Approved-Closed 11/15/2012	Amendment	34-165 1/13	CERA	Initial		40.600	34-165 1-13GenAmend(Grandfathered).pdf
8	Approved-Closed 11/15/2012	Amendment	34-166 1/13	CERA	Initial		40.600	34-166 1-13GenAmend (Grandfathered).pdf
9	Approved-Closed 11/15/2012	Amendment	34-167 1/13	CERA	Initial		40.600	34-167 1-13GenAmend (Grandfathered).pdf
10	Approved-Closed 11/15/2012	Amendment	34-168 1/13	CERA	Initial		40.600	34-168 1-13GenAmend (Grandfathered).pdf

Form Type Legend:

ADV	Advertising	AEF	Application/Enrollment Form
CER	Certificate	CERA	Certificate Amendment, Insert Page, Endorsement or Rider
DDP	Data/Declaration Pages	FND	Funding Agreement (Annuity, Individual and Group)
MTX	Matrix	NOC	Notice of Coverage
OTH	Other	OUT	Outline of Coverage
PJK	Policy Jacket	POL	Policy/Contract/Fraternal Certificate

SERFF Tracking #:

HLAD-128772440

State Tracking #:

Company Tracking #:

34-159

State:

Arkansas

Filing Company:

HMO Partners, Inc. d/b/a Health Advantage

TOI/Sub-TOI:

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POLA	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	SCH	Schedule Pages
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The following Health Advantage Evidence of Coverage (Non-Grandfathered) is hereby amended.

Evidence of Coverage, Standard HMO, Form #31-01

The following subsection amendments are effective on January 1, 2013.

BENEFITS AND SPECIFIC LIMITATIONS IN YOUR PLAN, introductory paragraphs are hereby amended to read as follows.

Because of the high cost of some services or treatments, as well as the difficulty in some cases of determining whether services are really needed, we include coverage for such services or treatments but place limits on the extent of coverage, either by limiting the number of Provider visits or treatments, or by specifying a dollar limit for services or treatments received during a Contract Year or other specified period of time. This Section 3.0 describes medical services, drugs, supplies, tests and equipment for which coverage is provided under the Plan, provided all terms, conditions, exclusions and limitations of the Plan, including the six coverage criteria, are satisfied. This Section 3.0 sets out specific limitations applicable to each covered medical service, drug, supply or equipment.

You will note references to Copayment and Coinsurance obligations. For a description of the amount of these obligations and how they may vary depending upon whether you select an In-Network or Out-of-Network Provider, refer to Section 5.0, the definition of Allowance or Allowable Charge as set out in the Glossary of Terms and the Schedule of Benefits.

BENEFITS AND SPECIFIC LIMITATIONS IN YOUR PLAN, "Dental Care and Orthodontic Services," Subsection 2. is hereby amended to read as follows.

2. Benefits for dental service. Dental services in connection with radiation treatment for cancer of the head or neck are covered.

BENEFITS AND SPECIFIC LIMITATIONS IN YOUR PLAN, "Organ Transplant Services" Subsections 7-10 are hereby amended to read as follows.

7. Coverage for high-dose or non-myeloablative chemotherapy, allogeneic or autologous stem or progenitor cell transplantation for the treatment of a medical condition is provided subject to Health Advantage's specific Coverage Policies relative to these specific conditions.

SPECIFIC PLAN EXCLUSIONS, Health Interventions, "Dental Care or Orthodontic Services," Subsection b. is hereby amended to read as follows.

- b. Benefits for dental service. Dental services in connection with radiation treatment for cancer of the head or neck are covered.

SPECIFIC PLAN EXCLUSIONS, Health Interventions, "Electrotherapy and electromagnetic stimulators" is hereby amended to read as follows.

Electrotherapy and electromagnetic stimulators. All treatment using electrotherapy stimulators, and electromagnetic stimulators, including services and supplies used in connection with such stimulators, and complications resulting from such treatment are not covered. However, subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Evidence of Coverage, coverage is provided for a Transcutaneous Electrical Nerve Stimulator (TENS) to

treat chronic pain due to peripheral nerve injury when that pain is unresponsive to medication. Coverage is also provided for neuromuscular electrical stimulation (NMES) for treatment of disuse atrophy where nerve supply to the muscle is intact, including but not limited to atrophy secondary to prolonged splinting or casting of the affected extremity, contracture due to scarring of soft tissue as in burn lesions and hip replacement surgery until orthotic training begins.

SPECIFIC PLAN EXCLUSIONS, Health Interventions, "Sleep Apnea, Portable Studies" is hereby amended to read as follows.

Sleep Apnea, Portable Studies. Studies for the diagnosis, assessment or management of obstructive sleep apnea are generally not covered. However, subject to all other terms, conditions, exclusions and limitations of the Plan as set forth in this Evidence of Coverage, coverage is provided for portable (at home) sleep studies when all of the following monitoring information is included: EEG, heart rate, Chin EMG, ECG, airflow, effort and oxygen saturations, channels to identify awake versus asleep and apnea events. Devices used are considered portable comprehensive polysomnography devices monitoring a minimum of seven channels.

SPECIFIC PLAN EXCLUSIONS, Health Interventions, "Vision enhancement" is hereby amended to read as follows.

Vision enhancement. Any procedure, treatment, service, equipment or supply used to modify vision by changing the refractive error of the eye is generally not covered. Examples of non-covered vision enhancement services include, but are not limited to, the refraction for and the provision of eyeglasses and contact lenses; intraocular lenses, and refractive keratoplasty, with the exception of excessive, visually debilitating residual astigmatism following anterior segment surgery, i.e. corneal transplantation, cataract extraction, etc. Laser Assisted In Situ Keratomileusis (LASIK) and all other related refractive procedures are not covered. However, subject to all the terms, conditions, exclusions and limitations of the Plan as set forth in this Evidence of Coverage, a procedure, treatment, service, equipment or supply to correct a refractive error of the eye is covered in two instances: (1) if such refractive error results from traumatic injury or corneal disease, infectious or non infectious, and (2) the implant of a monofocal lens following cataract extraction and the single acquisition of eyeglasses or contact lenses within the first six months following cataract surgery. With respect to such eyeglasses or contact lenses, tinting or anti-reflective coating and progressive lenses are not covered. Eyeglass frames are subject to a \$50 maximum Allowance or Allowable Charge. See Subsection 3.11.3.

PROVIDER NETWORK AND COST SHARING PROCEDURES, "Network Procedures" are hereby amended to add the following new Subsection.

Scope of Provider Payment - Global Payment. Health Advantage's payment to a Provider for their services as described in a Current Procedural Terminology ("CPT") or Healthcare Common Procedure Coding System ("HCPCS") code and reimbursed in accordance with the Resource-Based Relative Value System ("RBRVS") used by the Centers for Medicare & Medicaid Services ("CMS") is an all-inclusive, global payment that covers all elements of the service as described in the particular code billed. This means that whatever staffing, overhead costs, equipment, drugs, machinery, tools, technology, supplies, or materials of any kind that may be required in order for the billing Provider to perform the service or treatment described in the CPT or HCPCS code billed, Health Advantage's payment to the billing Provider of the Allowance or Allowable Charge for that CPT or HCPCS code constitutes the entire payment and the limit of benefits under this Evidence of Coverage with respect to the CPT or HCPCS code billed. A Provider who bills for a particular CPT or HCPCS code is deemed to represent that the billing Provider has performed and is responsible for provision of all services or treatments described in the CPT or HCPCS code, and is entitled to bill for such services or treatments. If Health Advantage pays for a Covered Service by applying the Allowance or Allowable Charge to the bill of a Provider who represents that the Provider has performed a service or treatment described in a CPT or HCPCS code as submitted to Health Advantage, Health Advantage shall

have no further obligation, nor is there coverage under this Evidence of Coverage, for bills from or payment to any other provider, entity or person, regardless of whether they assisted the billing Provider or furnished any staffing, equipment, drugs, machinery, tools, technology, supplies or materials of any kind to or for the benefit of the billing Provider. In other words, benefits under this Evidence of Coverage are limited to one, global payment for all components of any services falling within the scope of any CPT or HCPCS code service or treatment description, and Health Advantage will make only one payment with respect to such CPT or HCPCS code, even if multiple parties claim to have contributed a portion of the staffing, equipment, machinery, tools, technology, supplies or materials used by the billing Provider in the course of providing the service or treatment described in the CPT or HCPCS code.

For example, a physician who performs certain surgical procedures in the physician's office might choose to engage an equipment and supply company to set up the surgical table, furnish an assisting nurse, and also furnish certain surgical instruments, devices or supplies used by the physician. When the physician bills Health Advantage for the physician's performance of the surgical procedure described in a specific CPT or HCPCS code, Health Advantage will make a single, global payment to the physician for Covered Services described in the CPT or HCPCS code, and will not be obligated to pay for any charges of the equipment and supply company. In such circumstances, any charge or claim of payment due the equipment and supply company shall be the exclusive responsibility of the physician (or other provider) who engaged the equipment and supply company, and permitted or facilitated such company's access to the physician's patient. In any event, as noted above, no benefits are available under this Evidence of Coverage for any services, drugs, materials or supplies of the equipment and supply company. It is Health Advantage's policy (and this Evidence of Coverage is specifically intended to adopt the same) that no benefits shall be paid for "unbundled services" in excess of Health Advantage's Allowance or Allowable Charge for any service as described in the applicable CPT or HCPCS code. This means, for example, that if a physician and another category of provider (such as a durable medical equipment supplier, a laboratory, a nurse practitioner, a nurse, a physician's assistant or any other category of provider) agree together to divide up, split or "unbundle" the components of any CPT or HCPCS code, and attempt to bill separately for the various components each allegedly provides for the patient, benefits under this Evidence of Coverage shall nevertheless be limited to one Allowance per CPT or HCPCS code; in such circumstances, your benefits under this Evidence of Coverage will pay only one Allowable Charge for any Covered Service described in any single CPT or HCPCS code, and the various providers involved in any such "unbundling" action or agreement must resolve among themselves any division of that single Allowance or Allowable Charge between or among them. You can protect yourself from the possibility of billing in excess of the Allowable Charge in these circumstances by always inquiring in advance to be sure that each provider involved in your care or treatment is an In-Network Provider.

Please note that Health Advantage makes the following exceptions to the preceding general policy of one global payment (Allowance) per CPT or HCPCS code: (i) where CMS has developed and published an RBRVS policy that specifically recognizes that the Relative Value Units (RVUs) associated with a specific CPT or HCPCS code should be divided into both a professional and a technical component; or (ii) billing of the services of an assistant surgeon for those CPT or HCPCS codes that specifically recognize assistant surgery services as applicable; or (iii) billing of radiopharmaceuticals used in nuclear medicine procedures where such radiopharmaceuticals clearly are not included in the practice expense portion of the associated RVU as published and defined by CMS; or (iv) billing of a procedure or set of procedures that, per the applicable CPT or HCPCS code definition, is based solely on time consumed so that it is necessary to submit multiple units of the procedure in order to accurately report the total time devoted to the patient. In the specific four circumstances outlined in the preceding sentence, Health Advantage will recognize and pay more than one Allowance per CPT or HCPCS code, provided all other terms and conditions of this Evidence of Coverage are met. With respect to the first such circumstance involving RVUs divided between a professional and a technical component, Health Advantage's payment will be limited to one global payment (Allowance) for the applicable professional component, and one global payment (Allowance) for the technical component. In other words, even where CMS policy specifically recognizes division of an RVU into professional and technical components, Health Advantage will not be responsible for paying multiple providers or multiple billings for the professional component, nor will Health Advantage

be responsible for paying multiple providers or multiple billings for the technical component. Benefits under this Evidence of Coverage will be limited in such circumstances to one global payment (Allowance) for the professional component and one global payment (Allowance) for the technical component.

GLOSSARY OF TERMS, "Allowance or Allowable Charge" is hereby amended to read as follows.

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

At the option of Health Advantage, Allowance or Allowable Charges for services or supplies received out of Arkansas may be determined by the local Blue Cross and Blue Shield Plan, See Subsection 7.1.10 dealing with Out of Arkansas Claims. See Subsection 3.23.4 with respect to Allowance or Allowable Charge for transplants. See Subsection 3.3.2 with respect to Allowance or Allowable Charge for Outpatient Surgery Centers. **Please note that all benefits under this Evidence of Coverage are subject to and shall be paid only by reference to the Allowance or Allowable Charge as determined at the discretion of Health Advantage. This means that regardless of how much your health care Provider may bill for a given service, the benefits under this Evidence of Coverage will be limited by the Allowance or Allowable Charge we establish. If you use a Health Advantage-participating Provider, that Provider is obligated to accept our established rate as payment in full, and should only bill you for your Deductible, Coinsurance and any non-covered services; however, if you use a non-participating Provider, you will be responsible for all amounts billed in excess of Health Advantage Allowance or Allowable Charge.**

The payment to a Provider for their services as described in a Current Procedural Terminology ("CPT") or Healthcare Common Procedure Coding System ("HCPCS") code and reimbursed in accordance with the Resource-Based Relative Value System ("RBRVS") used by the Centers for Medicare & Medicaid Services ("CMS") is an all-inclusive, global payment that covers all elements of the service as described in the particular code billed. This means that whatever staffing, overhead costs, equipment, drugs, machinery, tools, technology, supplies, or materials of any kind that may be required in order for the billing Provider to perform the service or treatment described in the CPT or HCPCS code billed, Health Advantage's payment to the billing Provider of the Allowance or Allowable Charge for that CPT or HCPCS code constitutes the entire payment and the limit of benefits under this Evidence of Coverage with respect to the CPT or HCPCS code billed. A Provider who bills for a particular CPT or HCPCS code is deemed to represent that the billing Provider has performed and is responsible for provision of all services or treatments described in the CPT or HCPCS code, and is entitled to bill for such services or treatments. If Health Advantage pays for a Covered Service by applying the Allowance or Allowable Charge to the bill of a Provider who represents that the Provider has performed a service or treatment described in a CPT or HCPCS code as submitted to Health Advantage, Health Advantage shall have no further obligation, nor is there coverage under this Evidence of Coverage, for bills from or payment to any other provider, entity or person, regardless of whether they assisted the billing Provider or furnished any staffing, equipment, drugs, machinery, tools, technology, supplies or materials of any kind to or for the benefit of the billing Provider. In other words, benefits under this Evidence of Coverage are limited to one, global payment for all components of any services falling within the scope of any CPT or HCPCS code service or treatment description, and Health Advantage will make only one payment with respect to such CPT or HCPCS code, even if multiple parties claim to have contributed a portion of the staffing, equipment, machinery, tools, technology, supplies or materials used by the billing Provider in the course of providing the service or treatment described in the CPT or HCPCS code.

For example, a physician who performs certain surgical procedures in the physician's office might choose to engage an equipment and supply company to set up the surgical table, furnish an assisting nurse, and also furnish certain surgical instruments, devices or supplies used by the physician. When the physician bills Health Advantage for the physician's performance of the surgical procedure described in a specific CPT or HCPCS code, Health Advantage will make a

single, global payment to the physician for Covered Services described in the CPT or HCPCS code, and will not be obligated to pay for any charges of the equipment and supply company. In such circumstances, any charge or claim of payment due the equipment and supply company shall be the exclusive responsibility of the physician (or other provider) who engaged the equipment and supply company, and permitted or facilitated such company's access to the physician's patient. In any event, as noted above, no benefits are available under this Evidence of Coverage for any services, drugs, materials or supplies of the equipment and supply company. It is Health Advantage's policy (and this Evidence of Coverage is specifically intended to adopt the same) that no benefits shall be paid for "unbundled services" in excess of Health Advantage's Allowance or Allowable Charge for any service as described in the applicable CPT or HCPCS code. This means, for example, that if a physician and another category of provider (such as a durable medical equipment supplier, a laboratory, a nurse practitioner, a nurse, a physician's assistant or any other category of provider) agree together to divide up, split or "unbundle" the components of any CPT or HCPCS code, and attempt to bill separately for the various components each allegedly provides for the patient, benefits under this Evidence of Coverage shall nevertheless be limited to one Allowance per CPT or HCPCS code; in such circumstances, your benefits under this Evidence of Coverage will pay only one Allowance or Allowable Charge for any Covered Service described in any single CPT or HCPCS code, and the various providers involved in any such "unbundling" action or agreement must resolve among themselves any division of that single Allowance or Allowable Charge between or among them. You can protect yourself from the possibility of billing in excess of the Allowance or Allowable Charge in these circumstances by always inquiring in advance to be sure that each provider involved in your care or treatment is an In-Network Provider.

Please note that Health Advantage makes the following exceptions to the preceding general policy of one global payment (Allowance) per CPT or HCPCS code: (i) where CMS has developed and published an RBRVS policy that specifically recognizes that the Relative Value Units (RVUs) associated with a specific CPT or HCPCS code should be divided into both a professional and a technical component; or (ii) billing of the services of an assistant surgeon for those CPT or HCPCS codes that specifically recognize assistant surgery services as applicable; or (iii) billing of radiopharmaceuticals used in nuclear medicine procedures where such radiopharmaceuticals clearly are not included in the practice expense portion of the associated RVU as published and defined by CMS; or (iv) billing of a procedure or set of procedures that, per the applicable CPT or HCPCS code definition, is based solely on time consumed so that it is necessary to submit multiple units of the procedure in order to accurately report the total time devoted to the patient. In the specific four circumstances outlined in the preceding sentence, Health Advantage will recognize and pay more than one Allowance per CPT or HCPCS code, provided all other terms and conditions of this Evidence of Coverage are met. With respect to the first such circumstance involving RVUs divided between a professional and a technical component, Health Advantage's payment will be limited to one global payment (Allowance) for the applicable professional component, and one global payment (Allowance) for the technical component. In other words, even where CMS policy specifically recognizes division of an RVU into professional and technical components, Health Advantage will not be responsible for paying multiple providers or multiple billings for the professional component, nor will Health Advantage be responsible for paying multiple providers or multiple billings for the technical component. Benefits under this Evidence of Coverage will be limited in such circumstances to one global payment (Allowance) for the professional component and one global payment (Allowance) for the technical component.

This amendment becomes a part of the Health Advantage Evidence of Coverage. All provisions of the Evidence of Coverage which are not contrary to the provisions of this amendment remain in full force and effect.



David F. Bridges, President
HMO PARTNERS, INC, d/b/a/ HEALTH ADVANTAGE
P.O. Office Box 8069, Little Rock, Arkansas 72203-8069

The following Health Advantage Evidences of Coverage (Non-Grandfathered) are hereby amended.

Evidence of Coverage, HSA Open Access Plan, Form #: 31-06

Evidence of Coverage, HSA Open Access Plan with Preexisting, Form #31-07

The following subsection amendments are effective on January 1, 2013.

BENEFITS AND SPECIFIC LIMITATIONS IN YOUR PLAN, introductory paragraphs are hereby amended to read as follows.

Because of the high cost of some services or treatments, as well as the difficulty in some cases of determining whether services are really needed, we include coverage for such services or treatments but place limits on the extent of coverage, either by limiting the number of Provider visits or treatments, or by specifying a dollar limit for services or treatments received during a Contract Year or other specified period of time. This Section 3.0 describes medical services, drugs, supplies, tests and equipment for which coverage is provided under the Plan, provided all terms, conditions, exclusions and limitations of the Plan, including the six coverage criteria, are satisfied. This Section 3.0 sets out specific limitations applicable to each covered medical service, drug, supply or equipment.

You will note references to Deductible and Coinsurance obligations. For a description of the amount of these obligations and how they may vary depending upon whether you select an In-Network or Out-of-Network Provider, refer to Section 5.0, the definition of Allowance or Allowable Charge as set out in the Glossary of Terms and the Schedule of Benefits.

BENEFITS AND SPECIFIC LIMITATIONS IN YOUR PLAN, "Dental Care and Orthodontic Services," Subsection 2. is hereby amended to read as follows.

2. Benefits for dental service. Dental services in connection with radiation treatment for cancer of the head or neck are covered.

BENEFITS AND SPECIFIC LIMITATIONS IN YOUR PLAN, "Organ Transplant Services" Subsections 7-10 are hereby amended to read as follows.

7. Coverage for high-dose or non-myeloablative chemotherapy, allogeneic or autologous stem or progenitor cell transplantation for the treatment of a medical condition is provided subject to Health Advantage's specific Coverage Policies relative to these specific conditions.

SPECIFIC PLAN EXCLUSIONS, Health Interventions, "Dental Care or Orthodontic Services," Subsection b. is hereby amended to read as follows.

- b. Benefits for dental service. Dental services in connection with radiation treatment for cancer of the head or neck are covered.

SPECIFIC PLAN EXCLUSIONS, Health Interventions, "Electrotherapy and electromagnetic stimulators" is hereby amended to read as follows.

Electrotherapy and electromagnetic stimulators. All treatment using electrotherapy stimulators, and electromagnetic stimulators, including services and supplies used in connection with such stimulators, and complications resulting from such treatment are not covered. However, subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Evidence of

Coverage, coverage is provided for a Transcutaneous Electrical Nerve Stimulator (TENS) to treat chronic pain due to peripheral nerve injury when that pain is unresponsive to medication. Coverage is also provided for neuromuscular electrical stimulation (NMES) for treatment of disuse atrophy where nerve supply to the muscle is intact, including but not limited to atrophy secondary to prolonged splinting or casting of the affected extremity, contracture due to scarring of soft tissue as in burn lesions and hip replacement surgery until orthotic training begins.

SPECIFIC PLAN EXCLUSIONS, Health Interventions, "Sleep Apnea, Portable Studies" is hereby amended to read as follows.

Sleep Apnea, Portable Studies. Studies for the diagnosis, assessment or management of obstructive sleep apnea are generally not covered. However, subject to all other terms, conditions, exclusions and limitations of the Plan as set forth in this Benefit Certificate, coverage is provided for portable (at home) sleep studies when all of the following monitoring information is included: EEG, heart rate, Chin EMG, ECG, airflow, effort and oxygen saturations, channels to identify awake versus asleep and apnea events. Devices used are considered portable comprehensive polysomnography devices monitoring a minimum of seven channels.

SPECIFIC PLAN EXCLUSIONS, Health Interventions, "Vision enhancement" is hereby amended to read as follows.

Vision enhancement. Any procedure, treatment, service, equipment or supply used to modify vision by changing the refractive error of the eye is generally not covered. Examples of non-covered vision enhancement services include, but are not limited to, the refraction for and the provision of eyeglasses and contact lenses; intraocular lenses, and refractive keratoplasty, with the exception of excessive, visually debilitating residual astigmatism following anterior segment surgery, i.e. corneal transplantation, cataract extraction, etc. Laser Assisted In Situ Keratomileusis (LASIK) and all other related refractive procedures are not covered. However, subject to all the terms, conditions, exclusions and limitations of the Plan as set forth in this Benefit Certificate, a procedure, treatment, service, equipment or supply to correct a refractive error of the eye is covered in two instances: (1) if such refractive error results from traumatic injury or corneal disease, infectious or non infectious, and (2) the implant of a monofocal lens following cataract extraction and the single acquisition of eyeglasses or contact lenses within the first six months following cataract surgery. With respect to such eyeglasses or contact lenses, tinting or anti-reflective coating and progressive lenses are not covered. Eyeglass frames are subject to a \$50 maximum Allowance or Allowable Charge. See Subsection 3.11.3.

PROVIDER NETWORK AND COST SHARING PROCEDURES, "Network Procedures" are hereby amended to add the following new Subsection.

Scope of Provider Payment - Global Payment. Health Advantage's payment to a Provider for their services as described in a Current Procedural Terminology ("CPT") or Healthcare Common Procedure Coding System ("HCPCS") code and reimbursed in accordance with the Resource-Based Relative Value System ("RBRVS") used by the Centers for Medicare & Medicaid Services ("CMS") is an all-inclusive, global payment that covers all elements of the service as described in the particular code billed. This means that whatever staffing, overhead costs, equipment, drugs, machinery, tools, technology, supplies, or materials of any kind that may be required in order for the billing Provider to perform the service or treatment described in the CPT or HCPCS code billed, Health Advantage's payment to the billing Provider of the Allowance or Allowable Charge for that CPT or HCPCS code constitutes the entire payment and the limit of benefits under this Evidence of Coverage with respect to the CPT or HCPCS code billed. A Provider who bills for a particular CPT or HCPCS code is deemed to represent that the billing Provider has performed and is responsible for provision of all services or treatments described in the CPT or HCPCS code, and is entitled to bill for such services or treatments. If Health Advantage pays for a Covered Service by applying the Allowance or Allowable Charge to the bill of a Provider who represents that the Provider has performed a service or treatment described in a CPT or HCPCS code as submitted to Health Advantage, Health Advantage shall have no further obligation, nor is there coverage under this Evidence of Coverage, for bills from

or payment to any other provider, entity or person, regardless of whether they assisted the billing Provider or furnished any staffing, equipment, drugs, machinery, tools, technology, supplies or materials of any kind to or for the benefit of the billing Provider. In other words, benefits under this Evidence of Coverage are limited to one, global payment for all components of any services falling within the scope of any CPT or HCPCS code service or treatment description, and Health Advantage will make only one payment with respect to such CPT or HCPCS code, even if multiple parties claim to have contributed a portion of the staffing, equipment, machinery, tools, technology, supplies or materials used by the billing Provider in the course of providing the service or treatment described in the CPT or HCPCS code.

For example, a physician who performs certain surgical procedures in the physician's office might choose to engage an equipment and supply company to set up the surgical table, furnish an assisting nurse, and also furnish certain surgical instruments, devices or supplies used by the physician. When the physician bills Health Advantage for the physician's performance of the surgical procedure described in a specific CPT or HCPCS code, Health Advantage will make a single, global payment to the physician for Covered Services described in the CPT or HCPCS code, and will not be obligated to pay for any charges of the equipment and supply company. In such circumstances, any charge or claim of payment due the equipment and supply company shall be the exclusive responsibility of the physician (or other provider) who engaged the equipment and supply company, and permitted or facilitated such company's access to the physician's patient. In any event, as noted above, no benefits are available under this Evidence of Coverage for any services, drugs, materials or supplies of the equipment and supply company. It is Health Advantage's policy (and this Evidence of Coverage is specifically intended to adopt the same) that no benefits shall be paid for "unbundled services" in excess of Health Advantage's Allowance or Allowable Charge for any service as described in the applicable CPT or HCPCS code. This means, for example, that if a physician and another category of provider (such as a durable medical equipment supplier, a laboratory, a nurse practitioner, a nurse, a physician's assistant or any other category of provider) agree together to divide up, split or "unbundle" the components of any CPT or HCPCS code, and attempt to bill separately for the various components each allegedly provides for the patient, benefits under this Evidence of Coverage shall nevertheless be limited to one Allowance per CPT or HCPCS code; in such circumstances, your benefits under this Evidence of Coverage will pay only one Allowance or Allowable Charge for any Covered Service described in any single CPT or HCPCS code, and the various providers involved in any such "unbundling" action or agreement must resolve among themselves any division of that single Allowance or Allowable Charge between or among them. You can protect yourself from the possibility of billing in excess of the Allowance or Allowable Charge in these circumstances by always inquiring in advance to be sure that each provider involved in your care or treatment is an In-Network Provider.

Please note that Health Advantage makes the following exceptions to the preceding general policy of one global payment (Allowance) per CPT or HCPCS code: (i) where CMS has developed and published an RBRVS policy that specifically recognizes that the Relative Value Units (RVUs) associated with a specific CPT or HCPCS code should be divided into both a professional and a technical component; or (ii) billing of the services of an assistant surgeon for those CPT or HCPCS codes that specifically recognize assistant surgery services as applicable; or (iii) billing of radiopharmaceuticals used in nuclear medicine procedures where such radiopharmaceuticals clearly are not included in the practice expense portion of the associated RVU as published and defined by CMS; or (iv) billing of a procedure or set of procedures that, per the applicable CPT or HCPCS code definition, is based solely on time consumed so that it is necessary to submit multiple units of the procedure in order to accurately report the total time devoted to the patient. In the specific four circumstances outlined in the preceding sentence, Health Advantage will recognize and pay more than one Allowance per CPT or HCPCS code, provided all other terms and conditions of this Evidence of Coverage are met. With respect to the first such circumstance involving RVUs divided between a professional and a technical component, Health Advantage's payment will be limited to one global payment (Allowance) for the applicable professional component, and one global payment (Allowance) for the technical component. In other words, even where CMS policy specifically recognizes division of an RVU into professional and technical components, Health Advantage will not be responsible for paying multiple providers or multiple billings for the professional component, nor will Health Advantage be responsible for paying multiple providers or multiple billings for the

technical component. Benefits under this Evidence of Coverage will be limited in such circumstances to one global payment (Allowance) for the professional component and one global payment (Allowance) for the technical component.

GLOSSARY OF TERMS, "Allowance or Allowable Charge" is hereby amended to read as follows.

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

At the option of Health Advantage, Allowance or Allowable Charges for services or supplies received out of Arkansas may be determined by the local Blue Cross and Blue Shield Plan, See Subsection 7.1.10 dealing with Out of Arkansas Claims. See Subsection 3.23.4 with respect to Allowance or Allowable Charge for transplants. See Subsection 3.3.2 with respect to Allowance or Allowable Charge for Outpatient Surgery Centers. **Please note that all benefits under this Evidence of Coverage are subject to and shall be paid only by reference to the Allowance or Allowable Charge as determined at the discretion of Health Advantage. This means that regardless of how much your health care Provider may bill for a given service, the benefits under this Evidence of Coverage will be limited by the Allowance or Allowable Charge we establish. If you use a Health Advantage-participating Provider, that Provider is obligated to accept our established rate as payment in full, and should only bill you for your Deductible, Coinsurance and any non-covered services; however, if you use a non-participating Provider, you will be responsible for all amounts billed in excess of Health Advantage Allowance or Allowable Charge.**

The payment to a Provider for their services as described in a Current Procedural Terminology ("CPT") or Healthcare Common Procedure Coding System ("HCPCS") code and reimbursed in accordance with the Resource-Based Relative Value System ("RBRVS") used by the Centers for Medicare & Medicaid Services ("CMS") is an all-inclusive, global payment that covers all elements of the service as described in the particular code billed. This means that whatever staffing, overhead costs, equipment, drugs, machinery, tools, technology, supplies, or materials of any kind that may be required in order for the billing Provider to perform the service or treatment described in the CPT or HCPCS code billed, Health Advantage's payment to the billing Provider of the Allowance or Allowable Charge for that CPT or HCPCS code constitutes the entire payment and the limit of benefits under this Evidence of Coverage with respect to the CPT or HCPCS code billed. A Provider who bills for a particular CPT or HCPCS code is deemed to represent that the billing Provider has performed and is responsible for provision of all services or treatments described in the CPT or HCPCS code, and is entitled to bill for such services or treatments. If Health Advantage pays for a Covered Service by applying the Allowance or Allowable Charge to the bill of a Provider who represents that the Provider has performed a service or treatment described in a CPT or HCPCS code as submitted to Health Advantage, Health Advantage shall have no further obligation, nor is there coverage under this Evidence of Coverage, for bills from or payment to any other provider, entity or person, regardless of whether they assisted the billing Provider or furnished any staffing, equipment, drugs, machinery, tools, technology, supplies or materials of any kind to or for the benefit of the billing Provider. In other words, benefits under this Evidence of Coverage are limited to one, global payment for all components of any services falling within the scope of any CPT or HCPCS code service or treatment description, and Health Advantage will make only one payment with respect to such CPT or HCPCS code, even if multiple parties claim to have contributed a portion of the staffing, equipment, machinery, tools, technology, supplies or materials used by the billing Provider in the course of providing the service or treatment described in the CPT or HCPCS code.

For example, a physician who performs certain surgical procedures in the physician's office might choose to engage an equipment and supply company to set up the surgical table, furnish an assisting nurse, and also furnish certain surgical instruments, devices or supplies used by the physician. When the physician bills Health Advantage for the physician's performance of the surgical procedure described in a specific CPT or HCPCS code, Health Advantage will make a single, global payment to the physician for Covered Services described in the CPT or HCPCS

code, and will not be obligated to pay for any charges of the equipment and supply company. In such circumstances, any charge or claim of payment due the equipment and supply company shall be the exclusive responsibility of the physician (or other provider) who engaged the equipment and supply company, and permitted or facilitated such company's access to the physician's patient. In any event, as noted above, no benefits are available under this Evidence of Coverage for any services, drugs, materials or supplies of the equipment and supply company. It is Health Advantage's policy (and this Evidence of Coverage is specifically intended to adopt the same) that no benefits shall be paid for "unbundled services" in excess of Health Advantage's Allowance or Allowable Charge for any service as described in the applicable CPT or HCPCS code. This means, for example, that if a physician and another category of provider (such as a durable medical equipment supplier, a laboratory, a nurse practitioner, a nurse, a physician's assistant or any other category of provider) agree together to divide up, split or "unbundle" the components of any CPT or HCPCS code, and attempt to bill separately for the various components each allegedly provides for the patient, benefits under this Evidence of Coverage shall nevertheless be limited to one Allowance per CPT or HCPCS code; in such circumstances, your benefits under this Evidence of Coverage will pay only one Allowance or Allowable Charge for any Covered Service described in any single CPT or HCPCS code, and the various providers involved in any such "unbundling" action or agreement must resolve among themselves any division of that single Allowance or Allowable Charge between or among them. You can protect yourself from the possibility of billing in excess of the Allowance or Allowable Charge in these circumstances by always inquiring in advance to be sure that each provider involved in your care or treatment is an In-Network Provider.

Please note that Health Advantage makes the following exceptions to the preceding general policy of one global payment (Allowance) per CPT or HCPCS code: (i) where CMS has developed and published an RBRVS policy that specifically recognizes that the Relative Value Units (RVUs) associated with a specific CPT or HCPCS code should be divided into both a professional and a technical component; or (ii) billing of the services of an assistant surgeon for those CPT or HCPCS codes that specifically recognize assistant surgery services as applicable; or (iii) billing of radiopharmaceuticals used in nuclear medicine procedures where such radiopharmaceuticals clearly are not included in the practice expense portion of the associated RVU as published and defined by CMS; or (iv) billing of a procedure or set of procedures that, per the applicable CPT or HCPCS code definition, is based solely on time consumed so that it is necessary to submit multiple units of the procedure in order to accurately report the total time devoted to the patient. In the specific four circumstances outlined in the preceding sentence, Health Advantage will recognize and pay more than one Allowance per CPT or HCPCS code, provided all other terms and conditions of this Evidence of Coverage are met. With respect to the first such circumstance involving RVUs divided between a professional and a technical component, Health Advantage's payment will be limited to one global payment (Allowance) for the applicable professional component, and one global payment (Allowance) for the technical component. In other words, even where CMS policy specifically recognizes division of an RVU into professional and technical components, Health Advantage will not be responsible for paying multiple providers or multiple billings for the professional component, nor will Health Advantage be responsible for paying multiple providers or multiple billings for the technical component. Benefits under this Evidence of Coverage will be limited in such circumstances to one global payment (Allowance) for the professional component and one global payment (Allowance) for the technical component.

This amendment becomes a part of the Health Advantage Evidence of Coverage. All provisions of the Evidence of Coverage which are not contrary to the provisions of this amendment remain in full force and effect.



David F. Bridges, President
HMO PARTNERS, INC, d/b/a/ HEALTH ADVANTAGE
P.O. Office Box 8069, Little Rock, Arkansas 72203-8069



The following Health Advantage Evidences of Coverage (Non-Grandfathered) are hereby amended.

- Evidence of Coverage, BlueChoice POS Plan, Form #31-02
- Evidence of Coverage, BlueChoice POS Plan with Preexisting, Form #31-03
- Evidence of Coverage, BlueChoice Open Access POS Plan, Form #31-04
- Evidence of Coverage, BlueChoice Open Access POS Plan with Preexisting, Form #31-05
- Evidence of Coverage, HMO with Deductible, Form #31-15

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BENEFITS AND SPECIFIC LIMITATIONS IN YOUR PLAN, "Dental Care and Orthodontic Services," Subsection 2. is hereby amended to read as follows.

2. Benefits for dental service. Dental services in connection with radiation treatment for cancer of the head or neck are covered.

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SPECIFIC PLAN EXCLUSIONS, Health Interventions, "Dental Care or Orthodontic Services," Subsection b. is hereby amended to read as follows.

- b. Benefits for dental service. Dental services in connection with radiation treatment for cancer of the head or neck are covered.

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billing Provider has performed and is responsible for provision of all services or treatments described in the CPT or HCPCS code, and is entitled to bill for such services or treatments. If Health Advantage pays for a Covered Service by applying the Allowance or Allowable Charge to the bill of a Provider who represents that the Provider has performed a service or treatment described in a CPT or HCPCS code as submitted to Health Advantage, Health Advantage shall have no further obligation, nor is there coverage under this Evidence of Coverage, for bills from or payment to any other provider, entity or person, regardless of whether they assisted the billing Provider or furnished any staffing, equipment, drugs, machinery, tools, technology, supplies or materials of any kind to or for the benefit of the billing Provider. In other words, benefits under this Evidence of Coverage are limited to one, global payment for all components of any services falling within the scope of any CPT or HCPCS code service or treatment description, and Health Advantage will make only one payment with respect to such CPT or HCPCS code, even if multiple parties claim to have contributed a portion of the staffing, equipment, machinery, tools, technology, supplies or materials used by the billing Provider in the course of providing the service or treatment described in the CPT or HCPCS code.

For example, a physician who performs certain surgical procedures in the physician's office might choose to engage an equipment and supply company to set up the surgical table, furnish an assisting nurse, and also furnish certain surgical instruments, devices or supplies used by the physician. When the physician bills Health Advantage for the physician's performance of the surgical procedure described in a specific CPT or HCPCS code, Health Advantage will make a single, global payment to the physician for Covered Services described in the CPT or HCPCS code, and will not be obligated to pay for any charges of the equipment and supply company. In such circumstances, any charge or claim of payment due the equipment and supply company shall be the exclusive responsibility of the physician (or other provider) who engaged the equipment and supply company, and permitted or facilitated such company's access to the physician's patient. In any event, as noted above, no benefits are available under this Evidence of Coverage for any services, drugs, materials or supplies of the equipment and supply company. It is Health Advantage's policy (and this Evidence of Coverage is specifically intended to adopt the same) that no benefits shall be paid for "unbundled services" in excess of Health Advantage's Allowance or Allowable Charge for any service as described in the applicable CPT or HCPCS code. This means, for example, that if a physician and another category of provider (such as a durable medical equipment supplier, a laboratory, a nurse practitioner, a nurse, a physician's assistant or any other category of provider) agree together to divide up, split or "unbundle" the components of any CPT or HCPCS code, and attempt to bill separately for the various components each allegedly provides for the patient, benefits under this Evidence of Coverage shall nevertheless be limited to one Allowance per CPT or HCPCS code; in such circumstances, your benefits under this Evidence of Coverage will pay only one Allowance or Allowable Charge for any Covered Service described in any single CPT or HCPCS code, and the various providers involved in any such "unbundling" action or agreement must resolve among themselves any division of that single Allowance or Allowable Charge between or among them. You can protect yourself from the possibility of billing in excess of the Allowance or Allowable Charge in these circumstances by always inquiring in advance to be sure that each provider involved in your care or treatment is an In-Network Provider.

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

At the option of Health Advantage, Allowance or Allowable Charges for services or supplies received out of Arkansas may be determined by the local Blue Cross and Blue Shield Plan, See Subsection 7.1.10 dealing with Out of Arkansas Claims. See Subsection 3.23.4 with respect to Allowance or Allowable Charge for transplants. See Subsection 3.3.2 with respect to Allowance or Allowable Charge for Outpatient Surgery Centers. **Please note that all benefits under this Evidence of Coverage are subject to and shall be paid only by reference to the Allowance or Allowable Charge as determined at the discretion of Health Advantage. This means that regardless of how much your health care Provider may bill for a given service, the benefits under this Evidence of Coverage will be limited by the Allowance or Allowable Charge we establish. If you use a Health Advantage-participating Provider, that Provider is obligated to accept our established rate as payment in full, and should only bill you for your Deductible, Coinsurance and any non-covered services; however, if you use a non-participating Provider, you will be responsible for all amounts billed in excess of Health Advantage Allowance or Allowable Charge.**

The payment to a Provider for their services as described in a Current Procedural Terminology ("CPT") or Healthcare Common Procedure Coding System ("HCPCS") code and reimbursed in accordance with the Resource-Based Relative Value System ("RBRVS") used by the Centers for Medicare & Medicaid Services ("CMS") is an all-inclusive, global payment that covers all elements of the service as described in the particular code billed. This means that whatever staffing, overhead costs, equipment, drugs, machinery, tools, technology, supplies, or materials of any kind that may be required in order for the billing Provider to perform the service or treatment described in the CPT or HCPCS code billed, Health Advantage's payment to the billing Provider of the Allowance or Allowable Charge for that CPT or HCPCS code constitutes the entire payment and the limit of benefits under this Evidence of Coverage with respect to the CPT or HCPCS code billed. A Provider who bills for a particular CPT or HCPCS code is deemed to represent that the billing Provider has performed and is responsible for provision of all services or treatments described in the CPT or HCPCS code, and is entitled to bill for such services or treatments. If Health Advantage pays for a Covered Service by applying the Allowance or Allowable Charge to the bill of a Provider who represents that the Provider has performed a service or treatment described in a CPT or HCPCS code as submitted to Health Advantage, Health Advantage shall have no further obligation, nor is there coverage under this Evidence of Coverage, for bills from or payment to any other provider, entity or person, regardless of whether they assisted the billing Provider or furnished any staffing, equipment, drugs, machinery, tools, technology, supplies or materials of any kind to or for the benefit of the billing Provider. In other words, benefits under this Evidence of Coverage are limited to one, global payment for all components of any services falling within the scope of any CPT or HCPCS code service or treatment description, and Health Advantage will make only one payment with respect to such CPT or HCPCS code, even if multiple parties claim to have contributed a portion of the staffing, equipment, machinery, tools, technology, supplies or materials used by the billing Provider in the course of providing the service or treatment described in the CPT or HCPCS code.

For example, a physician who performs certain surgical procedures in the physician's office might choose to engage an equipment and supply company to set up the surgical table, furnish an assisting nurse, and also furnish certain surgical instruments, devices or supplies used by the physician. When the physician bills Health Advantage for the physician's performance of the surgical procedure described in a specific CPT or HCPCS code, Health Advantage will make a single, global payment to the physician for Covered Services described in the CPT or HCPCS code, and will not be obligated to pay for any charges of the equipment and supply company. In such circumstances, any charge or claim of payment due the equipment and supply company shall be the exclusive responsibility of the physician (or other provider) who engaged the equipment and supply company, and permitted or facilitated such company's access to the physician's patient. In any event, as noted above, no benefits are available under this Evidence of Coverage for any services, drugs, materials or supplies of the equipment and supply company. It is Health Advantage's policy (and this Evidence of Coverage is specifically intended to adopt the same) that no benefits shall be paid for "unbundled services" in excess of Health Advantage's Allowance or Allowable Charge for any service as described in the applicable CPT or HCPCS code. This means, for example, that if a physician and another category of provider (such as a durable medical equipment supplier, a laboratory, a nurse practitioner, a nurse, a physician's assistant or any other category of provider) agree together to divide up, split or "unbundle" the components of any CPT or HCPCS code, and attempt to bill separately for the various components each allegedly provides for the patient, benefits under this Evidence of Coverage shall nevertheless be limited to one Allowance per CPT or HCPCS code; in such circumstances, your benefits under this Evidence of Coverage will pay only one Allowance or Allowable Charge for any Covered Service described in any single CPT or HCPCS code, and the various providers involved in any such "unbundling" action or agreement must resolve among themselves any division of that single Allowance or Allowable Charge between or among them. You can protect yourself from the possibility of billing in excess of the Allowance or Allowable Charge in these circumstances by always inquiring in advance to be sure that each provider involved in your care or treatment is an In-Network Provider.

Please note that Health Advantage makes the following exceptions to the preceding general policy of one global payment (Allowance) per CPT or HCPCS code: (i) where CMS has developed and published an RBRVS policy that specifically recognizes that the Relative Value Units (RVUs) associated with a specific CPT or HCPCS code should be divided into both a professional and a technical component; or (ii) billing of the services of an assistant surgeon for those CPT or HCPCS codes that specifically recognize assistant surgery services as applicable; or (iii) billing of radiopharmaceuticals used in nuclear medicine procedures where such radiopharmaceuticals clearly are not included in the practice expense portion of the associated RVU as published and defined by CMS; or (iv) billing of a procedure or set of procedures that, per the applicable CPT or HCPCS code definition, is based solely on time consumed so that it is necessary to submit multiple units of the procedure in order to accurately report the total time devoted to the patient. In the specific four circumstances outlined in the preceding sentence, Health Advantage will recognize and pay more than one Allowance per CPT or HCPCS code, provided all other terms and conditions of this Evidence of Coverage are met. With respect to the first such circumstance involving RVUs divided between a professional and a technical component, Health Advantage's payment will be limited to one global payment (Allowance) for the applicable professional component, and one global payment (Allowance) for the technical component. In other words, even where CMS policy specifically recognizes division of an RVU into professional and technical components, Health Advantage will not be responsible for paying multiple providers or multiple billings for the professional component, nor will Health Advantage be responsible for paying multiple providers or multiple billings for the technical component. Benefits under this Evidence of Coverage will be limited in such circumstances to one global payment (Allowance) for the professional component and one global payment (Allowance) for the technical component.

This amendment becomes a part of the Health Advantage Evidence of Coverage. All provisions of the Evidence of Coverage which are not contrary to the provisions of this amendment remain in full force and effect.

A handwritten signature in black ink that reads "David Bridges". The signature is written in a cursive style with a large initial "D".

David F. Bridges, President
HMO PARTNERS, INC, d/b/a/ HEALTH ADVANTAGE
P.O. Office Box 8069, Little Rock, Arkansas 72203-8069

The following Health Advantage Evidence of Coverage (Non-Grandfathered) are hereby amended.

Evidence of Coverage, Conversion Plan, Form #31-08

The following subsection amendments are effective on January 1, 2013.

BENEFITS AND SPECIFIC LIMITATIONS IN YOUR PLAN, introductory paragraphs are hereby amended to read as follows.

Because of the high cost of some services or treatments, as well as the difficulty in some cases of determining whether services are really needed, we include coverage for such services or treatments but place limits on the extent of coverage, either by limiting the number of Provider visits or treatments, or by specifying a dollar limit for services or treatments received during a Contract Year or other specified period of time. This Section 3.0 describes medical services, drugs, supplies, tests and equipment for which coverage is provided under the Plan, provided all terms, conditions, exclusions and limitations of the Plan, including the six coverage criteria, are satisfied. This Section 3.0 sets out specific limitations applicable to each covered medical service, drug, supply or equipment.

You will note references to Coinsurance and Copayment obligations. For a description of the amount of these obligations and how they may vary depending upon whether you select an In-Network or Out-of-Network Provider, refer to Section 5.0, the definition of Allowance or Allowable Charge as set out in the Glossary of Terms and the Schedule of Benefits.

BENEFITS AND SPECIFIC LIMITATIONS IN YOUR PLAN, "Dental Care and Orthodontic Services," Subsection 2. is hereby amended to read as follows.

2. Benefits for dental service. Dental services in connection with radiation treatment for cancer of the head or neck are covered.

BENEFITS AND SPECIFIC LIMITATIONS IN YOUR PLAN, "Organ Transplant Services" Subsections 7-10 are hereby amended to read as follows.

7. Coverage for high-dose or non-myeloablative chemotherapy, allogeneic or autologous stem or progenitor cell transplantation for the treatment of a medical condition is provided subject to Health Advantage's specific Coverage Policies relative to these specific conditions.

SPECIFIC PLAN EXCLUSIONS, Health Interventions, "Dental Care or Orthodontic Services," Subsection b. is hereby amended to read as follows.

- b. Benefits for dental service. Dental services in connection with radiation treatment for cancer of the head or neck are covered.

SPECIFIC PLAN EXCLUSIONS, Health Interventions, "Electrotherapy and electromagnetic stimulators" is hereby amended to read as follows.

Electrotherapy and electromagnetic stimulators. All treatment using electrotherapy stimulators, and electromagnetic stimulators, including services and supplies used in connection with such stimulators, and complications resulting from such treatment are not covered. However, subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Evidence of

Coverage, coverage is provided for a Transcutaneous Electrical Nerve Stimulator (TENS) to treat chronic pain due to peripheral nerve injury when that pain is unresponsive to medication. Coverage is also provided for neuromuscular electrical stimulation (NMES) for treatment of disuse atrophy where nerve supply to the muscle is intact, including but not limited to atrophy secondary to prolonged splinting or casting of the affected extremity, contracture due to scarring of soft tissue as in burn lesions and hip replacement surgery until orthotic training begins.

SPECIFIC PLAN EXCLUSIONS, Health Interventions, "Sleep Apnea, Portable Studies" is hereby amended to read as follows.

Sleep Apnea, Portable Studies. Studies for the diagnosis, assessment or management of obstructive sleep apnea are generally not covered. However, subject to all other terms, conditions, exclusions and limitations of the Plan as set forth in this Evidence of Coverage, coverage is provided for portable (at home) sleep studies when all of the following monitoring information is included: EEG, heart rate, Chin EMG, ECG, airflow, effort and oxygen saturations, channels to identify awake versus asleep and apnea events. Devices used are considered portable comprehensive polysomnography devices monitoring a minimum of seven channels.

SPECIFIC PLAN EXCLUSIONS, Health Interventions, "Vision enhancement" is hereby amended to read as follows.

Vision enhancement. Any procedure, treatment, service, equipment or supply used to modify vision by changing the refractive error of the eye is generally not covered. Examples of non-covered vision enhancement services include, but are not limited to, the refraction for and the provision of eyeglasses and contact lenses; intraocular lenses, and refractive keratoplasty, with the exception of excessive, visually debilitating residual astigmatism following anterior segment surgery, i.e. corneal transplantation, cataract extraction, etc. Laser Assisted In Situ Keratomileusis (LASIK) and all other related refractive procedures are not covered. However, subject to all the terms, conditions, exclusions and limitations of the Plan as set forth in this Evidence of Coverage, a procedure, treatment, service, equipment or supply to correct a refractive error of the eye is covered in two instances: (1) if such refractive error results from traumatic injury or corneal disease, infectious or non infectious, and (2) the implant of a monofocal lens following cataract extraction and the single acquisition of eyeglasses or contact lenses within the first six months following cataract surgery. With respect to such eyeglasses or contact lenses, tinting or anti-reflective coating and progressive lenses are not covered. Eyeglass frames are subject to a \$50 maximum Allowance or Allowable Charge. See Subsection 3.11.3.

PROVIDER NETWORK AND COST SHARING PROCEDURES, "Network Procedures" are hereby amended to add the following new Subsection.

Scope of Provider Payment - Global Payment. Health Advantage's payment to a Provider for their services as described in a Current Procedural Terminology ("CPT") or Healthcare Common Procedure Coding System ("HCPCS") code and reimbursed in accordance with the Resource-Based Relative Value System ("RBRVS") used by the Centers for Medicare & Medicaid Services ("CMS") is an all-inclusive, global payment that covers all elements of the service as described in the particular code billed. This means that whatever staffing, overhead costs, equipment, drugs, machinery, tools, technology, supplies, or materials of any kind that may be required in order for the billing Provider to perform the service or treatment described in the CPT or HCPCS code billed, Health Advantage's payment to the billing Provider of the Allowance or Allowable Charge for that CPT or HCPCS code constitutes the entire payment and the limit of benefits under this Evidence of Coverage with respect to the CPT or HCPCS code billed. A Provider who bills for a particular CPT or HCPCS code is deemed to represent that the billing Provider has performed and is responsible for provision of all services or treatments described in the CPT or HCPCS code, and is entitled to bill for such services or treatments. If Health Advantage pays for a Covered Service by applying the Allowance or Allowable Charge to the bill of a Provider who represents that the Provider has performed a service or treatment

described in a CPT or HCPCS code as submitted to Health Advantage, Health Advantage shall have no further obligation, nor is there coverage under this Evidence of Coverage, for bills from or payment to any other provider, entity or person, regardless of whether they assisted the billing Provider or furnished any staffing, equipment, drugs, machinery, tools, technology, supplies or materials of any kind to or for the benefit of the billing Provider. In other words, benefits under this Evidence of Coverage are limited to one, global payment for all components of any services falling within the scope of any CPT or HCPCS code service or treatment description, and Health Advantage will make only one payment with respect to such CPT or HCPCS code, even if multiple parties claim to have contributed a portion of the staffing, equipment, machinery, tools, technology, supplies or materials used by the billing Provider in the course of providing the service or treatment described in the CPT or HCPCS code.

For example, a physician who performs certain surgical procedures in the physician's office might choose to engage an equipment and supply company to set up the surgical table, furnish an assisting nurse, and also furnish certain surgical instruments, devices or supplies used by the physician. When the physician bills Health Advantage for the physician's performance of the surgical procedure described in a specific CPT or HCPCS code, Health Advantage will make a single, global payment to the physician for Covered Services described in the CPT or HCPCS code, and will not be obligated to pay for any charges of the equipment and supply company. In such circumstances, any charge or claim of payment due the equipment and supply company shall be the exclusive responsibility of the physician (or other provider) who engaged the equipment and supply company, and permitted or facilitated such company's access to the physician's patient. In any event, as noted above, no benefits are available under this Evidence of Coverage for any services, drugs, materials or supplies of the equipment and supply company. It is Health Advantage's policy (and this Evidence of Coverage is specifically intended to adopt the same) that no benefits shall be paid for "unbundled services" in excess of Health Advantage's Allowance or Allowable Charge for any service as described in the applicable CPT or HCPCS code. This means, for example, that if a physician and another category of provider (such as a durable medical equipment supplier, a laboratory, a nurse practitioner, a nurse, a physician's assistant or any other category of provider) agree together to divide up, split or "unbundle" the components of any CPT or HCPCS code, and attempt to bill separately for the various components each allegedly provides for the patient, benefits under this Evidence of Coverage shall nevertheless be limited to one Allowance per CPT or HCPCS code; in such circumstances, your benefits under this Evidence of Coverage will pay only one Allowance or Allowable Charge for any Covered Service described in any single CPT or HCPCS code, and the various providers involved in any such "unbundling" action or agreement must resolve among themselves any division of that single Allowance or Allowable Charge between or among them. You can protect yourself from the possibility of billing in excess of the Allowance or Allowable Charge in these circumstances by always inquiring in advance to be sure that each provider involved in your care or treatment is an In-Network Provider.

Please note that Health Advantage makes the following exceptions to the preceding general policy of one global payment (Allowance) per CPT or HCPCS code: (i) where CMS has developed and published an RBRVS policy that specifically recognizes that the Relative Value Units (RVUs) associated with a specific CPT or HCPCS code should be divided into both a professional and a technical component; or (ii) billing of the services of an assistant surgeon for those CPT or HCPCS codes that specifically recognize assistant surgery services as applicable; or (iii) billing of radiopharmaceuticals used in nuclear medicine procedures where such radiopharmaceuticals clearly are not included in the practice expense portion of the associated RVU as published and defined by CMS; or (iv) billing of a procedure or set of procedures that, per the applicable CPT or HCPCS code definition, is based solely on time consumed so that it is necessary to submit multiple units of the procedure in order to accurately report the total time devoted to the patient. In the specific four circumstances outlined in the preceding sentence, Health Advantage will recognize and pay more than one Allowance per CPT or HCPCS code, provided all other terms and conditions of this Evidence of Coverage are met. With respect to the first such circumstance involving RVUs divided between a professional and a technical component, Health Advantage's payment will be limited to one global payment (Allowance) for the applicable professional component, and one global payment (Allowance) for the technical component. In other words, even where CMS policy specifically recognizes division of an RVU into professional and technical components, Health Advantage will not be responsible for paying

multiple providers or multiple billings for the professional component, nor will Health Advantage be responsible for paying multiple providers or multiple billings for the technical component. Benefits under this Evidence of Coverage will be limited in such circumstances to one global payment (Allowance) for the professional component and one global payment (Allowance) for the technical component.

GLOSSARY OF TERMS, "Allowance or Allowable Charge" is hereby amended to read as follows.

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

At the option of Health Advantage, Allowance or Allowable Charges for services or supplies received out of Arkansas may be determined by the local Blue Cross and Blue Shield Plan, See Subsection 7.1.10 dealing with Out of Arkansas Claims. See Subsection 3.23.4 with respect to Allowance or Allowable Charge for transplants. See Subsection 3.3.2 with respect to Allowance or Allowable Charge for Outpatient Surgery Centers. **Please note that all benefits under this Evidence of Coverage are subject to and shall be paid only by reference to the Allowance or Allowable Charge as determined at the discretion of Health Advantage. This means that regardless of how much your health care Provider may bill for a given service, the benefits under this Evidence of Coverage will be limited by the Allowance or Allowable Charge we establish. If you use a Health Advantage-participating Provider, that Provider is obligated to accept our established rate as payment in full, and should only bill you for your Deductible, Coinsurance and any non-covered services; however, if you use a non-participating Provider, you will be responsible for all amounts billed in excess of Health Advantage Allowance or Allowable Charge.**

The payment to a Provider for their services as described in a Current Procedural Terminology ("CPT") or Healthcare Common Procedure Coding System ("HCPCS") code and reimbursed in accordance with the Resource-Based Relative Value System ("RBRVS") used by the Centers for Medicare & Medicaid Services ("CMS") is an all-inclusive, global payment that covers all elements of the service as described in the particular code billed. This means that whatever staffing, overhead costs, equipment, drugs, machinery, tools, technology, supplies, or materials of any kind that may be required in order for the billing Provider to perform the service or treatment described in the CPT or HCPCS code billed, Health Advantage's payment to the billing Provider of the Allowance or Allowable Charge for that CPT or HCPCS code constitutes the entire payment and the limit of benefits under this Evidence of Coverage with respect to the CPT or HCPCS code billed. A Provider who bills for a particular CPT or HCPCS code is deemed to represent that the billing Provider has performed and is responsible for provision of all services or treatments described in the CPT or HCPCS code, and is entitled to bill for such services or treatments. If Health Advantage pays for a Covered Service by applying the Allowance or Allowable Charge to the bill of a Provider who represents that the Provider has performed a service or treatment described in a CPT or HCPCS code as submitted to Health Advantage, Health Advantage shall have no further obligation, nor is there coverage under this Evidence of Coverage, for bills from or payment to any other provider, entity or person, regardless of whether they assisted the billing Provider or furnished any staffing, equipment, drugs, machinery, tools, technology, supplies or materials of any kind to or for the benefit of the billing Provider. In other words, benefits under this Evidence of Coverage are limited to one, global payment for all components of any services falling within the scope of any CPT or HCPCS code service or treatment description, and Health Advantage will make only one payment with respect to such CPT or HCPCS code, even if multiple parties claim to have contributed a portion of the staffing, equipment, machinery, tools, technology, supplies or materials used by the billing Provider in the course of providing the service or treatment described in the CPT or HCPCS code.

For example, a physician who performs certain surgical procedures in the physician's office might choose to engage an equipment and supply company to set up the surgical table, furnish an assisting nurse, and also furnish certain surgical instruments, devices or supplies used by the physician. When the physician bills Health Advantage for the physician's performance of the

surgical procedure described in a specific CPT or HCPCS code, Health Advantage will make a single, global payment to the physician for Covered Services described in the CPT or HCPCS code, and will not be obligated to pay for any charges of the equipment and supply company. In such circumstances, any charge or claim of payment due the equipment and supply company shall be the exclusive responsibility of the physician (or other provider) who engaged the equipment and supply company, and permitted or facilitated such company's access to the physician's patient. In any event, as noted above, no benefits are available under this Evidence of Coverage for any services, drugs, materials or supplies of the equipment and supply company. It is Health Advantage's policy (and this Evidence of Coverage is specifically intended to adopt the same) that no benefits shall be paid for "unbundled services" in excess of Health Advantage's Allowance or Allowable Charge for any service as described in the applicable CPT or HCPCS code. This means, for example, that if a physician and another category of provider (such as a durable medical equipment supplier, a laboratory, a nurse practitioner, a nurse, a physician's assistant or any other category of provider) agree together to divide up, split or "unbundle" the components of any CPT or HCPCS code, and attempt to bill separately for the various components each allegedly provides for the patient, benefits under this Evidence of Coverage shall nevertheless be limited to one Allowance per CPT or HCPCS code; in such circumstances, your benefits under this Evidence of Coverage will pay only one Allowance or Allowable Charge for any Covered Service described in any single CPT or HCPCS code, and the various providers involved in any such "unbundling" action or agreement must resolve among themselves any division of that single Allowance or Allowable Charge between or among them. You can protect yourself from the possibility of billing in excess of the Allowance or Allowable Charge in these circumstances by always inquiring in advance to be sure that each provider involved in your care or treatment is an In-Network Provider.

Please note that Health Advantage makes the following exceptions to the preceding general policy of one global payment (Allowance) per CPT or HCPCS code: (i) where CMS has developed and published an RBRVS policy that specifically recognizes that the Relative Value Units (RVUs) associated with a specific CPT or HCPCS code should be divided into both a professional and a technical component; or (ii) billing of the services of an assistant surgeon for those CPT or HCPCS codes that specifically recognize assistant surgery services as applicable; or (iii) billing of radiopharmaceuticals used in nuclear medicine procedures where such radiopharmaceuticals clearly are not included in the practice expense portion of the associated RVU as published and defined by CMS; or (iv) billing of a procedure or set of procedures that, per the applicable CPT or HCPCS code definition, is based solely on time consumed so that it is necessary to submit multiple units of the procedure in order to accurately report the total time devoted to the patient. In the specific four circumstances outlined in the preceding sentence, Health Advantage will recognize and pay more than one Allowance per CPT or HCPCS code, provided all other terms and conditions of this Evidence of Coverage are met. With respect to the first such circumstance involving RVUs divided between a professional and a technical component, Health Advantage's payment will be limited to one global payment (Allowance) for the applicable professional component, and one global payment (Allowance) for the technical component. In other words, even where CMS policy specifically recognizes division of an RVU into professional and technical components, Health Advantage will not be responsible for paying multiple providers or multiple billings for the professional component, nor will Health Advantage be responsible for paying multiple providers or multiple billings for the technical component. Benefits under this Evidence of Coverage will be limited in such circumstances to one global payment (Allowance) for the professional component and one global payment (Allowance) for the technical component.

This amendment becomes a part of the Health Advantage Evidence of Coverage. All provisions of the Evidence of Coverage which are not contrary to the provisions of this amendment remain in full force and effect.



David F. Bridges, President
HMO PARTNERS, INC, d/b/a/ HEALTH ADVANTAGE
P.O. Office Box 8069, Little Rock, Arkansas 72203-8069

The following Health Advantage Evidence of Coverage (Non-Grandfathered) is hereby amended.

Evidence of Coverage, HMO Arkansas, Form #31-10

The following subsection amendments are effective on January 1, 2013.

BENEFITS AND SPECIFIC LIMITATIONS IN YOUR PLAN, introductory paragraphs are hereby amended to read as follows.

Because of the high cost of some services or treatments, as well as the difficulty in some cases of determining whether services are really needed, we include coverage for such services or treatments but place limits on the extent of coverage, either by limiting the number of Provider visits or treatments, or by specifying a dollar limit for services or treatments received during a Contract Year or other specified period of time. This Section 3.0 describes medical services, drugs, supplies, tests and equipment for which coverage is provided under the Plan, provided all terms, conditions, exclusions and limitations of the Plan, including the six coverage criteria, are satisfied. This Section 3.0 sets out specific limitations applicable to each covered medical service, drug, supply or equipment.

You will note references to Coinsurance and Copayment obligations. For a description of the amount of these obligations and how they may vary depending upon whether you select an In-Network or Out-of-Network Provider, refer to Section 5.0, the definition of Allowance or Allowable Charge as set out in the Glossary of Terms and the Schedule of Benefits.

BENEFITS AND SPECIFIC LIMITATIONS IN YOUR PLAN, "Dental Care and Orthodontic Services," Subsection 2. is hereby amended to read as follows.

2. Benefits for dental service. Dental services in connection with radiation treatment for cancer of the head or neck are covered.

BENEFITS AND SPECIFIC LIMITATIONS IN YOUR PLAN, "Organ Transplant Services" Subsections 7-10 are hereby amended to read as follows.

7. Coverage for high-dose or non-myeloablative chemotherapy, allogeneic or autologous stem or progenitor cell transplantation for the treatment of a medical condition is provided subject to Health Advantage's specific Coverage Policies relative to these specific conditions.

SPECIFIC PLAN EXCLUSIONS, Health Interventions, "Dental Care or Orthodontic Services," Subsection b. is hereby amended to read as follows.

- b. Benefits for dental service. Dental services in connection with radiation treatment for cancer of the head or neck are covered.

SPECIFIC PLAN EXCLUSIONS, Health Interventions, "Electrotherapy and electromagnetic stimulators" is hereby amended to read as follows.

Electrotherapy and electromagnetic stimulators. All treatment using electrotherapy stimulators, and electromagnetic stimulators, including services and supplies used in connection with such stimulators, and complications resulting from such treatment are not covered. However, subject

to all terms, conditions, exclusions and limitations of the Plan as set forth in this Evidence of Coverage, coverage is provided for a Transcutaneous Electrical Nerve Stimulator (TENS) to treat chronic pain due to peripheral nerve injury when that pain is unresponsive to medication. Coverage is also provided for neuromuscular electrical stimulation (NMES) for treatment of disuse atrophy where nerve supply to the muscle is intact, including but not limited to atrophy secondary to prolonged splinting or casting of the affected extremity, contracture due to scarring of soft tissue as in burn lesions and hip replacement surgery until orthotic training begins.

SPECIFIC PLAN EXCLUSIONS, Health Interventions, "Sleep Apnea, Portable Studies" is hereby amended to read as follows.

Sleep Apnea, Portable Studies. Studies for the diagnosis, assessment or management of obstructive sleep apnea are generally not covered. However, subject to all other terms, conditions, exclusions and limitations of the Plan as set forth in this Evidence of Coverage, coverage is provided for portable (at home) sleep studies when all of the following monitoring information is included: EEG, heart rate, Chin EMG, ECG, airflow, effort and oxygen saturations, channels to identify awake versus asleep and apnea events. Devices used are considered portable comprehensive polysomnography devices monitoring a minimum of seven channels.

SPECIFIC PLAN EXCLUSIONS, Health Interventions, "Vision enhancement" is hereby amended to read as follows.

Vision enhancement. Any procedure, treatment, service, equipment or supply used to modify vision by changing the refractive error of the eye is generally not covered. Examples of non-covered vision enhancement services include, but are not limited to, the refraction for and the provision of eyeglasses and contact lenses; intraocular lenses, and refractive keratoplasty, with the exception of excessive, visually debilitating residual astigmatism following anterior segment surgery, i.e. corneal transplantation, cataract extraction, etc. Laser Assisted In Situ Keratomileusis (LASIK) and all other related refractive procedures are not covered. However, subject to all the terms, conditions, exclusions and limitations of the Plan as set forth in this Evidence of Coverage, a procedure, treatment, service, equipment or supply to correct a refractive error of the eye is covered in two instances: (1) if such refractive error results from traumatic injury or corneal disease, infectious or non infectious, and (2) the implant of a monofocal lens following cataract extraction and the single acquisition of eyeglasses or contact lenses within the first six months following cataract surgery. With respect to such eyeglasses or contact lenses, tinting or anti-reflective coating and progressive lenses are not covered. Eyeglass frames are subject to a \$50 maximum Allowance or Allowable Charge. See Subsection 3.11.3.

PROVIDER NETWORK AND COST SHARING PROCEDURES, "Network Procedures" are hereby amended to add the following new Subsection.

Scope of Provider Payment - Global Payment. Health Advantage's payment to a Provider for their services as described in a Current Procedural Terminology ("CPT") or Healthcare Common Procedure Coding System ("HCPCS") code and reimbursed in accordance with the Resource-Based Relative Value System ("RBRVS") used by the Centers for Medicare & Medicaid Services ("CMS") is an all-inclusive, global payment that covers all elements of the service as described in the particular code billed. This means that whatever staffing, overhead costs, equipment, drugs, machinery, tools, technology, supplies, or materials of any kind that may be required in order for the billing Provider to perform the service or treatment described in the CPT or HCPCS code billed, Health Advantage's payment to the billing Provider of the Allowance or Allowable Charge for that CPT or HCPCS code constitutes the entire payment and the limit of benefits under this Evidence of Coverage with respect to the CPT or HCPCS code billed. A Provider who bills for a particular CPT or HCPCS code is deemed to represent that the billing Provider has performed and is responsible for provision of all services or treatments described in the CPT or HCPCS code, and is entitled to bill for such services or treatments. If Health Advantage pays for a Covered Service by applying the Allowance or Allowable Charge

to the bill of a Provider who represents that the Provider has performed a service or treatment described in a CPT or HCPCS code as submitted to Health Advantage, Health Advantage shall have no further obligation, nor is there coverage under this Evidence of Coverage, for bills from or payment to any other provider, entity or person, regardless of whether they assisted the billing Provider or furnished any staffing, equipment, drugs, machinery, tools, technology, supplies or materials of any kind to or for the benefit of the billing Provider. In other words, benefits under this Evidence of Coverage are limited to one, global payment for all components of any services falling within the scope of any CPT or HCPCS code service or treatment description, and Health Advantage will make only one payment with respect to such CPT or HCPCS code, even if multiple parties claim to have contributed a portion of the staffing, equipment, machinery, tools, technology, supplies or materials used by the billing Provider in the course of providing the service or treatment described in the CPT or HCPCS code.

For example, a physician who performs certain surgical procedures in the physician's office might choose to engage an equipment and supply company to set up the surgical table, furnish an assisting nurse, and also furnish certain surgical instruments, devices or supplies used by the physician. When the physician bills Health Advantage for the physician's performance of the surgical procedure described in a specific CPT or HCPCS code, Health Advantage will make a single, global payment to the physician for Covered Services described in the CPT or HCPCS code, and will not be obligated to pay for any charges of the equipment and supply company. In such circumstances, any charge or claim of payment due the equipment and supply company shall be the exclusive responsibility of the physician (or other provider) who engaged the equipment and supply company, and permitted or facilitated such company's access to the physician's patient. In any event, as noted above, no benefits are available under this Evidence of Coverage for any services, drugs, materials or supplies of the equipment and supply company. It is Health Advantage's policy (and this Evidence of Coverage is specifically intended to adopt the same) that no benefits shall be paid for "unbundled services" in excess of Health Advantage's Allowance or Allowable Charge for any service as described in the applicable CPT or HCPCS code. This means, for example, that if a physician and another category of provider (such as a durable medical equipment supplier, a laboratory, a nurse practitioner, a nurse, a physician's assistant or any other category of provider) agree together to divide up, split or "unbundle" the components of any CPT or HCPCS code, and attempt to bill separately for the various components each allegedly provides for the patient, benefits under this Evidence of Coverage shall nevertheless be limited to one Allowance per CPT or HCPCS code; in such circumstances, your benefits under this Evidence of Coverage will pay only one Allowance or Allowable Charge for any Covered Service described in any single CPT or HCPCS code, and the various providers involved in any such "unbundling" action or agreement must resolve among themselves any division of that single Allowance or Allowable Charge between or among them. You can protect yourself from the possibility of billing in excess of the Allowance or Allowable Charge in these circumstances by always inquiring in advance to be sure that each provider involved in your care or treatment is an In-Network Provider.

Please note that Health Advantage makes the following exceptions to the preceding general policy of one global payment (Allowance) per CPT or HCPCS code: (i) where CMS has developed and published an RBRVS policy that specifically recognizes that the Relative Value Units (RVUs) associated with a specific CPT or HCPCS code should be divided into both a professional and a technical component; or (ii) billing of the services of an assistant surgeon for those CPT or HCPCS codes that specifically recognize assistant surgery services as applicable; or (iii) billing of radiopharmaceuticals used in nuclear medicine procedures where such radiopharmaceuticals clearly are not included in the practice expense portion of the associated RVU as published and defined by CMS; or (iv) billing of a procedure or set of procedures that, per the applicable CPT or HCPCS code definition, is based solely on time consumed so that it is necessary to submit multiple units of the procedure in order to accurately report the total time devoted to the patient. In the specific four circumstances outlined in the preceding sentence, Health Advantage will recognize and pay more than one Allowance per CPT or HCPCS code, provided all other terms and conditions of this Evidence of Coverage are met. With respect to the first such circumstance involving RVUs divided between a professional and a technical component, Health Advantage's payment will be limited to one global payment (Allowance) for the applicable professional component, and one global payment (Allowance) for the technical component. In other words, even where CMS policy specifically recognizes division of an RVU

into professional and technical components, Health Advantage will not be responsible for paying multiple providers or multiple billings for the professional component, nor will Health Advantage be responsible for paying multiple providers or multiple billings for the technical component. Benefits under this Evidence of Coverage will be limited in such circumstances to one global payment (Allowance) for the professional component and one global payment (Allowance) for the technical component.

GLOSSARY OF TERMS, "Allowance or Allowable Charge" is hereby amended to read as follows.

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

At the option of Health Advantage, Allowance or Allowable Charges for services or supplies received out of Arkansas may be determined by the local Blue Cross and Blue Shield Plan, See Subsection 7.1.10 dealing with Out of Arkansas Claims. See Subsection 3.23.4 with respect to Allowance or Allowable Charge for transplants. See Subsection 3.3.2 with respect to Allowance or Allowable Charge for Outpatient Surgery Centers. **Please note that all benefits under this Evidence of Coverage are subject to and shall be paid only by reference to the Allowance or Allowable Charge as determined at the discretion of Health Advantage. This means that regardless of how much your health care Provider may bill for a given service, the benefits under this Evidence of Coverage will be limited by the Allowance or Allowable Charge we establish. If you use a Health Advantage-participating Provider, that Provider is obligated to accept our established rate as payment in full, and should only bill you for your Deductible, Coinsurance and any non-covered services; however, if you use a non-participating Provider, you will be responsible for all amounts billed in excess of Health Advantage Allowance or Allowable Charge.**

The payment to a Provider for their services as described in a Current Procedural Terminology ("CPT") or Healthcare Common Procedure Coding System ("HCPCS") code and reimbursed in accordance with the Resource-Based Relative Value System ("RBRVS") used by the Centers for Medicare & Medicaid Services ("CMS") is an all-inclusive, global payment that covers all elements of the service as described in the particular code billed. This means that whatever staffing, overhead costs, equipment, drugs, machinery, tools, technology, supplies, or materials of any kind that may be required in order for the billing Provider to perform the service or treatment described in the CPT or HCPCS code billed, Health Advantage's payment to the billing Provider of the Allowance or Allowable Charge for that CPT or HCPCS code constitutes the entire payment and the limit of benefits under this Evidence of Coverage with respect to the CPT or HCPCS code billed. A Provider who bills for a particular CPT or HCPCS code is deemed to represent that the billing Provider has performed and is responsible for provision of all services or treatments described in the CPT or HCPCS code, and is entitled to bill for such services or treatments. If Health Advantage pays for a Covered Service by applying the Allowance or Allowable Charge to the bill of a Provider who represents that the Provider has performed a service or treatment described in a CPT or HCPCS code as submitted to Health Advantage, Health Advantage shall have no further obligation, nor is there coverage under this Evidence of Coverage, for bills from or payment to any other provider, entity or person, regardless of whether they assisted the billing Provider or furnished any staffing, equipment, drugs, machinery, tools, technology, supplies or materials of any kind to or for the benefit of the billing Provider. In other words, benefits under this Evidence of Coverage are limited to one, global payment for all components of any services falling within the scope of any CPT or HCPCS code service or treatment description, and Health Advantage will make only one payment with respect to such CPT or HCPCS code, even if multiple parties claim to have contributed a portion of the staffing, equipment, machinery, tools, technology, supplies or materials used by the billing Provider in the course of providing the service or treatment described in the CPT or HCPCS code.

For example, a physician who performs certain surgical procedures in the physician's office might choose to engage an equipment and supply company to set up the surgical table, furnish an assisting nurse, and also furnish certain surgical instruments, devices or supplies used by the physician. When the physician bills Health Advantage for the physician's performance of the

surgical procedure described in a specific CPT or HCPCS code, Health Advantage will make a single, global payment to the physician for Covered Services described in the CPT or HCPCS code, and will not be obligated to pay for any charges of the equipment and supply company. In such circumstances, any charge or claim of payment due the equipment and supply company shall be the exclusive responsibility of the physician (or other provider) who engaged the equipment and supply company, and permitted or facilitated such company's access to the physician's patient. In any event, as noted above, no benefits are available under this Evidence of Coverage for any services, drugs, materials or supplies of the equipment and supply company. It is Health Advantage's policy (and this Evidence of Coverage is specifically intended to adopt the same) that no benefits shall be paid for "unbundled services" in excess of Health Advantage's Allowance or Allowable Charge for any service as described in the applicable CPT or HCPCS code. This means, for example, that if a physician and another category of provider (such as a durable medical equipment supplier, a laboratory, a nurse practitioner, a nurse, a physician's assistant or any other category of provider) agree together to divide up, split or "unbundle" the components of any CPT or HCPCS code, and attempt to bill separately for the various components each allegedly provides for the patient, benefits under this Evidence of Coverage shall nevertheless be limited to one Allowance per CPT or HCPCS code; in such circumstances, your benefits under this Evidence of Coverage will pay only one Allowance or Allowable Charge for any Covered Service described in any single CPT or HCPCS code, and the various providers involved in any such "unbundling" action or agreement must resolve among themselves any division of that single Allowance or Allowable Charge between or among them. You can protect yourself from the possibility of billing in excess of the Allowance or Allowable Charge in these circumstances by always inquiring in advance to be sure that each provider involved in your care or treatment is an In-Network Provider.

Please note that Health Advantage makes the following exceptions to the preceding general policy of one global payment (Allowance) per CPT or HCPCS code: (i) where CMS has developed and published an RBRVS policy that specifically recognizes that the Relative Value Units (RVUs) associated with a specific CPT or HCPCS code should be divided into both a professional and a technical component; or (ii) billing of the services of an assistant surgeon for those CPT or HCPCS codes that specifically recognize assistant surgery services as applicable; or (iii) billing of radiopharmaceuticals used in nuclear medicine procedures where such radiopharmaceuticals clearly are not included in the practice expense portion of the associated RVU as published and defined by CMS; or (iv) billing of a procedure or set of procedures that, per the applicable CPT or HCPCS code definition, is based solely on time consumed so that it is necessary to submit multiple units of the procedure in order to accurately report the total time devoted to the patient. In the specific four circumstances outlined in the preceding sentence, Health Advantage will recognize and pay more than one Allowance per CPT or HCPCS code, provided all other terms and conditions of this Evidence of Coverage are met. With respect to the first such circumstance involving RVUs divided between a professional and a technical component, Health Advantage's payment will be limited to one global payment (Allowance) for the applicable professional component, and one global payment (Allowance) for the technical component. In other words, even where CMS policy specifically recognizes division of an RVU into professional and technical components, Health Advantage will not be responsible for paying multiple providers or multiple billings for the professional component, nor will Health Advantage be responsible for paying multiple providers or multiple billings for the technical component. Benefits under this Evidence of Coverage will be limited in such circumstances to one global payment (Allowance) for the professional component and one global payment (Allowance) for the technical component.

This amendment becomes a part of the Health Advantage Evidence of Coverage. All provisions of the Evidence of Coverage which are not contrary to the provisions of this amendment remain in full force and effect.



David F. Bridges, President
HMO PARTNERS, INC, d/b/a/ HEALTH ADVANTAGE
P.O. Office Box 8069, Little Rock, Arkansas 72203-8069

The following Health Advantage Evidence of Coverage (Grandfathered) is hereby amended.

Evidence of Coverage, Standard HMO, Form #31-01

The following subsection amendments are effective on January 1, 2013.

BENEFITS AND SPECIFIC LIMITATIONS IN YOUR PLAN, introductory paragraphs are hereby amended to read as follows.

Because of the high cost of some services or treatments, as well as the difficulty in some cases of determining whether services are really needed, we include coverage for such services or treatments but place limits on the extent of coverage, either by limiting the number of Provider visits or treatments, or by specifying a dollar limit for services or treatments received during a Contract Year or other specified period of time. This Section 3.0 describes medical services, drugs, supplies, tests and equipment for which coverage is provided under the Plan, provided all terms, conditions, exclusions and limitations of the Plan, including the six coverage criteria, are satisfied. This Section 3.0 sets out specific limitations applicable to each covered medical service, drug, supply or equipment.

You will note references to Copayment and Coinsurance obligations. For a description of the amount of these obligations and how they may vary depending upon whether you select an In-Network or Out-of-Network Provider, refer to Section 5.0, the definition of Allowance or Allowable Charge as set out in the Glossary of Terms and the Schedule of Benefits.

BENEFITS AND SPECIFIC LIMITATIONS IN YOUR PLAN, " Preventive Care" Subsection 2 is hereby amended to read as follows.

2. Immunizations. Intradermally administered influenza vaccination(s) and enhanced immunogenicity are subject to the maximum benefit the Plan allows for intramuscular injectable influenza vaccine without thimerosal per Covered Person per Contact Year.

BENEFITS AND SPECIFIC LIMITATIONS IN YOUR PLAN, "Dental Care and Orthodontic Services," Subsection 2. is hereby amended to read as follows.

2. Benefits for dental service. Dental services in connection with radiation treatment for cancer of the head or neck are covered.

BENEFITS AND SPECIFIC LIMITATIONS IN YOUR PLAN, "Organ Transplant Services" Subsections 7-10 are hereby amended to read as follows.

7. Coverage for high-dose or non-myeloablative chemotherapy, allogeneic or autologous stem or progenitor cell transplantation for the treatment of a medical condition is provided subject to Health Advantage's specific Coverage Policies relative to these specific conditions.

SPECIFIC PLAN EXCLUSIONS, Health Interventions, "Dental Care or Orthodontic Services," Subsection b. is hereby amended to read as follows.

- b. Benefits for dental service. Dental services in connection with radiation treatment for cancer of the head or neck are covered.

SPECIFIC PLAN EXCLUSIONS, Health Interventions, "Electrotherapy and electromagnetic stimulators" is hereby amended to read as follows.

Electrotherapy and electromagnetic stimulators. All treatment using electrotherapy stimulators, and electromagnetic stimulators, including services and supplies used in connection with such stimulators, and complications resulting from such treatment are not covered. However, subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Evidence of Coverage, coverage is provided for a Transcutaneous Electrical Nerve Stimulator (TENS) to treat chronic pain due to peripheral nerve injury when that pain is unresponsive to medication. Coverage is also provided for neuromuscular electrical stimulation (NMES) for treatment of disuse atrophy where nerve supply to the muscle is intact, including but not limited to atrophy secondary to prolonged splinting or casting of the affected extremity, contracture due to scarring of soft tissue as in burn lesions and hip replacement surgery until orthotic training begins.

SPECIFIC PLAN EXCLUSIONS, Health Interventions, "Sleep Apnea, Portable Studies" is hereby amended to read as follows.

Sleep Apnea, Portable Studies. Studies for the diagnosis, assessment or management of obstructive sleep apnea are generally not covered. However, subject to all other terms, conditions, exclusions and limitations of the Plan as set forth in this Evidence of Coverage, coverage is provided for portable (at home) sleep studies when all of the following monitoring information is included: EEG, heart rate, Chin EMG, ECG, airflow, effort and oxygen saturations, channels to identify awake versus asleep and apnea events. Devices used are considered portable comprehensive polysomnography devices monitoring a minimum of seven channels.

SPECIFIC PLAN EXCLUSIONS, Health Interventions, "Vision enhancement" is hereby amended to read as follows.

Vision enhancement. Any procedure, treatment, service, equipment or supply used to modify vision by changing the refractive error of the eye is generally not covered. Examples of non-covered vision enhancement services include, but are not limited to, the refraction for and the provision of eyeglasses and contact lenses; intraocular lenses, and refractive keratoplasty, with the exception of excessive, visually debilitating residual astigmatism following anterior segment surgery, i.e. corneal transplantation, cataract extraction, etc. Laser Assisted In Situ Keratomileusis (LASIK) and all other related refractive procedures are not covered. However, subject to all the terms, conditions, exclusions and limitations of the Plan as set forth in this Evidence of Coverage, a procedure, treatment, service, equipment or supply to correct a refractive error of the eye is covered in two instances: (1) if such refractive error results from traumatic injury or corneal disease, infectious or non infectious, and (2) the implant of a monofocal lens following cataract extraction and the single acquisition of eyeglasses or contact lenses within the first six months following cataract surgery. With respect to such eyeglasses or contact lenses, tinting or anti-reflective coating and progressive lenses are not covered. Eyeglass frames are subject to a \$50 maximum Allowance or Allowable Charge. See Subsection 3.11.3.

PROVIDER NETWORK AND COST SHARING PROCEDURES, "Network Procedures" are hereby amended to add the following new Subsection.

Scope of Provider Payment - Global Payment. Health Advantage's payment to a Provider for their services as described in a Current Procedural Terminology ("CPT") or Healthcare Common Procedure Coding System ("HCPCS") code and reimbursed in accordance with the Resource-Based Relative Value System ("RBRVS") used by the Centers for Medicare & Medicaid Services ("CMS") is an all-inclusive, global payment that covers all elements of the service as described in the particular code billed. This means that whatever staffing, overhead costs, equipment, drugs, machinery, tools, technology, supplies, or materials of any kind that may be required in order for the billing Provider to perform the service or treatment described in the CPT or HCPCS code billed, Health Advantage's payment to the billing Provider of the

Allowance or Allowable Charge for that CPT or HCPCS code constitutes the entire payment and the limit of benefits under this Evidence of Coverage with respect to the CPT or HCPCS code billed. A Provider who bills for a particular CPT or HCPCS code is deemed to represent that the billing Provider has performed and is responsible for provision of all services or treatments described in the CPT or HCPCS code, and is entitled to bill for such services or treatments. If Health Advantage pays for a Covered Service by applying the Allowance or Allowable Charge to the bill of a Provider who represents that the Provider has performed a service or treatment described in a CPT or HCPCS code as submitted to Health Advantage, Health Advantage shall have no further obligation, nor is there coverage under this Evidence of Coverage, for bills from or payment to any other provider, entity or person, regardless of whether they assisted the billing Provider or furnished any staffing, equipment, drugs, machinery, tools, technology, supplies or materials of any kind to or for the benefit of the billing Provider. In other words, benefits under this Evidence of Coverage are limited to one, global payment for all components of any services falling within the scope of any CPT or HCPCS code service or treatment description, and Health Advantage will make only one payment with respect to such CPT or HCPCS code, even if multiple parties claim to have contributed a portion of the staffing, equipment, machinery, tools, technology, supplies or materials used by the billing Provider in the course of providing the service or treatment described in the CPT or HCPCS code.

For example, a physician who performs certain surgical procedures in the physician's office might choose to engage an equipment and supply company to set up the surgical table, furnish an assisting nurse, and also furnish certain surgical instruments, devices or supplies used by the physician. When the physician bills Health Advantage for the physician's performance of the surgical procedure described in a specific CPT or HCPCS code, Health Advantage will make a single, global payment to the physician for Covered Services described in the CPT or HCPCS code, and will not be obligated to pay for any charges of the equipment and supply company. In such circumstances, any charge or claim of payment due the equipment and supply company shall be the exclusive responsibility of the physician (or other provider) who engaged the equipment and supply company, and permitted or facilitated such company's access to the physician's patient. In any event, as noted above, no benefits are available under this Evidence of Coverage for any services, drugs, materials or supplies of the equipment and supply company. It is Health Advantage's policy (and this Evidence of Coverage is specifically intended to adopt the same) that no benefits shall be paid for "unbundled services" in excess of Health Advantage's Allowable Charge for any service as described in the applicable CPT or HCPCS code. This means, for example, that if a physician and another category of provider (such as a durable medical equipment supplier, a laboratory, a nurse practitioner, a nurse, a physician's assistant or any other category of provider) agree together to divide up, split or "unbundle" the components of any CPT or HCPCS code, and attempt to bill separately for the various components each allegedly provides for the patient, benefits under this Evidence of Coverage shall nevertheless be limited to one Allowance per CPT or HCPCS code; in such circumstances, your benefits under this Evidence of Coverage will pay only one Allowable Charge for any Covered Service described in any single CPT or HCPCS code, and the various providers involved in any such "unbundling" action or agreement must resolve among themselves any division of that single Allowance or Allowable Charge between or among them. You can protect yourself from the possibility of billing in excess of the Allowable Charge in these circumstances by always inquiring in advance to be sure that each provider involved in your care or treatment is an In-Network Provider.

Please note that Health Advantage makes the following exceptions to the preceding general policy of one global payment (Allowance) per CPT or HCPCS code: (i) where CMS has developed and published an RBRVS policy that specifically recognizes that the Relative Value Units (RVUs) associated with a specific CPT or HCPCS code should be divided into both a professional and a technical component; or (ii) billing of the services of an assistant surgeon for those CPT or HCPCS codes that specifically recognize assistant surgery services as applicable; or (iii) billing of radiopharmaceuticals used in nuclear medicine procedures where such radiopharmaceuticals clearly are not included in the practice expense portion of the associated RVU as published and defined by CMS; or (iv) billing of a procedure or set of procedures that, per the applicable CPT or HCPCS code definition, is based solely on time consumed so that it is necessary to submit multiple units of the procedure in order to accurately report the total time devoted to the patient. In the specific four circumstances outlined in the preceding sentence,

Health Advantage will recognize and pay more than one Allowance per CPT or HCPCS code, provided all other terms and conditions of this Evidence of Coverage are met. With respect to the first such circumstance involving RVUs divided between a professional and a technical component, Health Advantage's payment will be limited to one global payment (Allowance) for the applicable professional component, and one global payment (Allowance) for the technical component. In other words, even where CMS policy specifically recognizes division of an RVU into professional and technical components, Health Advantage will not be responsible for paying multiple providers or multiple billings for the professional component, nor will Health Advantage be responsible for paying multiple providers or multiple billings for the technical component. Benefits under this Evidence of Coverage will be limited in such circumstances to one global payment (Allowance) for the professional component and one global payment (Allowance) for the technical component.

GLOSSARY OF TERMS, "Allowance or Allowable Charge" is hereby amended to read as follows.

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

At the option of Health Advantage, Allowance or Allowable Charges for services or supplies received out of Arkansas may be determined by the local Blue Cross and Blue Shield Plan, See Subsection 7.1.10 dealing with Out of Arkansas Claims. See Subsection 3.23.4 with respect to Allowance or Allowable Charge for transplants. See Subsection 3.3.2 with respect to Allowance or Allowable Charge for Outpatient Surgery Centers. **Please note that all benefits under this Evidence of Coverage are subject to and shall be paid only by reference to the Allowance or Allowable Charge as determined at the discretion of Health Advantage. This means that regardless of how much your health care Provider may bill for a given service, the benefits under this Evidence of Coverage will be limited by the Allowance or Allowable Charge we establish. If you use a Health Advantage-participating Provider, that Provider is obligated to accept our established rate as payment in full, and should only bill you for your Deductible, Coinsurance and any non-covered services; however, if you use a non-participating Provider, you will be responsible for all amounts billed in excess of Health Advantage Allowance or Allowable Charge.**

The payment to a Provider for their services as described in a Current Procedural Terminology ("CPT") or Healthcare Common Procedure Coding System ("HCPCS") code and reimbursed in accordance with the Resource-Based Relative Value System ("RBRVS") used by the Centers for Medicare & Medicaid Services ("CMS") is an all-inclusive, global payment that covers all elements of the service as described in the particular code billed. This means that whatever staffing, overhead costs, equipment, drugs, machinery, tools, technology, supplies, or materials of any kind that may be required in order for the billing Provider to perform the service or treatment described in the CPT or HCPCS code billed, Health Advantage's payment to the billing Provider of the Allowance or Allowable Charge for that CPT or HCPCS code constitutes the entire payment and the limit of benefits under this Evidence of Coverage with respect to the CPT or HCPCS code billed. A Provider who bills for a particular CPT or HCPCS code is deemed to represent that the billing Provider has performed and is responsible for provision of all services or treatments described in the CPT or HCPCS code, and is entitled to bill for such services or treatments. If Health Advantage pays for a Covered Service by applying the Allowance or Allowable Charge to the bill of a Provider who represents that the Provider has performed a service or treatment described in a CPT or HCPCS code as submitted to Health Advantage, Health Advantage shall have no further obligation, nor is there coverage under this Evidence of Coverage, for bills from or payment to any other provider, entity or person, regardless of whether they assisted the billing Provider or furnished any staffing, equipment, drugs, machinery, tools, technology, supplies or materials of any kind to or for the benefit of the billing Provider. In other words, benefits under this Evidence of Coverage are limited to one, global payment for all components of any services falling within the scope of any CPT or HCPCS code service or treatment description, and Health Advantage will make only one payment with respect to such CPT or HCPCS code, even if multiple parties claim to have

contributed a portion of the staffing, equipment, machinery, tools, technology, supplies or materials used by the billing Provider in the course of providing the service or treatment described in the CPT or HCPCS code.

For example, a physician who performs certain surgical procedures in the physician's office might choose to engage an equipment and supply company to set up the surgical table, furnish an assisting nurse, and also furnish certain surgical instruments, devices or supplies used by the physician. When the physician bills Health Advantage for the physician's performance of the surgical procedure described in a specific CPT or HCPCS code, Health Advantage will make a single, global payment to the physician for Covered Services described in the CPT or HCPCS code, and will not be obligated to pay for any charges of the equipment and supply company. In such circumstances, any charge or claim of payment due the equipment and supply company shall be the exclusive responsibility of the physician (or other provider) who engaged the equipment and supply company, and permitted or facilitated such company's access to the physician's patient. In any event, as noted above, no benefits are available under this Evidence of Coverage for any services, drugs, materials or supplies of the equipment and supply company. It is Health Advantage's policy (and this Evidence of Coverage is specifically intended to adopt the same) that no benefits shall be paid for "unbundled services" in excess of Health Advantage's Allowance or Allowable Charge for any service as described in the applicable CPT or HCPCS code. This means, for example, that if a physician and another category of provider (such as a durable medical equipment supplier, a laboratory, a nurse practitioner, a nurse, a physician's assistant or any other category of provider) agree together to divide up, split or "unbundle" the components of any CPT or HCPCS code, and attempt to bill separately for the various components each allegedly provides for the patient, benefits under this Evidence of Coverage shall nevertheless be limited to one Allowance per CPT or HCPCS code; in such circumstances, your benefits under this Evidence of Coverage will pay only one Allowance or Allowable Charge for any Covered Service described in any single CPT or HCPCS code, and the various providers involved in any such "unbundling" action or agreement must resolve among themselves any division of that single Allowance or Allowable Charge between or among them. You can protect yourself from the possibility of billing in excess of the Allowance or Allowable Charge in these circumstances by always inquiring in advance to be sure that each provider involved in your care or treatment is an In-Network Provider.

Please note that Health Advantage makes the following exceptions to the preceding general policy of one global payment (Allowance) per CPT or HCPCS code: (i) where CMS has developed and published an RBRVS policy that specifically recognizes that the Relative Value Units (RVUs) associated with a specific CPT or HCPCS code should be divided into both a professional and a technical component; or (ii) billing of the services of an assistant surgeon for those CPT or HCPCS codes that specifically recognize assistant surgery services as applicable; or (iii) billing of radiopharmaceuticals used in nuclear medicine procedures where such radiopharmaceuticals clearly are not included in the practice expense portion of the associated RVU as published and defined by CMS; or (iv) billing of a procedure or set of procedures that, per the applicable CPT or HCPCS code definition, is based solely on time consumed so that it is necessary to submit multiple units of the procedure in order to accurately report the total time devoted to the patient. In the specific four circumstances outlined in the preceding sentence, Health Advantage will recognize and pay more than one Allowance per CPT or HCPCS code, provided all other terms and conditions of this Evidence of Coverage are met. With respect to the first such circumstance involving RVUs divided between a professional and a technical component, Health Advantage's payment will be limited to one global payment (Allowance) for the applicable professional component, and one global payment (Allowance) for the technical component. In other words, even where CMS policy specifically recognizes division of an RVU into professional and technical components, Health Advantage will not be responsible for paying multiple providers or multiple billings for the professional component, nor will Health Advantage be responsible for paying multiple providers or multiple billings for the technical component. Benefits under this Evidence of Coverage will be limited in such circumstances to one global payment (Allowance) for the professional component and one global payment (Allowance) for the technical component.

This amendment becomes a part of the Health Advantage Evidence of Coverage. All provisions of the Evidence of Coverage which are not contrary to the provisions of this amendment remain in full force and effect.



David F. Bridges, President
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**Health Advantage
Grandfathered Health Plan
Notice**

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

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to Health Advantage at 1-800-843-1329. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

The following Health Advantage Evidences of Coverage (Grandfathered) are hereby amended.

Evidence of Coverage, HSA Open Access Plan, Form #: 31-06

Evidence of Coverage, HSA Open Access Plan with Preexisting, Form #31-07

The following subsection amendments are effective on January 1, 2013.

BENEFITS AND SPECIFIC LIMITATIONS IN YOUR PLAN, introductory paragraphs are hereby amended to read as follows.

Because of the high cost of some services or treatments, as well as the difficulty in some cases of determining whether services are really needed, we include coverage for such services or treatments but place limits on the extent of coverage, either by limiting the number of Provider visits or treatments, or by specifying a dollar limit for services or treatments received during a Contract Year or other specified period of time. This Section 3.0 describes medical services, drugs, supplies, tests and equipment for which coverage is provided under the Plan, provided all terms, conditions, exclusions and limitations of the Plan, including the six coverage criteria, are satisfied. This Section 3.0 sets out specific limitations applicable to each covered medical service, drug, supply or equipment.

You will note references to Deductible and Coinsurance obligations. For a description of the amount of these obligations and how they may vary depending upon whether you select an In-Network or Out-of-Network Provider, refer to Section 5.0, the definition of Allowance or Allowable Charge as set out in the Glossary of Terms and the Schedule of Benefits.

BENEFITS AND SPECIFIC LIMITATIONS IN YOUR PLAN, " Preventive Care" Subsection 2 is hereby amended to read as follows.

2. Immunizations. Intradermally administered influenza vaccination(s) and enhanced immunogenicity are subject to the maximum benefit the Plan allows for intramuscular injectable influenza vaccine without thimerosal per Covered Person per Contract Year.

BENEFITS AND SPECIFIC LIMITATIONS IN YOUR PLAN, "Dental Care and Orthodontic Services," Subsection 2. is hereby amended to read as follows.

2. Benefits for dental service. Dental services in connection with radiation treatment for cancer of the head or neck are covered.

BENEFITS AND SPECIFIC LIMITATIONS IN YOUR PLAN, "Organ Transplant Services" Subsections 7-10 are hereby amended to read as follows.

7. Coverage for high-dose or non-myeloablative chemotherapy, allogeneic or autologous stem or progenitor cell transplantation for the treatment of a medical condition is provided subject to Health Advantage's specific Coverage Policies relative to these specific conditions.

SPECIFIC PLAN EXCLUSIONS, Health Interventions, "Dental Care or Orthodontic Services," Subsection b. is hereby amended to read as follows.

- b. Benefits for dental service. Dental services in connection with radiation treatment for cancer of the head or neck are covered.

SPECIFIC PLAN EXCLUSIONS, Health Interventions, "Electrotherapy and electromagnetic stimulators" is hereby amended to read as follows.

Electrotherapy and electromagnetic stimulators. All treatment using electrotherapy stimulators, and electromagnetic stimulators, including services and supplies used in connection with such stimulators, and complications resulting from such treatment are not covered. However, subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Evidence of Coverage, coverage is provided for a Transcutaneous Electrical Nerve Stimulator (TENS) to treat chronic pain due to peripheral nerve injury when that pain is unresponsive to medication. Coverage is also provided for neuromuscular electrical stimulation (NMES) for treatment of disuse atrophy where nerve supply to the muscle is intact, including but not limited to atrophy secondary to prolonged splinting or casting of the affected extremity, contracture due to scarring of soft tissue as in burn lesions and hip replacement surgery until orthotic training begins.

SPECIFIC PLAN EXCLUSIONS, Health Interventions, "Sleep Apnea, Portable Studies" is hereby amended to read as follows.

Sleep Apnea, Portable Studies. Studies for the diagnosis, assessment or management of obstructive sleep apnea are generally not covered. However, subject to all other terms, conditions, exclusions and limitations of the Plan as set forth in this Evidence of Coverage, coverage is provided for portable (at home) sleep studies when all of the following monitoring information is included: EEG, heart rate, Chin EMG, ECG, airflow, effort and oxygen saturations, channels to identify awake versus asleep and apnea events. Devices used are considered portable comprehensive polysomnography devices monitoring a minimum of seven channels.

SPECIFIC PLAN EXCLUSIONS, Health Interventions, "Vision enhancement" is hereby amended to read as follows.

Vision enhancement. Any procedure, treatment, service, equipment or supply used to modify vision by changing the refractive error of the eye is generally not covered. Examples of non-covered vision enhancement services include, but are not limited to, the refraction for and the provision of eyeglasses and contact lenses; intraocular lenses, and refractive keratoplasty, with the exception of excessive, visually debilitating residual astigmatism following anterior segment surgery, i.e. corneal transplantation, cataract extraction, etc. Laser Assisted In Situ Keratomileusis (LASIK) and all other related refractive procedures are not covered. However, subject to all the terms, conditions, exclusions and limitations of the Plan as set forth in this Evidence of Coverage, a procedure, treatment, service, equipment or supply to correct a refractive error of the eye is covered in two instances: (1) if such refractive error results from traumatic injury or corneal disease, infectious or non infectious, and (2) the implant of a monofocal lens following cataract extraction and the single acquisition of eyeglasses or contact lenses within the first six months following cataract surgery. With respect to such eyeglasses or contact lenses, tinting or anti-reflective coating and progressive lenses are not covered. Eyeglass frames are subject to a \$50 maximum Allowance or Allowable Charge. See Subsection 3.11.3.

PROVIDER NETWORK AND COST SHARING PROCEDURES, "Network Procedures" are hereby amended to add the following new Subsection.

Scope of Provider Payment - Global Payment. Health Advantage's payment to a Provider for their services as described in a Current Procedural Terminology ("CPT") or Healthcare Common Procedure Coding System ("HCPCS") code and reimbursed in accordance with the Resource-Based Relative Value System ("RBRVS") used by the Centers for Medicare & Medicaid Services ("CMS") is an all-inclusive, global payment that covers all elements of the service as described in the particular code billed. This means that whatever staffing, overhead costs, equipment, drugs, machinery, tools, technology, supplies, or materials of any kind that may be required in order for the billing Provider to perform the service or treatment described in the CPT or HCPCS code billed, Health Advantage's payment to the billing Provider of the

Allowable Charge for that CPT or HCPCS code constitutes the entire payment and the limit of benefits under this Evidence of Coverage with respect to the CPT or HCPCS code billed. A Provider who bills for a particular CPT or HCPCS code is deemed to represent that the billing Provider has performed and is responsible for provision of all services or treatments described in the CPT or HCPCS code, and is entitled to bill for such services or treatments. If Health Advantage pays for a Covered Service by applying the Allowance or Allowable Charge to the bill of a Provider who represents that the Provider has performed a service or treatment described in a CPT or HCPCS code as submitted to Health Advantage, Health Advantage shall have no further obligation, nor is there coverage under this Evidence of Coverage, for bills from or payment to any other provider, entity or person, regardless of whether they assisted the billing Provider or furnished any staffing, equipment, drugs, machinery, tools, technology, supplies or materials of any kind to or for the benefit of the billing Provider. In other words, benefits under this Evidence of Coverage are limited to one, global payment for all components of any services falling within the scope of any CPT or HCPCS code service or treatment description, and Health Advantage will make only one payment with respect to such CPT or HCPCS code, even if multiple parties claim to have contributed a portion of the staffing, equipment, machinery, tools, technology, supplies or materials used by the billing Provider in the course of providing the service or treatment described in the CPT or HCPCS code.

For example, a physician who performs certain surgical procedures in the physician's office might choose to engage an equipment and supply company to set up the surgical table, furnish an assisting nurse, and also furnish certain surgical instruments, devices or supplies used by the physician. When the physician bills Health Advantage for the physician's performance of the surgical procedure described in a specific CPT or HCPCS code, Health Advantage will make a single, global payment to the physician for Covered Services described in the CPT or HCPCS code, and will not be obligated to pay for any charges of the equipment and supply company. In such circumstances, any charge or claim of payment due the equipment and supply company shall be the exclusive responsibility of the physician (or other provider) who engaged the equipment and supply company, and permitted or facilitated such company's access to the physician's patient. In any event, as noted above, no benefits are available under this Evidence of Coverage for any services, drugs, materials or supplies of the equipment and supply company. It is Health Advantage's policy (and this Evidence of Coverage is specifically intended to adopt the same) that no benefits shall be paid for "unbundled services" in excess of Health Advantage's Allowable Charge for any service as described in the applicable CPT or HCPCS code. This means, for example, that if a physician and another category of provider (such as a durable medical equipment supplier, a laboratory, a nurse practitioner, a nurse, a physician's assistant or any other category of provider) agree together to divide up, split or "unbundle" the components of any CPT or HCPCS code, and attempt to bill separately for the various components each allegedly provides for the patient, benefits under this Evidence of Coverage shall nevertheless be limited to one Allowance per CPT or HCPCS code; in such circumstances, your benefits under this Evidence of Coverage will pay only one Allowable Charge for any Covered Service described in any single CPT or HCPCS code, and the various providers involved in any such "unbundling" action or agreement must resolve among themselves any division of that single Allowable Charge between or among them. You can protect yourself from the possibility of billing in excess of the Allowable Charge in these circumstances by always inquiring in advance to be sure that each provider involved in your care or treatment is an In-Network Provider.

Please note that Health Advantage makes the following exceptions to the preceding general policy of one global payment (Allowance) per CPT or HCPCS code: (i) where CMS has developed and published an RBRVS policy that specifically recognizes that the Relative Value Units (RVUs) associated with a specific CPT or HCPCS code should be divided into both a professional and a technical component; or (ii) billing of the services of an assistant surgeon for those CPT or HCPCS codes that specifically recognize assistant surgery services as applicable; or (iii) billing of radiopharmaceuticals used in nuclear medicine procedures where such radiopharmaceuticals clearly are not included in the practice expense portion of the associated RVU as published and defined by CMS; or (iv) billing of a procedure or set of procedures that, per the applicable CPT or HCPCS code definition, is based solely on time consumed so that it is necessary to submit multiple units of the procedure in order to accurately report the total time devoted to the patient. In the specific four circumstances outlined in the preceding sentence,

Health Advantage will recognize and pay more than one Allowance per CPT or HCPCS code, provided all other terms and conditions of this Evidence of Coverage are met. With respect to the first such circumstance involving RVUs divided between a professional and a technical component, Health Advantage's payment will be limited to one global payment (Allowance) for the applicable professional component, and one global payment (Allowance) for the technical component. In other words, even where CMS policy specifically recognizes division of an RVU into professional and technical components, Health Advantage will not be responsible for paying multiple providers or multiple billings for the professional component, nor will Health Advantage be responsible for paying multiple providers or multiple billings for the technical component. Benefits under this Evidence of Coverage will be limited in such circumstances to one global payment (Allowance) for the professional component and one global payment (Allowance) for the technical component.

GLOSSARY OF TERMS, "Allowable Charge" is hereby amended to read as follows.

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

At the option of Health Advantage, Allowance or Allowable Charges for services or supplies received out of Arkansas may be determined by the local Blue Cross and Blue Shield Plan, See Subsection 7.1.10 dealing with Out of Arkansas Claims. See Subsection 3.23.4 with respect to Allowance or Allowable Charge for transplants. See Subsection 3.3.2 with respect to Allowance or Allowable Charge for Outpatient Surgery Centers. **Please note that all benefits under this Evidence of Coverage are subject to and shall be paid only by reference to the Allowance or Allowable Charge as determined at the discretion of Health Advantage. This means that regardless of how much your health care Provider may bill for a given service, the benefits under this Evidence of Coverage will be limited by the Allowance or Allowable Charge we establish. If you use a Health Advantage participating Provider, that Provider is obligated to accept our established rate as payment in full, and should only bill you for your Deductible, Coinsurance and any non-covered services; however, if you use a non-participating Provider, you will be responsible for all amounts billed in excess of Health Advantage Allowance or Allowable Charge.**

The payment to a Provider for their services as described in a Current Procedural Terminology ("CPT") or Healthcare Common Procedure Coding System ("HCPCS") code and reimbursed in accordance with the Resource-Based Relative Value System ("RBRVS") used by the Centers for Medicare & Medicaid Services ("CMS") is an all-inclusive, global payment that covers all elements of the service as described in the particular code billed. This means that whatever staffing, overhead costs, equipment, drugs, machinery, tools, technology, supplies, or materials of any kind that may be required in order for the billing Provider to perform the service or treatment described in the CPT or HCPCS code billed, Health Advantage's payment to the billing Provider of the Allowance or Allowable Charge for that CPT or HCPCS code constitutes the entire payment and the limit of benefits under this Evidence of Coverage with respect to the CPT or HCPCS code billed. A Provider who bills for a particular CPT or HCPCS code is deemed to represent that the billing Provider has performed and is responsible for provision of all services or treatments described in the CPT or HCPCS code, and is entitled to bill for such services or treatments. If Health Advantage pays for a Covered Service by applying the Allowance or Allowable Charge to the bill of a Provider who represents that the Provider has performed a service or treatment described in a CPT or HCPCS code as submitted to Health Advantage, Health Advantage shall have no further obligation, nor is there coverage under this Evidence of Coverage, for bills from or payment to any other provider, entity or person, regardless of whether they assisted the billing Provider or furnished any staffing, equipment, drugs, machinery, tools, technology, supplies or materials of any kind to or for the benefit of the billing Provider. In other words, benefits under this Evidence of Coverage are limited to one, global payment for all components of any services falling within the scope of any CPT or HCPCS code service or treatment description, and Health Advantage will make only one payment with respect to such CPT or HCPCS code, even if multiple parties claim to have

contributed a portion of the staffing, equipment, machinery, tools, technology, supplies or materials used by the billing Provider in the course of providing the service or treatment described in the CPT or HCPCS code.

For example, a physician who performs certain surgical procedures in the physician's office might choose to engage an equipment and supply company to set up the surgical table, furnish an assisting nurse, and also furnish certain surgical instruments, devices or supplies used by the physician. When the physician bills Health Advantage for the physician's performance of the surgical procedure described in a specific CPT or HCPCS code, Health Advantage will make a single, global payment to the physician for Covered Services described in the CPT or HCPCS code, and will not be obligated to pay for any charges of the equipment and supply company. In such circumstances, any charge or claim of payment due the equipment and supply company shall be the exclusive responsibility of the physician (or other provider) who engaged the equipment and supply company, and permitted or facilitated such company's access to the physician's patient. In any event, as noted above, no benefits are available under this Evidence of Coverage for any services, drugs, materials or supplies of the equipment and supply company. It is Health Advantage's policy (and this Evidence of Coverage is specifically intended to adopt the same) that no benefits shall be paid for "unbundled services" in excess of Health Advantage's Allowance or Allowable Charge for any service as described in the applicable CPT or HCPCS code. This means, for example, that if a physician and another category of provider (such as a durable medical equipment supplier, a laboratory, a nurse practitioner, a nurse, a physician's assistant or any other category of provider) agree together to divide up, split or "unbundle" the components of any CPT or HCPCS code, and attempt to bill separately for the various components each allegedly provides for the patient, benefits under this Evidence of Coverage shall nevertheless be limited to one Allowance per CPT or HCPCS code; in such circumstances, your benefits under this Evidence of Coverage will pay only one Allowance or Allowable Charge for any Covered Service described in any single CPT or HCPCS code, and the various providers involved in any such "unbundling" action or agreement must resolve among themselves any division of that single Allowance or Allowable Charge between or among them. You can protect yourself from the possibility of billing in excess of the Allowance or Allowable Charge in these circumstances by always inquiring in advance to be sure that each provider involved in your care or treatment is an In-Network Provider.

Please note that Health Advantage makes the following exceptions to the preceding general policy of one global payment (Allowance) per CPT or HCPCS code: (i) where CMS has developed and published an RBRVS policy that specifically recognizes that the Relative Value Units (RVUs) associated with a specific CPT or HCPCS code should be divided into both a professional and a technical component; or (ii) billing of the services of an assistant surgeon for those CPT or HCPCS codes that specifically recognize assistant surgery services as applicable; or (iii) billing of radiopharmaceuticals used in nuclear medicine procedures where such radiopharmaceuticals clearly are not included in the practice expense portion of the associated RVU as published and defined by CMS; or (iv) billing of a procedure or set of procedures that, per the applicable CPT or HCPCS code definition, is based solely on time consumed so that it is necessary to submit multiple units of the procedure in order to accurately report the total time devoted to the patient. In the specific four circumstances outlined in the preceding sentence, Health Advantage will recognize and pay more than one Allowance per CPT or HCPCS code, provided all other terms and conditions of this Evidence of Coverage are met. With respect to the first such circumstance involving RVUs divided between a professional and a technical component, Health Advantage's payment will be limited to one global payment (Allowance) for the applicable professional component, and one global payment (Allowance) for the technical component. In other words, even where CMS policy specifically recognizes division of an RVU into professional and technical components, Health Advantage will not be responsible for paying multiple providers or multiple billings for the professional component, nor will Health Advantage be responsible for paying multiple providers or multiple billings for the technical component. Benefits under this Evidence of Coverage will be limited in such circumstances to one global payment (Allowance) for the professional component and one global payment (Allowance) for the technical component.

This amendment becomes a part of the Health Advantage Evidence of Coverage. All provisions of the Evidence of Coverage which are not contrary to the provisions of this amendment remain in full force and effect.



David F. Bridges, President
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**Health Advantage
Grandfathered Health Plan
Notice**

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

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to Health Advantage at 1-800-843-1329. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.



The following Health Advantage Evidences of Coverage (Grandfathered) are hereby amended.

- Evidence of Coverage, BlueChoice POS Plan, Form #31-02
- Evidence of Coverage, BlueChoice POS Plan with Preexisting, Form #31-03
- Evidence of Coverage, BlueChoice Open Access POS Plan, Form #31-04
- Evidence of Coverage, BlueChoice Open Access POS Plan with Preexisting, Form #31-05

The following subsection amendments are effective on January 1, 2013.

BENEFITS AND SPECIFIC LIMITATIONS IN YOUR PLAN, introductory paragraphs are hereby amended to read as follows.

Because of the high cost of some services or treatments, as well as the difficulty in some cases of determining whether services are really needed, we include coverage for such services or treatments but place limits on the extent of coverage, either by limiting the number of Provider visits or treatments, or by specifying a dollar limit for services or treatments received during a Contract Year or other specified period of time. This Section 3.0 describes medical services, drugs, supplies, tests and equipment for which coverage is provided under the Plan, provided all terms, conditions, exclusions and limitations of the Plan, including the six coverage criteria, are satisfied. This Section 3.0 sets out specific limitations applicable to each covered medical service, drug, supply or equipment.

You will note references to Deductible, Coinsurance and Copayment obligations. For a description of the amount of these obligations and how they may vary depending upon whether you select an In-Network or Out-of-Network Provider, refer to Section 5.0, the definition of Allowable Charge as set out in the Glossary of Terms and the Schedule of Benefits.

BENEFITS AND SPECIFIC LIMITATIONS IN YOUR PLAN, " Preventive Care" Subsection 2 is hereby amended to read as follows.

2. Immunizations. Intradermally administered influenza vaccination(s) and enhanced immunogenicity are subject to the maximum benefit the Plan allows for intramuscular injectable influenza vaccine without thimerosal per Covered Person per Contract Year.

BENEFITS AND SPECIFIC LIMITATIONS IN YOUR PLAN, "Dental Care and Orthodontic Services," Subsection 2. is hereby amended to read as follows.

2. Benefits for dental service. Dental services in connection with radiation treatment for cancer of the head or neck are covered.

BENEFITS AND SPECIFIC LIMITATIONS IN YOUR PLAN, "Organ Transplant Services" Subsections 7-10 are hereby amended to read as follows.

7. Coverage for high-dose or non-myeloablative chemotherapy, allogeneic or autologous stem or progenitor cell transplantation for the treatment of a medical condition is provided subject to Health Advantage's specific Coverage Policies relative to these specific conditions.

SPECIFIC PLAN EXCLUSIONS, Health Interventions, "Dental Care or Orthodontic Services," Subsection b. is hereby amended to read as follows.

- b. Benefits for dental service. Dental services in connection with radiation treatment for cancer of the head or neck are covered.

SPECIFIC PLAN EXCLUSIONS, Health Interventions, "Electrotherapy and electromagnetic stimulators" is hereby amended to read as follows.

Electrotherapy and electromagnetic stimulators. All treatment using electrotherapy stimulators, and electromagnetic stimulators, including services and supplies used in connection with such stimulators, and complications resulting from such treatment are not covered. However, subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Evidence of Coverage, coverage is provided for a Transcutaneous Electrical Nerve Stimulator (TENS) to treat chronic pain due to peripheral nerve injury when that pain is unresponsive to medication. Coverage is also provided for neuromuscular electrical stimulation (NMES) for treatment of disuse atrophy where nerve supply to the muscle is intact, including but not limited to atrophy secondary to prolonged splinting or casting of the affected extremity, contracture due to scarring of soft tissue as in burn lesions and hip replacement surgery until orthotic training begins.

SPECIFIC PLAN EXCLUSIONS, Health Interventions, "Sleep Apnea, Portable Studies" is hereby amended to read as follows.

Sleep Apnea, Portable Studies. Studies for the diagnosis, assessment or management of obstructive sleep apnea are generally not covered. However, subject to all other terms, conditions, exclusions and limitations of the Plan as set forth in this Evidence of Coverage, coverage is provided for portable (at home) sleep studies when all of the following monitoring information is included: EEG, heart rate, Chin EMG, ECG, airflow, effort and oxygen saturations, channels to identify awake versus asleep and apnea events. Devices used are considered portable comprehensive polysomnography devices monitoring a minimum of seven channels.

SPECIFIC PLAN EXCLUSIONS, Health Interventions, "Vision enhancement" is hereby amended to read as follows.

Vision enhancement. Any procedure, treatment, service, equipment or supply used to modify vision by changing the refractive error of the eye is generally not covered. Examples of non-covered vision enhancement services include, but are not limited to, the refraction for and the provision of eyeglasses and contact lenses; intraocular lenses, and refractive keratoplasty, with the exception of excessive, visually debilitating residual astigmatism following anterior segment surgery, i.e. corneal transplantation, cataract extraction, etc. Laser Assisted In situ Keratomileusis (LASIK) and all other related refractive procedures are not covered. However, subject to all the terms, conditions, exclusions and limitations of the Plan as set forth in this Evidence of Coverage, a procedure, treatment, service, equipment or supply to correct a refractive error of the eye is covered in two instances: (1) if such refractive error results from traumatic injury or corneal disease, infectious or non infectious, and (2) the implant of a monofocal lens following cataract extraction and the single acquisition of eyeglasses or contact lenses within the first six months following cataract surgery. With respect to such eyeglasses or contact lenses, tinting or anti-reflective coating and progressive lenses are not covered. Eyeglass frames are subject to a \$50 maximum Allowance or Allowable Charge. See Subsection 3.11.3.

PROVIDER NETWORK AND COST SHARING PROCEDURES, "Network Procedures" are hereby amended to add the following new Subsection.

Scope of Provider Payment - Global Payment. Health Advantage's payment to a Provider for their services as described in a Current Procedural Terminology ("CPT") or Healthcare Common Procedure Coding System ("HCPCS") code and reimbursed in accordance with the Resource-Based Relative Value System ("RBRVS") used by the Centers for Medicare & Medicaid Services ("CMS") is an all-inclusive, global payment that covers all elements of the service as described in the particular code billed. This means that whatever staffing, overhead costs, equipment, drugs, machinery, tools, technology, supplies, or materials of any kind that may be required in order for the billing Provider to perform the service or treatment described in the CPT or HCPCS code billed, Health Advantage's payment to the billing Provider of the Allowable Charge for that CPT or HCPCS code constitutes the entire payment and the limit of benefits under this Evidence of Coverage with respect to the CPT or HCPCS code billed. A Provider who bills for a particular CPT or HCPCS code is deemed to represent that the billing Provider has performed and is responsible for provision of all services or treatments described in the CPT or HCPCS code, and is entitled to bill for such services or treatments. If Health Advantage pays for a Covered Service by applying the Allowance or Allowable Charge to the bill of a Provider who represents that the Provider has performed a service or treatment described in a CPT or HCPCS code as submitted to Health Advantage, Health Advantage shall have no further obligation, nor is there coverage under this Evidence of Coverage, for bills from or payment to any other provider, entity or person, regardless of whether they assisted the billing Provider or furnished any staffing, equipment, drugs, machinery, tools, technology, supplies or materials of any kind to or for the benefit of the billing Provider. In other words, benefits under this Evidence of Coverage are limited to one, global payment for all components of any services falling within the scope of any CPT or HCPCS code service or treatment description, and Health Advantage will make only one payment with respect to such CPT or HCPCS code, even if multiple parties claim to have contributed a portion of the staffing, equipment, machinery, tools, technology, supplies or materials used by the billing Provider in the course of providing the service or treatment described in the CPT or HCPCS code.

For example, a physician who performs certain surgical procedures in the physician's office might choose to engage an equipment and supply company to set up the surgical table, furnish an assisting nurse, and also furnish certain surgical instruments, devices or supplies used by the physician. When the physician bills Health Advantage for the physician's performance of the surgical procedure described in a specific CPT or HCPCS code, Health Advantage will make a single, global payment to the physician for Covered Services described in the CPT or HCPCS code, and will not be obligated to pay for any charges of the equipment and supply company. In such circumstances, any charge or claim of payment due the equipment and supply company shall be the exclusive responsibility of the physician (or other provider) who engaged the equipment and supply company, and permitted or facilitated such company's access to the physician's patient. In any event, as noted above, no benefits are available under this Evidence of Coverage for any services, drugs, materials or supplies of the equipment and supply company. It is Health Advantage's policy (and this Evidence of Coverage is specifically intended to adopt the same) that no benefits shall be paid for "unbundled services" in excess of Health Advantage's Allowable Charge for any service as described in the applicable CPT or HCPCS code. This means, for example, that if a physician and another category of provider (such as a durable medical equipment supplier, a laboratory, a nurse practitioner, a nurse, a physician's assistant or any other category of provider) agree together to divide up, split or "unbundle" the components of any CPT or HCPCS code, and attempt to bill separately for the various components each allegedly provides for the patient, benefits under this Evidence of Coverage shall nevertheless be limited to one Allowance per CPT or HCPCS code; in such circumstances, your benefits under this Evidence of Coverage will pay only one Allowable Charge for any Covered Service described in any single CPT or HCPCS code, and the various providers involved in any such "unbundling" action or agreement must resolve among themselves any division of that single Allowable Charge between or among them. You can protect yourself from the possibility of billing in excess of the Allowable Charge in these

circumstances by always inquiring in advance to be sure that each provider involved in your care or treatment is an In-Network Provider.

Please note that Health Advantage makes the following exceptions to the preceding general policy of one global payment (Allowance) per CPT or HCPCS code: (i) where CMS has developed and published an RBRVS policy that specifically recognizes that the Relative Value Units (RVUs) associated with a specific CPT or HCPCS code should be divided into both a professional and a technical component; or (ii) billing of the services of an assistant surgeon for those CPT or HCPCS codes that specifically recognize assistant surgery services as applicable; or (iii) billing of radiopharmaceuticals used in nuclear medicine procedures where such radiopharmaceuticals clearly are not included in the practice expense portion of the associated RVU as published and defined by CMS; or (iv) billing of a procedure or set of procedures that, per the applicable CPT or HCPCS code definition, is based solely on time consumed so that it is necessary to submit multiple units of the procedure in order to accurately report the total time devoted to the patient. In the specific four circumstances outlined in the preceding sentence, Health Advantage will recognize and pay more than one Allowance per CPT or HCPCS code, provided all other terms and conditions of this Evidence of Coverage are met. With respect to the first such circumstance involving RVUs divided between a professional and a technical component, Health Advantage's payment will be limited to one global payment (Allowance) for the applicable professional component, and one global payment (Allowance) for the technical component. In other words, even where CMS policy specifically recognizes division of an RVU into professional and technical components, Health Advantage will not be responsible for paying multiple providers or multiple billings for the professional component, nor will Health Advantage be responsible for paying multiple providers or multiple billings for the technical component. Benefits under this Evidence of Coverage will be limited in such circumstances to one global payment (Allowance) for the professional component and one global payment (Allowance) for the technical component.

GLOSSARY OF TERMS, "Allowance or Allowable Charge" is hereby amended to read as follows.

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

At the option of Health Advantage, Allowance or Allowable Charges for services or supplies received out of Arkansas may be determined by the local Blue Cross and Blue Shield Plan, See Subsection 7.1.10 dealing with Out of Arkansas Claims. See Subsection 3.23.4 with respect to Allowance or Allowable Charge for transplants. See Subsection 3.3.2 with respect to Allowance or Allowable Charge for Outpatient Surgery Centers. **Please note that all benefits under this Evidence of Coverage are subject to and shall be paid only by reference to the Allowance or Allowable Charge as determined at the discretion of Health Advantage. This means that regardless of how much your health care Provider may bill for a given service, the benefits under this Evidence of Coverage will be limited by the Allowance or Allowable Charge we establish. If you use a Health Advantage-participating Provider, that Provider is obligated to accept our established rate as payment in full, and should only bill you for your Deductible, Coinsurance and any non-covered services; however, if you use a non-participating Provider, you will be responsible for all amounts billed in excess of Health Advantage Allowance or Allowable Charge.**

The payment to a Provider for their services as described in a Current Procedural Terminology ("CPT") or Healthcare Common Procedure Coding System ("HCPCS") code and reimbursed in accordance with the Resource-Based Relative Value System ("RBRVS") used by the Centers for Medicare & Medicaid Services ("CMS") is an all-inclusive, global payment that covers all elements of the service as described in the particular code billed. This means that whatever staffing, overhead costs, equipment, drugs, machinery, tools, technology, supplies, or materials of any kind that may be required in order for the billing Provider to perform the service or treatment described in the CPT or HCPCS code billed, Health Advantage's payment to the billing Provider of the Allowance or Allowable Charge for that CPT or HCPCS code constitutes the entire payment and the limit of benefits under this Evidence of Coverage with respect to the CPT or HCPCS code billed. A Provider who bills for a particular CPT or HCPCS code is

deemed to represent that the billing Provider has performed and is responsible for provision of all services or treatments described in the CPT or HCPCS code, and is entitled to bill for such services or treatments. If Health Advantage pays for a Covered Service by applying the Allowance or Allowable Charge to the bill of a Provider who represents that the Provider has performed a service or treatment described in a CPT or HCPCS code as submitted to Health Advantage, Health Advantage shall have no further obligation, nor is there coverage under this Evidence of Coverage, for bills from or payment to any other provider, entity or person, regardless of whether they assisted the billing Provider or furnished any staffing, equipment, drugs, machinery, tools, technology, supplies or materials of any kind to or for the benefit of the billing Provider. In other words, benefits under this Evidence of Coverage are limited to one, global payment for all components of any services falling within the scope of any CPT or HCPCS code service or treatment description, and Health Advantage will make only one payment with respect to such CPT or HCPCS code, even if multiple parties claim to have contributed a portion of the staffing, equipment, machinery, tools, technology, supplies or materials used by the billing Provider in the course of providing the service or treatment described in the CPT or HCPCS code.

For example, a physician who performs certain surgical procedures in the physician's office might choose to engage an equipment and supply company to set up the surgical table, furnish an assisting nurse, and also furnish certain surgical instruments, devices or supplies used by the physician. When the physician bills Health Advantage for the physician's performance of the surgical procedure described in a specific CPT or HCPCS code, Health Advantage will make a single, global payment to the physician for Covered Services described in the CPT or HCPCS code, and will not be obligated to pay for any charges of the equipment and supply company. In such circumstances, any charge or claim of payment due the equipment and supply company shall be the exclusive responsibility of the physician (or other provider) who engaged the equipment and supply company, and permitted or facilitated such company's access to the physician's patient. In any event, as noted above, no benefits are available under this Evidence of Coverage for any services, drugs, materials or supplies of the equipment and supply company. It is Health Advantage's policy (and this Evidence of Coverage is specifically intended to adopt the same) that no benefits shall be paid for "unbundled services" in excess of Health Advantage's Allowance or Allowable Charge for any service as described in the applicable CPT or HCPCS code. This means, for example, that if a physician and another category of provider (such as a durable medical equipment supplier, a laboratory, a nurse practitioner, a nurse, a physician's assistant or any other category of provider) agree together to divide up, split or "unbundle" the components of any CPT or HCPCS code, and attempt to bill separately for the various components each allegedly provides for the patient, benefits under this Evidence of Coverage shall nevertheless be limited to one Allowance per CPT or HCPCS code; in such circumstances, your benefits under this Evidence of Coverage will pay only one Allowance or Allowable Charge for any Covered Service described in any single CPT or HCPCS code, and the various providers involved in any such "unbundling" action or agreement must resolve among themselves any division of that single Allowance or Allowable Charge between or among them. You can protect yourself from the possibility of billing in excess of the Allowance or Allowable Charge in these circumstances by always inquiring in advance to be sure that each provider involved in your care or treatment is an In-Network Provider.

Please note that Health Advantage makes the following exceptions to the preceding general policy of one global payment (Allowance) per CPT or HCPCS code: (i) where CMS has developed and published an RBRVS policy that specifically recognizes that the Relative Value Units (RVUs) associated with a specific CPT or HCPCS code should be divided into both a professional and a technical component; or (ii) billing of the services of an assistant surgeon for those CPT or HCPCS codes that specifically recognize assistant surgery services as applicable; or (iii) billing of radiopharmaceuticals used in nuclear medicine procedures where such radiopharmaceuticals clearly are not included in the practice expense portion of the associated RVU as published and defined by CMS; or (iv) billing of a procedure or set of procedures that, per the applicable CPT or HCPCS code definition, is based solely on time consumed so that it is necessary to submit multiple units of the procedure in order to accurately report the total time devoted to the patient. In the specific four circumstances outlined in the preceding sentence, Health Advantage will recognize and pay more than one Allowance per CPT or HCPCS code, provided all other terms and conditions of this Evidence of Coverage are met. With respect to

the first such circumstance involving RVUs divided between a professional and a technical component, Health Advantage's payment will be limited to one global payment (Allowance) for the applicable professional component, and one global payment (Allowance) for the technical component. In other words, even where CMS policy specifically recognizes division of an RVU into professional and technical components, Health Advantage will not be responsible for paying multiple providers or multiple billings for the professional component, nor will Health Advantage be responsible for paying multiple providers or multiple billings for the technical component. Benefits under this Evidence of Coverage will be limited in such circumstances to one global payment (Allowance) for the professional component and one global payment (Allowance) for the technical component.

This amendment becomes a part of the Health Advantage Evidence of Coverage. All provisions of the Evidence of Coverage which are not contrary to the provisions of this amendment remain in full force and effect.



David F. Bridges, President
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**Health Advantage
Grandfathered Health Plan
Notice**

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

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to Health Advantage at 1-800-843-1329. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

The following Health Advantage Evidences of Coverage (Grandfathered) are hereby amended.

Evidence of Coverage, Conversion Plan, Form #31-08
Evidence of Coverage, Guest Membership, Form #31-09

The following subsection amendments are effective on January 1, 2013.

BENEFITS AND SPECIFIC LIMITATIONS IN YOUR PLAN, introductory paragraphs are hereby amended to read as follows.

Because of the high cost of some services or treatments, as well as the difficulty in some cases of determining whether services are really needed, we include coverage for such services or treatments but place limits on the extent of coverage, either by limiting the number of Provider visits or treatments, or by specifying a dollar limit for services or treatments received during a Contract Year or other specified period of time. This Section 3.0 describes medical services, drugs, supplies, tests and equipment for which coverage is provided under the Plan, provided all terms, conditions, exclusions and limitations of the Plan, including the six coverage criteria, are satisfied. This Section 3.0 sets out specific limitations applicable to each covered medical service, drug, supply or equipment.

You will note references to Coinsurance and Copayment obligations. For a description of the amount of these obligations and how they may vary depending upon whether you select an In-Network or Out-of-Network Provider, refer to Section 5.0, the definition of Allowance or Allowable Charge as set out in the Glossary of Terms and the Schedule of Benefits.

BENEFITS AND SPECIFIC LIMITATIONS IN YOUR PLAN, " Preventive Care" Subsection 2 is hereby amended to read as follows.

2. Immunizations. Intradermally administered influenza vaccination(s) and enhanced immunogenicity are subject to the maximum benefit the Plan allows for intramuscular injectable influenza vaccine without thimerosal per Covered Person per Contract Year.

BENEFITS AND SPECIFIC LIMITATIONS IN YOUR PLAN, "Dental Care and Orthodontic Services," Subsection 2. is hereby amended to read as follows.

2. Benefits for dental service. Dental services in connection with radiation treatment for cancer of the head or neck are covered.

BENEFITS AND SPECIFIC LIMITATIONS IN YOUR PLAN, "Organ Transplant Services" Subsections 7-10 are hereby amended to read as follows.

7. Coverage for high-dose or non-myeloablative chemotherapy, allogeneic or autologous stem or progenitor cell transplantation for the treatment of a medical condition is provided subject to Health Advantage's specific Coverage Policies relative to these specific conditions.

SPECIFIC PLAN EXCLUSIONS, Health Interventions, "Dental Care or Orthodontic Services," Subsection b. is hereby amended to read as follows.

- b. Benefits for dental service. Dental services in connection with radiation treatment for cancer of the head or neck are covered.

SPECIFIC PLAN EXCLUSIONS, Health Interventions, "Electrotherapy and electromagnetic stimulators" is hereby amended to read as follows.

Electrotherapy and electromagnetic stimulators. All treatment using electrotherapy stimulators, and electromagnetic stimulators, including services and supplies used in connection with such stimulators, and complications resulting from such treatment are not covered. However, subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Evidence of Coverage, coverage is provided for a Transcutaneous Electrical Nerve Stimulator (TENS) to treat chronic pain due to peripheral nerve injury when that pain is unresponsive to medication. Coverage is also provided for neuromuscular electrical stimulation (NMES) for treatment of disuse atrophy where nerve supply to the muscle is intact, including but not limited to atrophy secondary to prolonged splinting or casting of the affected extremity, contracture due to scarring of soft tissue as in burn lesions and hip replacement surgery until orthotic training begins.

SPECIFIC PLAN EXCLUSIONS, Health Interventions, "Sleep Apnea, Portable Studies" is hereby amended to read as follows.

Sleep Apnea, Portable Studies. Studies for the diagnosis, assessment or management of obstructive sleep apnea are generally not covered. However, subject to all other terms, conditions, exclusions and limitations of the Plan as set forth in this Evidence of Coverage, coverage is provided for portable (at home) sleep studies when all of the following monitoring information is included: EEG, heart rate, Chin EMG, ECG, airflow, effort and oxygen saturations, channels to identify awake versus asleep and apnea events. Devices used are considered portable comprehensive polysomnography devices monitoring a minimum of seven channels.

SPECIFIC PLAN EXCLUSIONS, Health Interventions, "Vision enhancement" is hereby amended to read as follows.

Vision enhancement. Any procedure, treatment, service, equipment or supply used to modify vision by changing the refractive error of the eye is generally not covered. Examples of non-covered vision enhancement services include, but are not limited to, the refraction for and the provision of eyeglasses and contact lenses; intraocular lenses, and refractive keratoplasty, with the exception of excessive, visually debilitating residual astigmatism following anterior segment surgery, i.e. corneal transplantation, cataract extraction, etc. Laser Assisted In Situ Keratomileusis (LASIK) and all other related refractive procedures are not covered. However, subject to all the terms, conditions, exclusions and limitations of the Plan as set forth in this Evidence of Coverage, a procedure, treatment, service, equipment or supply to correct a refractive error of the eye is covered in two instances: (1) if such refractive error results from traumatic injury or corneal disease, infectious or non infectious, and (2) the implant of a monofocal lens following cataract extraction and the single acquisition of eyeglasses or contact lenses within the first six months following cataract surgery. With respect to such eyeglasses or contact lenses, tinting or anti-reflective coating and progressive lenses are not covered. Eyeglass frames are subject to a \$50 maximum Allowance or Allowable Charge. See Subsection 3.11.3.

PROVIDER NETWORK AND COST SHARING PROCEDURES, "Network Procedures" are hereby amended to add the following new Subsection.

Scope of Provider Payment - Global Payment. Health Advantage's payment to a Provider for their services as described in a Current Procedural Terminology ("CPT") or Healthcare Common Procedure Coding System ("HCPCS") code and reimbursed in accordance with the Resource-Based Relative Value System ("RBRVS") used by the Centers for Medicare & Medicaid Services ("CMS") is an all-inclusive, global payment that covers all elements of the service as described in the particular code billed. This means that whatever staffing, overhead costs, equipment, drugs, machinery, tools, technology, supplies, or materials of any kind that may be required in order for the billing Provider to perform the service or treatment described in

the CPT or HCPCS code billed, Health Advantage's payment to the billing Provider of the Allowable Charge for that CPT or HCPCS code constitutes the entire payment and the limit of benefits under this Evidence of Coverage with respect to the CPT or HCPCS code billed. A Provider who bills for a particular CPT or HCPCS code is deemed to represent that the billing Provider has performed and is responsible for provision of all services or treatments described in the CPT or HCPCS code, and is entitled to bill for such services or treatments. If Health Advantage pays for a Covered Service by applying the Allowance or Allowable Charge to the bill of a Provider who represents that the Provider has performed a service or treatment described in a CPT or HCPCS code as submitted to Health Advantage, Health Advantage shall have no further obligation, nor is there coverage under this Evidence of Coverage, for bills from or payment to any other provider, entity or person, regardless of whether they assisted the billing Provider or furnished any staffing, equipment, drugs, machinery, tools, technology, supplies or materials of any kind to or for the benefit of the billing Provider. In other words, benefits under this Evidence of Coverage are limited to one, global payment for all components of any services falling within the scope of any CPT or HCPCS code service or treatment description, and Health Advantage will make only one payment with respect to such CPT or HCPCS code, even if multiple parties claim to have contributed a portion of the staffing, equipment, machinery, tools, technology, supplies or materials used by the billing Provider in the course of providing the service or treatment described in the CPT or HCPCS code.

For example, a physician who performs certain surgical procedures in the physician's office might choose to engage an equipment and supply company to set up the surgical table, furnish an assisting nurse, and also furnish certain surgical instruments, devices or supplies used by the physician. When the physician bills Health Advantage for the physician's performance of the surgical procedure described in a specific CPT or HCPCS code, Health Advantage will make a single, global payment to the physician for Covered Services described in the CPT or HCPCS code, and will not be obligated to pay for any charges of the equipment and supply company. In such circumstances, any charge or claim of payment due the equipment and supply company shall be the exclusive responsibility of the physician (or other provider) who engaged the equipment and supply company, and permitted or facilitated such company's access to the physician's patient. In any event, as noted above, no benefits are available under this Evidence of Coverage for any services, drugs, materials or supplies of the equipment and supply company. It is Health Advantage's policy (and this Evidence of Coverage is specifically intended to adopt the same) that no benefits shall be paid for "unbundled services" in excess of Health Advantage's Allowable Charge for any service as described in the applicable CPT or HCPCS code. This means, for example, that if a physician and another category of provider (such as a durable medical equipment supplier, a laboratory, a nurse practitioner, a nurse, a physician's assistant or any other category of provider) agree together to divide up, split or "unbundle" the components of any CPT or HCPCS code, and attempt to bill separately for the various components each allegedly provides for the patient, benefits under this Evidence of Coverage shall nevertheless be limited to one Allowance per CPT or HCPCS code; in such circumstances, your benefits under this Evidence of Coverage will pay only one Allowable Charge for any Covered Service described in any single CPT or HCPCS code, and the various providers involved in any such "unbundling" action or agreement must resolve among themselves any division of that single Allowable Charge between or among them. You can protect yourself from the possibility of billing in excess of the Allowable Charge in these circumstances by always inquiring in advance to be sure that each provider involved in your care or treatment is an In-Network Provider.

Please note that Health Advantage makes the following exceptions to the preceding general policy of one global payment (Allowance) per CPT or HCPCS code: (i) where CMS has developed and published an RBRVS policy that specifically recognizes that the Relative Value Units (RVUs) associated with a specific CPT or HCPCS code should be divided into both a professional and a technical component; or (ii) billing of the services of an assistant surgeon for those CPT or HCPCS codes that specifically recognize assistant surgery services as applicable; or (iii) billing of radiopharmaceuticals used in nuclear medicine procedures where such radiopharmaceuticals clearly are not included in the practice expense portion of the associated RVU as published and defined by CMS; or (iv) billing of a procedure or set of procedures that, per the applicable CPT or HCPCS code definition, is based solely on time consumed so that it is necessary to submit multiple units of the procedure in order to accurately report the total time

devoted to the patient. In the specific four circumstances outlined in the preceding sentence, Health Advantage will recognize and pay more than one Allowance per CPT or HCPCS code, provided all other terms and conditions of this Evidence of Coverage are met. With respect to the first such circumstance involving RVUs divided between a professional and a technical component, Health Advantage's payment will be limited to one global payment (Allowance) for the applicable professional component, and one global payment (Allowance) for the technical component. In other words, even where CMS policy specifically recognizes division of an RVU into professional and technical components, Health Advantage will not be responsible for paying multiple providers or multiple billings for the professional component, nor will Health Advantage be responsible for paying multiple providers or multiple billings for the technical component. Benefits under this Evidence of Coverage will be limited in such circumstances to one global payment (Allowance) for the professional component and one global payment (Allowance) for the technical component.

GLOSSARY OF TERMS, " Allowance or Allowable Charge" is hereby amended to read as follows.

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

At the option of Health Advantage, Allowance or Allowable Charges for services or supplies received out of Arkansas may be determined by the local Blue Cross and Blue Shield Plan, See Subsection 7.1.10 dealing with Out of Arkansas Claims. See Subsection 3.23.4 with respect to Allowance or Allowable Charge for transplants. See Subsection 3.3.2 with respect to Allowance or Allowable Charge for Outpatient Surgery Centers. **Please note that all benefits under this Evidence of Coverage are subject to and shall be paid only by reference to the Allowance or Allowable Charge as determined at the discretion of Health Advantage. This means that regardless of how much your health care Provider may bill for a given service, the benefits under this Evidence of Coverage will be limited by the Allowance or Allowable Charge we establish. If you use a Health Advantage-participating Provider, that Provider is obligated to accept our established rate as payment in full, and should only bill you for your Deductible, Coinsurance and any non-covered services; however, if you use a non-participating Provider, you will be responsible for all amounts billed in excess of Health Advantage Allowance or Allowable Charge.**

The payment to a Provider for their services as described in a Current Procedural Terminology ("CPT") or Healthcare Common Procedure Coding System ("HCPCS") code and reimbursed in accordance with the Resource-Based Relative Value System ("RBRVS") used by the Centers for Medicare & Medicaid Services ("CMS") is an all-inclusive, global payment that covers all elements of the service as described in the particular code billed. This means that whatever staffing, overhead costs, equipment, drugs, machinery, tools, technology, supplies, or materials of any kind that may be required in order for the billing Provider to perform the service or treatment described in the CPT or HCPCS code billed, Health Advantage's payment to the billing Provider of the Allowance or Allowable Charge for that CPT or HCPCS code constitutes the entire payment and the limit of benefits under this Evidence of Coverage with respect to the CPT or HCPCS code billed. A Provider who bills for a particular CPT or HCPCS code is deemed to represent that the billing Provider has performed and is responsible for provision of all services or treatments described in the CPT or HCPCS code, and is entitled to bill for such services or treatments. If Health Advantage pays for a Covered Service by applying the Allowance or Allowable Charge to the bill of a Provider who represents that the Provider has performed a service or treatment described in a CPT or HCPCS code as submitted to Health Advantage, Health Advantage shall have no further obligation, nor is there coverage under this Evidence of Coverage, for bills from or payment to any other provider, entity or person, regardless of whether they assisted the billing Provider or furnished any staffing, equipment, drugs, machinery, tools, technology, supplies or materials of any kind to or for the benefit of the billing Provider. In other words, benefits under this Evidence of Coverage are limited to one, global payment for all components of any services falling within the scope of any CPT or HCPCS code service or treatment description, and Health Advantage will make only one

payment with respect to such CPT or HCPCS code, even if multiple parties claim to have contributed a portion of the staffing, equipment, machinery, tools, technology, supplies or materials used by the billing Provider in the course of providing the service or treatment described in the CPT or HCPCS code.

For example, a physician who performs certain surgical procedures in the physician's office might choose to engage an equipment and supply company to set up the surgical table, furnish an assisting nurse, and also furnish certain surgical instruments, devices or supplies used by the physician. When the physician bills Health Advantage for the physician's performance of the surgical procedure described in a specific CPT or HCPCS code, Health Advantage will make a single, global payment to the physician for Covered Services described in the CPT or HCPCS code, and will not be obligated to pay for any charges of the equipment and supply company. In such circumstances, any charge or claim of payment due the equipment and supply company shall be the exclusive responsibility of the physician (or other provider) who engaged the equipment and supply company, and permitted or facilitated such company's access to the physician's patient. In any event, as noted above, no benefits are available under this Evidence of Coverage for any services, drugs, materials or supplies of the equipment and supply company. It is Health Advantage's policy (and this Evidence of Coverage is specifically intended to adopt the same) that no benefits shall be paid for "unbundled services" in excess of Health Advantage's Allowance or Allowable Charge for any service as described in the applicable CPT or HCPCS code. This means, for example, that if a physician and another category of provider (such as a durable medical equipment supplier, a laboratory, a nurse practitioner, a nurse, a physician's assistant or any other category of provider) agree together to divide up, split or "unbundle" the components of any CPT or HCPCS code, and attempt to bill separately for the various components each allegedly provides for the patient, benefits under this Evidence of Coverage shall nevertheless be limited to one Allowance per CPT or HCPCS code; in such circumstances, your benefits under this Evidence of Coverage will pay only one Allowance or Allowable Charge for any Covered Service described in any single CPT or HCPCS code, and the various providers involved in any such "unbundling" action or agreement must resolve among themselves any division of that single Allowance or Allowable Charge between or among them. You can protect yourself from the possibility of billing in excess of the Allowance or Allowable Charge in these circumstances by always inquiring in advance to be sure that each provider involved in your care or treatment is an In-Network Provider.

Please note that Health Advantage makes the following exceptions to the preceding general policy of one global payment (Allowance) per CPT or HCPCS code: (i) where CMS has developed and published an RBRVS policy that specifically recognizes that the Relative Value Units (RVUs) associated with a specific CPT or HCPCS code should be divided into both a professional and a technical component; or (ii) billing of the services of an assistant surgeon for those CPT or HCPCS codes that specifically recognize assistant surgery services as applicable; or (iii) billing of radiopharmaceuticals used in nuclear medicine procedures where such radiopharmaceuticals clearly are not included in the practice expense portion of the associated RVU as published and defined by CMS; or (iv) billing of a procedure or set of procedures that, per the applicable CPT or HCPCS code definition, is based solely on time consumed so that it is necessary to submit multiple units of the procedure in order to accurately report the total time devoted to the patient. In the specific four circumstances outlined in the preceding sentence, Health Advantage will recognize and pay more than one Allowance per CPT or HCPCS code, provided all other terms and conditions of this Evidence of Coverage are met. With respect to the first such circumstance involving RVUs divided between a professional and a technical component, Health Advantage's payment will be limited to one global payment (Allowance) for the applicable professional component, and one global payment (Allowance) for the technical component. In other words, even where CMS policy specifically recognizes division of an RVU into professional and technical components, Health Advantage will not be responsible for paying multiple providers or multiple billings for the professional component, nor will Health Advantage be responsible for paying multiple providers or multiple billings for the technical component. Benefits under this Evidence of Coverage will be limited in such circumstances to one global payment (Allowance) for the professional component and one global payment (Allowance) for the technical component.

This amendment becomes a part of the Health Advantage Evidence of Coverage. All provisions of the Evidence of Coverage which are not contrary to the provisions of this amendment remain in full force and effect.



David F. Bridges, President
HMO PARTNERS, INC, d/b/a/ HEALTH ADVANTAGE
P.O. Office Box 8069, Little Rock, Arkansas 72203-8069

**Health Advantage
Grandfathered Health Plan
Notice**

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

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to Health Advantage at 1-800-843-1329. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

The following Health Advantage Evidence of Coverage (Grandfathered) is hereby amended.

Evidence of Coverage, HMO Arkansas, Form #31-10

The following subsection amendments are effective on January 1, 2013.

BENEFITS AND SPECIFIC LIMITATIONS IN YOUR PLAN, introductory paragraphs are hereby amended to read as follows.

Because of the high cost of some services or treatments, as well as the difficulty in some cases of determining whether services are really needed, we include coverage for such services or treatments but place limits on the extent of coverage, either by limiting the number of Provider visits or treatments, or by specifying a dollar limit for services or treatments received during a Contract Year or other specified period of time. This Section 3.0 describes medical services, drugs, supplies, tests and equipment for which coverage is provided under the Plan, provided all terms, conditions, exclusions and limitations of the Plan, including the six coverage criteria, are satisfied. This Section 3.0 sets out specific limitations applicable to each covered medical service, drug, supply or equipment.

You will note references to Coinsurance and Copayment obligations. For a description of the amount of these obligations and how they may vary depending upon whether you select an In-Network or Out-of-Network Provider, refer to Section 5.0, the definition of Allowance or Allowable Charge as set out in the Glossary of Terms and the Schedule of Benefits.

BENEFITS AND SPECIFIC LIMITATIONS IN YOUR PLAN, " Preventive Care" Subsection 2 is hereby amended to read as follows.

2. Immunizations. Intradermally administered influenza vaccination(s) and enhanced immunogenicity are subject to the maximum benefit the Plan allows for intramuscular injectable influenza vaccine without thimerosal per Covered Person per Contract Year.

BENEFITS AND SPECIFIC LIMITATIONS IN YOUR PLAN, "Dental Care and Orthodontic Services," Subsection 2. is hereby amended to read as follows.

2. Benefits for dental service. Dental services in connection with radiation treatment for cancer of the head or neck are covered.

BENEFITS AND SPECIFIC LIMITATIONS IN YOUR PLAN, "Organ Transplant Services" Subsections 7-10 are hereby amended to read as follows.

7. Coverage for high-dose or non-myeloablative chemotherapy, allogeneic or autologous stem or progenitor cell transplantation for the treatment of a medical condition is provided subject to Health Advantage's specific Coverage Policies relative to these specific conditions.

SPECIFIC PLAN EXCLUSIONS, Health Interventions, "Dental Care or Orthodontic Services," Subsection b. is hereby amended to read as follows.

- b. Benefits for dental service. Dental services in connection with radiation treatment for cancer of the head or neck are covered.

SPECIFIC PLAN EXCLUSIONS, Health Interventions, "Electrotherapy and electromagnetic stimulators" is hereby amended to read as follows.

Electrotherapy and electromagnetic stimulators. All treatment using electrotherapy stimulators, and electromagnetic stimulators, including services and supplies used in connection with such stimulators, and complications resulting from such treatment are not covered. However, subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Evidence of Coverage, coverage is provided for a Transcutaneous Electrical Nerve Stimulator (TENS) to treat chronic pain due to peripheral nerve injury when that pain is unresponsive to medication. Coverage is also provided for neuromuscular electrical stimulation (NMES) for treatment of disuse atrophy where nerve supply to the muscle is intact, including but not limited to atrophy secondary to prolonged splinting or casting of the affected extremity, contracture due to scarring of soft tissue as in burn lesions and hip replacement surgery until orthotic training begins.

SPECIFIC PLAN EXCLUSIONS, Health Interventions, "Sleep Apnea, Portable Studies" is hereby amended to read as follows.

Sleep Apnea, Portable Studies. Studies for the diagnosis, assessment or management of obstructive sleep apnea are generally not covered. However, subject to all other terms, conditions, exclusions and limitations of the Plan as set forth in this Evidence of Coverage, coverage is provided for portable (at home) sleep studies when all of the following monitoring information is included: EEG, heart rate, Chin EMG, ECG, airflow, effort and oxygen saturations, channels to identify awake versus asleep and apnea events. Devices used are considered portable comprehensive polysomnography devices monitoring a minimum of seven channels.

SPECIFIC PLAN EXCLUSIONS, Health Interventions, "Vision enhancement" is hereby amended to read as follows.

Vision enhancement. Any procedure, treatment, service, equipment or supply used to modify vision by changing the refractive error of the eye is generally not covered. Examples of non-covered vision enhancement services include, but are not limited to, the refraction for and the provision of eyeglasses and contact lenses; intraocular lenses, and refractive keratoplasty, with the exception of excessive, visually debilitating residual astigmatism following anterior segment surgery, i.e. corneal transplantation, cataract extraction, etc. Laser Assisted In Situ Keratomileusis (LASIK) and all other related refractive procedures are not covered. However, subject to all the terms, conditions, exclusions and limitations of the Plan as set forth in this Evidence of Coverage, a procedure, treatment, service, equipment or supply to correct a refractive error of the eye is covered in two instances: (1) if such refractive error results from traumatic injury or corneal disease, infectious or non infectious, and (2) the implant of a monofocal lens following cataract extraction and the single acquisition of eyeglasses or contact lenses within the first six months following cataract surgery. With respect to such eyeglasses or contact lenses, tinting or anti-reflective coating and progressive lenses are not covered. Eyeglass frames are subject to a \$50 maximum Allowance or Allowable Charge. See Subsection 3.11.3.

PROVIDER NETWORK AND COST SHARING PROCEDURES, "Network Procedures" are hereby amended to add the following new Subsection.

Scope of Provider Payment - Global Payment. Health Advantage's payment to a Provider for their services as described in a Current Procedural Terminology ("CPT") or Healthcare Common Procedure Coding System ("HCPCS") code and reimbursed in accordance with the Resource-Based Relative Value System ("RBRVS") used by the Centers for Medicare & Medicaid Services ("CMS") is an all-inclusive, global payment that covers all elements of the service as described in the particular code billed. This means that whatever staffing, overhead costs, equipment, drugs, machinery, tools, technology, supplies, or materials of any kind that may be required in order for the billing Provider to perform the service or treatment described in the CPT or HCPCS code billed, Health Advantage's payment to the billing Provider of the

Allowable Charge for that CPT or HCPCS code constitutes the entire payment and the limit of benefits under this Evidence of Coverage with respect to the CPT or HCPCS code billed. A Provider who bills for a particular CPT or HCPCS code is deemed to represent that the billing Provider has performed and is responsible for provision of all services or treatments described in the CPT or HCPCS code, and is entitled to bill for such services or treatments. If Health Advantage pays for a Covered Service by applying the Allowance or Allowable Charge to the bill of a Provider who represents that the Provider has performed a service or treatment described in a CPT or HCPCS code as submitted to Health Advantage, Health Advantage shall have no further obligation, nor is there coverage under this Evidence of Coverage, for bills from or payment to any other provider, entity or person, regardless of whether they assisted the billing Provider or furnished any staffing, equipment, drugs, machinery, tools, technology, supplies or materials of any kind to or for the benefit of the billing Provider. In other words, benefits under this Evidence of Coverage are limited to one, global payment for all components of any services falling within the scope of any CPT or HCPCS code service or treatment description, and Health Advantage will make only one payment with respect to such CPT or HCPCS code, even if multiple parties claim to have contributed a portion of the staffing, equipment, machinery, tools, technology, supplies or materials used by the billing Provider in the course of providing the service or treatment described in the CPT or HCPCS code.

For example, a physician who performs certain surgical procedures in the physician's office might choose to engage an equipment and supply company to set up the surgical table, furnish an assisting nurse, and also furnish certain surgical instruments, devices or supplies used by the physician. When the physician bills Health Advantage for the physician's performance of the surgical procedure described in a specific CPT or HCPCS code, Health Advantage will make a single, global payment to the physician for Covered Services described in the CPT or HCPCS code, and will not be obligated to pay for any charges of the equipment and supply company. In such circumstances, any charge or claim of payment due the equipment and supply company shall be the exclusive responsibility of the physician (or other provider) who engaged the equipment and supply company, and permitted or facilitated such company's access to the physician's patient. In any event, as noted above, no benefits are available under this Evidence of Coverage for any services, drugs, materials or supplies of the equipment and supply company. It is Health Advantage's policy (and this Evidence of Coverage is specifically intended to adopt the same) that no benefits shall be paid for "unbundled services" in excess of Health Advantage's Allowable Charge for any service as described in the applicable CPT or HCPCS code. This means, for example, that if a physician and another category of provider (such as a durable medical equipment supplier, a laboratory, a nurse practitioner, a nurse, a physician's assistant or any other category of provider) agree together to divide up, split or "unbundle" the components of any CPT or HCPCS code, and attempt to bill separately for the various components each allegedly provides for the patient, benefits under this Evidence of Coverage shall nevertheless be limited to one Allowance per CPT or HCPCS code; in such circumstances, your benefits under this Evidence of Coverage will pay only one Allowable Charge for any Covered Service described in any single CPT or HCPCS code, and the various providers involved in any such "unbundling" action or agreement must resolve among themselves any division of that single Allowable Charge between or among them. You can protect yourself from the possibility of billing in excess of the Allowable Charge in these circumstances by always inquiring in advance to be sure that each provider involved in your care or treatment is an In-Network Provider.

Please note that Health Advantage makes the following exceptions to the preceding general policy of one global payment (Allowance) per CPT or HCPCS code: (i) where CMS has developed and published an RBRVS policy that specifically recognizes that the Relative Value Units (RVUs) associated with a specific CPT or HCPCS code should be divided into both a professional and a technical component; or (ii) billing of the services of an assistant surgeon for those CPT or HCPCS codes that specifically recognize assistant surgery services as applicable; or (iii) billing of radiopharmaceuticals used in nuclear medicine procedures where such radiopharmaceuticals clearly are not included in the practice expense portion of the associated RVU as published and defined by CMS; or (iv) billing of a procedure or set of procedures that, per the applicable CPT or HCPCS code definition, is based solely on time consumed so that it is necessary to submit multiple units of the procedure in order to accurately report the total time devoted to the patient. In the specific four circumstances outlined in the preceding sentence,

Health Advantage will recognize and pay more than one Allowance per CPT or HCPCS code, provided all other terms and conditions of this Evidence of Coverage are met. With respect to the first such circumstance involving RVUs divided between a professional and a technical component, Health Advantage's payment will be limited to one global payment (Allowance) for the applicable professional component, and one global payment (Allowance) for the technical component. In other words, even where CMS policy specifically recognizes division of an RVU into professional and technical components, Health Advantage will not be responsible for paying multiple providers or multiple billings for the professional component, nor will Health Advantage be responsible for paying multiple providers or multiple billings for the technical component. Benefits under this Evidence of Coverage will be limited in such circumstances to one global payment (Allowance) for the professional component and one global payment (Allowance) for the technical component.

GLOSSARY OF TERMS, "Allowance or Allowable Charge" is hereby amended to read as follows.

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

At the option of Health Advantage, Allowance or Allowable Charges for services or supplies received out of Arkansas may be determined by the local Blue Cross and Blue Shield Plan, See Subsection 7.1.10 dealing with Out of Arkansas Claims. See Subsection 3.23.4 with respect to Allowance or Allowable Charge for transplants. See Subsection 3.3.2 with respect to Allowance or Allowable Charge for Outpatient Surgery Centers. **Please note that all benefits under this Evidence of Coverage are subject to and shall be paid only by reference to the Allowance or Allowable Charge as determined at the discretion of Health Advantage. This means that regardless of how much your health care Provider may bill for a given service, the benefits under this Evidence of Coverage will be limited by the Allowance or Allowable Charge we establish. If you use a Health Advantage-participating Provider, that Provider is obligated to accept our established rate as payment in full, and should only bill you for your Deductible, Coinsurance and any non-covered services; however, if you use a non-participating Provider, you will be responsible for all amounts billed in excess of Health Advantage Allowance or Allowable Charge.**

The payment to a Provider for their services as described in a Current Procedural Terminology ("CPT") or Healthcare Common Procedure Coding System ("HCPCS") code and reimbursed in accordance with the Resource-Based Relative Value System ("RBRVS") used by the Centers for Medicare & Medicaid Services ("CMS") is an all-inclusive, global payment that covers all elements of the service as described in the particular code billed. This means that whatever staffing, overhead costs, equipment, drugs, machinery, tools, technology, supplies, or materials of any kind that may be required in order for the billing Provider to perform the service or treatment described in the CPT or HCPCS code billed, Health Advantage's payment to the billing Provider of the Allowance or Allowable Charge for that CPT or HCPCS code constitutes the entire payment and the limit of benefits under this Evidence of Coverage with respect to the CPT or HCPCS code billed. A Provider who bills for a particular CPT or HCPCS code is deemed to represent that the billing Provider has performed and is responsible for provision of all services or treatments described in the CPT or HCPCS code, and is entitled to bill for such services or treatments. If Health Advantage pays for a Covered Service by applying the Allowance or Allowable Charge to the bill of a Provider who represents that the Provider has performed a service or treatment described in a CPT or HCPCS code as submitted to Health Advantage, Health Advantage shall have no further obligation, nor is there coverage under this Evidence of Coverage, for bills from or payment to any other provider, entity or person, regardless of whether they assisted the billing Provider or furnished any staffing, equipment, drugs, machinery, tools, technology, supplies or materials of any kind to or for the benefit of the billing Provider. In other words, benefits under this Evidence of Coverage are limited to one, global payment for all components of any services falling within the scope of any CPT or HCPCS code service or treatment description, and Health Advantage will make only one payment with respect to such CPT or HCPCS code, even if multiple parties claim to have

contributed a portion of the staffing, equipment, machinery, tools, technology, supplies or materials used by the billing Provider in the course of providing the service or treatment described in the CPT or HCPCS code.

For example, a physician who performs certain surgical procedures in the physician's office might choose to engage an equipment and supply company to set up the surgical table, furnish an assisting nurse, and also furnish certain surgical instruments, devices or supplies used by the physician. When the physician bills Health Advantage for the physician's performance of the surgical procedure described in a specific CPT or HCPCS code, Health Advantage will make a single, global payment to the physician for Covered Services described in the CPT or HCPCS code, and will not be obligated to pay for any charges of the equipment and supply company. In such circumstances, any charge or claim of payment due the equipment and supply company shall be the exclusive responsibility of the physician (or other provider) who engaged the equipment and supply company, and permitted or facilitated such company's access to the physician's patient. In any event, as noted above, no benefits are available under this Evidence of Coverage for any services, drugs, materials or supplies of the equipment and supply company. It is Health Advantage's policy (and this Evidence of Coverage is specifically intended to adopt the same) that no benefits shall be paid for "unbundled services" in excess of Health Advantage's Allowance or Allowable Charge for any service as described in the applicable CPT or HCPCS code. This means, for example, that if a physician and another category of provider (such as a durable medical equipment supplier, a laboratory, a nurse practitioner, a nurse, a physician's assistant or any other category of provider) agree together to divide up, split or "unbundle" the components of any CPT or HCPCS code, and attempt to bill separately for the various components each allegedly provides for the patient, benefits under this Evidence of Coverage shall nevertheless be limited to one Allowance per CPT or HCPCS code; in such circumstances, your benefits under this Evidence of Coverage will pay only one Allowance or Allowable Charge for any Covered Service described in any single CPT or HCPCS code, and the various providers involved in any such "unbundling" action or agreement must resolve among themselves any division of that single Allowance or Allowable Charge between or among them. You can protect yourself from the possibility of billing in excess of the Allowance or Allowable Charge in these circumstances by always inquiring in advance to be sure that each provider involved in your care or treatment is an In-Network Provider.

Please note that Health Advantage makes the following exceptions to the preceding general policy of one global payment (Allowance) per CPT or HCPCS code: (i) where CMS has developed and published an RBRVS policy that specifically recognizes that the Relative Value Units (RVUs) associated with a specific CPT or HCPCS code should be divided into both a professional and a technical component; or (ii) billing of the services of an assistant surgeon for those CPT or HCPCS codes that specifically recognize assistant surgery services as applicable; or (iii) billing of radiopharmaceuticals used in nuclear medicine procedures where such radiopharmaceuticals clearly are not included in the practice expense portion of the associated RVU as published and defined by CMS; or (iv) billing of a procedure or set of procedures that, per the applicable CPT or HCPCS code definition, is based solely on time consumed so that it is necessary to submit multiple units of the procedure in order to accurately report the total time devoted to the patient. In the specific four circumstances outlined in the preceding sentence, Health Advantage will recognize and pay more than one Allowance per CPT or HCPCS code, provided all other terms and conditions of this Evidence of Coverage are met. With respect to the first such circumstance involving RVUs divided between a professional and a technical component, Health Advantage's payment will be limited to one global payment (Allowance) for the applicable professional component, and one global payment (Allowance) for the technical component. In other words, even where CMS policy specifically recognizes division of an RVU into professional and technical components, Health Advantage will not be responsible for paying multiple providers or multiple billings for the professional component, nor will Health Advantage be responsible for paying multiple providers or multiple billings for the technical component. Benefits under this Evidence of Coverage will be limited in such circumstances to one global payment (Allowance) for the professional component and one global payment (Allowance) for the technical component.

This amendment becomes a part of the Health Advantage Evidence of Coverage. All provisions of the Evidence of Coverage which are not contrary to the provisions of this amendment remain in full force and effect.



David F. Bridges, President
HMO PARTNERS, INC, d/b/a/ HEALTH ADVANTAGE
P.O. Office Box 8069, Little Rock, Arkansas 72203-8069

**Health Advantage
Grandfathered Health Plan
Notice**

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

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to Health Advantage at 1-800-843-1329. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

SERFF Tracking #:

HLAD-128772440

State Tracking #:**Company Tracking #:**

34-159

State:

Arkansas

Filing Company:

HMO Partners, Inc. d/b/a Health Advantage

TOI/Sub-TOI:

HOrg02G Group Health Organizations - Health Maintenance (HMO)/HOrg02G.002A Any Size Group - PPO

Product Name:

2013 General Amendments

Project Name/Number:

Amendments/34-159,34-160,34-161,34-162,34-163,34-164,34-165,34-166,34-167,34-168 1/13

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	11/15/2012
Comments:	Please see attached.		
Attachment(s):	Flesch Certification Form HA,34-159 to 34-168 1-13.pdf		

		Item Status:	Status Date:
Bypassed - Item:	Application	Approved-Closed	11/15/2012
Bypass Reason:	Not required.		

		Item Status:	Status Date:
Bypassed - Item:	Health - Actuarial Justification	Approved-Closed	11/15/2012
Bypass Reason:	Not required.		

		Item Status:	Status Date:
Bypassed - Item:	PPACA Uniform Compliance Summary	Approved-Closed	11/15/2012
Bypass Reason:	Not PPACA related.		

Health Advantage



An Independent Licensee of the Blue Cross and Blue Shield Association

Re: HMO Partners, Inc. d/b/a Health Advantage
Form Nos. 34-159,34-160,34-161,34-162,34-163,34-164,34-165,34-166,34-167,
34-168 1/13

FLESCH READING EASE CERTIFICATION

This is to certify that the above referenced documents have achieved a Flesch Reading Ease Score average of 40.6 and comply with the requirements of A.C.A. §23-80-201 *et. seq.*, cited as the Life and Disability Insurance Policy Language Simplification Act.

Dail Brulje

Name

President

Title

November 15, 2012

Date