

State: Arkansas **Filing Company:** HMO Partners, Inc. d/b/a Health Advantage
TOI/Sub-TOI: HOrg02G Group Health Organizations - Health Maintenance (HMO)/HOrg02G.002B Any Size Group - POS
Product Name: Tyson Products
Project Name/Number: GEC, EOC and Amendment/30-04, 31-16, 34-179 1/13

Filing at a Glance

Company: HMO Partners, Inc. d/b/a Health Advantage
 Product Name: Tyson Products
 State: Arkansas
 TOI: HOrg02G Group Health Organizations - Health Maintenance (HMO)
 Sub-TOI: HOrg02G.002B Any Size Group - POS
 Filing Type: Form
 Date Submitted: 01/18/2013
 SERFF Tr Num: HLAD-128857066
 SERFF Status: Closed-Approved-Closed
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 State Status: Approved-Closed
 Co Tr Num: 30-04, 31-16, 34-179 1/13

 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: 01/23/2013
 Disposition Status: Approved-Closed
 Implementation Date:

 State Filing Description:

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General Information

Project Name: GEC, EOC and Amendment	Status of Filing in Domicile: Pending
Project Number: 30-04, 31-16, 34-179 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: 01/23/2013	Deemer Date:
State Status Changed: 01/23/2013	Submitted By: Evelyn Laney
Created By: Evelyn Laney	
Corresponding Filing Tracking Number:	
PPACA: Not PPACA-Related	
PPACA Notes: null	
Include Exchange Intentions:	No

Filing Description:

Attached please find forms 30-04, 31-16, and 34-179 1/13 for your review and approval if indicated. These documents are the Tyson Group Contract, Tyson's Evidence of Coverage and Tyson's Extraterritorial Rider. All of these forms are specifically developed for a Tyson Continuation Plan and will not be used with any other group. 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:	\$150.00

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Retaliatory? No
Fee Explanation: \$50.00 per form
Per Company: No

Company	Amount	Date Processed	Transaction #
HMO Partners, Inc. d/b/a Health Advantage	\$150.00	01/18/2013	66679699

SERFF Tracking #: HLAD-128857066

State Tracking #:

Company Tracking #:

30-04, 31-16, 34-179 1/13

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	01/23/2013	01/23/2013

SERFF Tracking #:

HLAD-128857066

State Tracking #:

Company Tracking #:

30-04, 31-16, 34-179 1/13

State:

Arkansas

Filing Company:

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

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Product Name:

Tyson Products

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Disposition

Disposition Date: 01/23/2013

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	Group Enrollment Contract	Approved-Closed	Yes
Form	Evidence of Coverage	Approved-Closed	Yes
Form	Amendment	Approved-Closed	Yes

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Form Schedule

Lead Form Number: 30-04 1/13

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
1	Approved-Closed 01/23/2013	Group Enrollment Contract	30-04 1/13	POL	Initial		40.500	30-04 1-13Tyson GEC.pdf
2	Approved-Closed 01/23/2013	Evidence of Coverage	31-16 1/13	POL	Initial		40.500	31-16 1-13 Tyson (POS).pdf
3	Approved-Closed 01/23/2013	Amendment	34-179 1/13	CERA	Initial		40.500	34-179 1-13 Tyson.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
POLA	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	SCH	Schedule Pages

Health Advantage



An Independent Licensee of the Blue Cross and Blue Shield Association

**HMO Partners, Inc.
d/b/a Health Advantage
320 West Capitol Avenue
Little Rock, Arkansas 72201
(501) 378-2363
(800) 843-1329**

**GROUP CONTRACT
Tyson Continuation Plan**

Health Advantage agrees to provide to the Subscribers of the Group, and their covered Dependents, the benefits set forth in the Evidence of Coverage, attached to and incorporated as part of this Group Contract in accordance with the terms, provisions and limitations of this Contract.

This Contract is issued in consideration of the Group's application, a copy of which is attached, the Group's Covenants set forth in this Contract, and the Group's payment of the premium.

This Contract becomes effective at 12:01 a.m. on the Effective Date shown on the Group Application. The Contract is renewable month to month, by payment of the monthly premium. The premium for the Contract may be adjusted upon 30 days notice. The Contract is subject to termination according to its terms.

The Evidence of Coverage, the Group Application, the Enrollment Application, any Change Forms and any attachments, riders, endorsements or amendments are part of this Group Contract.

It is signed at our Home Office on the Effective Date.

A handwritten signature in black ink that reads "Dail Brulje".

President

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EVIDENCE OF COVERAGE.....	Attachment

1.0 DEFINITIONS

- 1.1 **Application** means the Large or Small Employer Application that is executed by the Contract Holder.
- 1.2 **Child** means a Subscriber's natural Child, legally adopted Child or Stepchild. "Child" also means a Child that has been placed with the Subscriber for adoption. "Child" also means a Child for whom the Subscriber must provide medical support under a qualified medical child support order or for whom the Subscriber has been appointed the legal guardian.
In order to document coverage for an adopted Child, a Child for whom there is a qualified medical child support order, or a Child who is a ward of a guardian, Group shall obtain and maintain a copy of the applicable petition for adoption or adoption papers, the qualified medical child support order or court order of guardianship and make these documents available to Health Advantage upon request.
- 1.3 **Contract** or **Group Contract** means this document and includes the Evidence of Coverage issued to Subscribers, amendments, the Application of the Employer and individual enrollment forms, under which Health Advantage provides coverage to Members.
- 1.4 **Claims Paid** means the amount paid by Health Advantage for covered health care services.
- 1.5 **Contract Holder** means the Employer as shown in the Application.
- 1.6 **Contract Month** means a month commencing on the first day of a calendar month and expiring on the last day of that calendar month or commencing on the fifteenth day of a month and expiring on the fourteenth day of the following month, depending upon the billing cycle applied by Health Advantage.
- 1.7 **Contract Year** means a year commencing on the Effective Date and expiring at mid-night Central Time on the day immediately prior to the anniversary of the Effective Date.
- 1.8 **Deficit Premium Stabilization Reserve or Deficit PSR** means the amount that Claims Paid and Retention during a Contract Year exceed the PSR at the beginning of the Contract Year plus Premium paid during the Contract Year. A Deficit PSR is owed by the Group to Health Advantage.
- 1.9 **Dependent** means any member of the Subscriber's family who meets the eligibility requirements of the Plan as set out in the Evidence of Coverage, who is enrolled in the Plan and for whom Health Advantage receives a premium.
- 1.10 **Employer** means a sole proprietorship, partnership or corporation that is the Contract Holder.
- 1.11 **Evidence of Coverage** means the document containing the benefits, conditions, limitations and exclusions of the Group Contract plus the Schedule of Benefits and any amendments signed by an Officer of Health Advantage.
- 1.12 **Electronic Data Exchange Enrollment** means the process by which a Group submits eligibility data electronically to Health Advantage for the purposes of adding, deleting or modifying Health Advantage's enrollment records. Electronic data submitted to Health Advantage will be relied upon in determining eligibility, effective dates and termination dates of coverage under the terms of the Group's health benefit plan.
- 1.13 **Expected Claims** means projected Claims Paid actuarially determined by Health Advantage prior to the beginning of each Contract Year.
- 1.14 **Grace Period** means the period of 30 consecutive days beginning with any premium due date after the first which shall be allowed for payment of premium.
- 1.15 **Group** means the Employer or party that has entered into this Group Contract with Health Advantage under which Health Advantage will cover Health Interventions for eligible Subscriber's and their Dependents.
- 1.16 **Initial Deposit** means an amount the Group contributes into the PSR on commencement of the initial Contract Year.
- 1.17 **Loss of Eligibility** means loss of coverage as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment. Loss of Eligibility

does not include a loss due to a failure of the Member to pay premium contribution on a timely basis or termination of coverage for cause.

- 1.18 **Member** means a Subscriber or Dependent who is covered under this Contract.
- 1.19 **Plan** means the Employee Health Benefit Plan established by the Employer. The terms of the Plan are set forth in this document.
- 1.20 **Plan Administrator** means the Employer.
- 1.21 **Plan Year** means the Plan Year stated in the Employee Health Benefit Plan Summary Plan Description, or if not stated in that document, or if that document does not exist, the twelve month period ending on the day before the anniversary date of the effective date of this Contract.
- 1.22 **Premium** means the sum of Expected Claims + Retention + PSR Funding Payment.
- 1.23 **Premium Stabilization Reserve or PSR** means an amount determined at the end of each Contract Year or at the termination of the Contract that equals the PSR at the beginning of the Contract Year plus the Premium paid during the Contract Year less Claims Paid and less Retention. The PSR can be either positive (Surplus PSR) or negative (Deficit PSR).
- 1.24 **Premium Stabilization Reserve Funding Payment or PSR Funding Payment** means an amount determined by Health Advantage prior to each Contract Year designed to achieve and maintain the Target Surplus.
- 1.25 **Retention** means that portion of the Premium paid to Health Advantage to cover administration costs, contribution to reserves, contingency margin and taxes and fees. Health Advantage determines Retention at the beginning of each Contract Year.
- 1.26. **Special Enrollment Period** means a thirty (30) day period during which time a Subscriber or Subscriber's Dependent may enroll in the Plan, after his or her initial Waiting Period (Eligibility Period or Eligibility Date) and not be a Late Enrollee. Special Enrollment Periods occur in two instances:
 - 1. After the termination of another Health Plan: A Special Enrollment Period occurs (i) after a Subscriber's or Dependent's coverage under another health plan terminated as a result of Loss of Eligibility or (ii) after the employer providing such other health Plan terminated its contributions.
 - 2. After the addition of a dependent: A Special Enrollment Period occurs for a Subscriber, Subscriber's Spouse or Subscriber's new Dependent Child (i) after the Subscriber marries; (ii) after a Subscriber's Child is born or (iii) a Subscriber adopts a Child or has a Child placed with the Subscriber for adoption.
- 1.27 **Subscriber** means an individual who meets the eligibility requirements for an Employee in the Plan as set out in the Evidence of Coverage, who is enrolled in the Plan and for whom Health Advantage receives a premium.
- 1.28 **Surplus Premium Stabilization Reserve or Surplus PSR** means the amount that the PSR at the beginning of the Contract Year plus Premium paid during the Contract Year exceed Claims Paid and Retention during a Contract Year. Surplus PSR is held by Health Advantage but owned by the Group.
- 1.29 **Target Surplus** means a theoretical surplus amount used solely for determining the PSR funding payment. Target surplus generally consists of 2 months expected claims plus a provision for shock claims and is determined at each renewal by Health Advantage.

2.0 COVENANTS OF THE GROUP

As part of the consideration for this Contract, Group understands, acknowledges and agrees:

- 2.1 **Plan Administrator:** The Group is the Plan Administrator of the Employee Health Benefit Plan ("Plan"), the terms of which are set forth in this Contract. The Group gives Health Advantage authority and full discretion to audit the Group's records relating to this Contract and to determine all questions arising in connection with the coverage benefits, including but not limited to eligibility, interpretation of Plan language, and findings of fact with regard to any such questions.

The actions, determinations and interpretations of Health Advantage acting on behalf of the Plan within the scope of this authority shall be conclusive and binding on the Group and the Member, subject to the Appeal Procedure set out in Section 7.0 of the Evidence of Coverage.

2.2 Electronic Data Exchange Enrollment:

1. Contract Holder has selected an Electronic Data Exchange Enrollment process for use with this Contract.
2. Contract Holder shall verify the accuracy of information submitted electronically on Subscribers and Dependents and assure this information is transmitted to Health Advantage.
3. Additions, deletions and changes in coverage must be communicated to Health Advantage in a timely manner in the format required by Health Advantage in order to be effective. Health Advantage shall not be responsible for any additions, deletions or changes in coverage or errors in such additions, deletions or changes if proper procedures as required by Health Advantage are not followed. Health Advantage shall be entitled to rely upon any data submitted by a Contract Holder in electronic format.
4. Contract Holder shall obtain and maintain the documents described in this Contract at Subsection 1.2; Subsections 3.2.6.a., 3.2.6.c., 3.2.6.d.; and Subsection 3.3.1.b.(ii) to support eligibility status of Subscribers and Dependents. Contract Holder shall provide these documents to Health Advantage upon request.
5. **The Contract Holder shall indemnify Health Advantage for any claims Health Advantage erroneously pays or any damages Health Advantage incurs as a result of the Contract Holder failing to provide timely, accurate information to Health Advantage of a change in the eligibility status of a Subscriber or Dependent.**

2.3 Subscriber Participation: Unless this Contract is provided as a second health plan for the Group, the Group shall assure that the percentage of eligible Subscribers of the Group covered by this Contract shall not be less than the percentage of the Subscriber participation specified in the Group Application and the number of Subscribers covered by this Contract shall not be less than the minimum number specified in the Group Application.

2.4 Payment of Premium:

1. The Group shall remit directly to Health Advantage on behalf of each Subscriber and his/her Dependents the Premium payments for each month this Contract is in force, on or before the first day of each Contract Month. "Pay," "Paid" or "Payment," when used here in reference to premium, premium due dates or the Grace Period shall mean that the full amount of all funds due actually received by Health Advantage at its principal offices in Little Rock, Arkansas. Placing a check into the U.S. mail or with any courier service shall not constitute payment under this Contract unless or until the check is actually received by Health Advantage at its principal office. Nor shall any invalid or dishonored check constitute payment.
2. Monthly Payments
 1. Prior to the first day of the first Contract Month of the initial Contract Year, Group shall pay to Health Advantage the Initial Deposit specified in the Application, plus the monthly Premium specified in the Application.
 2. Prior to the first day of the second Contract Month and each subsequent Contract Months of the initial Contract Year, Group shall pay to Health Advantage the monthly Premium specified in the Application.
 3. Prior to the first day of each Contract Month of the second or subsequent Contract Years, Group shall pay to Health Advantage the monthly Premium specified in the renewal Application for the Contract Year.
 4. Each month the PSR will increase, if Claims Paid is less than Expected Claims, or PSR will decrease if Claims Paid exceeds Expected Claims.

5. At the end of each Contract Year, if Group decides to renew the Contract, the Surplus PSR or Deficit PSR will be carried forward.
 5. Sixty (60) days prior to the beginning of each subsequent Contract Year, Group and Health Advantage shall agree to the Premium for such Contract Year.
- 2.5 **Equal Contributions:** The Group agrees to contribute toward the cost of the Health Advantage premium an amount no less than the amount contributed toward any other health plan offered by the Group, up to the total cost of the Health Advantage premium.
- 2.6 **Employer Contributions:** The Group agrees to contribute toward the cost of the Health Advantage premium an amount no less than 50% of the total monthly premium for the Subscribers.
- 2.7 **HIPAA:** The Group, as Plan Administrator, is legally obligated, along with Health Advantage, to comply with the provisions of the Health Insurance Portability and Accountability Act of 1996, ("HIPAA"). The Group shall assist Health Advantage in providing Certificates of Creditable Coverage to Members, both Subscribers and Dependents, who terminate their coverage under this Contract, in accordance with the provisions of HIPAA. The Group agrees to indemnify and hold Health Advantage harmless if any action or inaction of the Group results in Health Advantage being charged with violating HIPAA.
- 2.8 **HIPAA Privacy:**
1. **Restrictions on Use and Disclosure of Protected Health Information (PHI)**

Employer hereby agrees to the following restrictions on Employer's use of, access to, or disclosure of PHI of Plan participants:

 - a. Employer may use or disclose PHI only for Plan administrative purposes, as required by law, or as permitted under the HIPAA Privacy Rules; and
 - b. If Employer discloses PHI to any agents or subcontractors, Employer shall first require the agents or subcontractors to agree to the same restrictions on use and disclosure of PHI as the Employer has agreed to herein; and
 - c. Employer shall not use or disclose PHI for employment-related actions or decisions or in connection with any other benefit or benefit plan of Employer; and
 - d. Employer will promptly report to the Plan (through the Firewall Department, as designated below) any use or disclosure of PHI by Employer or within Employer's organization that is inconsistent with the uses or disclosures allowed under this Amendment; and
 - e. Employer shall allow Plan participants to inspect and copy any PHI related to the Plan participant that is in a designated record set in Employer's custody and control, as permitted or required by the HIPAA Privacy Rules, subject to certain exceptions recognized in the Rules; and
 - f. Employer shall amend, or allow Health Advantage as the carrier for the Plan to amend, any portion of a Plan participant's PHI, to the extent permitted or required under the HIPAA Privacy Rules; and
 - g. If Employer makes some types of disclosures of PHI for purposes other than payment or health care operations, Employer will make available such information as is required under the Rules to render an accounting to the Plan participant of such disclosures. Consistent with the Rules, Employer shall not be obligated to provide information for an accounting if disclosures are for certain Plan related purposes, such as payment of benefits or health care operations, or if the Plan participant authorized the disclosures; and
 - h. Employer shall make its internal practices, books, and records, relating to its use and disclosure of PHI of Plan participants available to the U.S. Department of Health and Human Services upon its request; and
 - i. Employer shall, if feasible, return or destroy all PHI of Plan participants in

Employer's custody or control that Employer has received from the Plan (through the Firewall Department, as designated below) when Employer no longer needs such PHI to administer the Plan. If it is not feasible for Employer to return or destroy PHI, Employer will limit the use or disclosure of any PHI that it cannot feasibly return or destroy to those purposes that make return or destruction of the information infeasible; and

- j. Employer shall require that all employees or classes of employees included within the Firewall Department designation, as set forth below, must limit their access to and use of any PHI of Plan participants to activities required or needed for proper administration of the Plan and Plan benefits. Employer shall take appropriate steps to discipline, including, where appropriate, termination of, any employee who violates the requirements of this Amendment.

2. **Designation of Firewall Department**

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

All employees or other workforce members under the control of Employer assigned to and working in the Human Resources Department or Division or the Employee Benefits Department or Division of Employer, or otherwise serving on a regular and routine basis to fulfill personnel or employee benefits administration functions for Employer, including but not limited to all employees whose job duties require communication and interaction with Health Advantage as the carrier for the Plan, regarding any plan administration, claims or eligibility-related matters.

2.9 **Agent for Members:** The Group is the agent for the Subscribers and their Dependents in all dealings between Subscribers or Dependents and Health Advantage, including:

1. payment of premiums to Health Advantage;
2. notifying Health Advantage of changes in Subscriber or Dependent status;
3. securing and forwarding to Health Advantage electronic data for coverage of new Subscribers or new Dependents; and
4. providing Subscribers and Dependents all communications and notices from Health Advantage.

2.10 **Contract with HMO Partners, Inc. d/b/a Health Advantage:** On behalf of Group and its subscribers or members, the Group acknowledges its understanding that this Contract constitutes a contract solely between the Group and HMO Partners, Inc. d/b/a Health Advantage, that HMO Partners, Inc. is an independent corporation operating under a license with the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans, (the "Association") permitting HMO Partners, Inc. to use the Blue Cross and Blue Shield Service Marks in the State of Arkansas, and that HMO Partners, Inc. is not contracting as the agent of the Association. The Group further acknowledges and agrees that it has not entered into this Contract based upon representations by any person other than HMO Partners, Inc. and that no person, entity, or organization other than HMO Partners, Inc. shall be held accountable or liable to Group for any of the obligations created under this Contract.

2.11 **Group to Distribute and Account for Premium Rebates**

In the event federal or state law requires Health Advantage to rebate a portion of an annual premium payment, Health Advantage will pay the Group the total rebate applicable to the Group Contract, and Group, on behalf of Health Advantage, will distribute from the rebate a pro-rata share of the rebate to each Subscriber and former Subscriber based upon their contribution to the premium rebated.

Group shall assure appropriate notification to federal and state tax agencies and that each payment to Subscribers and former Subscribers will be accompanied by appropriate federal and state documentation, e.g. Form W-2.

Group shall develop and retain records and documentation evidencing accurate distribution of any rebate and shall provide such records to Health Advantage upon request. Such records shall include:

1. The amount of the premium paid by each Subscriber;
2. The amount of the premium paid by the Group;
3. The amount of the rebate provided to each Subscriber;
4. The amount of the rebate retained by the Group; and
5. The amount of any unclaimed rebate and how and when it will be or was distributed.

Group will assure that any unclaimed rebate amounts will be reported in accordance with the unclaimed property laws of the applicable Subscriber's state of domicile.

Group will indemnify Health Advantage in the event Health Advantage suffers any fines, penalties or expenses, including reasonable attorney's fees, due to the Group's failure to carry out its obligations under this Section 2.10 of the Group Contract.

3.0 SUBSCRIBER AND DEPENDENT COVERAGE

3.1 **Eligibility for Coverage.** The following provisions outline the eligibility requirements for Subscribers and Dependents by Health Advantage. In order to be covered, you must meet either the requirements for a Subscriber or a Dependent.

1. **Subscriber Coverage.** To be eligible, a Subscriber must:
 - a. complete the required Waiting Period, if applicable;
 - b. be in a class of employees who are included in the Plan; and
 - c. live or work in the BlueCard Service Area.
2. **Dependent Coverage.** Eligible Dependents are the Subscriber's:
 - a. Spouse;
 - b. Child less than 26 years of age, or
 - c. unmarried Child who is incapable of self support because of mental retardation or physical disability, provided 1.) such Child is or was under the limiting age of dependency stated in Subsection b. above at the time of application for coverage in the Plan or 2.) if not under such limiting age, has had continuous health plan coverage, i.e. no break in coverage greater than 63 days, at the time of application for coverage in the Plan.

NOTE: Domestic partners are not eligible for coverage as Dependents under this Evidence of Coverage.

3. **Additional Eligibility Requirements for Dependent Coverage.** In order for a Subscriber's Dependent to be eligible for coverage:
 - a. the Subscriber must be eligible for and have coverage; and
 - b. the Dependent must not be in active military service.
4. **Proof of Mental Retardation or Physical Disability.** In order for Dependent coverage to be provided due to mental retardation or physical disability, proof of the Child's dependency and retardation or physical disability must be furnished to Health Advantage prior to the Child's attainment of the applicable limiting age referenced in sections 3.1.2.b. and 3.1.2.c. above. Such proof must at least demonstrate that the Child is unable to obtain or continue a job or position in the course of commerce and that his or her parent(s) are providing 50% or more of his financial support (i.e. are declaring the Child as a dependent on their federal income tax return). Subsequent evaluation for continued

retardation or physical disability and dependency may be required by Health Advantage, but not more frequently than once per year. A Subscriber who first becomes eligible under the Plan may enroll a retarded or disabled Dependent Child provided the retardation or disability commenced before the limiting age, and the Child has been continuously covered under a health benefit plan as a Dependent of the Subscriber since before attaining the limiting age. Health Advantage's determination of eligibility shall be conclusive.

5. **Military Duty.** If a Member is called to active duty in the armed services of the United States of America, the Member's (and any covered dependents) coverage may be continued on COBRA for a period of 18 months or under the Uniformed Services Employment and Reemployment Rights Act (USERRA) for a period of 24 months. However, the Member must elect to continue coverage under USERRA within sixty days of activation. A former Member returning from active military service may enroll in the Plan within 90 days of his or her return to employment, provided the Employer continues to sponsor the Plan and payment of premium is timely made. The effective date of coverage for the employee returning from active military service will be the first day of reemployment. Health Advantage may require a copy of the returning member's orders terminating the active duty or other proof of the active duty or termination date thereof.

3.2 **Effective Date of Coverage.** The following provisions outline Health Advantage's policies relative to effective dates of coverage for you and/or your dependents.

1. **Application and Effective Date.** In order for a Subscriber's coverage to take effect, the Group must submit eligibility data for the Subscriber and any Dependents through the Electronic Data Exchange Enrollment mechanism. The effective date(s) of coverage shall be determined in accordance with this Subsection 3.2 and indicated by Health Advantage on the ID card, Schedule of Benefits or letter issued to Members by Health Advantage.
2. **Subscribers and Dependents on Contract Effective Date.** Coverage under this Evidence of Coverage shall become effective on the Group Contract effective date for all Subscribers and Dependents for whom electronic data is submitted and premium is paid during the Initial Open Enrollment Period prior to the Group Contract effective date. Coverage, subject to all other terms, conditions, exclusions and limitations of the Plan, will be extended to an eligible Subscriber or Dependent who is an inpatient in a Hospital on the effective date. This includes any eligible employee or dependent that is confined in a Hospital or other institution.
3. **New Subscriber Effective Date.** If Health Advantage receives a Subscriber's enrollment data within thirty (30) days of the date the Subscriber is first eligible for coverage, the Subscriber's coverage will become effective 12:01 a.m. on the first day the Subscriber is eligible for coverage.
4. **Coverage in the Case of Late Enrollment:** If an employee or an employee's dependent's electronic data is not submitted when initially eligible for coverage, the employee or dependent cannot subsequently obtain coverage, except during a Special Enrollment Period.
5. **Initial Enrollment Period for Existing Dependents:** If the Subscriber has eligible Dependents on the date the Subscriber's coverage begins, the Subscriber's Dependents' coverage will begin on the Subscriber's Effective Date if:
 1. Group submits electronic data for the Subscriber's Dependents' coverage within 30 days of the Subscriber's Effective Date; and
 2. The appropriate premium is timely paid.
6. **Effective Date for Newly Acquired Dependents.** In no event will a Subscriber's Dependent's coverage become effective prior to the Subscriber's effective date. If a Subscriber acquires a new eligible Dependent after the date the Subscriber's coverage begins, coverage for a new Dependent will become effective in accordance with the

following provisions:

- a. **Spouse.** When a Subscriber marries and wishes to have the Subscriber's Spouse covered, the Group shall submit electronic data within 30 days of the date of marriage. The effective date will be the date of marriage and the Spouse will not be a Late Enrollee. If a Group submits electronic data after the 30-day period, coverage for the Spouse will become effective in accordance with the provisions for Late Enrollees. See Subsection 3.2.4, above.

In order to document coverage provided by this Subsection 3.2.6.a., Group shall obtain and maintain a copy of the marriage certificate and make this document available to Health Advantage upon request.

- b. **Newborn Children.** Coverage for a Subscriber's newborn Child shall become effective as of the Child's date of birth if the Group gives Health Advantage notice by submitting electronic data to Health Advantage for the Child within 90 days of the Child's date of birth and the appropriate premium to cover the newborn Child from the date of birth is paid. If the Group submits the electronic data after the applicable 90-day time period, coverage for the Subscriber's newborn Child will become effective in accordance with the provisions for Late Enrollees. See Subsection 3.2.4, above.

In the event that the mother of the child is unmarried or the last name of the child is different from that of the Subscriber, in order to document coverage provided by this Subsection 3.2.6.b., Group shall obtain and maintain a copy of the birth certificate and make this document available to Health Advantage upon request.

- c. **Qualified Medical Child Support Order.** If a court has ordered a Subscriber to provide coverage for a Child, coverage will be effective on the first day of the month following the date Health Advantage receives notification of the court order and electronic data from the Group. In the event a court has ordered an employee of the Group who is not covered by the Plan to provide coverage for a child, the employee will be enrolled with the child on the first day of the month following Health Advantage's receipt of a written application or electronic data submission from the Group, a custodial parent of the Child, a child support agency having a duty to collect or enforce support for the Child, or the Child, provided, however that the premium is received when due.

In order to document coverage provided by this Subsection 3.2.6.c., Group shall obtain and maintain a copy of the qualified medical child support order and make this document available to Health Advantage upon request.

- d. **Newly Adopted Children.** Subject to payment of all applicable premiums, coverage for a Child placed with a Subscriber for adoption or for whom the Subscriber has filed a petition for adoption, shall begin on the date the Child is placed for adoption or the date of the filing of the petition for adoption, provided electronic data for the Child's coverage is submitted to Health Advantage within 60 days after the placement or the filing of the petition. The coverage shall begin from the moment of birth if the petition for adoption or placement for adoption occurred and the electronic data for coverage is submitted to Health Advantage within 60 days of the Child's birth. If the Group submits electronic data after such 60-day period, coverage for the adopted Child will become effective in accordance with the provisions for Late Enrollees. See Subsection 3.2.4, above. The coverage shall terminate upon the dismissal, denial, abandonment or withdrawal of the adoption, whichever occurs first.

In order to document coverage provided by this Subsection 3.2.6.d., Group shall obtain and maintain a copy of the petition for adoption or adoption papers and make these documents available to Health Advantage upon

request.

- e. **Other Dependents.** Electronic data for enrollment received by Health Advantage within 30 days of the date that any other dependent first qualifies as an eligible Dependent will result in coverage for such dependent on the date that electronic data for coverage is received by Health Advantage. Such Dependent will not be a Late Enrollee. If the Group submits the electronic data after the 30 day period, coverage for the Dependent will become effective in accordance with the provisions for Late Enrollees. See Subsection 3.2.4, above.
- 8. **Special Enrollment Period** is the 30-day period during which time an employee or employee's dependent may enroll in the Plan, after his or her initial Eligibility Date and not be a Late Enrollee. Special Enrollment Periods occur **ONLY** in two instances:
 - a. **After the Termination of Another Health Plan.** A Special Enrollment Period occurs (i) after an employee's or dependent's coverage under another health plan terminated as a result of Loss of Eligibility, or (ii) after the employer providing such other health plan terminated its contributions. The coverage effective date will be the 1st day following loss of prior coverage.
 - b. **After the Addition of a Dependent.** A Special Enrollment Period occurs for an employee, employee's spouse or employee's new dependent child (i) after the Subscriber marries, (ii) after a Subscriber's child is born, or (iii) after a Subscriber adopts a child or has a child placed with the Subscriber for adoption. The effective date of coverage shall be governed by the provisions of this Evidence of Coverage concerning addition of a Spouse, a newborn Child or an adopted Child, as applicable.
- 9. **Medicaid or State Child Health Insurance Program ("CHIP") Special Enrollment Period** is a 60-day period during which time an employee or employee's dependent may enroll in the Plan, after his or her initial Eligibility Date and not be a Late Enrollee. Medicaid or CHIP Special Enrollment Periods occur **ONLY** in two instances:
 - a. **After the Termination of Medicaid or CHIP Coverage.** A Medicaid or CHIP Special Enrollment Period begins on the day an employee's or dependent's coverage under Medicaid or CHIP terminates as a result of Loss of Eligibility.
 - b. **After Eligibility for Employment Assistance under Medicaid or CHIP.** A Medicaid or CHIP Special Enrollment Period occurs for an employee or employee's dependent who becomes eligible for assistance, with respect to coverage under group health plans or health insurance plans under Medicaid or CHIP (including under any waiver or demonstration project conducted under or in relation Medicaid or CHIP).

3.3 **Termination of Coverage.** The following provisions outline Health Advantage's policies relative to termination of coverage for the Group, you and/or your dependents.

- 1. **Termination of Coverage.** Coverage is subject to all terms and conditions of the Plan, and coverage will terminate under certain conditions described in various other places throughout this document. If coverage is not terminated under any other provision of this document, coverage for a Member shall terminate if any of the following events occur:
 - a. Coverage shall terminate at 12:00 midnight Central time on the date of event when:
 - i. A Subscriber or Member dies.
 - ii. This Plan terminates.
 - iii. The Employer to which the Group Contract is issued, terminates or ceases to sponsor the Plan.
 - iv. The Member ceases to be eligible as a Subscriber or Dependent for any reason.
 - v. The Member is a Dependent Spouse who becomes legally separated or divorced from the Subscriber*.

****In order to document a divorce or legal separation, Group shall obtain and maintain a copy of the divorce decree or legal separation papers and make these documents available to Health Advantage upon request.***

- b. A Member's coverage shall terminate at 12:00 midnight Central Time on the last day of the applicable premium period for which premium was paid if premium is not paid on or before the next premium due date.
2. **Termination of a Member's Coverage for Cause.**
- a. **Bases for Termination.** Health Advantage may terminate coverage under this Evidence of Coverage, including termination by rescission of all coverage retroactive to the Member's original effective date, upon fifteen (15) days' written notice for:
 - i. concealment of information, misrepresentation (whether intentional or not) or fraud in obtaining coverage; or
 - ii. concealment of information, misrepresentation (whether intentional or not) or fraud in the filing of a claim for services, supplies, or in the use of services or facilities.
 - b. **Concealment or Misrepresentation.** For purposes of this termination for cause provision, concealment of information or a misrepresentation occurs if (i) information is withheld or if incorrect information is provided that is material to the risk assumed by Health Advantage, or (ii) Health Advantage would not have issued this Group Contract, would have charged a higher premium, or would not have paid a claim in the manner it was paid had Health Advantage known the facts concealed or misrepresented, or (iii) there is a causal relationship between the concealed information or the incorrect information provided and an illness resulting in a claim under this Group Contract.
 - c. **Termination Effective Date.** Rescission of coverage shall become effective on the Member's original effective date. If Health Advantage elects to terminate the coverage other than by rescission, the termination shall be effective upon the later of (i) fifteen (15) days after a written notice of termination for cause is posted in the U.S. Mail, addressed to the Member at his or her last known address as provided by the Member to Health Advantage; or (ii) the date stated in the termination notice letter to Member.
 - d. **Appeal Procedure.** A Member may appeal a termination for cause. Such an appeal must be submitted in writing, addressed to "Health Advantage - For Cause Appeals, Post Office Box 8069, Little Rock, Arkansas 72203." In order for the appeal to be considered Health Advantage must receive the appeal prior to the later of (i) fifteen (15) days after a written notice of termination for cause is posted in the U.S. Mail, addressed to the Member at his or her last known address as provided by Member to Health Advantage; or (ii) the termination effective date stated in the termination notice letter to Member.
3. **Premium Refunds.** If Health Advantage terminates the coverage of a Member, premium payments received on account of the terminated Member applicable to periods after the effective date of termination shall be refunded to the Employer within 30 days, and Health Advantage shall have no further liability under the Group Policy.
4. **Employer Terminations.** If the Employer terminates coverage of a Member, the Employer must request Health Advantage refund premiums paid for such Member's coverage within 60 days from the effective date of termination of such coverage. Failure of the Employer to make a refund request within 60 days of the effective date of termination of the Member's coverage shall result in the Employer waiving refund of any premiums paid for such coverage. If claims have been paid past the termination date, the payment amount of the claims will be deducted from premium refunds.

5. **Termination of the Group Contract, Impact on Members.** The coverage of all Members shall terminate if the Group Contract is terminated.

3.4 Continuation Privileges

1. **Continuation of Hospital Benefits When Group Contract is Replaced.** If a Member is hospitalized on the date the Group terminates coverage with Health Advantage and replaces the coverage with another company, coverage for the Member will continue until the date the Member is discharged or until benefits under the Plan are exhausted, whichever occurs first.
2. **Continuation Rights under State Law**
 - a. If a Member's employment terminates or dependency status changes the Member shall have the right under state law to elect continuation of coverage under the Plan as outlined below. In order to be eligible for this option, Member must:
 - i. have been continuously covered under this Group Contract for at least three (3) consecutive months prior to employment termination or change in dependency status; and
 - ii. make the election by notifying Health Advantage in writing no later than ten (10) days after the employment termination or change in dependency status.
 - b. Continuation shall terminate on the earliest of:
 - i. one hundred twenty (120) days after the date the election is made;
 - ii. the date the Member fails to make any premium payments or the Employer fails to pay the premium to Health Advantage;
 - iii. the date the Member is or could be covered by Medicare;
 - iv. the date on which the Member is covered for similar benefits under another group or individual contract;
 - v. the date on which the Member becomes eligible for similar benefits under another group Plan;
 - vi. the date on which similar benefits are provided for or available to the Member under any state or federal law; or
 - vii. the date on which the Group Contract terminates.
 - c. If a Member qualifies for continuation of coverage, the Member may elect a conversion contract instead of continuation of group coverage. See Section 3.5 Conversion Privileges. If a Member has elected continuation under this Subsection 3.4.2, the Member shall have the option of conversion coverage at the end of the maximum continuation period.

3.5 Conversion Privileges

1. **Eligibility.** If a Member's coverage under the Plan terminates for any reason other than
 - a. failure to pay any sum required by the Group toward the cost of coverage under this Evidence of Coverage, if any, or
 - b. cause (see Section 3.3.2) or,
 - c. the Group Contract being replaced by a health benefit plan provided by an organization other than Health Advantage, then the Member may apply for a conversion plan issued by Health Advantage if
 - i. the Member is not eligible for Medicare coverage; or
 - ii. the Member is not eligible for coverage under any other group health plan that provides coverage for preexisting conditions.
2. **Benefits.** The Conversion Plan will be provided by Health Advantage at the conversion rates in effect at the time of the conversion. The benefits in the Conversion Plan will not necessarily equal or match those benefits provided in the Group Contract. No evidence of

good health or insurability will be required to effect the conversion.

3. **Written Application Deadline.** In order to obtain a Conversion Plan, written application to convert and payment of applicable premium charges must be submitted to the Company within 30 days following the date on which Health Advantage sends the Member a notice of termination of coverage.

4.0 CLAIMS

4.1 Claim Processing and Claim Appeal Procedures.

Health Advantage shall process claims and conduct appeals in accordance with the claim processing and appeal procedures set out in the Evidence of Coverage.

4.2 Facility of Payment

1. Health Advantage may, at its option, pay all or any benefits to the hospital, other institutions or the person giving medical services or supplies to the Member.
2. Any payment made according to the above paragraph shall discharge Health Advantage to the extent of any such payment. Health Advantage shall not be bound to see to the use of the money so paid.

4.3 Legal Actions

The Member may not initiate legal action with respect to a claim until the Member has exhausted his or her rights of appeal under the Plan. No legal action shall be brought after the expiration of three (3) years from the time that a claim is required to be submitted.

4.4 Assignment

No assignment of benefits under this Contract shall be valid until approved and accepted by Health Advantage. Health Advantage reserves the right to make payment of benefits, in its sole discretion, directly to the provider of service or to the Member.

5.0 GENERAL PROVISIONS

- 5.1 **Entire Contract:** The entire contract is made up of this Group Contract, the Evidence of Coverage issued to Subscribers, the Group Application and any attachments, riders, endorsements or amendments. The electronic data submitted representing Member eligibility also becomes a part of this Contract. Identification Cards issued to Members are for convenient summary only and do not constitute part of this Contract of coverage. In the absence of fraud, all statements made by the Group are representations and not warranties. No such statement shall be used in any contest under this Contract unless it is contained in a written instrument and a copy of such instrument is or has been furnished to the Group.

- 5.2 **Time Limit on Certain Defenses:** Except for nonpayment of premium, this Contract shall not be contested after it has been in force for two years. Statements from a Member shall not be used to void coverage or deny a claim unless:

1. the statements are contained in a written document signed by the Member; and
2. the loss on which claim is based occurs within two (2) years following the date of the signed written document.

- 5.3 **Term of This Contract:** This Contract is renewable from month to month by payment of the premium. It shall remain in force until terminated in accordance with its terms.

- 5.4 **Changes to Contract:** Health Advantage reserves the right to amend this Contract, in which case the amendment shall be deemed an amendment to the Plan. The procedure for amendment to this Contract and the Plan shall be that Health Advantage shall give 30 days' written notice to the Group prior to the next renewal date of the Contract. The change shall go into effect on the date fixed in the notice.

No agent or employee of Health Advantage may change or modify any benefit, term, condition, limitation or exclusion of this Contract. Any change or amendment must be in writing and signed by an officer of Health Advantage.

- 5.5 **Non-Assignment:** This Contract is not assign able to any other Group.
- 5.6 **Waiver:** The failure of either Health Advantage, Group or a Member to enforce any provision of this Contract shall not be deemed or construed to be a waiver of the enforceability of such provision. Similarly, the failure to enforce any remedy arising from a default under the terms of this Contract shall not be deemed or be construed to be a waiver of such default.
- 5.7 **Changes in Premium Rates:** Health Advantage reserves the right to establish a revised schedule of premium payments on each renewal date of the Evidence of Coverage upon thirty (30) days written notice to the Group. If a change in the Evidence of Coverage is required by law or regulation which increases Health Advantage's risk under this Evidence of Coverage, Health Advantage reserves the right to change the schedule of premium payments upon twenty (20) days written notice to the Group.
- 5.8 **Premium Payments:** All premiums are payable at Health Advantage's Home Office. The Group must make the first premium payment on or before the date the coverage is scheduled to take effect. Future premiums are due and payable in advance.
- 5.9 **Misstatement of Age:** If the age of a Covered Person has been misstated and such misstatement requires a correction in the premium rate, premiums shall be adjusted to the premium rate for the correct age, and the difference in past premium paid shall be paid to or refunded by Health Advantage.
- 5.10 **Right of Rescission.** Fraud or intentional misrepresentation of material fact(s) may be used by Health Advantage as the basis for rescission of coverage of the Contract Holder, any Subscriber or any Dependent.
- 5.11 **Grace Period:** Any premium for this coverage which is not paid on or before the date it becomes due is in default. After the first premium payment, the Group shall be allowed a 31 days grace period. During the grace period, the coverage shall remain in force, but only if payment in full for the past due amount and any current monthly premium coming due during the Grace Period is received within the Grace Period. If such payment is not received on or before the 31st day of the Grace Period, all coverage shall terminate as of the date on which premium was due and payable, and no coverage shall be recognized or available during the Grace Period. Group shall be obligated to fully inform all Subscribers and Dependents of any delinquency and if Group fails to do so, if any Member incurs services during any Grace Period or delinquency which are not eligible for coverage because the coverage subsequently terminated for non payment of the full premium prior to the end of the Grace Period, Group shall be solely liable for payment for such incurred services and shall indemnify and hold Health Advantage harmless for any and all claims, damages, fines, penalties, losses, expenses, judgments, awards, settlements, punitive damages, attorneys' fees or costs of any kind which are incurred by Health Advantage as a result of any claim or lawsuit by a Member for such services. The Group is subject to a late premium payment charge equal to the Health Advantage cost of funds, which is set by the bank with whom Health Advantage does business.
- 5.12 **Termination of This Contract:**
1. The Group may terminate this Contract on any premium due date by giving Health Advantage written notice of termination in advance of the premium due date. Any premiums paid beyond the requested termination date shall be refunded.
 2. Run-Out Period (applicable to any Contract Termination)
 - a. During the six months immediately following a Contract termination Health Advantage will continue to pay claims for services rendered prior to the termination. Health Advantage will not pay claims submitted after the end of this run-out period.

- b. If there is a Deficit PSR when the Contract terminates, Group shall pay the full deficit to Health Advantage.
 - c. If there is a Surplus PSR when the Contract terminates, Health Advantage will apply the Surplus PSR to the payment of claims submitted during the run-out period.
 - d. Following the run-out period, Health Advantage shall calculate and present a settlement to the Group of any remaining Surplus PSR or Deficit PSR, including Claims Paid during the run-out period. Within 60 days of the settlement presentation Health Advantage shall pay Group any surplus or Group shall pay Health Advantage any deficit.
3. Health Advantage may terminate this Contract on any premium due date if:
 - a. the premium due is not paid within the Grace Period;
 - b. the percentage of eligible employees of the Group covered by the Contract becomes less than the percentage of employee participation specified in the Group Application, or if the number of Subscribers falls below the minimum number of Subscribers specified in the Group Application;
 - c. the Group fails to contribute the agreed upon share of the premiums specified in the Group Application; or
 - d. the Group performs an act or practice that constitutes fraud or makes an intentional misrepresentation of a material fact under the terms of the coverage.
4. Health Advantage may terminate this Contract upon giving the Group 90 days notice, in the event Health Advantage discontinues issuing this Contract form in the State of Arkansas. In such event Health Advantage shall offer the Group the option to purchase any other group health coverage currently being offered by Health Advantage in Arkansas.
5. When the Contract terminates, in addition to the run out period, the Group is liable to Health Advantage for payment of all premiums and late charges which are due but unpaid at the time of termination.
6. It is the duty of the Group, and not Health Advantage, to notify all affected Members that the Contract and their coverage is terminated. Health Advantage shall not be responsible under any circumstances to provide notices to any employee or other covered person of the status of premium payments, coverage or the lack of coverage under this Contract or the Plan.
7. This Group Enrollment Contract shall terminate as of the date on which the premium was due and payable, if the premium due is not paid within the Grace Period.
8. If this Contract terminates due to nonpayment of premium, the Group may be eligible for reinstatement in the sole discretion of Health Advantage, provided certain conditions are met. The following items are required to be submitted for reinstatement to be considered.
 - a. Payment via cashier's check for all premiums due;
 - b. Payment via cashier's check of a non-refundable reinstatement application fee in the amount of \$350 (or such other amount as may be deemed by Health Advantage to cover reinstatement processing); and
 - c. Completion and return of a signed group application for reinstatement.A reinstatement request, together with the above requirements must be submitted within fifteen (15) days of the date on the "confirmation of termination" letter. The reinstatement request will then be forwarded to a designated underwriter for review. Following review (which Health Advantage will attempt to complete on most applications within 3-5 business days), the Group will be notified of the decision regarding the reinstatement request.

5.13 Refunds of Premiums

If Health Advantage terminates the coverage of a Member, premium payments received on account of the terminated Member applicable to periods after the effective date of termination shall be refunded to the Employer, unless the Member had made a contribution to the premium and there was no basis for rescission. Such refund shall be made within 30 days, and Health Advantage shall have no further liability under this Group Contract.

If the Employer terminates coverage of a Member, Health Advantage shall refund premium payments applicable to periods after the effective date of termination, provided that the Employer can demonstrate that the Member made no contribution to such premium payments. The Employer must request Health Advantage refund premiums paid for such Member's coverage within 60 days from the effective date of termination of such coverage. Failure of the Employer to make a refund request within 60 days of the effective date of termination of the Member's coverage shall result in the Employer waiving refund of any premiums paid for such coverage. If claims have been paid past the termination date, the payment amount of the claims will be deducted from premium refunds.

5.14. Claim Recoveries.

There may be circumstances in which Health Advantage recovers amounts paid as claims expense from a provider of services, from a Member or from a third party. Such circumstances include rebates paid to Health Advantage by pharmaceutical manufacturers based upon amounts of claims paid by Health Advantage for certain specified pharmaceuticals, amounts recovered by Health Advantage from health care providers or pharmaceutical manufacturers through certain legal actions instituted by Health Advantage relating to the claims expense of more than one Member, recoveries by Health Advantage of overpayments made to health care providers or to Members, and recoveries from other parties with whom Health Advantage contracts or otherwise relies upon for payment or pricing of claims. The following rules govern Health Advantage's actions with respect to such recoveries:

1. In the event that such a recovery relates to a claim paid more than two years before the recovery, no adjustment will be made to any Deductible or Coinsurance paid by a Member and Health Advantage shall be entitled to retain such recoveries for its own use.
If the recovery relates to a claim paid within two years and is not otherwise addressed in this subsection, Deductibles and Coinsurance amounts for a Member will be adjusted if affected by the recovery.
2. Only recoveries made within two years of the date of the error by Health Advantage or overpayments to health care providers or to Members by Health Advantage will be applied for the purpose of group rating or divisible surplus calculation, if applicable. The cost actually paid by Health Advantage to procure such recoveries will be treated as an administrative expense in considering group rating or divisible surplus, if applicable.
3. In the event Health Advantage receives from pharmaceutical manufacturers rebates based upon amounts of claims paid for certain specified pharmaceuticals, Health Advantage shall be entitled to retain such rebates for its own use, and no adjustments will be made to claims paid or to Deductibles or Coinsurance amounts paid by a Member.
4. If a Member is no longer covered by Health Advantage at the time of any such recovery, regardless of the amount or of the time of such recovery, Health Advantage shall be entitled to retain such recovery for its own use.
5. If such recovery amounts can not be attributed on an individual basis, because of having been paid as a lump sum settlement for less than the total amount of claims expense of Health Advantage or otherwise, no adjustments will be made to any Deductible or Coinsurance amounts paid by the Member and Health Advantage shall be entitled to retain such recovery for its own use.

5.15 Records and Reports: The Group shall keep records and furnish information to Health Advantage upon request regarding:

1. Subscribers and their Dependents;

2. changes in Subscribers' coverage; and
3. termination of coverage.

5.16 Evidences of Coverage

Health Advantage shall provide the Contract Holder with Evidences of Coverage or booklets like the one which is incorporated into and made a part of this Contract. It is the obligation of the Contract Holder to distribute these Evidences of Coverage to each Member.

5.17 Summary of Benefits and Coverage

1. Health Advantage shall provide the Group with Summaries of Benefits and Coverage (SBCs) mandated by federal law.
2. It is the obligation of the Group to distribute the SBCs to:
 - a. Subscribers or Dependents enrolling in the Plan along with other written enrollment materials;
 - b. Subscribers or Dependents on the first date they are eligible to enroll in the Plan if no written enrollment materials are distributed;
 - c. Newly enrolled Subscribers and Dependents upon the first date of their coverage if there were changes to the SBC distributed in accordance with subsections 5.17.2.a. or 5.17.2.b.;
 - d. Subscribers or Dependents enrolling in the Plan during a Special Enrollment Period no later than ninety (90) days after such enrollment;
 - e. Covered Persons when the Policyholder receives the annual renewal application material from Health Advantage;
 - f. A Covered Person within seven (7) business days after the Covered Person requests the SBC.
3. In making the distributions required by Subsection 4.17.2., the Policyholder understands and agrees:
 - a. If a Subscriber and Dependent reside at the same address, distribution of the SBC to the Subscriber shall also constitute distribution to the Dependent.
 - b. If a Dependent resides at a different address than the Subscriber, required distributions of the SBC to the Dependent must be made to the Dependent's address.
 - c. If the Plan provides multiple benefit packages, e.g. alternative Evidences of Coverage, the Group need only provide an SBC for the benefit package for which the Covered Person is enrolled upon the annual renewal of the Plan.
 - d. However, if the Plan provides multiple benefit packages, if a Covered Person requests a SBC for a package in which he or she is not enrolled, the Group will provide such SBC within seven (7) business days of receiving the request.

5.18 ERISA Notices and Plan Documents: Group, and not Health Advantage, shall be responsible, as Plan Administrator, for providing all ERISA notices and summary plan descriptions to Members.

5.19 Sex and Number: When used in this Contract, the masculine includes the feminine, the singular the plural, and the plural the singular.

5.20 Conformity With Statutes: If any provision does not comply with any law of the State of Arkansas, this Contract is deemed amended to meet the minimum requirements of the law, unless such law is pre-empted by federal law or found to be void by a court of competent jurisdiction, in which case any amendment to the Contract required by the pre-empted or voided law shall be deemed rescinded.

5.21 Out-of-Arkansas Services. Health Advantage has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Programs." Whenever Members access healthcare services outside the geographic area Health Advantage serves, the State of Arkansas, the claim for those services may be processed through one of these Inter-Plan

Programs and presented to Health Advantage for payment in accordance with the rules of the Inter-Plan Programs policies then in effect. The Inter-Plan Programs available to Members under this contract are described generally below.

Typically, Members, when accessing care outside the geographic area Health Advantage serves, obtain care from healthcare providers that have a contractual agreement (i.e., are “participating providers”) with the local Blue Cross and/or Blue Shield Licensee in that other geographic area (“Host Blue”). In some instances, Members may obtain care from non-participating healthcare providers. Health Advantage payment practices in both instances are described below.

Health Advantage covers only limited healthcare services received outside of our service area. As used in this subsection, 4.20 “Out-of-Arkansas Covered Healthcare Services” include for example, emergency care or urgent care obtained outside the geographic area we serve. Any other services will not be covered when processed through any Inter-Plan Programs arrangements. These “other services” must be provided or authorized by Member’s primary care physician (“PCP”).

1. **BlueCard® Program**

Under the BlueCard® Program, when Members access covered healthcare services within the geographic area served by a Host Blue, Health Advantage will remain responsible to you for fulfilling Health Advantage’s contractual obligations. However, in accordance with applicable Inter-Plan Programs policies then in effect, the Host Blue will be responsible for providing such services as contracting and handling substantially all interactions with its participating healthcare providers.

The financial terms of the BlueCard Program are described generally below. Individual circumstances may arise that are not directly covered by this description; however, in those instances, our action will be consistent with the spirit of this description.

a. **Liability Calculation Method Per Claim**

The calculation of the Member liability on claims for covered healthcare services processed through the BlueCard Program, if not a flat dollar copayment, will be based on the lower of the healthcare provider's billed covered charges or the negotiated price made available to Health Advantage by the Host Blue.

Host Blues may use various methods to determine a negotiated price, depending on the terms of each Host Blue’s healthcare provider contracts. The negotiated price made available to Health Advantage by the Host Blue may represent a payment negotiated by a Host Blue with a healthcare provider that is one of the following:

- (i) an actual price. An actual price is a negotiated payment without any other increases or decreases, or
- (ii) an estimated price. An estimated price is a negotiated payment reduced or increased by a percentage to take into account certain payments negotiated with the provider and other claim- and non-claim-related transactions. Such transactions may include, but are not limited to, anti-fraud and abuse recoveries, provider refunds not applied on a claim-specific basis, retrospective settlements, and performance-related bonuses or incentives; or
- (iii) an average price. An average price is a percentage of billed covered charges representing the aggregate payments negotiated by the Host Blue with all of its healthcare providers or a similar classification of its providers and other claim- and non-claim-related transactions. Such transactions may include the same ones as noted above for an estimated price.

Host Blues using either an estimated price or an average price may, in accordance with Inter-Plan Programs policies, prospectively increase or reduce such prices to correct for over- or underestimation of past prices (i.e., prospective adjustments

may mean that a current price reflects additional amounts or credits for claims already paid to providers or anticipated to be paid to or received from providers). However, the amount paid by the Member is a final price; no future price adjustment will result in increases or decreases to the pricing of past claims. The BlueCard Program requires that the price submitted by a Host Blue to Health Advantage is a final price irrespective of any future adjustments based on the use of estimated or average pricing.

A small number of states require a Host Blue either (i) to use a basis for determining Member liability for covered healthcare services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or (ii) to add a surcharge. Should the state in which healthcare services are accessed mandate liability calculation methods that differ from the negotiated price methodology or require a surcharge, Health Advantage would then calculate Member liability in accordance with applicable law.

b. **Return of Overpayments**

Under the BlueCard Program, recoveries from a Host Blue or its participating healthcare providers can arise in several ways, including, but not limited to, anti-fraud and abuse recoveries, healthcare provider/hospital audits, credit balance audits, utilization review refunds, and unsolicited refunds. In some cases, the Host Blue will engage a third party to assist in identification or collection of recovery amounts. The fees of such a third party may be netted against the recovery. Recovery amounts determined in this way will be applied in accordance with applicable Inter-Plan Programs policies, which generally require correction on a claim-by-claim or prospective basis.

2. **Non-Participating Healthcare Providers Outside Health Advantage's Service Area**

a. **Member Liability Calculation**

When Out-of-Area Covered Healthcare Services are received from non-participating healthcare providers, the amount(s) a Member pays for such services will generally be based on either the Host Blue's nonparticipating healthcare provider local payment or the pricing arrangements required by applicable state law. In these situations, the Member may be responsible for the difference between the amount that the non-participating healthcare provider bills and the payment Health Advantage will make for the covered services as set forth in this paragraph.

b. **Exceptions**

In some exception cases, Health Advantage may pay claims from nonparticipating healthcare providers for Out-of Area Covered Healthcare Services based on the provider's billed charge, such as in situations where a Member did not have reasonable access to a participating provider, as determined by Health Advantage in our sole and absolute discretion or by applicable state law. In other exception cases, we may pay such a claim based on the payment we would make if Health Advantage were paying a non-participating provider for the same covered healthcare services inside of Health Advantage's service area, as described elsewhere in this contract where the Host Blue's corresponding payment would be more than Health Advantage's in-service area non-participating provider payment, or in our sole and absolute discretion, we may negotiate a payment with such a provider on an exception basis. In any of these exception situations, the Member may be responsible for the difference between the amount that the non-participating healthcare provider bills and the payment Health Advantage will make for the covered services as set forth in this paragraph.



Health Advantage

An Independent Licensee of the Blue Cross and Blue Shield Association

BLUECHOICE OPEN ACCESS

POINT OF SERVICE EVIDENCE OF COVERAGE

IMPORTANT NOTICE

COVERED BENEFITS RECEIVED FROM AN OUT-OF-NETWORK PROVIDER, EXCEPT IN CERTAIN CIRCUMSTANCES (SEE SECTION 5.0.), ARE PAID AT A RATE LESS THAN LIKE COVERED BENEFITS RECEIVED FROM AN IN-NETWORK PROVIDER. (SEE YOUR SCHEDULE OF BENEFITS)

**HMO PARTNERS, INC. d/b/a HEALTH ADVANTAGE
320 WEST CAPITOL AVENUE
LITTLE ROCK, ARKANSAS 72201**

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ATTACH SCHEDULE OF BENEFITS

PATIENT PROTECTIONS

Health Advantage generally allows the designation of a Primary Care Physician. You have the right to designate any Primary Care Physician who participates in our network and who is available to accept you or your family members. For information on how to select a Primary Care Physician, and for a list of the participating Primary Care Physicians, contact Health Advantage or visit our Website at WWW.HEALTHADVANTAGE-HMO.COM.

For children, you may designate a pediatrician as the Primary Care Physician.

You do not need prior authorization from Health Advantage or from any other person (including a Primary Care Physician) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Health Advantage or visit our Website at WWW.HEALTHADVANTAGE-HMO.COM.

1.0 HOW THE COVERAGE UNDER YOUR HEALTH BENEFIT PLAN WORKS

- 1.1 Your employer has established and maintains an employee health benefit plan ("Plan") for employees and their eligible dependents. The Employer administers that Plan and actively promotes the Plan to its employees. The Employer and you, through your premium contributions, have purchased a health benefit plan provided by the Group Contract and Evidence of Coverage issued by HMO Partners, Inc. d/b/a Health Advantage that provides a range of coverage for medical services you may need. This is a very valuable benefit for you, but you should understand clearly that your Plan does NOT cover all medical services, drugs, supplies, tests or equipment ("Health Interventions" or "Interventions"). A Plan covering all Health Interventions would be prohibitively expensive. For that reason, we have offered and you have purchased a more limited Plan. This document is your guide to what you have and have not purchased; in other words, what is and is not eligible for benefits under your Plan. **Accordingly, you should read this entire document carefully both now and BEFORE you obtain medical or preventive health services to be sure you understand what is covered and the limitations on your coverage.**
- 1.2 The philosophy and purpose behind your Plan is that we want you to have coverage for the vast majority of medical needs you may face, including most hospital and physician services, emergency care, preventive and wellness services, medications, supplies and equipment. However, in order to keep costs of your Plan within reasonable limits, we have deliberately excluded coverage of a number of specific Health Interventions, we have placed coverage limits on some other Interventions, and we have established an overall standard we call the "Primary Coverage Criteria" that each and every claim for benefits must meet in order to be covered under your Plan.
- 1.3 Here is an important thing for you to clearly understand. For any Health Intervention, there are several general coverage criteria that must be met in order for that Intervention to qualify for coverage under your Plan.
1. The Primary Coverage Criteria must be met.
 2. The Health Intervention must conform to specific limitations stated in your Plan.
 3. The Health Intervention must not be specifically excluded under the terms of your Plan.
 4. At the time of the Intervention, you must meet the Plan's eligibility standards.
 5. You must comply with the Plan's Provider network and cost sharing arrangements which may include a referral from your Primary Care Physician; and
 6. You must follow the Plan's procedures for filing claims.
- The following discussion will give you a brief description of each of these qualifications.
- 1.4 **The Primary Coverage Criteria.** The Primary Coverage Criteria apply to ALL benefits you may claim under your Plan. It does not matter what types of Health Intervention may be involved or when or where you obtain the Intervention. The Primary Coverage Criteria are designed to allow Plan benefits for only those Health Interventions that are proven as safe and effective treatment. The Primary Coverage Criteria also provide benefits only for the least invasive or risky Intervention when such Intervention would safely and effectively treat the medical condition; or they provide benefits for treatment in an outpatient, doctor's office or home care setting when such treatment would be a safe and effective alternative to hospitalization. Examples of the types of Health Interventions that the Primary Coverage Criteria exclude from coverage include such things as the cost of hospitalization for a minor cold or some other condition that could be treated outside the hospital, or the cost of an investigational drug or treatment such as herbal therapy, or some forms of Chemotherapy not shown to have any beneficial or curative effect on a particular cancerous condition. Finally, the Primary Coverage Criteria require that if there are two or more effective alternative Health Interventions, the Plan should limit its payment to the Allowance or Allowable Charge for the most cost effective Intervention. The specific coverage standards that must be met under the Primary Coverage Criteria are outlined in detail in Section 2.0 of this document.
- 1.5 **Specific Limitations in Your Plan.** Because of the high cost of some Health Interventions, as well as the difficulty in some cases of determining whether an Intervention is really needed, we include coverage for such Health Interventions 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 treatment received during a contract year or other specified time period. Examples of such limitations include a limit on the number of covered visits for physical, occupational, speech, chiropractic and cardiac rehabilitative therapy services. Other types of limitations include requirements that an Intervention be provided in a particular location or by a Provider holding a particular type of license, or in accordance with a written

treatment plan or other documentation. Common benefits and limitations are outlined in detail in Section 3.0 of this document. You will note that this document refers to Coverage Policies we have developed that may address limitations of coverage for a particular service, treatment or drug. You may request a copy of our Coverage Policy with respect to a particular service, treatment or drug, or, if you have Internet access, you may review our established Coverage Policies on our web site at WWW.HEALTHADVANTAGE-HMO.COM.

- 1.6 **Specific Exclusions in Your Plan.** There are many possible reasons why we have selected a particular condition, health care Provider, Health Intervention, or service to be excluded from your Plan. Some exclusions are based on the availability of other coverage or financing for certain types of injuries. For example, injuries you receive on the job are generally covered by workers' compensation. Other exclusions are based on the need to try to keep your coverage affordable, covering basic health care service needs, but not covering every possible desired Intervention. The exclusion for Cosmetic Services is an example of this type of exclusion. The plan excludes coverage of some health care Providers because we believe the Provider is not qualified or because the Provider lacks appropriate training or experience to provide a service, or that the service lies outside his/her scope of practice. For example the plan does not cover services rendered by unlicensed Providers or by Hospital residents, interns, students or fellows.

Other exclusions are based on our judgment that the need for such Health Intervention is questionable in many cases, or that the services are of unknown or unproven beneficial effect. Examples of these types of exclusions include biofeedback and cranial electrotherapy stimulation devices, as well as some forms of high dose Chemotherapy and bone marrow transplantation. **Before you undergo treatment or tests, you should review the specific exclusions listed in Section 4.0 of this document. If you have any questions about whether a specific exclusion applies, discuss it with your doctor(s). Call our Customer Service representatives if you need assistance.** You may also request a copy of our Coverage Policy with respect to a particular service, treatment or drug, or, if you have Internet access, you may review all our established Coverage Policies on our web site at WWW.HEALTHADVANTAGE-HMO.COM.

- 1.7 **Provider Network and Cost Sharing Procedures.** Your plan does not provide coverage for one hundred percent of the costs associated with covered Health Interventions. You are expected to pay Copayments, Deductible and Coinsurance. You are encouraged to select, and to maintain a patient-physician relationship with, your Primary Care Physician. Your coverage includes a special limitation in the form of provider network requirements. These provisions are designed to try to hold down the costs of your coverage by limiting the coverage to those physicians, hospitals or other health care providers who participate in our provider networks, and by having your primary care physician consult with you in advance on whether the sometimes more expensive services of a specialist are really needed, or whether the primary care physician can adequately address the problem. You and your physician are always free to make any decision you believe is best for you concerning whether to receive any particular service or treatment, or whether to see any provider (in or out of the network). However, if you do decide to go "out-of-network" for services or treatment, your coverage will be reduced or limited to the out-of-network rate. In some cases, you also may be required to meet certain prior approval of coverage or precertification of coverage procedures as outlined in this document. There are exceptions to the network for emergencies or, in rare cases upon approval by Health Advantage, where services or treatment covered under your Plan are not available for some reason from an In-Network Provider. In-Network Providers are identified in our published provider directory, or you may call Customer Service to ask about a specific provider, or visit our Website at WWW.HEALTHADVANTAGE-HMO.COM. A full explanation of the provider network requirements and your payment obligations applicable to your Plan is set forth in Section 5.0 and the Schedule of Benefits.

- 1.8 **Eligibility Standards.** You must be eligible for benefits under your Plan at the time you receive a Health Intervention. Eligibility standards are set forth in Section 6.0 of this document. Since your coverage is through a group contract, this means you must be an eligible member of the Group, either as a Subscriber or an eligible Dependent of a Subscriber. In order to be an eligible member of the Group, you must meet the Group eligibility standards, which often include limited enrollment periods or Waiting Periods before your Group coverage takes effect. In all cases, in order to be considered "eligible" for coverage, your Plan must be valid and in force at the time the services or treatment are provided. All premiums must be timely paid. It is important to understand the provisions of Section 6.0 that outline the circumstances under which your coverage may terminate under the Plan. This section also describes the special situations provided by state and federal law that allow continued coverage

under the Plan for a limited time after you are no longer a Subscriber or Dependent. This section also describes the circumstances under which you may convert your coverage to an individual plan.

- 1.9 **Claim Filing Procedures.** Your Plan provides procedures that you, your Provider or your Authorized Representative must follow in filing claims with Health Advantage. Your failure to follow these procedures could result in significant delays in the processing of your claim, as well as potential denial of benefits. For example not informing a provider of your coverage under the Evidence of Coverage which causes the claim to not meet timely filing requirements will make you fully responsible for charges for services from that provider. These procedures are set out in Section 7.0. In addition, Section 7.0 explains how you can appeal a benefit determination in the event you believe that such benefit determination does not comply with the terms of the Plan.
- 1.10 **Plan Administration.** Information about the incentives Health Advantage provides In-Network Physicians is set out in Section 8.0. Certain important matters, not otherwise described in this Evidence of Coverage, are described in Section 9.0. Section 10.0 is a glossary of defined terms used in the Evidence of Coverage. Finally, Section 11.0 provides information the Plan is required to provide in accordance with the Employee Retirement Income Security Act of 1974 (ERISA).

2.0 PRIMARY COVERAGE CRITERIA

- 2.1 **Purpose and Effect of Primary Coverage Criteria.** The Primary Coverage Criteria are set out in this Section 2.0 of this document. The Primary Coverage Criteria are designed to allow Plan benefits for only those Interventions that are proven as safe and effective treatment. Another goal of the Primary Coverage Criteria is to provide benefits only for the least invasive or risky Intervention when such Intervention would safely and effectively treat the medical condition, or to provide benefits for treatment in an outpatient, doctor's office or home care setting when such treatment would be a safe and effective alternative to hospitalization. Finally, if there is more than one effective Health Intervention available, the Primary Coverage Criteria allow the Plan to limit its payment to the Allowance or Allowable Charge for the most cost-effective Intervention. Regardless of anything else in this Plan, and regardless of any other communications or materials you may receive in connection with your Plan, you will not have coverage for any service, any medication, any treatment, any procedure or any equipment, supplies or associated costs UNLESS the Primary Coverage Criteria set forth in this Section are met. At the same time, bear in mind that just because the Primary Coverage Criteria are met does not necessarily mean the treatment or services will be covered under your Plan. For example, a Health Intervention that meets the Primary Coverage Criteria will be excluded if the condition being treated is a non-covered treatment excluded by the Plan. (See Subsection 4.1) As explained in the preceding Section 1.0, the Primary Coverage Criteria represent one category of six general coverage criteria that must be met for coverage in all cases. The Primary Coverage Criteria are as follows:

2.2 Elements of the Primary Coverage Criteria.

In order to be covered, medical services, drugs, treatments, procedures, tests, equipment or supplies ("Interventions") must be recommended by your treating physician and meet all of the following requirements:

1. The Intervention must be an item or service delivered or undertaken primarily to prevent, diagnose, detect, treat, palliate or alleviate a medical condition or to maintain or restore functional ability of the mind or body. A "medical condition" means a disease, illness, injury, pregnancy or a biological or psychological condition that, if untreated, impairs or threatens to impair ability of the body or mind to function in a normal, healthy manner.
2. The Intervention must be proven to be effective (as defined in Subsections 2.3.1.a. or 2.3.1.b, below) in preventing, treating, diagnosing, detecting, or palliating a medical condition.
3. The Intervention must be the most appropriate supply or level of service, considering potential benefits and harm to the patient. The following three examples illustrate application of this standard (but are not intended to limit the scope of the standard): (i) An Intervention is not appropriate, for purposes of the Primary Coverage Criteria, if it would expose the patient to more invasive procedures or greater risks when less invasive procedures or less risky Interventions would be safe and effective to diagnose, detect, treat or palliate a medical condition. (ii) An Intervention is not appropriate, under the Primary Coverage Criteria, if it involves hospitalization or other intensive treatment settings when the Intervention could be administered safely and effectively in an outpatient or other less intensive setting, such as the home. Certain forms of therapy (examples include chiropractor services, physical therapy, speech or occupational therapy) are not considered appropriate for purposes of coverage if the

frequency or duration of therapy reaches a point of maintenance, where the patient remains at the same functional level and further therapy would not improve functional capacity or ambulation.

4. The Primary Coverage Criteria allow the Plan to limit its coverage to payment of the Allowance or Allowable Charge for the most cost-effective Intervention.

"Cost-effective" means a Health Intervention where the benefits and harms relative to the costs represent an economically efficient use of resources for patients with the medical condition being treated through the Health Intervention. For example, if the benefits and risks to the patient of two alternative Interventions are comparable, a Health Intervention costing \$1,000 will be more cost effective than a Health Intervention costing \$10,000. "Cost-effective" shall not necessarily mean the lowest price.

2.3 **Primary Coverage Criteria Definitions.** The following definitions are used in describing the elements of the Primary Coverage Criteria:

1. **Effective defined**

- a. An existing Intervention (one that is commonly recognized as accepted or standard treatment or which has gained widespread, substantially unchallenged use and acceptance throughout the United States) will be deemed "effective" for purposes of the Primary Coverage Criteria if the Intervention is found to achieve its intended purpose and to prevent, cure, alleviate or enable diagnosis or detection of a medical condition without exposing the patient to risks that outweigh the potential benefits. This determination will be based on consideration of the following factors, in descending order of priority and weight:
 - i. scientific evidence, as defined in Subsection 2.3.2, below (where available); or
 - ii. if scientific evidence is not available, expert opinion(s) (whether published or furnished by private letter or report) of an Independent Medical Reviewer(s) with education, training and experience in the relevant medical field or subject area; or
 - iii. if scientific evidence is not available, and if expert opinion is either unavailable for some reason or is substantially equally divided, professional standards, as defined and qualified in Subsection 2.3.3, below, may be consulted.
 - iv. If neither scientific evidence, expert opinion nor professional standards show that an existing Intervention will achieve its intended purpose to prevent, cure, alleviate or enable diagnosis or detection of a medical condition, then Health Advantage in its discretion may find that such existing Intervention is not effective and on that basis fails to meet the Primary Coverage Criteria.
- b. A new Intervention (one that is not commonly recognized as accepted or standard treatment or which has not gained widespread, substantially unchallenged use and acceptance throughout the United States) will be deemed "effective" for purposes of the Primary Coverage Criteria if there is scientific evidence (as defined in Subsection 2.3.2, below) showing that the Intervention will achieve its intended purpose and will prevent, cure, alleviate or enable diagnosis or detection of a medical condition without exposing the patient to risks that outweigh the potential benefits. Scientific evidence is deemed to exist to show that a new Intervention is **not** effective if the procedure is the subject of an ongoing phase I, II, or III trial or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis. If there is a lack of scientific evidence regarding a new Intervention, or if the available scientific evidence is in conflict or the subject of continuing debate, the new Intervention shall be deemed "not effective," and therefore not covered in accordance with the Primary Coverage Criteria, with one exception -- if there is a new Intervention for which clinical trials have not been conducted because the disease at issue is rare or new or affects only a remote population, then the Intervention may be deemed "effective" if, but only if, it meets the definition of "effective" as defined for existing Interventions in Subsection 2.3.1.a, above.

2. **Scientific Evidence defined.** "Scientific Evidence," for purposes of the Primary Coverage Criteria, shall mean only one or more of the following listed sources of relevant clinical information and evaluation:
 - a. Results of randomized controlled clinical trials, as published in the authoritative medical and scientific literature that directly demonstrate a statistically significant positive effect of an Intervention on a medical condition. For purposes of this Subsection a., "authoritative medical and scientific literature" shall be such publications as are recognized by Health Advantage, listed in its Coverage Policy or otherwise listed as authoritative medical and scientific literature on Health Advantage's web site at WWW.HEALTHADVANTAGE-HMO.COM; or
 - b. Published reports of independent technology or pharmaceutical assessment organizations recognized as authoritative by Health Advantage. For purposes of this Subsection b. an independent technology or pharmaceutical assessment organization shall be considered "authoritative" if it is recognized as such by Health Advantage, listed in its Coverage Policy or otherwise listed as authoritative on Health Advantage's web site at WWW.HEALTHADVANTAGE-HMO.COM.
3. **Professional Standards defined.** "Professional standards," for purposes of applying the "effectiveness" standard of the Primary Coverage Criteria to an existing Intervention, shall mean only the published clinical standards, published guidelines or published assessments of professional accreditation or certification organizations or of such accredited national professional associations as are recognized by Health Advantage's Medical Director as speaking authoritatively on behalf of the licensed medical professionals participating in or represented by the associations. Health Advantage shall have full discretion whether to accept or reject the statements of any professional association or professional accreditation or certification organization as "professional standards" for purposes of this Primary Coverage Criteria. No such statements shall be regarded as eligible to be classified as "professional standards" under the Primary Coverage Criteria unless such statements specifically address effectiveness of the Intervention, and conclude with substantial supporting evidence that the Intervention is safe, that its benefits outweigh potential risks to the patient, and that it is more likely than not to achieve its intended purpose and to prevent, cure, alleviate or enable diagnosis or detection of a medical condition.

2.4 Application and Appeal of Primary Coverage Criteria.

1. The following rules apply to any application of the Primary Coverage Criteria. Health Advantage shall have full discretion in applying the Primary Coverage Criteria, and in interpreting any of its terms or phrases, or the manner in which it shall apply to a given Intervention. No Intervention shall be deemed to meet the Primary Coverage Criteria unless the Intervention qualifies under ALL of the following rules:
 - a. Illegality – An Intervention does not meet the Primary Coverage Criteria if it is illegal to administer or receive it under federal laws or regulations or the law or regulations of the state where administered.
 - b. FDA Position – An Intervention does not meet the Primary Coverage Criteria if it involves any device or drug that requires approval of the U.S. Food and Drug Administration ("FDA"), and FDA approval for marketing of the drug, or of the device for a particular medical condition, has not been issued prior to your date of service. In addition, an Intervention does not meet the Primary Coverage Criteria if the FDA or the U.S. Department of Health and Human Services or any agency or division thereof, through published reports or statements, or through official announcements or press releases issued by authorized spokespersons, have concluded that the Intervention or a means or method of administering it is unsafe, unethical or contrary to federal laws or regulations. Neither FDA Pre-Market Approval nor FDA finding of substantial equivalency under 510(k) automatically guarantees coverage of a drug or device.
 - c. Proper License – An Intervention does not meet the Primary Coverage Criteria if the health care professional or facility administering it does not hold the proper license, permit, accreditation or other regulatory approval required under applicable laws or regulations in order to administer the Intervention.
 - d. Plan Exclusions, Limitations or Eligibility Standards – Even if an Intervention otherwise meets the Primary Coverage Criteria, it is not covered under this Plan if the Intervention

is subject to a Plan exclusion or limitation, or if you fail to meet Plan eligibility requirements.

- e. Position Statements of Professional Organizations – Regardless of whether an Intervention meets some of the other requirements of the Primary Coverage Criteria, the Intervention shall not be covered under the Plan if any national professional association, any accrediting or certification organization, any widely-used medical compendium, or published guidelines of any national or international workgroup of scientific or medical experts have classified such Intervention or its means or method of administration as "experimental" or "investigational" or as questionable or of unknown benefit. However, an Intervention that fails to meet other requirements of the Primary Coverage Criteria shall not be covered under the Plan, even if any of the foregoing organizations or groups classify the Intervention as not "experimental" or not "investigational," or conclude that it is beneficial or no longer subject to question. For purposes of this Subsection e., "national professional association" or "accrediting or certifying organization," or "national or international workgroup of scientific or medical experts" shall be such organizations or groups recognized by Health Advantage, listed in its Coverage Policy or otherwise listed as authoritative on Health Advantage's web site at WWW.HEALTHADVANTAGE-HMO.COM.
 - f. Coverage Policy – With respect to certain, treatments, services, tests, equipment, drugs or supplies, Health Advantage has developed specific Coverage Policies, which have been put into writing, and are published on Health Advantage's web site at WWW.HEALTHADVANTAGE-HMO.COM. If Health Advantage has developed a specific Coverage Policy that applies to the drug, treatment, service, test, equipment or supply that you received or seek to have covered under your Plan, the Coverage Policy shall be deemed to be determinative in evaluating whether such drug, treatment, service, test, equipment or supply meets the Primary Coverage Criteria; however, the absence of a specific Coverage Policy with respect to any particular drug, treatment, service, test, equipment or supply shall not be construed to mean that such drug, treatment, service, test, equipment or supply meets the Primary Coverage Criteria.
2. You may appeal a determination by Health Advantage that an Intervention does not meet the Primary Coverage Criteria by contacting the Member Response Coordinator. Use the procedures for appeals outlined in Sections 7.2 and 7.3.
 3. Any appeal available with respect to a Primary Coverage Criteria determination shall be subject to the terms, conditions and definitions set forth in the Primary Coverage Criteria. An appeal shall also be subject to the terms, conditions and definitions set forth elsewhere in this Plan. The Appeals Reviewer or an External Review organization shall render its independent evaluation so as to comply with and achieve the intended purpose of the Primary Coverage Criteria and other provisions of this Plan.

3.0 BENEFITS AND SPECIFIC LIMITATIONS IN YOUR PLAN

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, test 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 Allowance or Allowable Charge as set out in the Glossary of Terms and the Schedule of Benefits.

- 3.1 **Professional Services.** Subject to all terms, conditions, exclusions and limitations of the Plan set forth in this Evidence of Coverage, coverage is provided for the following professional services when performed by a Physician. All Covered Services are subject to the applicable Deductible, Copayment and Coinsurance specified in the Schedule of Benefits.

1. **Primary Care Physician Office Visits.** Coverage is provided for the diagnosis and treatment of illness or Injury when provided in the medical office of a Primary Care Physician. Member is responsible for the Deductible, Copayment and Coinsurance specified in the Schedule of Benefits.
 2. **Specialty Care Provider Office Visits.** Coverage is provided for the diagnosis and treatment of illness or Injury when provided in the medical office of the Specialty Care Provider. The Member is responsible for the Deductible, Copayment and Coinsurance specified in the Schedule of Benefits.
 3. **Physician Hospital Visits.** Coverage is provided for services of Physicians for diagnosis, treatment and consultation while the Member is admitted as an inpatient in a Hospital for Covered Services.
 4. **Telephone and Other Electronic Consultation.** Telephone calls or other forms of electronic consultation (e.g. e-mail, internet or video) between a Provider and a Member, or between a Provider and another Provider, for consultation, medical management, or coordinating care, including reporting or obtaining tests or laboratory results, are generally not covered. See Subsection 4.4.15. However, subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Evidence of Coverage, communications made by a Physician responsible for the direct care of a Member in Case Management with involved health care Providers are covered.
 5. **Surgical Services.** Coverage is provided for services of Physicians for surgery, either as an inpatient or outpatient. If coverage is provided for two (2) or more surgical operations performed during the same surgical encounter or for bilateral procedures, payment for the secondary or subsequent procedure will be made at a reduced rate. In general, overall payment for one or more procedures during the same operative setting will be no more than if the procedures had been done by one physician. Details as to how such payments are calculated are provided to In-network physicians through *Provider News* and Coverage Policy. Further, Health Advantage's payment for an assistant surgeon shall be limited to one physician qualified to act as an assistant for the surgical procedure.
 6. **Assistant Surgeon Services.** Not all surgeries merit coverage for an assistant surgeon. Further, the Company's payment for a covered assistant surgeon shall be limited to one Physician qualified to act as an assistant for the surgical procedure.
 7. **Standby Physicians.** Services of standby physicians are only covered in the event such physician is required to assist with certain high-risk services specified by Health Advantage, and only for such time as such physician is in immediate proximity to the patient.
 8. **Abortions.** Abortions are generally not covered, see Subsection 4.3.1. Pregnancy terminations under the direction of a Physician are covered, but only when performed in an In-Network Hospital or Outpatient Hospital setting.
- 3.2 **Preventive Health Services.** Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Evidence of Coverage, Health Advantage will pay one hundred percent (100%) of the Allowance or Allowable Charges for the routine preventive health services listed below when provided by a Primary Care Physician or an advanced practice nurse or physician's assistant who provides primary medical care in the areas of general practice, pediatrics, family practice, internal medicine or obstetrics/gynecology, which are performed in the Primary Care Physician's office. Coverage is also provided for certain preventive health services listed below when performed in an Outpatient Hospital or Ambulatory Surgery Center setting when the service cannot be performed in an office by a Primary Care Physician.
1. evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force but not for the related treatment of disease; and
 2. routine immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved; and
 3. with respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
 4. with respect to women, such additional preventive care and screenings not described in paragraph (1) as provided for in comprehensive guidelines supported by the Health Resources

- and Services Administration for purposes of this subsection; and
5. the current recommendations of the United States Preventive Service Task Force regarding breast cancer screening, mammography, and prevention shall be considered the most current other than those issued in or around November 2009.

3.3 **Hospital Services.** Subject to all terms, conditions, exclusions and limitations of the Plan set forth in this Evidence of Coverage, including applicable Deductible, Copayment and Coinsurance specified in the Schedule of Benefits, coverage is provided for the following Hospital services. All Hospital Services must be performed or prescribed by a Physician and provided by a Hospital.

1. **Inpatient Hospital Services.** This benefit is subject to the following specific limitations:
 - a. Payment for Hospital charges for inpatient admissions shall be limited to the lesser of the billed charge or the Allowance or Allowable Charge established by Health Advantage.
 - b. If you have a condition requiring that you be isolated from other patients, Health Advantage will pay for an isolation unit equipped and staffed as such.
 - c. In the event services are rendered for a covered benefit during an inpatient admission to a Hospital where the admitting diagnosis was for a non-covered benefit, Health Advantage will pay that portion of the Hospital Charge which is attributable to services rendered for the covered benefit.
 - d. The services of social workers shall be included in the basic daily room and board allowance.
 - e. Hospital admissions outside the state of Arkansas are subject to Pre-admission Notification. Please call the number listed on the Identification Card to notify Health Advantage of the admission.
 - f. Services rendered in a Hospital in a country outside of the United States of America shall not be paid except at the sole discretion of Health Advantage.
 - g. Admissions to a Long Term Acute Care Hospital or to a Long Term Acute Care division of a Hospital are subject to Pre-admission Notification. Please call the number listed on the Identification Card to notify Health Advantage of the admission.
2. **Outpatient Hospital Services.** Coverage is provided for services of an Outpatient Hospital, Outpatient Surgery Center or Outpatient Radiation Therapy Center. However, if you use an out of state Outpatient Surgery Center that does not contract with the local Blue Cross and Blue Shield Plan, payment for all such services, including Professional Services, will be limited to the Allowance or Allowable Charge for all the services or \$500 whichever is less. See Subsection 3.4.
3. **Hospital Services in Connection with Dental Treatment.** Health Advantage generally does not cover dental services, See Subsection 3.20. Subject to Prior Approval from Health Advantage, coverage is provided for hospital services, including anesthesia, services in connection with treatment for a complex dental condition provided to: (i) a Member under seven (7) years of age who is determined by two (2) dentists (in separate practices) to require the dental treatment without delay; (ii) a Member with a diagnosis of serious mental or physical condition; or (iii) a Member, certified by his or her primary care physician to have a significant behavioral problem. **Please note Prior Approval does not guarantee payment or assure coverage, it means only that the information furnished to us at the time indicates that the hospital services meet the Primary Coverage Criteria requirements set out in Subsections 2.4.1.b., e., or f. All services must still meet all other coverage terms, conditions and limitations, and coverage for these services may still be limited or denied, if, when the claims for the services are received by us, investigation shows that a benefit exclusion or limitation applies, that the Member ceased to be eligible for benefits on the date the services were provided, that coverage lapsed for non-payment of premium, that out-of-network limitations apply, or any other basis specified in this Evidence of Coverage.**

3.4 **Ambulatory Surgery Center.** Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Evidence of Coverage and subject to the Deductible, Copayment and Coinsurance specified in the Schedule of Benefits, coverage is provided for specific surgical services received at an Ambulatory Surgery Center that are performed or prescribed by a Physician. Covered services include diagnostic imaging and laboratory services required to augment a surgical service and performed on the

same day as such surgical service. Ambulatory Surgery Center services in connection with treatment for a complex dental condition are provided in accordance with Subsection 3.3.3. A list of services covered in an Ambulatory Surgery Center is available on our web site WWW.HEALTHADVANTAGE-HMO.COM. However, if you use an out of state Ambulatory Surgery Center that does not contract with the local Blue Cross and Blue Shield Plan, payment for all such services, including Professional Services, will be limited to the Allowance or Allowable Charge incurred for all the services or \$500, whichever is less.

- 3.5 **Outpatient Diagnostic Services.** Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Evidence of Coverage, coverage is provided for diagnostic services and materials, including but not limited to, diagnostic imaging (e.g. x-rays, fluoroscopy, ultrasounds, radionuclide studies) electrocardiograms, electroencephalograms and laboratory tests when performed or prescribed by a Physician and subject to the Deductible, Copayment and Coinsurance specified in the Schedule of Benefits.
- 3.6 **Advanced Diagnostic Imaging Services.** Computed tomography scanning ("CT SCAN"), Magnetic Resonance Angiography or Imaging ("MRI/MRA"), Nuclear Cardiology and positron emission tomography scans ("PET SCAN") (collectively referred to as "Advanced Diagnostic Imaging") require prior approval from Health Advantage. **Please note that Prior Approval does not guarantee payment or assure coverage; it means only that the information furnished to us at the time indicates that the CT SCAN, MRI/MRA, Nuclear Cardiology or PET SCAN meets the Primary Coverage Criteria requirements set out in Subsection 2.2. and the Applications of the Primary Coverage Criteria set out in Subsections 2.4.1.b., e., or f. All services, including any advanced diagnostic imaging receiving Prior Approval, must still meet all other coverage terms, conditions, and limitations, and coverage for any advanced diagnostic imaging receiving Prior Approval may still be limited or denied if, when the claims for the advanced diagnostic imaging are received by us, investigation shows that a benefit exclusion or limitation applies, that the Member ceased to be eligible for benefits on the date services were provided, that coverage lapsed for non-payment of premium, that out-of-network limitations apply, or any other basis specified in this Evidence of Coverage.**
- 3.7 **Maternity.** Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Evidence of Coverage, coverage is provided for Maternity Care when performed or prescribed by a Physician subject to the Deductible, Copayment and Coinsurance amounts specified in the Schedule of Benefits.
1. **Maternity and Obstetrical Care.** Coverage is provided for Maternity and Obstetrical Care, including Routine Prenatal Care and postnatal care; and use of Hospital delivery rooms and related facilities; special procedures as may be necessary. Routine Prenatal Care includes the coverage of one routine ultrasound only. See Subsection 4.3.83 concerning exclusion of additional routine ultrasounds.
 2. **Midwives.** Services provided by any lay midwife are not covered. See Subsection 4.2.5. However, subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Evidence of Coverage, coverage is provided for services provided by a certified nurse midwife who has a collaborative agreement with a Physician who is within immediate proximity to the Hospital utilized by the certified nurse midwife, in case there is need for assistance during the delivery.
 3. **Newborn Care in the Hospital.** Provided the Child's coverage becomes effective on his or her date of birth in accordance with the provisions of Section 6.0, coverage is provided for a hospital stay for the mother and newborn child of at least forty-eight (48) hours following a vaginal delivery or at least ninety-six (96) hours following a cesarean section, unless the treating provider, after consulting with the mother, discharges the mother or newborn child earlier. A Subscriber or Spouse's newborn Child will be covered from the date of birth, including use of newborn nursery (for up to five (5) days or until the mother is discharged, whichever is the lesser period of time) and related services.

If a Child is born in an Out-of-Network hospital because the Subscriber's Spouse has other health plan coverage, or if such Child is an adopted child born in an Out-of-Network hospital, nursery charges are covered up to the Allowance or Allowable Charge incurred.
 4. **Family Planning Services.** Coverage is provided for the following family planning services when authorized and provided by In-Network Physicians:

- a. Counseling and planning services for infertility when provided by In-Network Physicians;
- b. Infertility Testing. Coverage is provided for certain services to diagnose infertility. Diagnostic procedures are limited to semen analysis of the covered Spouse, endometrial biopsy, hystero-salpingography and diagnostic laparoscopy.
- c. Pregnancy terminations when provided according to the Health Advantage Coverage Policy and when performed in an In-Network Hospital setting. See Section 4.3.1.
- d. Oral Contraceptives are only covered under Section 3.22 Medications when the Employer purchases a retail drug benefit rider through Health Advantage.
- e. Voluntary sterilizations (vasectomies and tubal ligations). Reversals not covered.

NOTE: Treatment of infertility, including prescription drugs, is not a covered benefit.

- 5. **Genetic Testing.** In general, genetic testing to determine: (1) the likelihood of developing a disease or condition, (2) the presence of a disease or condition in a relative, (3) the likelihood of passing an inheritable disease, condition or congenital abnormality to an offspring, (4) genetic testing of the products of amniocentesis to determine the presence of a disease, condition or congenital anomaly in the fetus, (5) genetic testing of a symptomatic Member's blood or tissue to determine if the Member has a specific disease or condition, and (6) genetic testing to determine the anticipated response to a particular pharmaceutical, are not covered.

However, subject to the terms, conditions, exclusions and limitations of the Plan set forth in this Evidence of Coverage, a limited number of specific genetic tests may be covered for situations (4) or (5) referenced above when the Health Advantage has determined that the particular genetic test (a) is the only way to diagnose the disease or condition, (b) has been scientifically proven to improve outcomes when used to direct treatment, and (c) will affect the individual's treatment plan. A limited number of specific genetic tests may be covered for situation (6) referenced above if criteria (b) and (c) above are met. Health Advantage has full discretion in determining which particular genetic tests may be eligible for benefits as an exception to this exclusion under situations (4), (5) or (6). Any published Health Advantage Coverage Policy regarding a genetic test will control whether or not benefits are available for that genetic test as an exception to this exclusion

- 3.8 **Therapy Services.** Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Evidence of Coverage, coverage is provided for inpatient and outpatient therapy services when performed or prescribed by a Physician. Such therapy services include physical and occupational therapy. Such therapy services shall include services provided for developmental delay, developmental speech or language disorder, developmental coordination disorder and mixed developmental disorder. Therapy services must be performed by an appropriate registered physical, occupational or speech-language therapist licensed by the appropriate State Licensing Board and must be furnished in accordance with a written treatment Plan established and certified by the treating Physician. This benefit is subject to the Copayment and/or Deductible and Coinsurance specified in the Schedule of Benefits.

- 1. **Inpatient Therapy.** Coverage is provided for inpatient therapy services, including professional services, when performed or prescribed by a Physician and rendered in a Hospital.
- 2. **Outpatient Therapy.** Coverage is provided for outpatient therapy services when performed or prescribed by a Physician. Coverage for outpatient visits for physical therapy, occupational therapy and chiropractic services is limited to an aggregate maximum of thirty (30) visits per Member per Contract Year. See Subsection 10.65 - Outpatient Therapy Visit.
- 3. **Speech Therapy.** Coverage for speech therapy is limited to a maximum of thirty (30) visits per Member per Contract Year. However, treatment of speech, language, voice, communication and auditory processing disorder in a group setting is not a covered benefit.
- 4. **Cardiac and Pulmonary Rehabilitation Therapy.** Coverage for cardiac and pulmonary rehabilitation therapy is provided in accordance with Coverage Policy. Coverage for cardiac rehabilitation therapy limited to a maximum of 36 visits per Member per Contract Year. However, coverage is not provided for cardiac or pulmonary rehabilitation therapy from Freestanding Facilities. Peripheral vascular disease rehabilitation therapy is not covered. See Subsection 4.3.63.
- 5. **Cognitive Rehabilitation.** Cognitive Rehabilitation is generally not covered. See Subsections 4.3.14 and 10.11.

6. **Radio-Frequency Thermal Therapy.** The use of radio-frequency thermal therapy for treatment of orthopedic conditions is not covered. See Subsection 4.3.66. However, subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Evidence of Coverage, coverage for radio-frequency thermal therapy is provided and included in the payment for the primary procedure of the orthopedic condition.
- 3.9 **Mental Illness and Substance Abuse Services (Alcohol and Drug Abuse).** Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Evidence of Coverage, coverage is provided for Health Interventions to treat Mental Illness and Substance Abuse.
1. **Outpatient Health Interventions.**
Coverage of Mental Illness and Substance Abuse Health Interventions during office visits and other forms of outpatient treatment, including full-day program services is subject to the Deductible and Coinsurance set out in the Schedule of Benefits.
 2. **Inpatient and Intensive Outpatient Program Health Interventions**
 - a. Coverage for Inpatient Hospitalization or Intensive Outpatient Programs for Mental Illness or Substance Abuse Health Interventions is subject to the following requirements.
 - i. Inpatient Hospitalization requires a patient to receive Covered Services 24 hours a day as an inpatient in a Hospital.
 - ii. Intensive Outpatient Programs generally require the patient to receive Covered Services lasting two to four hours a day, three to five days per week in a Hospital outpatient setting.
 - b. Coverage is subject to the Deductible and Coinsurance set forth in the Schedule of Benefits.
 - c. **The treating facility must be a Hospital.** See Glossary of Terms. Treatment received at a Freestanding Residential Substance Abuse Treatment Center or at a Freestanding Psychiatric Residential Treatment Facility is not a covered benefit.
 3. The following services and treatments are not covered.
 - a. **Health and Behavior Assessment/Intervention.** Evaluation of psychosocial factors potentially impacting physical health problems and treatments are not covered. This includes health and behavior assessment procedures used to identify psychological, behavioral, emotional, cognitive, and social factors affecting physical health problems. See Subsection 4.3.37.
 - b. **Hypnotherapy.** Hypnotherapy is not covered for any diagnosis or medical condition. See Subsection 4.3.44.
 - c. **Marriage and Family Therapy.** Marriage and family therapy or counseling services are not covered. See Subsection 4.3.51.
 - d. **Sex Changes/Sex Therapy.** Care, services or treatment for non-congenital transsexualism, gender dysphoria or sexual reassignment or change are not covered. This exclusion includes medications, implants, hormone therapy, surgery, medical or psychiatric treatment or other treatment of sexual dysfunction including Prescription Medication and sex therapy. See Subsection 4.3.70.
- 3.10 **Emergency Care Services.** Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Evidence of Coverage, coverage is provided for Emergency Care. When Emergency Care is needed the Member should seek care at the nearest facility. Emergency Care received within forty-eight (48) hours of the emergency is subject to the Deductible, Copayment and Coinsurance specified in the Schedule of Benefits. If the Member is admitted as an inpatient to the same hospital where Emergency Care was rendered, the Emergency Care Copayment is waived and all services are subject to the inpatient Deductible, Copayment and Coinsurance.
1. **After-Hours Clinic or Urgent Care Center.** Services provided in an after-hours or urgent care center are subject to the Deductible and Coinsurance for each visit.
 2. **Observation Services.** Observation services are covered when ordered by an In-Network Physician. Observation Services ordered in conjunction with an emergency room visit or outpatient visit are subject to the Emergency Care Deductible, Copayment and Coinsurance for each visit.
 3. **Transfer to In-Network Hospital.** Continuing or follow-up treatment for Injury or Emergency Care is limited to care that meets Primary Coverage Criteria before you can be safely

transferred, without medically harmful or injurious consequences, to an In-Network Hospital in the Service Area. Services are subject to all applicable Deductible, Copayment and Coinsurance.

4. **Emergency Hospital Admissions.** You are responsible for notifying Health Advantage of an emergency admission to an In-Network Hospital in the Service Area or a Hospital outside the Service Area within 24 hours or the next business day. Failure to notify Health Advantage may result in the Member paying a greater portion of the medical bill.

5. **Medical Review of Emergency Care.** Emergency Care is subject to medical review. If, based upon the signs and symptoms presented at the time of treatment as documented by attending health care personnel, Health Advantage determines that a visit to the emergency room fails to meet the definition of Emergency Care as set out in this Evidence of Coverage (See Subsection 10.30 Emergency Care), coverage shall be subject to all applicable Deductible, Copayment and Coinsurance.

3.11 **Durable Medical Equipment.** Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Evidence of Coverage, coverage is provided for Durable Medical Equipment (DME) when prescribed by an In-Network Physician according to the guidelines specified below. This benefit, together with the benefit for equipment under Subsection 3.17, Home Health Services, is subject to the Deductible, Copayment and Coinsurance specified in the Schedule of Benefits. Coinsurance for Durable Medical Equipment and Medical Supplies used in connection with Durable Medical Equipment is not applied to the Annual Coinsurance Maximum.

1. Durable Medical Equipment is equipment which (1) can withstand repeated use; and (2) is primarily and customarily used to serve a medical purpose; and (3) generally is not useful to a person in the absence of an illness or injury; and (4) is appropriate for use in the home. Coverage for Durable Medical Equipment and Medical Supplies is provided when the Durable Medical Equipment is provided in accordance with Coverage Policy. Examples of Durable Medical Equipment include, but are not limited to, oxygen equipment, wheelchairs and crutches.

2. Durable Medical Equipment delivery or set up charges are included in the Allowance or Allowable Charge for the Durable Medical Equipment.

3. A single acquisition of eyeglasses or contact lenses within the first six months following cataract surgery is covered. With respect to such eyeglasses or contact lenses, tinting or anti-reflective coating and progressive lenses are not covered. The Allowance or Allowable Charge is based on the cost for basic glasses or contact lenses. Eyeglass frames are subject to a separate \$50 maximum Allowance or Allowable Charge when provided within the first six months following cataract surgery.

4. Replacement of DME is covered only when necessitated by normal growth or when it exceeds its useful life. Maintenance and repairs resulting from misuse or abuse of DME are the responsibility of the Member.

5. When it is more cost effective, Health Advantage in its discretion will purchase rather than lease equipment. In making such purchase, Health Advantage may deduct previous rental payments from its purchase Allowance.

6. Coverage for Medical Supplies used in connection with Durable Medical Equipment is limited to a 90-day supply per purchase.

3.12 **Medical Supplies.** Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Evidence of Coverage, Medical Supplies (See Subsection 10.53), other than Medical Supplies that can be purchased without a prescription, are covered when prescribed by a Physician.

1. Expenses for Medical Supplies provided in a Physician's office are included in the reimbursement for the procedure or service for which the supplies are used.

2. Coverage for Medical Supplies is limited to a 31-day supply per month.

3. Coverage for Medical Supplies used in connection with Durable Medical Equipment, Subsection 3.11, is subject to the Deductible, Coinsurance and Copayment specified in the Schedule of Benefits. Coinsurance for Medical Supplies used in connection with Durable Medical is not applied to the Annual Coinsurance Maximum.

4. Expenses for Medical Supplies provided in connection with home infusion therapy are included in the reimbursement for the procedure or service for which the supplies are used.

3.13 **Prosthetic and Orthotic Devices and Services.** Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Evidence of Coverage, and subject to the Deductible,

Copayment and Coinsurance specified in the Schedule of Benefits, coverage is provided for prosthetic and orthotic devices, including associated services, and its repair if such device is required for treatment of a condition arising from an illness or Accidental Injury. Health Advantage will provide you the Allowable Charge for a prosthetic device. Replacement of a prosthetic or orthotic device is covered no more frequently than once per three-year period except when necessitated by normal growth or when the age of the prosthetic or orthotic device exceeds the device's useful life. Maintenance and repair resulting from misuse or abuse of a prosthetic or orthotic device are the responsibility of the Member.

Hearing aids, prosthetic devices to assist hearing or talking devices are not generally covered. See Subsection 4.3.38. Additionally, there is no coverage for cochlear implants, auditory brain stem implants or osseointegrated hearing aids.

- 3.14 **Diabetes Management Services.** Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Evidence of Coverage, Health Advantage will pay for one Diabetes Self-Management Training Program per lifetime per Member. Such training program must be in compliance with the national standards for diabetes self-management education programs developed by the American Diabetes Association. If there is significant change in the Member's symptoms or conditions which under Coverage Policy make it necessary to change the Member's diabetic management process, Health Advantage will pay for an additional Diabetes Self-Management Training Program. This benefit is payable for training in or out of the hospital that has been prescribed by a Physician.

Foot care is generally not covered, see Subsection 4.3.32. However, subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Evidence of Coverage, coverage of foot care is provided when required for prevention of complications associated with diabetes mellitus.

Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Evidence of Coverage, the Plan will cover one eye examination to screen for diabetic retinopathy per Contract Year for Members who are diagnosed with diabetes.

If provided in Coverage Policy, Health Advantage will pay for Durable Medical Equipment, Medical Supplies and services for the treatment of diabetes. The Health Advantage Allowance or Allowable Charge for Insulin Pumps is \$4,400.

- 3.15 **Ambulance Services.** Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Evidence of Coverage, coverage is provided for ground, water or air Ambulance Services to the nearest hospital in the event Emergency Care is needed. (See Subsection 10.30 Emergency Care.) Air Ambulance Services are only covered when the Member could not be safely transported in another manner. The coverage for Ambulance Services is subject to the Deductible, Copayment and Coinsurance specified in the Schedule of Benefits.

- 3.16 **Skilled Nursing Facility Services.** Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Evidence of Coverage, coverage is provided for Skilled Nursing Facility services when authorized in advance by a Physician. See Subsection 10.90 for the definition of Skilled Nursing Facility. This benefit is subject to the Deductible, Copayment and Coinsurance specified in the Schedule of Benefits. This Skilled Nursing Facility services benefit is subject to the following conditions:

1. The admission must be within seven days of release from a Hospital;
2. The Skilled Nursing Facility services are of a temporary nature and increase ability to function;
3. Custodial Care is not covered (See Subsections 4.4.7 and 10.21);
4. Coverage is provided for a maximum number of days as set forth in the Schedule of Benefits per Member per Contract Year.

- 3.17 **Home Health Services.** Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Evidence of Coverage, including but not limited to the exclusion of Custodial Care (see Subsections 4.4.7 and 10.21), coverage is provided for Home Health Services when Coverage Policy supports the need for in-home service and such care is prescribed or ordered by a Physician. Covered Services must be provided through and billed by a licensed home health agency. Covered Services provided in the home include services of a Registered Professional Nurse (R.N.), a Licensed Practical Nurse (L.P.N.) or a Licensed Psychiatric Technical Nurse (L.P.T.N.), provided the nurse is not related to you by blood or marriage or does not ordinarily reside in your home. Home Health visits are subject to the Deductible, Copayment and Coinsurance specified in the Schedule of Benefits. (Home infusion services are not covered by this Section 3.17, but are covered under Subsection 3.22.1.d.)

- 3.18 **Hospice Care.** Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Evidence of Coverage, if the Member has been diagnosed and certified by the attending Physician as having a terminal illness with a life expectancy of six months or less, and if arranged through a Health

Advantage Case Manager, Health Advantage will pay the Allowance or Allowable Charge for Hospice Care. The services must be rendered by an entity licensed by the Arkansas Department of Health or other appropriate state licensing agency and accepted by Health Advantage as a Provider. This benefit is subject to the Deductible, Copayment and Coinsurance specified in the Schedule of Benefits.

3.19 **Oral Surgery.** Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Evidence of Coverage, Health Advantage will pay only for the following non-dental oral surgical procedures:

1. Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth when pathological examination is required.
2. Surgical procedures required to treat an Accidental Injury (See Subsection 10.1 Accidental Injury) to jaws, cheeks, lips, tongue, roof and floor of the mouth. Injury to a tooth or teeth while eating is not considered an Accidental Injury; treatment of such injury will not be covered.
3. Excision of exostoses of jaws and hard palate.
4. External incision and drainage of cellulitis.
5. Incision of accessory sinuses, salivary glands or ducts.

3.20 **Dental Care or Orthodontic Services.** Dental Care and orthodontic services are not covered.

1. Benefits for Accidental Injury. However, if a Member has an Accidental Injury, benefits will be provided, subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Evidence of Coverage, for Dental Care and x-rays necessary to correct damage to a Non-diseased Tooth or surrounding tissue caused by the Accidental Injury. The Member must seek treatment within 72 hours of injury for services to be covered. Coverage is subject to the Deductible, Copayment and Coinsurance specified in the Schedule of Benefits to a maximum benefit of \$2000 with the following limitations:
 - a. Only the Non-diseased Tooth or Teeth avulsed or extracted as a direct result of the Accidental Injury and the Non-diseased Tooth or Teeth immediately adjacent will be considered for replacement
 - b. Orthodontic services are limited to the stabilization and re-alignment of the accident-involved teeth to their pre-accident position. Reimbursement for this service will be based on a per tooth allowance.
 - c. Injury to teeth while eating is not considered an Accidental Injury.
 - d. Double abutments are not covered.
 - e. Any Health Intervention related to dental caries or tooth decay is not covered.
 - f. Removal of teeth is not covered.
 - g. Dental implants of titanium osseointegrated fixtures or fixtures of any other material are not covered.
2. Benefits for dental service. Dental services in connection with radiation treatment for cancer of the head or neck are covered.
3. Benefits for anesthesia services. Hospital and Ambulatory Surgery Center services and anesthesia services related to dental procedures, including services to children, are covered in accordance with Subsection 3.3.3.

3.21 **Reconstructive Surgery. Cosmetic Services are not covered. (See Subsections 4.4.5 and 10.18)**

Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Evidence of Coverage, and subject to the Deductible and Coinsurance specified in the Schedule of Benefits, coverage is provided for the following reconstructive surgery procedures when prescribed or ordered by a Physician:

1. Treatment provided for the correction of defects incurred in an Accidental Injury sustained by the Member
2. Surgery performed on a child for the correction of a cleft palate or cleft lip, removal of a port-wine stain or hemangioma (**only** on the face), or correction of a congenital abnormality. Orthognathic surgery is not covered. See Subsection 4.3.57. *In order to be covered such corrective surgery for a congenital defect must be performed when the child is 12 years of age or younger, unless, in its sole discretion Health Advantage determines that due to the complexity of the procedure, such surgery could not be performed prior to the child's 12th birthday. Dental Care to correct congenital defects is not a covered benefit.*

3. Treatment provided when it is incidental to disease or for reconstructive surgery following neoplastic (cancer) surgery.
4. In connection with a mastectomy resulting from cancer surgery, services for (a) reconstruction of the breast on which the cancer-related surgery was performed; (b) surgery to reconstruct the other breast to produce a symmetrical appearance; and (c) prostheses and services to correct physical complications for all stages of the mastectomy, including lymphedemas.
5. Reduction mammoplasty, if such reduction mammoplasty meets Coverage Criteria and is Prior Approved by Health Advantage is covered.

3.22 **Medications.** Subject to all terms, conditions, exclusions and limitations of the Plan set forth in this Evidence of Coverage, coverage is provided for Prescription Medication. (See Subsection 10.79 Prescription Medication.) This coverage varies, depending upon the sites of service where the Medication is received by the Member.

1. **Sites of Service**

- a. **Hospital or Ambulatory Surgical Center.** The benefit for Medications received from a Hospital or an Ambulatory Surgical Center is included in the Allowance or Allowable Charge for the Hospital Services. See Subsections 3.3 and 3.4.
- b. **Physician's Office.** The benefit for Medications administered in a Physician's office is covered based upon the Allowance or Allowable Charge for the Medication and subject to the Deductible, Coinsurance and Copayment specified in the Schedule of Benefits. Conditions of coverage set forth in Subsections 3.22.2.a, b and c are applicable to this coverage.
- c. **Retail Pharmacy (Drug Store).** There is no coverage for Prescription Medications that may be purchased from a retail pharmacy (drug store) unless the Employer purchases a retail drug benefit rider from Health Advantage. See Subsection 4.3.64.
- d. **Home Infusion Therapy Pharmacy.** The benefit for Medications received from a licensed retail pharmacy designated by Health Advantage as a home infusion therapy Provider is covered based upon the Allowance or Allowable Charge for the Medication.
 - i. **Covered Medications.** Medications are covered subject to the Deductible, Copayment and Coinsurance listed in the Schedule of Benefits,
 - ii. FDA approved medications that exist as separate components and are intended for reconstitution prior to administration are covered. Examples include, but are not limited to, total parental, intravenous antibiotics and hydration therapy.
 - iii. **Conditions of Coverage.** Conditions of coverage set forth in Subsections 3.22.2. a, b, c, d and e are applicable to this coverage.
 - iv. **Medical Supplies.** Medical Supplies used in connection with home infusion therapy are covered under this Subsection 3.22.1.d. See Subsection 3.12.
 - v. **Administration Charges.** Charges to administer or inject Medication by a licensed medical professional operating under his/her scope of practice are covered under this Subsection 3.22.1.d. according to the allowable fee schedule for skilled nursing under both home infusion therapy and Home Health.

2. **Conditions of Coverage**

- a. **Prior Approval.** Selected Prescription Medications, as designated from time to time by Health Advantage, are subject to Prior Approval through criteria established by Health Advantage before coverage is allowed. A list of Medications for which Prior Approval is required is available from Health Advantage upon request or, if you have Internet access, you may review this list on Health Advantage's web site at WWW.HEALTHADVANTAGE-HMO.COM. This Subsection 3.22.2.a. is applicable to Prescription Medication covered by Subsections 3.22.1.b and d.
- b. **Specialty Medications.** Selected Prescription Medications are designated by Health Advantage as "Specialty Medications" due to their route of administration, approved indication, unique nature, or inordinate cost. These medications usually require defined handling and home storage demands, crucial patient education, and careful monitoring. Such medications include, but are not limited to growth hormones, blood modifiers, immunoglobulins, and medications for the treatment of hemophilia, deep vein

thrombosis, hepatitis C, Crohn's disease, cystic fibrosis, multiple sclerosis and rheumatoid arthritis. Specialty Medications may be A Medications or B Medications. Specialty Medications classified as A Medications are not covered unless the Employer purchases a retail drug benefit rider from Health Advantage. Specialty Medications classified as B Medications are covered. (See Subsection 10.79 for definitions of "A Medications" and "B Medications.") Coverage for Specialty Medications is subject to Prior Approval and may only be purchased through a specialty pharmacy vendor under contract with Health Advantage. A list of Specialty Medications is available from Health Advantage upon request or, if you have Internet access, you may review this list on Health Advantage's web site at WWW.HEALTHADVANTAGE-HMO.COM. This Subsection 3.22.2.b is applicable to Prescription Medication covered by Subsections 3.22.1.b and d.

- c. **Formulary.** Except in limited circumstances set out in this Subsection 3.22.2.c. and elsewhere in this Evidence of Coverage, a Prescription Medication must be listed in the Formulary in order to be covered. (See Subsection 10.34 Formulary.) However, if a Prescription Medication in the Formulary causes or has caused adverse or harmful reactions for a particular Member, or has been shown to be ineffective in the treatment of a Member's particular disease or condition, such Member may be able to obtain coverage for a Prescription Medication not in the Formulary by requesting Prior Approval. This Subsection 3.22.2.c is applicable to Prescription Medication covered by Subsections 3.22.1. b. and d.
- d. **Step Therapy.** Selected Prescription Medications as designated from time to time by Health Advantage in its discretion, are subject to Step Therapy restrictions. (See Subsection 10.94 Step Therapy.) Such Step Therapy must be completed before coverage for the selected Prescription Medication is provided. The Step Therapy requirements for a particular Prescription Medication are available from Health Advantage upon request. This Subsection 3.22.2.d is applicable to Prescription Medication covered by Subsections 3.22.1. d.
- e. **Dispensing Quantities — Limitations**

A Prescription Medication will not be covered for any quantity or period in excess of that authorized by the prescribing Physician or health care Provider.

Early refills are covered at the discretion of Health Advantage. A prescription will not be covered if refilled after one year from the original date of the prescription.

Coverage of selected Prescription Medications as designated from time to time by Health Advantage in its discretion, is subject to Dose Limitations. (See Subsection 10.26 Dose Limitation.) The Dose Limitation for a particular Prescription Medication is available from Health Advantage upon request.

This Subsection 3.22.2.e is applicable to Prescription Medication covered by Subsections 3.22.1. d.

3.23 **Organ Transplant Services.** Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Evidence of Coverage, coverage is provided for human-to-human organ or tissue transplants in accordance with the following specific conditions:

1. Not all transplants are covered. There must be a specific Coverage Policy which allows benefits for the transplant in question, and the Member must meet all of the required criteria necessary for coverage set forth in the Coverage Policy and in this Evidence of Coverage.
2. Except for kidney and cornea transplants, coverage for transplant services requires Prior Approval by Health Advantage. A request for approval must be submitted to Health Advantage prior to receiving any transplant services, including transplant evaluation. **Please note that Prior Approval does not guarantee payment or assure coverage; it means only that the information furnished to us at the time indicates that the transplant meets the Primary Coverage Criteria requirements set out in Subsection 2.2. and the Applications of the Primary Coverage Criteria set out in Subsections 2.4.1.b., e., or f. All services, including any transplant receiving Prior Approval, must still meet all other coverage terms, conditions, and limitations, and coverage for any transplant receiving Prior Approval may still be limited or denied if, when the claims for the transplant are received by us, investigation shows that a benefit exclusion or limitation applies, that the Member ceased to be eligible for benefits on the date services were provided, that coverage**

lapsed for non-payment of premium, that out-of-network limitations apply, or any other basis specified in this Evidence of Coverage.

3. The transplant benefit is subject to the Deductible and Coinsurance specified in the Schedule of Benefits.
4. Notwithstanding any other provisions of this Evidence of Coverage, at the option of Health Advantage, the Allowance or Allowable Charge for an organ transplant, including any charge for the procurement of the organ, hospital services, physician services and associated costs, including costs of complications arising from the original procedure that occur within the Transplant Global Period, shall be limited to the lesser of (a) ninety percent (90%) of the billed charges or (b) the global payment determined as payment in full by a Blue Cross and Blue Shield Association Blue Distinction Centers for Transplant participating facility or a facility that has contracted with Health Advantage to provide the organ transplant. If the Covered Person receives the transplant from a facility outside of Arkansas that is not in the Blue Distinction Centers for Transplant network, but is contracted with a local Blue Cross and/or Blue Shield Plan, the Allowable Charge shall be the price contracted by such Blue Cross and/or Blue Shield Plan. **Please note that our payments for any transplant (whether performed within the transplant network or by a non-participating facility) are limited to a global payment that applies to all covered transplant services; we will not pay any amounts in excess of the global payment for services the facility or any physician or other health care Provider or supplier may bill or attempt to bill separately, because the global payment is deemed to include payment for all related necessary services (other than non-covered services). If you use a facility participating in the Blue Distinction Centers for Transplant network, that facility has agreed to accept the global payment as payment in full, and should not bill you for any excess amount above the global payment, except for applicable Deductible, Coinsurance or non-covered services; however, a non-participating facility may bill you for all amounts it may charge above the global payment. These charges above the global payment could amount to thousands of dollars in additional out of pocket expenses to you.**
5. When the Member is the potential transplant recipient, a living donor's hospital costs for the removal of the organ are covered with the following limitations:
 - a. Allowance or Allowable Charges are only covered for the period beginning on the day before the transplant to the date of discharge or 39 days, whichever is less.
 - b. Donor testing is covered only if the tested donor is found compatible.
6. Solid organ transplants of any kind are not covered for individuals with a malignancy that is presently active or in partial remission. A solid organ transplant of any kind is not covered for a Member that has had a malignancy removed or treated in the 3 years prior to the proposed transplant. For purposes of this section, malignancy includes a malignancy of the brain or meninges, head or neck, bronchus or lung, thyroid, parathyroid, thymus, pleura, esophagus, heart or pericardium, liver, stomach, small or large bowel, rectum, kidney, bladder, prostate, testicle, ovary, uterus, other organs associated with the genito-urinary tract, bones, muscle, nerves, blood vessels, leukemia, lymphoma or melanoma. The only exception to this non-coverage is for solid organ transplant for hepatocellular carcinoma under certain circumstances, as outlined in the Coverage Policy for hepatocellular carcinoma.
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.

3.24 **Medical Foods and Low Protein Modified Food Products.** Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Evidence of Coverage, coverage is provided for Medical Foods and Low Protein Modified Food Products for the treatment of a Member diagnosed with phenylketonuria, galactosemia, organic acidemias, fatty acid and oxidative disorders, and disorders of amino acid metabolism if

1. the Medical Foods and Low Protein Modified Food Products are administered under the order of a licensed Physician; and
2. the Medical Foods and Low Protein Food Modified Products are prescribed in accordance with Coverage Policy for the therapeutic treatment of phenylketonuria, galactosemia, organic acidemias, fatty acid and oxidative disorders, and disorders of amino acid metabolism.

This benefit is subject to the Deductible, Copayment and Coinsurance specified in the Schedule of Benefits. However, any services or supplies provided for dietary and nutritional services, unless such services or supplies are the sole source of nutrition for the Member, are not covered. See Subsection 4.3.21.

- 3.25 **Prenatal Tests and Testing of Newborn Children.** Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Evidence of Coverage, coverage is provided for prenatal tests and tests of newborn children that are supported by Coverage Policy. Examples of such tests that are covered include testing for Down's syndrome, hypothyroidism, sickle-cell anemia, phenylketonuria/galactosemia, (PKU) and other disorders of metabolism. This benefit is subject to the Deductible, Copayment and Coinsurance specified in the Schedule of Benefits.
- 3.26 **Testing and Evaluation.** Subject to all other terms, conditions, exclusions and limitations of the Plan set forth in this Evidence of Coverage, coverage is provided for the following testing and evaluation, limited to fifteen (15) hours per Member per year. This benefit is further subject to the Deductible and Coinsurance specified in the Schedule of Benefits.
1. Psychological testing, including but not limited to, assessment of personality, emotionality and intellectual abilities;
 2. For Children under the age of six (6), childhood developmental testing, including but not limited to assessment of motor, language, social, adaptive or cognitive function by standardized developmental instruments;
 3. Neurobehavioral status examination, including, but not limited to assessment of thinking, reasoning and judgment;
 4. Neuropsychological testing, including, but not limited to Halstead-Reitan, Luria and WAIS-R.
- 3.27 **Complications of Smallpox Vaccine.** Subject to all other terms, conditions, exclusions and limitations of the Plan as set forth in this Evidence of Coverage, coverage is provided for complications resulting from a smallpox vaccination. This benefit is subject to the Deductible, Copayment and Coinsurance specified in the Schedule of Benefits.
- 3.28 **Neurologic Rehabilitation Facility Services.** Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Evidence of Coverage, coverage is provided for Neurologic Rehabilitation Facility services. This benefit is subject to the Deductible, Copayment and/or Coinsurance specified in the Schedule of Benefits. This Neurologic Rehabilitation Facility services benefit is subject to the following conditions:
1. The Subscriber must be suffering from Severe Traumatic Brain Injury;
 2. The admission must be within 7 days of release from a Hospital;
 3. Health Advantage must provide written approval of the admission to the Neurologic Rehabilitation Facility prior to the Subscriber receiving Neurologic Rehabilitation Facility services. **Please note that Prior Approval does not guarantee payment or assure coverage; it means only that the information furnished to us at the time indicates that the proposed services meet the Primary Coverage Criteria requirements set out in Subsection 2.2 and the application of the Primary Coverage Criteria set out in Subsections 2.4.1.b, e., or f. All services, including services receiving Prior Approval, must meet all other coverage terms, conditions, limitations and services received at a Neurologic Rehabilitation Facility receiving Prior Approval may still be limited or denied, if, when the claims for such services are received by us, investigation shows that a benefit exclusion or limitation applies, that the Member ceased to be eligible for benefits on the date the services were provided, that coverage lapsed for non-payment of premium, that out-of-network limitations apply, or any other basis specified in this Evidence of Coverage.**
 4. The Neurologic Rehabilitation Facility services are of a temporary nature with a potential to increase ability to function;
 5. Custodial Care is not covered (See Subsections 4.4.7 and 10.21); and
 6. Coverage is provided for a maximum of 60 days per Member per lifetime.
- 3.29 **Miscellaneous Health Interventions.** Subject to all other terms, conditions, exclusions and limitations of the Plan set forth in this Evidence of Coverage, coverage is provided for the following:
1. **Chelation Therapy.** Chelation therapy is generally not covered, see Subsection 4.3.12. However, subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Evidence of Coverage, chelation therapy for control of ventricular arrhythmias or heart block

- associated with digitalis toxicity, emergency treatment of hypercalcemia, extreme conditions of metal toxicity, including thalassemia intermedia with hemosiderosis, Wilson's disease (hepatolenticular degeneration), lead poisoning and hemochromatosis is covered.
2. **Contraceptive Devices.** Subject to all other terms, conditions, exclusions and limitations of the Plan as set forth in this Evidence of Coverage, coverage is provided for contraceptive devices when prescribed by a Physician. This benefit is subject to the Deductible, Copayment and Coinsurance specified in the Schedule of Benefits.
 3. **Dietary and Nutritional Counseling Services.** Subject to all other terms, conditions, exclusions and limitations of the Plan as set forth in this Evidence of Coverage, and subject to the Deductible, Copayment and Coinsurance specified in the Schedule of Benefits, coverage is provided for dietary and nutritional counseling services when provided in conjunction with Diabetic Self-Management Training, for services needed by Members in connection with cleft palate management and for nutritional assessment programs provided in and by a Hospital and approved by Health Advantage.
 4. **Electrotherapy stimulators.** Treatment using electrotherapy stimulators are generally not covered, see Subsection 4.3.24. However, 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.
 5. **Enteral Feedings.** Enteral feedings are generally not covered, see Subsection 4.3.26. However, enteral feedings are covered when such feedings have been approved and documented by an In-Network Physician as being the Member's sole source of nutrition. Enteral feedings require Prior Approval by Case Management.
 6. **Gastric Pacemaker Coverage.** Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Evidence of Coverage including the Deductible, Copayment and/or Coinsurance set out in the Schedule of Benefits, coverage is provided for gastric pacemakers that receive Prior Approval from Health Advantage. **Please note that Prior Approval does not guarantee payment or assure coverage; it means only that the information furnished to us at the time indicates that the gastric pacemaker meets the Primary Coverage Criteria requirements set out in Subsection 2.2. and the Applications of the Primary Coverage Criteria set out in Subsections 2.4.1.b., e., or f. All services, including any gastric pacemaker receiving Prior Approval, must still meet all other coverage terms, conditions, and limitations, and coverage for any gastric pacemaker receiving Prior Approval may still be limited or denied if, when the claims for the gastric pacemaker are received by us, investigation shows that a benefit exclusion or limitation applies, that the Member ceased to be eligible for benefits on the date services were provided, that coverage lapsed for non-payment of premium, that out-of-network limitations apply, or any other basis specified in this Evidence of Coverage.**
 7. **High Frequency Chest Wall Oscillators.** Subject to all other terms, conditions, exclusions and limitations of the Plan as set forth in this Evidence of Coverage, and subject to the Deductible, Copayment and Coinsurance specified in the Schedule of Benefits, coverage is provided, to Member's age 17 or older with cystic fibrosis, for one high frequency chest wall oscillator during such Member's lifetime.
 8. **Inotropic Agents for Congestive Heart Failure.** Chronic, intermittent infusion of positive inotropic agents for patients with severe congestive heart failure is not covered. See Subsection 4.3.46. However, subject to all terms, conditions, exclusions and limitations of the Plan set forth in this Evidence of Coverage, where the patient is on a cardiac transplant list at a hospital where there is an ongoing cardiac transplantation program, the Plan will cover infusion of inotropic agents.
 9. **Pilot Project Coverage.** Subject to all terms, conditions, exclusions and limitations of the Plan set forth in this Evidence of Coverage, from time to time, Health Advantage may provide coverage of medical interventions that are excluded under the terms of the Plan as set out in this Evidence of Coverage, under terms, conditions, exclusions and limitations of a Company authorized Pilot Program. You can learn the medical interventions that are covered by a Company authorized Pilot Program, and the terms, conditions, exclusions and limitations of such coverage by visiting Health Advantage's website at WWW.HEALTHADVANTAGE-HMO.COM. or by calling Customer Service.

10. **Trans-telephonic Home Spirometry.** Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Evidence of Coverage, trans-telephonic home or ambulatory spirometry is covered for patients who have had a lung transplant.
 11. **Vision Enhancement.** Subject to all other 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 single acquisition of eyeglasses or contact lenses within the first six months following cataract surgery. The Plan does not cover the implantation of a multifocal lens; however, if a multifocal lens is implanted after a cataract extraction, the Plan will pay the Allowance or Allowed Charge for a monofocal lens. With respect to such eyeglasses or contact lenses, tinting or anti-reflective coating and progressive lenses are not covered. See Subsection 3.11.3.
- 3.30 **Autism Spectrum Disorder Benefits.** Subject to all other terms, conditions, exclusions and limitations of the Plan as set forth in this Evidence of Coverage as well as the Deductible, Copayment and/or Coinsurance set out in the Schedule of Benefits, coverage is provided for Members with autism spectrum disorder that is diagnosed by a licensed doctor of medicine or licensed psychologist. Further, subject to Prior Approval from Health Advantage as well as the Deductible, Copayment and/or Coinsurance set out in the Schedule of Benefits, coverage is provided for applied behavior analysis when provided by or supervised by a Board Certified Behavioral Analyst and provided to Members under the age of 18. **Please note that Prior Approval does not guarantee payment or assure coverage; it means only that the information furnished to Health Advantage at the time indicates that the applied behavior analysis meets the Primary Coverage Criteria requirements set out in Subsection 2.2. and the Applications of the Primary Coverage Criteria set out in Subsections 2.4.1.b., e., or f. All services, including any applied behavior analysis receiving Prior Approval, must still meet all other coverage terms, conditions, and limitations, and coverage for any applied behavior analysis receiving Prior Approval may still be limited or denied if, when the claims for the applied behavior analysis are received by Health Advantage, investigation shows that a benefit exclusion or limitation applies, that the Member ceased to be eligible for benefits on the date services were provided, that coverage lapsed for non-payment of premium, that out-of-network limitations apply, or any other basis specified in this Evidence of Coverage.**
- 3.31 **Vision Benefits.** Subject to all other terms, conditions, exclusions and limitations of the Plan as set forth in this Evidence of Coverage as well as the Copayment and/or Coinsurance set out in the Schedule of Benefits, coverage is provided for the following vision benefits.
1. Eye examinations are covered once per Member per 12-month period without charge.
 2. Lenses* are covered once per Member per 12-month period; and
 3. Frames* are covered once per Member per 12-month period; OR
 4. Contact Lenses*, other than disposable lenses, are covered once per Member per 12-month period; OR
 5. Contact Lenses*, disposable lenses, are covered once per Member per 12-month period.
- * Coverage is provided for either contact lenses OR frames and lenses, but not both, during any 12-month period.** Coverage for lenses include standard single vision, bi-focal and tri-focal lenses. Other lens types such as a progressive, shaded, etc. can be purchased at an additional cost. All coverage is subject to the Allowance or Allowable Charge as determined by Health Advantage.

4.0 SPECIFIC PLAN EXCLUSIONS

Even if the Primary Coverage Criteria (See Section 2.0) are met, coverage of a particular service, supply or condition may not be covered under the terms of this Evidence of Coverage. This Section 4.0 describes the conditions, Provider services, Health Interventions and miscellaneous fees or services for which coverage is excluded.

4.1 Other Conditions.

Complications of non-covered treatments. Care, services or treatment required as a result of complications from a treatment or service not covered under this Evidence of Coverage are not covered. This is true even if coverage was provided through a previous carrier.

4.2 **Health Care Providers.**

1. Custodial Care Facility. Services or supplies furnished by an institution which is primarily a place of rest or a place for the aged are not covered. Residential long term care facilities for mental health or eating disorders are not covered. Youth homes or any similar institution are not covered.
2. Freestanding Cardiac Care Facility. Treatment received at a Freestanding Cardiac Care Facility is not covered.
3. Freestanding Residential Treatment Center. Treatment received at a Freestanding Substance Abuse Residential Treatment Center or a Freestanding Psychiatric Residential Treatment Center is not covered.
4. Immediate Relatives. Professional services performed by a person who ordinarily resides in the covered Member's home, including self, or is related to the covered Member as a Spouse, parent, Child, brother or sister, grandparent and grandchild, whether the relationship is by blood or exists in law are not covered.
5. Midwives, Not Certified. Services provided by a midwife who is not a licensed certified nurse midwife in the state where he or she renders services and who does not have a collaborative agreement with a Physician are not covered.
6. Physical Therapy Aide. Services or supplies provided by a physical therapy aide are not covered.
7. Provider, Excluded. Health Interventions received from any Provider who has been excluded from participation in any federally funded program, are not covered.
8. Recreational Therapist. Services or supplies provided by a recreational therapist are not covered.
9. Residents, interns, students or fellows. Services performed or provided by a Hospital resident, intern, student or fellow of any medical related discipline are not covered.
10. Unlicensed Providers or Provider Outside Scope of Practice. Coverage is not provided for treatment, procedures or services received from any person or entity, including but not limited to Physicians, who is required to be licensed to perform the treatment, procedure or service, but (1) is not so licensed, or (2) has had his license suspended, revoked or otherwise terminated for any reason, or (3) has a license that does not, in the opinion of Health Advantage's Medical Director, include within its scope the treatment, procedure or service provided.

4.3 **Health Interventions.**

1. Abortion. Abortion is not covered. However, subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Evidence of Coverage pregnancy terminations under the direction of a Physician are covered, but only when performed in an In-Network Hospital or In-Network Outpatient Hospital setting.
2. Abuse of Medications. Medications, drugs or substances used in an abusive, destructive or injurious manner are not covered, except when caused by a mental or physical illness.
3. Acne Medications. Topical Vitamin A acid, retinoic acid, tretinoin or similar agents for individuals age 26 and above without Prior Approval are not covered.
4. Acupuncture. Acupuncture and services related to acupuncture are not covered.
5. Adoptive Immunotherapy. Adoptive immunotherapy, (lymphokine-activated killer (LAK) therapy, tumor-infiltrating lymphocyte (TIL) therapy, autolymphocyte therapy (ATL)) is not covered.
6. Allergy Testing by Serial Endpoint Titration (SET). Allergy testing by serial endpoint titration (SET) is generally not covered. However, subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Evidence of Coverage, coverage may be provided for SET upon proof that the Member has airborne allergies with such severe reactions that standard allergy testing is considered too dangerous to attempt.
7. Antigen immunotherapy. Antigen immunotherapy for repeat fetal loss is not covered.
8. Behavior/conduct disorders. Services provided for treatment of adolescent behavior or conduct disorders, oppositional disorders or neuroeducational testing are not covered.
9. Bereavement services. Medical social services and outpatient family counseling and/or therapy for bereavement, except if provided as Hospice Care, are not covered.
10. Biofeedback. Biofeedback and other forms of self-care or self-help training, and any related diagnostic testing are not covered for any diagnosis or medical condition.

11. Blood Typing. Blood Typing or DNA analysis for paternity testing is not covered.
12. Chelation therapy. Services or supplies provided as, or in conjunction with, chelation therapy, are generally not covered. Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Evidence of Coverage, chelation therapy for control of ventricular arrhythmias or heart block associated with digitalis toxicity, emergency treatment of hypercalcemia, extreme conditions of metal toxicity, including thalassemia intermedia with hemosiderosis, Wilson's disease (hepatolenticular degeneration), lead poisoning and hemochromatosis is covered. See Subsection 3.29.1.
13. Chemical Ecology. Diagnostic studies and treatment of multiple chemical sensitivities, environmental illness, environmental hypersensitivity disorder, total allergy syndrome or chemical ecology is not covered.
14. Cognitive Rehabilitation. Services or supplies provided as or in conjunction with, Cognitive Rehabilitation are not covered. See Subsection 10.11. However, subject to all terms, conditions, exclusions and limitation of the Plan as set forth in this Evidence of Coverage, coverage is provided for Neurologic Rehabilitation Facility Services for Members with Severe Traumatic Brain Injury. See Subsection 3.28.
15. Compound Medications. Compound Medications are not covered.
16. Compression Garments. All types of compression garments, support hose or elastic supports are not covered even when purchased with a Prescription. However, subject to all terms conditions, exclusions and limitation of the Plan as set forth in this document, coverage is provided for compression garments specifically designed to treat severe burns or compression sleeves and gloves used to treat lymphedemas following mastectomy.
17. Cranial electrotherapy or cranial electromagnetic stimulation devices. Cranial electrotherapy or electromagnetic stimulation devices are not covered.
18. Current Perception Threshold Test. The current perception threshold test or the use of a Nervespace ElectroNeurometer is not covered.
19. Dental Care or orthodontic services. Dental Care and orthodontic services are not covered.
 1. Benefits for Accidental Injury. However, if a Member has an Accidental Injury, benefits will be provided, subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Evidence of Coverage, for Dental Care and x-rays necessary to correct damage to a Non-diseased Tooth or surrounding tissue caused by the Accidental Injury. The Member must seek treatment within 72 hours of injury for services to be covered. Coverage is subject to the Deductible, Copayment and Coinsurance specified in the Schedule of Benefits to a maximum benefit of \$2,000 with the following limitations:
 - i. Only the Non-diseased Tooth or Teeth avulsed or extracted as a direct result of the Accidental Injury and the Non-diseased Tooth or Teeth immediately adjacent will be considered for replacement.
 - ii. Orthodontic services are limited to the stabilization and re-alignment of the accident-involved teeth to their pre-accident position. Reimbursement for this service will be based on a per tooth allowance.
 - iii. Injury to teeth while eating is not considered an Accidental Injury.
 - iv. Double abutments are not covered.
 - v. Any Health Intervention related to dental caries or tooth decay is not covered.
 - vi. Removal of teeth is not covered.
 2. Benefits for dental service. Dental services in connection with radiation treatment for cancer of the head or neck are covered.
 3. Benefits for anesthesia services. Hospital and Ambulatory Surgery Center services and anesthesia services related to dental or orthodontic procedures, including services to children, are covered in accordance with Subsection 3.3.3.
20. Dental Implants. Dental implants of titanium osseointegrated fixtures or of any other material, are not covered regardless of the diagnosis, medical condition, accident or injury.
21. Dietary and Nutritional Services. Any services or supplies provided for dietary and nutritional services, including but not limited to medical nutrition therapy, unless such dietary supplies are the sole source of nutrition for the Member, are not covered. Baby formula or thickening

- agents, whether prescribed by a Physician or acquired over the counter, is not a covered benefit. However, subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Evidence of Coverage, coverage is provided for Medical Foods and Low Protein Modified Food Products for the treatment of phenylketonuria, galactosemia, organic acidemias, fatty acid and oxidative disorders, and disorders of amino acid metabolism. See Subsection 3.24.
22. Dynamic Orthotic Cranioplasty. Dynamic orthotic cranioplasty is not covered.
 23. Eating Disorders. Anorexia, bulimia and services related to eating disorders including long-term rehabilitative services are not covered except as provided in accordance with Subsection 3.9.
 24. 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.
 25. Enhanced External Counterpulsation. Enhanced external counterpulsation (EECP) is generally 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 one course of enhanced external counterpulsation for the treatment of disabling angina in patients who are NYHA Class III or IV, or equivalent classification; who have experienced inadequate control of anginal symptoms with a medication regimen that consists of optimal dosages of platelet inhibitors, beta-blockers, calcium channel blockers, long-acting nitrates, lipid-lowering drugs and antihypertensives when these drugs are appropriate and there is no contraindication to any of these drugs; and who are not amenable to surgical cardiac intervention such as angioplasty or coronary artery bypass grafting. Repeat courses of EECP are not covered.
 26. Enteral Feedings. Enteral feedings are generally not covered. However, subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Evidence of Coverage, enteral feedings are covered when such feedings have been approved and documented by an In-Network Physician as the Member's sole source of nutrition with Prior Approval by Case Management.
 27. Environmental Intervention. Services or supplies used in adjusting a Member's home, place of employment or other environment so that it meets the Member's physical or psychological condition are not covered.
 28. Excessive Use. Excessive use of Medications is not covered. For purposes of this exclusion, each Member agrees that Health Advantage shall be entitled to deny coverage of medications on grounds of excessive use when Health Advantage's medical director, in his sole discretion, determines (1.) that a Member has exceeded the dosage level, frequency or duration of medications recommended as safe or reasonable by major peer-reviewed medical journals specified by the United States Department of Health and Human Services pursuant to section 1861(t)(2)(B) of the Social Security Act, 42 U.S.C. §1395(x)(t)(2)(B), as amended, standard reference compendia or by the Pharmacy & Therapeutics Committee; or (2.) that a Member has obtained or attempted to obtain the same medication from more than one Physician for the same or overlapping periods of time; or (3.) that the pattern of Prescription purchases, changes of Physicians or pharmacy or other information indicates that a Member has obtained or sought to obtain excessive quantities of Medications. Each Member hereby authorizes Health Advantage to communicate with any Physician, health care Provider or pharmacy for the purpose of reviewing and discussing the Member's Prescription history, use or activity to evaluate for excessive use.
 29. Exercise programs. Exercise programs for treatment of any condition are not covered.
 30. Extracorporeal Shock Wave Therapy. Extracorporeal shock wave therapy (ESWT) for any musculoskeletal condition, including but not limited to plantar fasciitis or tennis elbow, is not covered.
 31. Family Planning. The following family planning services are not covered.

- a. reversal of sterilization
 - b. preimplantation
 - c. surrogate mothers
 - d. treatment of infertility
 - e. in vitro fertilization
32. Foot care. Non-custom shoe inserts are not covered. Services or supplies for the treatment of subluxations of the foot, arthroeresis for flat feet, care of corns, bunions, (except capsular or bone surgery), calluses, toe nails, fallen arches, weak feet, chronic foot strain, and symptomatic complaints of the feet are not covered. However, subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Evidence of Coverage, foot care is provided when required for prevention of complications associated with diabetes mellitus.
 33. Fraud or Material Misrepresentation. Health Interventions, including but not limited to Medications, obtained by unauthorized or fraudulent use of the ID card or by material misrepresentation are not covered.
 34. Free Health Interventions. Health Interventions, including but not limited to Medications, provided or dispensed without charge to the Member or for which, normally (in professional practice), there is no charge, are not covered.
 35. Genetic testing. In general, genetic testing to determine: (1) the likelihood of developing a disease or condition, (2) the presence of a disease or condition in a relative, (3) the likelihood of passing an inheritable disease, condition or congenital abnormality to an offspring, (4) genetic testing of the products of amniocentesis to determine the presence of a disease, condition or congenital anomaly in the fetus, (5) genetic testing of a symptomatic Member's blood or tissue to determine if the Member has a specific disease or condition, and (6) genetic testing to determine the anticipated response to a particular pharmaceutical, are not covered.
 However, subject to the terms, conditions, exclusions and limitations of the Plan set forth in this Evidence of Coverage, a limited number of specific genetic tests may be covered for situations (4) or (5) referenced above when the Health Advantage has determined that the particular genetic test (a) is the only way to diagnose the disease or condition, (b) has been scientifically proven to improve outcomes when used to direct treatment, and (c) will affect the individual's treatment plan. A limited number of specific genetic tests may be covered for situation (6) referenced above if criteria (b) and (c) above are met. Health Advantage has full discretion in determining which particular genetic tests may be eligible for benefits as an exception to this exclusion under situations (4), (5) or (6). Any published Health Advantage Coverage Policy regarding a genetic test will control whether or not benefits are available for that genetic test as an exception to this exclusion.
 36. Hair loss or growth. Wigs, hair transplants or any Medication (e.g. Rogaine, minoxidil, etc.) that is taken for hair growth, whether or not prescribed by a Physician, are not covered regardless of the cause of hair loss. Treatment of male or female pattern baldness is not covered.
 37. Health and Behavior Assessment/Intervention. Evaluation of psychosocial factors potentially impacting physical health problems and treatments are not covered. This includes health and behavior assessment procedures used to identify psychological, behavioral, emotional, cognitive, and social factors affecting physical health problems. This does not include psychiatric services.
 38. Hearing or talking aids. Regardless of the reason for the hearing or speech disability, hearing aids, prosthetic devices to assist hearing, or talking devices including special computers are not covered. The testing for, the fitting of or the repair of such hearing aids and prosthetic devices to assist hearing or talking devices is not covered. Additionally, there is no coverage for cochlear implants, auditory brain stem implants or osseointegrated hearing aids.
 39. Heat Bandage. Treatment of a wound with a Warm-up Active Wound Therapy device or a noncontact radiant heat bandage is not covered.
 40. High dose Chemotherapy, Autologous Transplants, Allogeneic Transplants or Nonmyeloablative Allogeneic Stem Cell Transplantation. High dose Chemotherapy, Autologous Transplants, Allogeneic Transplants or Nonmyeloablative Allogeneic Stem Cell Transplantation are not covered except in the limited circumstances set forth in Subsection 3.23.
 41. Hippo Therapy. Hippo therapy is not covered.

42. Home delivery. Services and supplies received in connection with child birth in the home are not covered regardless of the Provider.
43. Home Uterine Activity Monitor. Home uterine activity monitors or their use is not covered.
44. Hypnotherapy. Hypnotherapy is not covered for any diagnosis or medical condition.
45. Illegal Uses. Medications, drugs or substances that are illegal to dispense, possess, consume or use under the laws of the United States or any state, or that are dispensed or used in an illegal manner, are not covered.
46. Inotropic Agents for Congestive Heart Failure. Chronic, intermittent infusion of positive inotropic agents for patients with severe congestive heart failure is not covered. However, subject to all terms, conditions, exclusions and limitations of the Plan set forth in this Evidence of Coverage, where the patient is on a cardiac transplant list at a hospital where there is an ongoing cardiac transplantation program, the Plan will cover infusion of inotropic agents.
47. In Vitro Chemoresistance and Chemosensitivity Assays. In vitro chemoresistance and chemosensitivity assays for neoplastic disease, including but not limited to extreme drug resistance assays, histoculture drug response assay or a fluorescent cytoprint assay are not covered.
48. Laser Treatment of Spinal Intradiscal and Paravertebral Disc Disorders. Laser treatment of spinal intradiscal and paravertebral disc disorders is not covered.
49. Learning Disabilities. Services or supplies provided for learning disabilities, i.e. reading disorder, alexia, developmental dyslexia, dyscalculia, spelling difficulty and other learning difficulties, are not covered.
50. Lost Medications. Replacement of previously filled Prescription Medications because the initial Prescription Medication was lost, stolen, spilled, contaminated, etc. are not covered.
51. Marriage and Family Therapy. Marriage and family therapy or counseling services are not covered.
52. Medical Supplies. Medical Supplies that can be purchased without a prescription or over the counter, whether or not a prescription was obtained, are not covered; for example, medication coated dressings are not covered even with a Physician Prescription. However, subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Evidence of Coverage, Medical Supplies necessary for the management of diabetes mellitus or for home health services are covered. See Subsection 3.12 Medical Supplies, Subsection 3.14 Diabetes Management Services and Section 3.17 Home Health Services. Expenses for Medical Supplies provided in a Physician's office are included in the reimbursement for the procedure or service for which the supplies are used.
53. Medication Therapy Management Services. Medication therapy management services by a pharmacist, including but not limited to a review of a Member's history and medical profile, an evaluation of Prescription Medication, over-the-counter medications and herbal medications, are not covered.
54. Naturopath/Homeopath Treatment. Naturopathic or Homeopathic treatments of any condition are not covered.
55. Off-Label Use. (a) Except as provided in subsection (b) or (c) of this subsection, Prescription Medications that are not approved by the FDA for a particular use or purpose or when used for a purpose other than the purpose for which FDA approval is given are not covered. (b) From time to time a particular clinical use of a Prescription Medication may be determined to be safe and efficacious by the medical director, managed pharmacy director, and/or the Pharmacy and Therapeutics Committee, even without labeling of such indication or use by the FDA. This occurs because of clear and convincing evidence from the Medical Literature, and often in consultation with practicing Physicians of the appropriate specialty in the community. Such "off-label" use will be covered, though Prior Approval is often (but not always) required. Other than the list of Medications requiring Prior Approval cited above, a complete list of Medications and their approved off-label indications is not available. (c) A Prescription Medication approved by the FDA for the treatment of cancer, though not approved to treat the specific cancer for which it has been prescribed, will be covered provided:
 - a. the Prescription Medication has been recognized as safe and effective for treatment of that specific type of cancer in any of the following standard reference compendia, unless the use is identified as "not indicated" or otherwise inappropriate or not recommended,

- in one or more of these standard reference compendia: (A) The American Hospital Formulary Service Drug Information; (B) The National Comprehensive Cancer Network Drugs and Biologics Compendium; (C) The Elsevier Gold Standard's Clinical Pharmacology; or
- b. the Prescription Medication has been recognized as safe and effective for treatment of that specific type of cancer in two (2) articles from Medical Literature that have not had their recognition of the Prescription Medication's safety and effectiveness contradicted by clear and convincing evidence presented in another article from Medical Literature; or
 - c. other authoritative compendia as identified by the Secretary of the United States Department of Health and Human Services or the commissioner may be used to provide coverage by Health Advantage at the Health Advantage's discretion.
56. Oral, Implantable and Injectable Contraceptives. Oral, implantable and injectable contraceptive drugs, and Prescription barrier methods that are not on the Formulary are not covered.
 57. Orthognathic Surgery. The surgical repositioning of segments of the mandible or maxilla containing one to several teeth, or the bodily repositioning of entire jaws, whether to reduce a dislocation of temporomandibular joint or for any other purpose, is 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 the repositioning of the mandible or maxilla after an Injury or the treatment of a tumor. For coverage of Oral Surgery and Reconstructive Surgery, See Subsections 3.19 and 3.21.
 58. Orthoptic, Pleoptic or Vision Therapy. Orthoptic, pleoptic or vision therapy services are generally not covered. However, subject to all terms, conditions, exclusions and limitations of the Plan as set out in this Evidence of Coverage, coverage is provided for office-based orthoptic training in the treatment of convergence insufficiency when supported by the Coverage Policy on Orthoptic Training for the Treatment of Vision and Learning Disabilities.
 59. Over the Counter Medications. Medications (except insulin) which do not by law require a Prescription from a Physician are not covered.
 60. Pain Pump, Disposable. Disposable pain pumps following surgery are not covered.
 61. Percutaneous diskectomy and Radio-frequency Thermocoagulation. Any method of percutaneous diskectomy, including, but not limited to, automated or manual percutaneous diskectomy, laser diskectomy, radiofrequency nucleotomy or nucleolysis, and coblation therapy, is not covered. Radio-frequency Thermocoagulation or Intradiscal electrothermal therapy for discogenic or other forms of back pain are not covered.
 62. Percutaneous Sacroplasty. Percutaneous sacroplasty is not covered.
 63. Peripheral Vascular Disease Rehabilitation Therapy. Peripheral vascular disease rehabilitation therapy is not covered.
 64. Prescription Medication Purchased at a Retail Pharmacy. Prescription Medications purchased at a retail pharmacy are not covered unless the Employer purchases a retail drug benefit rider from Health Advantage.
 65. Prolotherapy. Prolotherapy or Sclerotherapy for the stimulation of tendon or ligament tissue or for pain relief in a localized area of musculoskeletal origin is not covered.
 66. Radio-frequency Thermal Therapy for Treatment of Orthopedic Conditions. The use of radio-frequency thermal therapy for treatment of orthopedic conditions is not covered.
 67. Rest cures. Services or supplies for rest cures are not covered.
 68. Seasonal Affective Disorder (SAD). Use of photo therapy or light therapy to treat seasonal affective disorder or depression is not covered.
 69. Sensory Stimulation for Coma Patients. Sensory stimulation, whether visual, auditory, olfactory, gustatory, cutaneous or kinesthetic, for coma patients is not covered.
 70. Sex changes/sex therapy. Care, services or treatment for non-congenital transsexualism, gender dysphoria or sexual reassignment or change are not covered. This exclusion includes medications, implants, hormone therapy, surgery, medical or psychiatric treatment or other treatment of sexual dysfunction including Prescription Medications and sex therapy.

71. Sexual Dysfunction Medications. Medications used for the treatment of sexual dysfunction, including but not limited to medications for erectile dysfunction, are not covered regardless of the reason(s) for the sexual dysfunction.
72. Short stature syndrome. Any services related to the treatment of short stature syndrome, except for laboratory documented growth hormone deficiency, are not covered.
73. 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.
74. Snoring. Devices, procedures or supplies to treat snoring are not covered.
75. Smoking cessation/Caffeine addiction. Treatment of caffeine or nicotine addiction, smoking cessation Prescription Medication products, including, but not limited to, nicotine gum and nicotine patches are not covered.
76. Sperm and Embryo Storage. Collecting, storing, freezing or thawing of specimens of sperm or embryos for later use is not covered.
77. Substance Addiction. Medications used to sustain or support an addiction or substance dependency are not covered.
78. Tanning equipment or salon. The purchase or rental of tanning equipment, supplies or the services of a tanning salon are not covered.
79. Temporomandibular Joint. Treatment of disease or dysfunction of the temporomandibular joint is not covered, unless the Employer purchases a rider from Health Advantage.
80. Thermography. Thermography, the measuring of self-emanating infrared radiation that reveals temperature variation at the surface of the body, is not covered.
81. Thoracoscopic Laser Ablation of Emphysematous Pulmonary Bullae. Thoracoscopic laser ablation of emphysematous pulmonary bullae is not covered.
82. Transplant procedures. The following transplant procedures and services are not covered:
 - a. Solid organ transplants of any kind are not covered for a Member with a malignancy of any kind that is presently active, in partial remission or in complete remission less than two years. A solid organ transplant of any kind is not covered for a Member that has had a malignancy removed or treated in the 3 years prior to the proposed transplant. For purposes of this section, malignancy includes a malignancy of the brain or meninges, head or neck, bronchus or lung, thyroid, parathyroid, thymus, pleura, esophagus, heart or pericardium, liver, stomach, small or large bowel, rectum, kidney, bladder, prostate, testicle, ovary, uterus, other organs associated with the genito-urinary tract, bones, muscle, nerves, blood vessels, leukemia, lymphoma or melanoma. Exceptions to this non-coverage are (i) hepatocellular carcinoma under certain circumstances, as outlined in the Coverage Policy for hepatocellular carcinoma, and (ii) basal cell and squamous cell carcinomas of the skin, absent lymphatic or distant metastasis.
 - b. Organ transplants not authorized by Coverage Policy are not covered.
83. Ultrasounds. More than one basic level obstetrical ultrasound during Routine Prenatal Care is not covered.
84. Vision enhancement. Any procedure, treatment, service, equipment or supply used to enhance vision by changing the refractive error of the eye is not covered. Examples of non-covered visual 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 other 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 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 separate \$50 maximum Allowance or Allowable Charge when provided within the first six months following cataract surgery. See Subsection 3.11.3.

85. Vitamins or Baby Formula. Vitamins or food/nutrient supplements, except those that are Prescription Medications not available over the counter, are not covered. Baby formula and thickening agents, even if prescribed by a Physician, is 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 Medical Foods and Low Protein Modified Food Products for the treatment of phenylketonuria, galactosemia, organic acidemias, fatty acid and oxidative disorders, and disorders of amino acid metabolism. See Subsection 3.24.
86. Vocational rehabilitation. Vocational rehabilitation services, vocational counseling and testing, employment counseling or services to assist a Member in gaining employment, are not covered.
87. Weight Control. Medications prescribed, dispensed or used for the treatment of obesity, or for use in any program of, weight control, weight reduction, weight loss or dietary control are not covered. Weight loss surgical procedures, including complications relating thereto, are not covered.
88. Whole body computed tomography. Whole body computed tomography is not covered.
89. Wound Treatment. Blood derived growth factors are not covered.

4.4 **Miscellaneous Fees and Services.**

1. Administrative Fees. Fees incurred for acquiring or copying medical records, sales tax, preparation of records for insurance carriers or insurance agencies, medical evaluation for life, disability or any type of insurance coverage are not covered.
2. Appointments. Charges resulting from the failure to keep a scheduled visit with a Physician or other Provider are not covered.
3. Clinical Trials. Services or supplies provided in connection with a phase I, II, III or IV clinical trial or any study to determine the maximum tolerated dose, toxicity, safety, efficacy, or efficacy as compared with a standard means of treatment or diagnosis of a drug, device or medical treatment or procedure are not covered.
4. Comfort items. Personal hygiene or comfort items including but not limited to, spray nozzle, heating pad, heating lamp, hot water bottle, ice cap, television, radio, telephone, guest meals, whirlpool bath, adjustable bed, automobile/van conversion or addition of patient lifts, hand control, or wheel chair ramp, and home modifications such as overhead patient lift and wheelchair ramps are not covered.
5. Cosmetic Services. All services or procedures related to or complications resulting from Cosmetic Services are not covered even if coverage was provided through a previous carrier.
6. Court ordered or third party recommended treatment. Services required or recommended by third parties, including physicals and/or vaccines/immunizations for employment, overseas travel, camp, marriage licensing, insurance, and services ordered by a court or arranged by law enforcement officials, unless otherwise covered by the Plan, are not covered.
7. Custodial Care. Services or supplies for custodial, convalescent, domiciliary or supportive care and non-medical services to assist a Member with activities of daily living are not covered. (See Subsection 10.21, Custodial Care.)
8. Donor services. Services or supplies incident to organ and tissue transplant, or other procedures when the Member acts as the donor are not covered except for Autologous services.

When the Member is the potential transplant recipient, a living donor's hospital costs for the removal of the organ are covered with the following limitations:

- a. Allowance or Allowable Charges for the organ removal as well as any complications resulting from the organ removal are only covered for the period beginning on the day before the transplant to the date of discharge or 39 days, whichever is less.
- b. Services for testing of a donor who is found to be incompatible are not covered.

9. Education Programs. Education programs, including but not limited to physical education programs in a group setting, health club memberships, athletic training, back schools, Work Hardening and Work Integration (Community) training, 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 Diabetes Self-Management Training. See Subsection 3.14.
10. Excess charges. The part of an expense for care and treatment of an illness or Accidental Injury that is in excess of the Allowance or Allowable Charge is not covered.
11. Postage or Delivery Charges. Charges for shipping, packaging, handling or delivering Medications are not separately covered.
12. Prescription Medications used in connection with Health Interventions Not Covered by Plan. Prescription Medications used or intended to be used in connection with or arising from a treatment, service, condition, sickness, disease, injury, or bodily malfunction that is not covered under this Evidence of Coverage, or for which this Evidence of Coverage's benefits have been exhausted, are not covered.
13. Services Received Outside the United States. Services or supplies received outside of the United States of America shall not be covered except at the sole discretion of Health Advantage.
14. Telephone and Other Electronic Consultation. Telephone calls or other forms of electronic consultation (e.g. e-mail, internet or video) between a Provider and a Member, or between a Provider and another Provider, for medical management or coordinating care, are not covered. This includes reporting or obtaining tests or laboratory results. However, subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Evidence of Coverage, communications made by a Physician responsible for the direct care of a Member in Case Management with involved health care Providers are covered.
15. Travel or accommodations. Travel or transportation as a treatment or to receive consultation or treatment, except Ambulance Services covered under Subsection 3.15, are not covered. Accommodations, while receiving treatment or consultation or for any other purpose, are not covered.
16. War. Services or supplies provided for treatment of disease or injuries sustained while serving in the military forces of any nation are not covered.
17. Workers Compensation. Treatment of any compensable injury, as defined by the Workers' Compensation Law is not covered, regardless of whether or not the Member filed a claim for workers' compensation benefits in a timely manner. See Subsection 5.3 Other Plans and Benefit Programs.

5.0 PROVIDER NETWORK AND COST SHARING PROCEDURES

The plan may afford you significant savings if you obtain Health Interventions from In-network Providers. This Section explains the provider network procedures you should follow in order to effectively utilize the services of In-Network Providers, see Subsection 5.1. Under your plan, you are responsible for part of the costs associated with covered services, supplies, equipment and treatment. Your responsibilities are explained in this Section, see Subsection 5.2. Finally, this Section explains how costs of benefits that are covered by another benefit plan are covered by the Plan, see Subsection 5.3.

5.1 Network Procedures

1. **Standard Benefits.** Subject to all terms, conditions, exclusions and limitations of the Plan set forth in this Evidence of Coverage, coverage is provided for Health Interventions you receive from a Provider as defined by the Plan. See Subsection 10.83. This coverage is most effective and advantageous for you when the services of In-Network Providers are used. All Benefits are subject to the Health Advantage Allowance or Allowable Charge.
2. **Primary Care Physician (PCP) Selection.** You are encouraged to select and maintain a patient-physician relationship with your PCP. The PCP selected must be an In-Network Physician listed in the Health Advantage Provider Directory as a PCP and must be accepting Members. You may contact Customer Service to select a PCP or change your PCP. The Provider Directory is available at WWW.HEALTHADVANTAGE-HMO.COM. PCP changes are effective on the first day of the following month. If you change your PCP, any outstanding Referral(s) from a previous PCP will terminate, unless the new PCP reauthorizes such Referral.

3. **Open Access.** This plan is an Open Access Plan, which allows you to receive In-Network benefits for Covered Services provided by In-Network Providers without first having these services authorized, referred or arranged by a PCP.
4. **Point of Service (POS) Option.** This plan is a Point of Service (POS) Plan. A POS Plan allows a Member the option of obtaining Covered Services from an Out-of-Network Provider without first receiving authorization from the Member's Primary Care Physician or Health Advantage. However, the POS option is not as effective or advantageous for you as when the services of In-Network Providers are used. Claims associated with services provided by Out-of-Network Providers may have less advantageous Deductible, Coinsurance and Annual Coinsurance Maximum than claims for services of In-Network Providers. For the definitions and explanation of the terms "Deductible," "Coinsurance," and "Annual Coinsurance Maximum" please refer to Section 10.0 Glossary of Terms and Subsection 5.2.
5. **Out-of-Network Providers.** Reimbursement for services by Out-of-Network Providers generally will be less than payment for the same services when provided by an In-Network Provider and could result in substantial out-of-pocket expense. The Out-of-Network Deductible, Coinsurance and Annual Coinsurance Maximum set forth in the Schedule of Benefits are applied to the Allowance or Allowable Charges for services and supplies you receive from an Out-of-Network Provider, unless:
 - a. **Emergency or Imperative Care Services.** The Intervention is for Emergency Care (see Subsection 10.30) or Imperative Care (see Subsection 10.45) and initial services are provided within forty-eight (48) hours of the onset of the injury or illness, in which case the applicable In-Network Copayment, Coinsurance and Annual Coinsurance Maximum apply;
 - b. **Continuity of Care, Prior to Coverage.** You request coverage by notifying Health Advantage that prior to the effective date of your coverage, you were engaged with an Out-of-Network Provider for a scheduled procedure or ongoing treatment otherwise covered under the terms of this Plan, and that a change from such Out-of-Network Provider for such procedure or treatment would be detrimental to your health. If Health Advantage approves coverage for the scheduled procedure or ongoing treatment, benefits will be provided, subject to applicable In-Network Copayments, Coinsurance and Annual Coinsurance Limit to claims for services and supplies rendered by the Out-of-Network Provider for such condition after Health Advantage's written approval until the procedure or treatment ends or until the end of ninety (90) days, whichever occurs first;
 - c. **Continuity of Care, Pregnancy, Prior to Coverage.** You request coverage by notifying Health Advantage that prior to the effective date of your coverage, you were receiving obstetrical care from an Out-of-Network Provider for a pregnancy otherwise covered under the terms of this Evidence of Coverage, and that you were in the third trimester of your pregnancy on the effective date of your coverage. If Health Advantage approves In-Network coverage for the requested obstetrical care, benefits will be provided, subject to applicable In-Network Copayments, Coinsurance and Annual Coinsurance Limits for services and supplies received from this Out-of-Network Provider after Health Advantage's written approval and will continue to apply to claims for services and supplies rendered by such Out-of-Network Provider until the completion of the pregnancy, including two (2) months of postnatal visits;
 - d. **Provider Leaves Health Advantage Network.** You request coverage by notifying Health Advantage that your Provider was formerly an In-Network Provider when your ongoing treatment for an acute condition covered under the terms of the Plan began and that you request In-Network benefits for the continuation of such ongoing treatment. If Health Advantage approves coverage for the ongoing treatment, benefits will be provided, subject to applicable In-Network Copayments, Coinsurance and Annual Coinsurance Limits for services and supplies rendered by the Out-of-Network Provider for such condition after Health Advantage's written approval until the end of the current episode of treatment or until the end of ninety (90) days, whichever occurs first;
 - e. **Provider Leaves Health Advantage Network, Pregnancy.** You request coverage by notifying Health Advantage that your Provider was formerly an In-Network Provider

when you began receiving obstetrical care for a pregnancy covered under the terms of the Plan, and that you were in the third trimester of your pregnancy on the date that the Provider left the Health Advantage network. If Health Advantage approves coverage for the requested obstetrical care, benefits will be provided, subject to applicable In-Network Copayments, Coinsurance and Annual Coinsurance Limits, for services and supplies received from this Out-of-Network Provider after Health Advantage's written approval and will continue to apply to claims for services and supplies rendered by such Out-of-Network Provider until the completion of the pregnancy, including two (2) months of postnatal visits.

- f. **Out-of-Network Referral.** You request coverage by notifying Health Advantage prior to receiving a Health Intervention and Health Advantage has determined that the required covered services or supplies associated with such Health Intervention are not available from an In-Network Provider and has provided you a written approval of in-network coverage for such services or supplies, applicable In-Network Copayments, Coinsurance and Annual Coinsurance Limit will apply to the claims for the services that you receive from the Out-of-Network Provider.

Notification to Health Advantage of requests for coverage of out-of-network services should be made by writing Health Advantage, Attention: Medical Audit and Review Services, Post Office Box 8069, Little Rock, Arkansas 72203, and should be received at least 15 working days prior to your receipt of such services or supplies. See Section 7.0 for procedures related to urgent care requests.

6. **No Balance Billing from In-Network Providers.** In-Network Providers are paid directly by Health Advantage and have agreed to accept Health Advantage's payment for covered services as payment in full except for applicable Copayments, Coinsurance and any specific benefit limitation, if applicable. **A Member is responsible for billed charges in excess of Health Advantage's payment when Providers who are not In-Network Providers render services. These excess charges could amount to thousands of dollars in additional out of pocket expenses to the Member.**
7. **Provider Directory.** The determination of whether a Provider is In-Network or Out-of-Network is the responsibility of Health Advantage. Health Advantage or your Employer can provide a list of In-Network Providers. You may also obtain a list of In-Network Providers on the Health Advantage web site WWW.HEALTHADVANTAGE-HMO.COM. A Provider's network status may change; therefore You should verify a Provider's status by calling Customer Service at (800) 843-1329 prior to your receipt of services.
8. **Blue Card Program.** Your plan includes the BlueCard program. This program allows you to receive in-network benefits without the provider billing more than the Allowance or Allowable Charge for Covered Services from a Provider located outside of Arkansas, provided such Provider contracts with the local Blue Cross or Blue Shield Company. Your expenses will be limited to the applicable In-Network Deductible, Copayment and Coinsurance. You may verify the BlueCard status of an out of state Provider by calling 1-800-810-2583. For a description of how to file BlueCard claims, refer to Subsection 7.1.10.
9. **Provider Status may Change.** It is possible that you might not be able to obtain services from a particular In-Network Provider. The network of Providers is subject to change. You might find that a particular In-Network Provider may not be accepting new patients. If a Provider leaves the Health Advantage Network or is otherwise not available to you, unless Subsection 5.1.4 applies, you must choose another In-Network Provider to receive In-Network benefits.
10. **Providers may not be In-Network for All Services.** An In-Network Provider's agreement may not include all covered benefits. In particular all services provided at as In-Network Hospital may not be provided by an In-Network Provider; e.g. anesthesia, radiology or laboratory tests. Some In-Network Providers contract with Health Advantage to provide only certain covered benefits, but not all covered benefits. Some Providers choose to be an In-Network Provider for only some Covered Services. Refer to the Provider directory, ask your Provider or contact Customer Service for assistance.
11. **Relation of Health Advantage to Providers.** The relationship between Health Advantage and In-Network Providers is that of independent contractors. Health Advantage is not a provider of health care services but instead offers health plan coverage for services provided by treating provider(s). Health Advantage does not recommend, direct or control delivery of any health

care services. In-Network Providers are not agents or employees of Health Advantage. Neither Health Advantage nor any employee of Health Advantage is an employee or agent of In-Network Providers. Health Advantage shall not be liable for any claim or demand because of damages arising out of, or in any manner connected with, any injuries suffered by the Member while receiving care from any In-Network Provider.

12. **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.

5.2. **Member's Financial Obligations for Allowance or Allowable Charges under the Plan**

1. **Copayment.** In order to receive a Health Intervention from an In-Network Provider, a Member must pay a Copayment, which is expressed as either a dollar amount or a percentage of the Allowances or Allowable Charges in the Schedule of Benefits. Copayments do not count toward the Annual Coinsurance Maximum.
2. **Deductible.** For those covered Health Interventions, which are specified in the Schedule of Benefits as being subject to a Deductible, each Contract Year, before the Plan makes a benefit payment, a Member must pay the cost of a covered service equal to the Annual Deductible specified in the Schedule of Benefits. If the Plan provides family coverage, in order for the Plan to make a benefit payment, the Member who received the health intervention either must have claims for Health Interventions during the Contract Year that meet or exceed the individual Annual Deductible, or the combined claims of the members of the Member's family Health Interventions during the Contract Year must equal or exceed the Annual Family Deductible. No further Deductible will be required for the balance of the year, regardless of what member of the family incurs a claim.
3. **Coinsurance.** Once applicable Copayment and Deductible requirements are satisfied, a Member is responsible for Coinsurance, which is a percentage of the Allowance or Allowable Charges for claims incurred, until the Member's payment equals the Annual Coinsurance Maximum specified in the Schedule of Benefits. After the Annual Coinsurance Maximum is satisfied, subject to the provisions of Subsections 5.2.3.b and 5.2.3.c. of this Evidence of Coverage, the Member will have no further Coinsurance responsibility with respect to the Allowance or Allowable Charges incurred during the balance of the Contract Year for services and supplies received from In-Network or Out-of-Network Providers, as applicable.
 - a. **Determination of Annual Coinsurance Maximum.**
 - i. Health Interventions received from In-Network Providers or in accordance with 5.1.5 of this Evidence of Coverage:
 - (1.) A Member with individual coverage, must incur the Allowance or Allowable Charges for services and supplies from In-Network Providers equal to or exceeding the In-Network Individual Annual Coinsurance Maximum specified in the Schedule of Benefits.

- (2.) If the Plan provides family coverage (coverage other than individual coverage), all the Members in the family will meet the In-Network Family Annual Coinsurance Maximum once any number of Members in the family have collectively incurred Allowed Charges for services and supplies from In-Network Providers that equal or exceed the In-Network Family Annual Coinsurance Maximum specified in the Schedule of Benefits.
 - (3.) Once a Member has satisfied the In-Network Annual Coinsurance Maximum as specified in Subsections 5.2.3.a.i. or ii., the Out-of-Network Coinsurance becomes twenty percent (20%), rather than the percentage set forth in the Schedule of Benefits, unless the Schedule of Benefits or this Evidence of Coverage specifies a different Coinsurance percentage for the particular service or supply that is the subject of the claim.
- ii. Health Interventions received from Out-of-Network Providers.
- (1.) A Member with individual coverage must incur the Allowance or Allowable Charges for services and supplies from Out-of-Network Providers equal to or exceeding the Out-of-Network Individual Annual Coinsurance Maximum specified in the Schedule of Benefits.
 - (2.) If the Plan provides family coverage (coverage other than individual coverage), all the Members in the family will meet the Out-of-Network Family Annual Coinsurance Maximum once any number of Members in the family have collectively incurred Allowed Charges for services and supplies from Out-of-Network Providers that equal or exceed the Out-of-Network Family Annual Coinsurance Maximum specified in the Schedule of Benefits.
- b. **Allowance or Allowable Charges Not Applicable to Annual Coinsurance Maximum.** No Allowance or Allowable Charges paid for services or supplies from Out-of-Network Providers shall accumulate to or be impacted by the satisfaction of the In-Network Annual Coinsurance Maximum, unless Health Advantage determines that the Out-of-Network Provider should be treated as an In-Network Provider in accordance with one of the provisions listed in Subsection 5.1.3. No Allowance or Allowable Charges paid for Mental Health and substance abuse services, Subsection 3.9 or Durable Medical Equipment, Subsection 3.11 shall accumulate to or be impacted by the satisfaction of the In-Network Annual Coinsurance Maximum. No Allowance or Allowable Charges paid for services covered by a copayment shall accumulate to or be impacted by the satisfaction of the In-Network Annual Coinsurance Maximum.
- c. **Allowance or Allowable Charges Not Impacted by the satisfaction of a Annual Coinsurance Maximum.** Allowance or Allowable Charges incurred for treatment of skilled nursing facility service and home health services may be included in the accumulation of Allowance or Allowable Charges for the purpose of meeting the Annual Coinsurance Maximum, but payment for such services shall be limited both to the maximum amounts payable and the Coinsurance percentages set forth in Subsections 3.16 and 3.17, respectively of this Evidence of Coverage.

5.3 Other Plans and Benefit Programs

1. **Coordination of Benefits.** Coordination of Benefits (COB) applies when a Member has coverage under more than one Health Benefit Plan. Health Advantage may annually request that a Member verify the existence of other coverage.
- a. **Definitions.** For purposes of this Subsection 5.3 only, the following words and phrases shall have the following meanings:
- i. "Allowable Expenses" means any necessary, reasonable and customary item of expense at least a portion of which is covered under at least one of the Health Benefit Plans covering the person for whom claim is made. When a Health Benefit Plan provides benefits in the form of coverage for services, the reasonable cash value of each service rendered shall be deemed to be both an Allowable Expense and a benefit paid.

- ii. "Health Benefit Plan" means any of the following which provide coverage for medical care or treatment:
 - (1) Coverage under government programs, including Medicare, required or provided by any statute unless coordination of benefits with any such program is forbidden by law.
 - (2) Group coverage or any other arrangement of coverage for individuals in a group whether on an insured or uninsured basis, including health maintenance organization or other form of group coverage; hospital indemnity benefits in excess of \$200 per day; medical care components of group long-term care contracts; and medical benefits under group or individual automobile contracts.
 - (3) An individually underwritten accident and health insurance policy which reduces benefits because of the existence of other insurance.

The term "Health Benefit Plan" shall be construed separately with respect to:

- (1) Each Policy, contract or other arrangement for benefits or services.
- (2) That portion of any such Policy, contract or other arrangement which reserves the right to take the benefits of other Health Benefit Plans into consideration in determining its benefits and that portion which does not.

- b. Health Advantage shall have the right to coordinate benefits between this Plan and any other Health Benefit Plan covering a Member.

The rules establishing the order of benefit determination between this Evidence of Coverage and any other Health Benefit Plan covering the Member on whose behalf a claim is made are as follows:

- i. The benefits of a Health Benefit Plan which does not have a "coordination of benefits with other health plans" provision shall in all cases be determined and applied to claims before the benefits of this Evidence of Coverage.
- ii. If according to the rules set forth in Subsection c. of this Section, the benefits of another Health Benefit Plan that contains a provision coordinating its benefits with this Plan would be determined and applied, before the benefits of this Plan have been determined and applied, the benefits of such other Health Benefit Plan will be considered before the determination of benefits under this Plan.
- iii. Under no circumstances shall benefits payable and paid under this Plan together with any other Health Benefit Plans exceed the total charge for services a Member received.

- c. **Order of Benefit Determination:** The order of benefit determination as to a Member's claim shall be as follows:

- i. **Non-Dependent or Dependent.** The benefits of a plan which covers the person on whose expenses a claim is based other than as a dependent shall be determined and applied before the benefits of a plan which covers such person as a dependent. (By way of example only, if one Plan [Plan A] covers a person as an employee and the other plan covers the person as a dependent of an employee [Plan B], then Plan A is deemed "primary" and Plan A's benefits will be applied and paid before any consideration of Plan B.)

- ii. **Child Covered Under More Than One Plan.** When the parents of a dependent child are married, the benefits of a plan which covers the person on whose expenses a claim is based as a dependent child of a person whose date of birth, excluding year of birth, occurs earlier in a calendar year, shall be determined before the benefits of a plan which covers such person as a dependent child of a person whose date of birth, excluding year of birth, occurs later in a calendar year. If the other plan does not have the provisions of this paragraph regarding coverage of dependent children of married parents, or if both parents have the same birthday, the plan that has covered either of the parents longer is primary.

The following rules apply to determine the order of benefit determination for a dependent child of parents who are separated or divorced:

- (1) When the parents are separated or divorced and there is a court decree which fixes financial responsibility on one of the parents for the medical, dental, or other health care expenses with respect to the child, the benefits of a plan which covers the child as a dependent of the parent with such financial responsibility shall be determined before the benefits of any other plan which covers the child as a dependent child.
 - (2) When the parents are separated or divorced and the parent with custody of the child has not remarried, if there is no court decree fixing financial responsibility on one of the parents for the medical, dental or other health care expense with respect to the child, the benefits of a plan which covers the child as a dependent of the parent with custody of the child will be determined before the benefits of a plan which covers the child as a dependent of the parent without custody.
 - (3) When the parents are divorced and the parent with custody of the child has remarried, if there is no court decree fixing financial responsibility on one parent for the medical, dental or other health care expense with respect to the child, the benefits of a plan which covers the child as a dependent of the parent with custody shall be determined before the benefits of a plan which covers that child as a dependent of the step-parent, and the benefits of a plan which covers that child as a dependent of the step-parent will be determined before the benefits of a plan which covers that child as a dependent of the parent without custody.
- iii. **Active or Inactive Subscriber.** When paragraphs (i) or (ii) above do not apply so as to establish an order of benefits determination, the plan that covers a person as an employee who is neither laid off nor retired, is primary. The same would hold true if a person is a dependent of a person covered as a retiree and an employee. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored. Coverage provided to an individual as a retired worker and as a dependent of an actively working spouse will be determined under the rule set out in paragraph (i) above.
 - iv. **Continuation coverage.** When paragraphs (i), (ii) or (iii) above do not apply so as to establish an order of benefits determination, if a person whose coverage is provided under a right of continuation provided by federal or state law also is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree (or as that person's dependent) is primary, and the continuation coverage is secondary. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.
 - v. **Longer or Shorter Length of Coverage.** When paragraphs (i), (ii), (iii) or (iv) above do not apply so as to establish an order of benefits determination, the plan that covered the person as an employee, member, subscriber or retiree longer is primary.
 - vi. If the preceding rules do not determine the primary plan, the allowable expenses shall be shared equally between the plans meeting the definition of health benefit plan, Subsection 5.3.1.a.(ii). In addition, this plan will not pay more than it would have paid had it been primary.
2. **Medicare, Military or Government Benefits.** If a Member is a Medicare beneficiary, benefits under the Plan will be determined in accordance with the Medicare Secondary Payer rules. Services and benefits for treatment of military service-connected disabilities to which a Member is legally entitled from a military or government benefit plan shall in all cases be provided before the benefits of this Evidence of Coverage.
 3. **Workers' Compensation.** There are no benefits under this Evidence of Coverage for treatment of any injury which will sustain a claim for damages from Workers' Compensation. This regardless of whether or not the Member filed a claim for workers' compensation benefits.

Health Advantage will presume that if the Member makes a claim for worker's compensation benefits, the injury for which the Member makes any such claim is an injury which will sustain a claim for damages under the Workers' Compensation Law. Therefore, Health Advantage will not be liable for payment of any benefits as to such a claim, unless the full Workers' Compensation Commission finds that the Member's injury was not a compensable injury; and, the finding is not overturned on appeal. The foregoing presumption of non-coverage under this Evidence of Coverage also applies to any case in which the Member's workers' compensation benefits claim is settled by joint petition or otherwise. In this case, no benefits will be paid under this Evidence of Coverage with respect to such a claim, regardless of the settlement amount.

Nor will Health Advantage pay benefits for injury or illness for which the Member receives any benefits under the Workers' Compensation Law, state or federal workers' compensation, employer's liability or occupational disease law, or motor vehicle no-fault law, regardless of any limitations in scope or coverage amount which may apply to the Member's benefits claim under such laws.

In the event that Health Advantage pays any claim by the Member for benefits under this Evidence of Coverage, and subsequently learns that the Member has filed a claim for workers' compensation benefits as to such claim, or that the Member has settled a workers' compensation claim with any workers' compensation carrier, or has otherwise received any amount toward payment of such a claim under the Workers' Compensation Law, state or federal workers' compensation, employer's liability or occupational disease law, or motor vehicle no-fault law, the Member agrees to reimburse Health Advantage to the full extent of its payments on such claim.

4. **Acts of Third Parties (Subrogation/Reimbursement).** If a Member is injured by a third party, Health Advantage is subrogated to all rights the Member may have against any party liable for payment of medical treatment (including any and all insurance carriers) to the extent of payment for the services or benefits provided. The Member must cooperate fully with Health Advantage in its efforts to collect from the third party. See Subsection 5.3.5. Health Advantage may assert its subrogation rights independently of the Member. In addition to the above-referenced subrogation rights, Health Advantage also has reimbursement rights should the Member, or the legal representative, estate or heirs of the Member recover damages by settlement, verdict or otherwise, for an accident, injury or illness. If a recovery is made, the Member shall promptly reimburse the Plan any monetary recovery made by the Member and includes, but is not limited to, uninsured and underinsured motorist coverage, any no-fault insurance, medical payments coverage, direct recoveries from liable parties, or any other source.
5. **Member's Cooperation.** Each Member shall complete and submit to Health Advantage such consents, releases, assignments and other documents as may be requested by Health Advantage in order to obtain or assure reimbursement from other health benefit plan(s), from Medicare, from Workers' Compensation, or through subrogation. Any Member who fails to so cooperate will be liable for and agrees to pay to Health Advantage the amount of funds Health Advantage had to expend as a result of such failure to cooperate and Health Advantage shall be entitled to withhold coverage of or offset future claim payments for benefits, services, payments or credits due under this Evidence of Coverage in order to collect the Member's liability resulting from his or her failure to cooperate.
6. **Health Advantage's Right to Overpayments.** Whenever payments have been made by Health Advantage in a total amount, at any time, in excess of 100% of the amount of payment necessary at that time to satisfy the intent of this Evidence of Coverage, Health Advantage shall have the right to recover such payment, to the extent of such excess, from among one or more of the following as Health Advantage shall determine: any person or persons to, or for, or with respect to whom, such payments were made; any insurance company or companies; or any other organization or organizations to which such payments were made.

6.0 ELIGIBILITY STANDARDS

Even if a Health Intervention you receive would be covered under the other coverage standards of this document, you still must be eligible for benefits under your Plan and your coverage must be in effect at the time you receive such Intervention in order to receive benefits. This Section sets out the standards for eligibility under the Plan, Subsection 6.1; the policies for determining a Member's effective date, Subsection 6.2; policies governing termination of coverage, Subsection 6.3; the options a person who has lost eligibility may have under

state and federal law to continue coverage under the Plan, Subsection 6.4; and the rights a person who has lost eligibility may have to receive a Conversion Plan from Health Advantage, Subsection 6.5.

6.1 **Eligibility for Coverage.** The following provisions outline the eligibility requirements for Subscribers and Dependents by Health Advantage. In order to be covered, you must meet either the requirements for a Subscriber or a Dependent.

1. **Subscriber Coverage.** To be eligible, a Subscriber must:
 - a. complete the required Waiting Period, if applicable;
 - b. be in a class of employees who are included in the Plan; and
 - c. live or work in the BlueCard Service Area.
2. **Dependent Coverage.** Eligible Dependents are the Subscriber's:
 - a. Spouse;
 - b. Child less than 26 years of age;
 - c. unmarried Child who is incapable of self support because of mental retardation or physical disability, provided 1.) such Child is or was under the limiting age of dependency stated in Subsection b. above at the time of application for coverage in the Plan or 2.) if not under such limiting age, has had continuous health plan coverage, i.e. no break in coverage greater than 63 days, at the time of application for coverage in the Plan.

NOTE: Domestic partners are not eligible for coverage as Dependents under this Evidence of Coverage.

3. **Additional Eligibility Requirements for Dependent Coverage.** In order for a Subscriber's Dependent to be eligible for coverage:
 - a. the Subscriber must be eligible for and have coverage; and
 - b. the Dependent must not be in active military service.
4. **Proof of Mental Retardation or Physical Disability.** In order for Dependent coverage to be provided due to mental retardation or physical disability, proof of the Child's dependency and retardation or physical disability must be furnished to Health Advantage prior to the Child's attainment of the applicable limiting age referenced in sections 6.1.2.b. and 6.1.2.c. above. Such proof must at least demonstrate that the Child is unable to obtain or continue a job or position in the course of commerce and that his or her parent(s) are providing 50% or more of his financial support (i.e. are declaring the Child as a dependent on their federal income tax return). Subsequent evaluation for continued retardation or physical disability and dependency may be required by Health Advantage, but not more frequently than once per year. A Subscriber who first becomes eligible under the Plan may enroll a retarded or disabled Dependent Child provided the retardation or disability commenced before the limiting age, and the Child has been continuously covered under a health benefit plan as a Dependent of the Subscriber since before attaining the limiting age. Health Advantage's determination of eligibility shall be conclusive.
5. **Military Duty.** If a Member is called to active duty in the armed services of the United States of America, the Member's (and any covered dependents) coverage may be continued on COBRA for a period of 18 months or under the Uniformed Services Employment and Reemployment Rights Act (USERRA) for a period of 24 months. However, the Member must elect to continue coverage under USERRA within sixty days of activation. A former Member returning from active military service may enroll in the Plan within 90 days of his or her return to employment, provided the Employer continues to sponsor the Plan and payment of premium is timely made. The effective date of coverage for the employee returning from active military service will be the first day of reemployment. Health Advantage may require a copy of the returning member's orders terminating the active duty or other proof of the active duty or termination date thereof.

6.2 **Effective Date of Coverage.** The following provisions outline Health Advantage's policies relative to effective dates of coverage for you and/or your dependents.

1. **Application and Effective Date.** In order for a Subscriber's coverage to take effect, the Group must submit eligibility data for the Subscriber and any Dependents through the Electronic Data Exchange Enrollment mechanism. The effective date(s) of coverage shall be determined in accordance with this Subsection 6.2 and indicated by Health Advantage on the ID card, Schedule of Benefits or letter issued to Members by Health Advantage.

2. **Subscribers and Dependents on Contract Effective Date.** Coverage under this Evidence of Coverage shall become effective on the Group Contract effective date for all Subscribers and Dependents for whom electronic data is submitted and premium is paid during the Initial Open Enrollment Period prior to the Group Contract effective date. Coverage, subject to all other terms, conditions, exclusions and limitations of the Plan, will be extended to an eligible Subscriber or Dependent who is an inpatient in a Hospital on the effective date. This includes any eligible employee or dependent that is confined in a Hospital or other institution.
3. **New Subscriber Effective Date.** If Health Advantage receives a Subscriber's enrollment data within thirty (30) days of the date the Subscriber is first eligible for coverage, the Subscriber's coverage will become effective 12:01 a.m. on the first day the Subscriber is eligible for coverage.
4. **Coverage in the Case of Late Enrollment:** If an employee or an employee's dependent's electronic data is not submitted when initially eligible for coverage, the employee or dependent cannot subsequently obtain coverage, except during a Special Enrollment Period.
5. **Initial Enrollment Period for Existing Dependents:** If the Subscriber has eligible Dependents on the date the Subscriber's coverage begins, the Subscriber's Dependents' coverage will begin on the Subscriber's Effective Date if:
 1. Group submits electronic data for the Subscriber's Dependents' coverage within 30 days of the Subscriber's Effective Date; and
 2. The appropriate premium is timely paid.
6. **Effective Date for Newly Acquired Dependents.** In no event will a Subscriber's Dependent's coverage become effective prior to the Subscriber's effective date. If a Subscriber acquires a new eligible Dependent after the date the Subscriber's coverage begins, coverage for a new Dependent will become effective in accordance with the following provisions:
 - a. **Spouse.** When a Subscriber marries and wishes to have the Subscriber's Spouse covered, the Group shall submit electronic data within 30 days of the date of marriage. The effective date will be the date of marriage and the Spouse will not be a Late Enrollee. If a Group submits electronic data after the 30-day period, coverage for the Spouse will become effective in accordance with the provisions for Late Enrollees. See Subsection 6.2.4, above.
 - b. **Newborn Children.** Coverage for a Subscriber's newborn Child shall become effective as of the Child's date of birth if the Group gives Health Advantage notice by submitting electronic data to Health Advantage for the Child within 90 days of the Child's date of birth and the appropriate premium to cover the newborn Child from the date of birth is paid. If the Group submits the electronic data after the applicable 90-day time period, coverage for the Subscriber's newborn Child will become effective in accordance with the provisions for Late Enrollees. See Subsection 6.2.4, above.
 - c. **Qualified Medical Child Support Order.** If a court has ordered a Subscriber to provide coverage for a Child, coverage will be effective on the first day of the month following the date Health Advantage receives notification of the court order and electronic data from the Group. In the event a court has ordered an employee of the Group who is not covered by the Plan to provide coverage for a child, the employee will be enrolled with the child on the first day of the month following Health Advantage's receipt of a written application or electronic data submission from the Group, a custodial parent of the Child, a child support agency having a duty to collect or enforce support for the Child, or the Child, provided, however that the premium is received when due.
 - d. **Newly Adopted Children.** Subject to payment of all applicable premiums, coverage for a Child placed with a Subscriber for adoption or for whom the Subscriber has filed a petition for adoption, shall begin on the date the Child is placed for adoption or the date of the filing of the petition for adoption, provided electronic data for the Child's coverage is submitted to Health Advantage within 60 days after the placement or the filing of the petition. The coverage shall begin from the moment of birth if the petition for adoption or placement for adoption occurred and the electronic data for coverage is submitted to Health Advantage within 60 days of the Child's birth. If the Group submits electronic data after such 60-day period, coverage for the adopted Child will become effective in accordance with the provisions for Late Enrollees. See Subsection 6.2.4, above. The

coverage shall terminate upon the dismissal, denial, abandonment or withdrawal of the adoption, whichever occurs first.

- e. **Other Dependents.** Electronic data for enrollment received by Health Advantage within 30 days of the date that any other dependent first qualifies as an eligible Dependent will result in coverage for such dependent on the date that electronic data for coverage is received by Health Advantage. Such Dependent will not be a Late Enrollee. If the Group submits the electronic data after the 30 day period, coverage for the Dependent will become effective in accordance with the provisions for Late Enrollees. See Subsection 6.2.4, above.

7. **Special Enrollment Period** is the 30-day period during which time an employee or employee's dependent may enroll in the Plan, after his or her initial Eligibility Date and not be a Late Enrollee. Special Enrollment Periods occur **ONLY** in two instances:

- a. **After the Termination of Another Health Plan.** A Special Enrollment Period occurs (i) after an employee's or dependent's coverage under another health plan terminated as a result of loss of eligibility, or (ii) after the employer providing such other health plan terminated its contributions. The coverage effective date will be the 1st day following loss of prior coverage.
- b. **After the Addition of a Dependent.** A Special Enrollment Period occurs for an employee, employee's spouse or employee's new dependent child (i) after the Subscriber marries, (ii) after a Subscriber's child is born, or (iii) after a Subscriber adopts a child or has a child placed with the Subscriber for adoption. The effective date of coverage shall be governed by the provisions of this Evidence of Coverage concerning addition of a Spouse, a newborn Child or an adopted Child, as applicable.

8. **Medicaid or State Child Health Insurance Program ("CHIP") Special Enrollment Period** is a 60-day period during which time an employee or employee's dependent may enroll in the Plan, after his or her initial Eligibility Date and not be a Late Enrollee. The status of Late Enrollee is important with respect to the Preexisting Condition exclusion. See Subsection 4.1.1. Medicaid or CHIP Special Enrollment Periods occur **ONLY** in two instances:

- a. **After the Termination of Medicaid or CHIP Coverage.** A Medicaid or CHIP Special Enrollment Period begins on the day an employee's or dependent's coverage under Medicaid or CHIP terminates as a result of Loss of Eligibility.
- b. **After Eligibility for Employment Assistance under Medicaid or CHIP.** A Medicaid or CHIP Special Enrollment Period occurs for an employee or employee's dependent who becomes eligible for assistance, with respect to coverage under group health plans or health insurance plans under Medicaid or CHIP (including under any waiver or demonstration project conducted under or in relation Medicaid or CHIP).

6.3 **Termination of Coverage.** The following provisions outline Health Advantage's policies relative to termination of coverage for the Group, you and/or your dependents.

1. **Termination of Coverage.** Coverage is subject to all terms and conditions of the Plan, and coverage will terminate under certain conditions described in various other places throughout this document. If coverage is not terminated under any other provision of this document, coverage for a Member shall terminate if any of the following events occur:

- a. Coverage shall terminate at 12:00 midnight Central time on the date of event when:
 - i. A Subscriber or Member dies.
 - ii. This Plan terminates.
 - iii. The Employer to which the Group Contract is issued, terminates or ceases to sponsor the Plan.
 - iv. The Member ceases to be eligible as a Subscriber or Dependent for any reason.
 - v. The Member is a Dependent Spouse who becomes legally separated or divorced from the Subscriber.
- b. A Member's coverage shall terminate at 12:00 midnight Central Time on the last day of the applicable premium period for which premium was paid if premium is not paid on or before the next premium due date.

2. **Termination of a Member's Coverage for Cause.**
 - a. **Bases for Termination.** Health Advantage may terminate coverage under this Evidence of Coverage, including termination by rescission of all coverage retroactive to the Member's original effective date, upon fifteen (15) days' written notice for:
 - i. concealment of information, misrepresentation (whether intentional or not) or fraud in obtaining coverage; or
 - ii. concealment of information, misrepresentation (whether intentional or not) or fraud in the filing of a claim for services, supplies, or in the use of services or facilities.
 - b. **Concealment or Misrepresentation.** For purposes of this termination for cause provision, concealment of information or a misrepresentation occurs if (i) information is withheld or if incorrect information is provided that is material to the risk assumed by Health Advantage, or (ii) Health Advantage would not have issued this Evidence of Coverage, would have charged a higher premium, or would not have paid a claim in the manner it was paid had Health Advantage known the facts concealed or misrepresented, or (iii) there is a causal relationship between the concealed information or the incorrect information provided and an illness resulting in a claim under this Evidence of Coverage.
 - c. **Termination Effective Date.** Rescission of coverage shall become effective on the Member's original effective date. If Health Advantage elects to terminate the coverage other than by rescission, the termination shall be effective upon the later of (i) fifteen (15) days after a written notice of termination for cause is posted in the U.S. Mail, addressed to the Member at his or her last known address as provided by the Member to Health Advantage; or (ii) the date stated in the termination notice letter to Member.
 - d. **Appeal Procedure.** A Member may appeal a termination for cause. Such an appeal must be submitted in writing, addressed to "Health Advantage—For Cause Appeals, Post Office Box 8069, Little Rock, Arkansas 72203." In order for the appeal to be considered Health Advantage must receive the appeal prior to the later of (i) fifteen (15) days after a written notice of termination for cause is posted in the U.S. Mail, addressed to the Member at his or her last known address as provided by Member to Health Advantage; or (ii) the termination effective date stated in the termination notice letter to Member.
3. **Premium Refunds.** If Health Advantage terminates the coverage of a Member, premium payments received on account of the terminated Member applicable to periods after the effective date of termination shall be refunded to the Employer within 30 days, and Health Advantage shall have no further liability under the Group Policy.
4. **Employer Terminations.** If the Employer terminates coverage of a Member, the Employer must request Health Advantage refund premiums paid for such Member's coverage within 60 days from the effective date of termination of such coverage. Failure of the Employer to make a refund request within 60 days of the effective date of termination of the Member's coverage shall result in the Employer waiving refund of any premiums paid for such coverage. If claims have been paid past the termination date, the payment amount of the claims will be deducted from premium refunds.
5. **Termination of the Group Contract, Impact on Members.** The coverage of all Members shall terminate if the Group Contract is terminated.

6.4 Continuation Privileges

1. **Continuation of Hospital Benefits When Group Contract is Replaced.** If a Member is hospitalized on the date the Group terminates coverage with Health Advantage and replaces the coverage with another company, coverage for the Member will continue until the date the Member is discharged or until benefits under the Plan are exhausted, whichever occurs first.
2. **Continuation Rights under State Law**
 - a. If a Member's employment terminates or dependency status changes the Member shall have the right under state law to elect continuation of coverage under the Plan as outlined below. In order to be eligible for this option, Member must:
 - i. have been continuously covered under this Evidence of Coverage for at least three (3) consecutive months prior to employment termination or change in

- dependency status; and
 - ii. make the election by notifying Health Advantage in writing no later than ten (10) days after the employment termination or change in dependency status.
 - b. Continuation shall terminate on the earliest of:
 - i. one hundred twenty (120) days after the date the election is made;
 - ii. the date the Member fails to make any premium payments or the Employer fails to pay the premium to Health Advantage;
 - iii. the date the Member is or could be covered by Medicare;
 - iv. the date on which the Member is covered for similar benefits under another group or individual contract;
 - v. the date on which the Member becomes eligible for similar benefits under another group Plan;
 - vi. the date on which similar benefits are provided for or available to the Member under any state or federal law; or
 - vii. the date on which the Group Contract terminates.
 - c. If a Member qualifies for continuation of coverage, the Member may elect a conversion contract instead of continuation of group coverage. See Section 6.5 Conversion Privileges. If a Member has elected continuation under this Subsection 6.4.2, the Member shall have the option of conversion coverage at the end of the maximum continuation period.

6.5 Conversion Privileges

1. **Eligibility.** If a Member's coverage under the Plan terminates for any reason other than
 - a. failure to pay any sum required by the Group toward the cost of coverage under this Evidence of Coverage, if any, or
 - b. cause (see Section 6.3.2) or,
 - c. the Group Contract being replaced by a health benefit plan provided by an organization other than Health Advantage, then the Member may apply for a conversion plan issued by Health Advantage if
 - i. the Member is not eligible for Medicare coverage; or
 - ii. the Member is not eligible for coverage under any other group health plan that provides coverage for preexisting conditions.
2. **Benefits.** The Conversion Plan will be provided by Health Advantage at the conversion rates in effect at the time of the conversion. The benefits in the Conversion Plan will not necessarily equal or match those benefits provided in the Group Contract. No evidence of good health or insurability will be required to effect the conversion.
3. **Written Application Deadline.** In order to obtain a Conversion Plan, written application to convert and payment of applicable premium charges must be submitted to the Company within 30 days following the date on which Health Advantage sends the Member a notice of termination of coverage.

7.0 CLAIM PROCESSING AND APPEALS

Health Advantage acting on behalf of the Plan has authority and full discretion to determine all questions arising in connection with your benefits, including but not limited to eligibility, interpretation of Plan language and findings of fact with regard to such questions. The actions, determinations and interpretations of Health Advantage acting on behalf of the Plan with respect to all such matters, and with respect to any matter within the scope of its authority, shall be conclusive and binding on you and the Plan.

In reviewing a claim for benefits, Health Advantage will apply the terms, conditions, exclusions and limitations of the Plan set out in this Evidence of Coverage, including but not limited to the Primary Coverage Criteria, Section 2.0; the specific limitations of the Plan, Section 3.0; the specific plan exclusions, Section 4.0; the cost sharing and Provider network procedures of the Plan, Section 5.0; and the eligibility standards of the Plan, Section 6.0.

This Section 7 sets out the procedures you must follow in submitting a request for coverage, called a "claim for benefits" or a "claim," with your Plan, Subsection 7.1. The section describes procedures you must follow to file oral or written complaints, Subsection 7.2. The section also describes your rights to appeal if a claim for

benefits is denied either in whole or in part, Subsections 7.3 and 7.4. Finally, this section sets out how you may have an Authorized Representative to represent you in submitting claims or appeals, Subsection 7.5.

7.1 Claim Processing.

1. **Claim for Benefits.** "Claim for benefits" means (1) a request for payment for a service, supply, medication, equipment or treatment covered by the Plan or (2) a request for Prior Approval for a service, supply, medication, test, equipment or treatment covered by the Plan where the Plan conditions receipt of payment for such service, supply, medication, equipment or treatment on approval in advance by Health Advantage.
2. **Who May Submit a Claim.** A Member, a Provider with an assignment of the claim that is approved by Health Advantage or the Member's Authorized Representative may submit a claim. See Subsection 7.5 below concerning the Authorized Representative.
3. **Classifications of Claims.** There are four general types of claims for benefits possible under the Plan. The type of claim involved affects the procedures for filing the claim and the timing of the benefit determination by Health Advantage.

- a. **Post-Service Claims.** The most common claim involves post-service benefit determination. Such a claim results when a Member obtains a medical service, medication, supply, test, equipment or other treatment and then, in accordance with the terms of the Plan, the Member or the Member's Authorized Representative submits a claim for benefits to Health Advantage. Examples of post-service claims are claims involving physician office visits, maternity care, outpatient services, and most medications obtained through a managed pharmacy benefit.

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

Post-Service Claims may be submitted electronically in accordance with Health Advantage's electronic claim filing procedures, or such claims may be mailed to Health Advantage Claims Division, Post Office Box 8069, Little Rock, Arkansas 72203. If you fail to disclose your coverage under this Evidence of Coverage which causes the claim to not be filed timely by the Provider of service, you will be fully responsible for charges for services from the Provider.

If Health Advantage is able to process your post-service claim without requesting additional information, it will notify you of its claim determination within 30 days of Health Advantage's receipt of the claim. Health Advantage will forward any payment resulting from the claim determination within 45 days (30 days if the claim is submitted electronically) of Health Advantage's receipt of the claim.

If Health Advantage requires information reasonably necessary to determine whether or to what extent benefits are covered under the Plan, as specified in Subsection 7.1.4. below, Health Advantage will suspend the claim and request the needed information. If you or your treating Provider supplies Health Advantage the required information within ninety (90) days of the claim suspension, Health Advantage will notify you of its claim determination within 15 days after Health Advantage receives such information. Health Advantage will forward any payment resulting from the claim determination within 30 days of Health Advantage's receipt of the required information. If Health Advantage does not receive the required information within the 90-day period, 15 days later, the suspended claim becomes a denied claim, subject to appeal. See Subsection 7.3 Claim Appeals to the Plan.

- b. **Pre-Service Claims.** The terms of the Plan condition receipt of certain benefits on Health Advantage giving approval in advance of the Member obtaining a requested medical service, drug, supply, test or equipment that such medical service, drug, supply, test or equipment meets Primary Coverage Criteria. Examples of some Plan benefits requiring pre-service claims are claims for Hospital and anesthesia services for dental procedures, Subsection 3.3.3; for Advanced Diagnostic Imaging services, Subsection 3.6; Specialty Medications, Subsection 3.22; for most transplants, Subsection 3.23; reduction mammoplasty, Subsection 3.21.5; Out-of-Network Services, Subsection 5.1.4; enteral feedings, Subsection 3.29.5. **Please note that prior**

approval does not guarantee payment or assure coverage; it means only that the information furnished to Health Advantage at the time indicates that the Health Intervention that is the subject of the pre-service claim meets the Primary Coverage Criteria. (See Section 2.0.) A claim receiving prior approval as a pre-service claim must still meet all other coverage terms, conditions, and limitations. Coverage for any such pre-service claim receiving prior approval may still be limited or denied if, when the claimed Intervention is completed and Health Advantage receives the post-service claim(s), investigation shows that a benefit exclusion or limitation applies, that the Member ceased to be eligible for benefits on the date services were provided, that coverage lapsed for non-payment of premium, that out-of-network limitations apply, or any other basis specified in this Evidence of Coverage applies to limit or exclude the claim.

Pre-service claims should be submitted to the Health Advantage Medical Audit and Review Services, FAX (501) 378-6647 or mailed to Post Office Box 3688, Little Rock, Arkansas 72203. If Health Advantage is able to process your pre-service claim without requesting additional information, it will notify you of its determination in a time appropriate for the medical exigencies, but in no case later than 15 days from the date it received the pre-service claim.

If Health Advantage requires information reasonably necessary to determine whether the requested medical service, drug, supply, test or equipment meets the Primary Coverage Criteria under the Plan, Health Advantage will suspend the claim and request the needed information. If you or your treating Provider supplies Health Advantage the required information within ninety (90) days of the claim suspension, Health Advantage will notify you of its claim determination within 15 days after Health Advantage receives such information. If Health Advantage does not receive the required information within the 90-day period, 15 days later, the suspended claim will become a denied claim, subject to appeal. See Subsection 7.3. Claim Appeals to the Plan.

After you have received the Health Intervention that was the subject of an approved pre-service claim, you must submit a post-service claim in accordance with Subsection 7.1.3.a., above.

- c. **Claims Involving Urgent Care.** A claim involving urgent care must be a pre-service claim (See Subsection 7.1.3.b. above) for which a health care professional with knowledge of the claimant's condition certifies that the processing of the claim in the time period for making a non-urgent pre-service claim determination (1) could seriously jeopardize the life or health of the claimant or the ability of the claimant to maintain or regain maximum function, or (2) would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

A claim involving urgent care must be submitted in writing, via mail, facsimile or e-mail, in a format authorized by Health Advantage's claim filing procedures. **A claim involving urgent care must include the medical records pertinent to the urgent condition.**

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

If Health Advantage requires information reasonably necessary to determine whether the requested medical service, drug, supply, test or equipment meets the Primary Coverage Criteria under the Plan, Health Advantage will notify your physician within 24 hours of receiving the claim and request the needed information. If you or your treating Provider supplies Health Advantage the required information within 48 hours, Health Advantage will notify you of its claim determination within 48 hours after Health Advantage receives such information. If Health Advantage does not receive the required information within the 48-hour period, the claim will be denied, subject to appeal. See Subsection 7.3 Claim Appeals to the Plan.

If the urgent care claim is a request to extend previously approved benefit for ongoing treatment, Health Advantage shall make a determination within 24 hours after receipt of

the claim, provided the claim is received at least 24 hours prior to the expiration of the previously approved benefit.

Please note that approval of a claim involving urgent care does not guarantee payment or assure coverage; it means only that the information furnished to Health Advantage at the time indicates that the Health Intervention that is the subject of the claim involving urgent care meets the Primary Coverage Criteria. A Health Intervention receiving prior approval as a claim involving urgent care, must still meet all other coverage terms, conditions, and limitations. Coverage for any such claim may still be limited or denied if, when the claimed Intervention is completed and Health Advantage receives the post-service claim(s), investigation shows that a benefit exclusion or limitation applies, that the Member ceased to be eligible for benefits on the date services were provided, that coverage lapsed for non-payment of premium, that out-of-network limitations apply, or any other basis specified in this Evidence of Coverage applies to limit or exclude the claim.

After you have received the Health Intervention that was the subject of a claim involving urgent care, you must submit a post-service claim in accordance with Subsection 7.1.3.a., above.

- d. **Claims involving Ongoing Care or Concurrent Review.** Health Advantage's termination or reduction of a previously granted benefit under the Plan (other than by Plan amendment or termination) results in a claim involving ongoing care or concurrent review. Health Advantage shall give an explanation of the reduction or termination of a benefit to the Member, as specified in Subsection 7.1.6, with sufficient time prior to the termination or reduction to allow for an appeal under Subsection 7.3.8.d. to be completed before the termination or reduction takes place.

4. **Information Reasonably Necessary to Process a Claim.**

- a. In order to be a claim, the submission must comply with the filing and coding policies and procedures established by Health Advantage. You may request a copy of the claim coding policies and procedures from Health Advantage or from your Provider. If the submission fails to comply with the claim filing or code policies or procedures, Health Advantage shall return the submission to the person that submitted it. If the claim involved is a pre-service claim, the submission shall be returned as soon as possible, but no later than 5 days (24 hours for a claim involving urgent care), and Health Advantage shall indicate on the returned submission the proper procedures to be followed.
- b. In addition to the claim completed in accordance with Health Advantage's claim filing procedures, depending upon the service, supply, medication, equipment or treatment that is the subject of the claim, Health Advantage may require one or more of the following items of information to enable Health Advantage to determine whether or to what extent the claimed benefit is covered by the Plan:
 - i. Information in order to determine if a limitation or exclusion of the Plan is applicable to the claim, or
 - ii. Medical information in order to determine the price for a medical procedure, or
 - iii. Information in order to determine if the Member who received the claimed services is eligible under the terms of the Plan, or
 - iv. Information in order to determine if the claim is covered by another health benefit plan, workers' compensation, a government supported program, or a liable third party, or
 - v. Information in order to determine the obligation of each health benefit plan or government program under coordination of benefits rules, or
 - vi. Information in order to determine if there has been fraud or a fraudulent or material misrepresentation with respect to the claim.

- 5. **Member's Responsibility with Respect to Claim Information.** Before any benefits can be paid, you agree, as a condition of coverage under the Plan, to authorize and direct any Provider of medical services or supplies to furnish to Health Advantage, its agents, or any of its affiliates, upon request, all records, or copies thereof, relating to such services or supplies. Further, as a

condition of your coverage, you agree to authorize the release of such records to any third party review person or entity, for purposes of medical review or second opinion surgery. Finally, as a condition of coverage, you agree to fully and truthfully respond to inquiries from Health Advantage about your claim or condition, including, but not limited to, your other, health benefit coverage, insurance coverage, third party liability, or workers' compensation benefits and to request that any Physician or other Provider respond to all such inquiries. You understand and agree that your failure to respond to inquiries from Health Advantage or failure to cooperate fully to obtain information requested by Health Advantage from your Physician or other health care Provider shall be, by itself, grounds for denial of benefits under the Plan.

6. **Explanation of Benefit Determination.** Upon making a determination of a claim, Health Advantage will deliver to you the following information:
 - a. The specific reason or reasons for the determination with information sufficient to identify the claim involved (including the date of service, the health care provider, the claim amount and a way that the Member may learn the diagnosis and treatment codes and their descriptions);
 - b. Reference to the specific plan provision(s) on which the determination is based;
 - c. A description of any additional information necessary for the claim to be perfected and an explanation of why such information is necessary;
 - d. A description of the Plan's appeal process, see Subsection 7.3 below. If the claim involves urgent care, a description of the expedited appeals process, see Subsection 7.3.10. below.
 - e. If the determination was based in whole or in part on a Health Advantage Coverage Policy an explanation of how to obtain a copy of the Coverage Policy at no cost. See Subsection 2.4.1.f. above.
7. **Informal Claim Review.** If you have questions about an Explanation of Benefit Determination, you may contact Customer Service (Telephone toll free (800) 843-1329, or write Health Advantage, Customer Service, Post Office Box 8069, Little Rock, Arkansas 72203) and ask that the determination be reviewed. Customer Service will respond in like manner with answers to your request. This informal review is not an Appeal (see Subsection 7.3 below) nor a substitute for an appeal. Nor must you ask for an informal review in order to request an appeal.
8. **Benefit Inquiries.** From time to time you or your Provider may want an indication whether a service, supply, medication, equipment or treatment is an eligible benefit of the Plan. You may make a benefit inquiry to Health Advantage Customer Service Division, Post Office Box 8069, Little Rock, Arkansas 72203, or by Telephone to toll free (800) 843-1329.
 - a. A benefit inquiry is not a claim. You should understand that a benefit inquiry is different from a pre-service claim. In the case of a benefit inquiry the Plan does not specify that receipt of the benefit in question is conditioned upon Prior Approval of Health Advantage (see Subsection 7.1.3.b Pre-Service Claims, above).
 - b. **Health Advantage's response to a benefit inquiry is not a guarantee of payment. Health Advantage's ultimate determination of a claim will be based upon the relevant facts as applied to the terms, conditions, limitations and exclusions of the Plan.** A benefit inquiry is not a claim. Health Advantage's response to a benefit inquiry is not a claim determination. Health Advantage's response is based upon the information available to Health Advantage at the time of the inquiry and such information may not be current or accurate. Health Advantage reserves the right to make a final determination of the post-service claim resulting from a Health Intervention that may have been the subject of a benefit inquiry after the Intervention has been completed and all relevant facts are known.
 - c. A benefit inquiry is not subject to appeal.
9. **Member's Responsibility with Respect to Erroneous Claim Payments.** Despite our best efforts, we may make a claim payment which is not for a benefit provided under the Plan, or we may make payment to you when payment should have gone directly to the Provider of treatment or services instead. In the event of an erroneous or mistaken payment, you agree to refund the full amount of such payment to us promptly upon our request. If Health Advantage does not receive the full amount of the refund due, Health Advantage will have the right to offset

future payments made to you or your Provider under this Policy/ Evidence of Coverage or under any other Policy/Evidence of Coverage you have with Health Advantage now or in the future.

10. **Out-of-Arkansas Services**

We have a variety of relationships with other Blue Cross and/or Blue Shield Plans and their Licensed Controlled Affiliates ("Licensees") referred to generally as "Inter-Plan Programs." Whenever you obtain healthcare services outside of our service area, the State of Arkansas, the claims for these services may be processed through one of these Inter-Plan Programs.

Typically, when accessing care outside our service area, you will obtain care from healthcare providers that have a contractual agreement (i.e., are "participating providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, you may obtain care from non-participating healthcare providers. Our payment practices in both instances are described below.

We cover only limited healthcare services received outside of our service area. As used in this Subsection, 7.1.10 "Out-of-Area Covered Healthcare Services" include only emergency care or urgent care obtained outside the geographic area we serve. Any other services will not be covered when processed through any Inter-Plan Programs arrangements. These "other services" must be provided or authorized by your primary care physician ("PCP").

a. **BlueCard[®] Program**

i. Under the BlueCard[®] Program, when you obtain Out-of-Area Covered Healthcare Services within the geographic area served by a Host Blue, we will remain responsible for fulfilling our contractual obligations. However the Host Blue is responsible for contracting with and generally handling all interactions with its participating healthcare providers.

ii. The BlueCard Program enables you to obtain Out-of-Area Covered Healthcare Services, as defined above, from a healthcare provider participating with a Host Blue, where available. The participating healthcare provider will automatically file a claim for the Out-of-Area Covered Healthcare Services provided to you, so there are no claim forms for you to fill out. You will be responsible for the member copayment amount, as stated in your Evidence of Coverage.

b. **Emergency Care Services:** If you experience a Medical Emergency while traveling outside the Health Advantage service area, go to the nearest Emergency or Urgent Care facility. Whenever you access covered healthcare services outside our service area and the claim is processed through the BlueCard Program, the amount you pay for covered healthcare services, if not a flat dollar copayment, is calculated based on the lower of:

- The billed covered charges for your covered services; or
- The negotiated price that the Host Blue makes available to us.

i. Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to your healthcare provider. Sometimes, it is an estimated price that takes into account special arrangements with your healthcare provider or provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of healthcare providers after taking into account the same types of transactions as with an estimated price.

ii. Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price we use for your claim because they will not be applied retroactively to claims already paid.

iii. Laws in a small number of states may require the Host Blue to add a surcharge to your calculation. If any state laws mandate other liability calculation methods, including a surcharge, we would then calculate your liability for any covered healthcare services according to applicable law.

c. **Non-Participating Healthcare Providers Outside of Our Service Area, the State of Arkansas**

- i. **Your Liability Calculation.** When Out-of-Area Covered Healthcare Services are received from non-participating healthcare providers, the amount you pay for such services will generally be based on either the Host Blue's non-participating healthcare provider local payment or the pricing arrangements required by applicable state law. In these situations, you will be liable for the difference between the amount that the non-participating healthcare provider bills and the payment we will make for the covered services as set forth in this Evidence of Coverage.
- ii. **Exceptions.** In certain situations, we may use other payment bases, such as a billed covered charges, the payment we would make if the healthcare services had been obtained within our service area, or a special negotiated payment, as permitted under the Inter-Plan Programs Policies, to determine the amount we will pay for services rendered by nonparticipating healthcare providers. In these situations, you may be liable for the difference between the amount that the non-participating healthcare provider bills and the payment we will make for the covered services as set forth in this Evidence of Coverage.

7.2 Complaints

1. **Definition.** A complaint is an expression of dissatisfaction about Health Advantage.
2. **Oral Complaints.** A Member having a complaint regarding any aspect of Health Advantage may contact a Customer Service Representative toll free at 1-800-843-1329 who will assist in resolving the matter informally. If the Member is not satisfied with the resolution, a written complaint may be submitted. A Member is not required to make an oral complaint prior to submitting a written complaint.
3. **Written Complaints.** Health Advantage will acknowledge receipt of a written complaint within 5 working days. Health Advantage will investigate the complaint and send the Member a response with resolution. If Health Advantage is unable to resolve the written complaint within 30 calendar days due to circumstances beyond its control, Health Advantage will provide notice of the reason for the delay before the 30th calendar day.

7.3 Claim Appeals to the Plan (Internal Review).

1. **Legal Actions.** Prior to initiating legal action, you must file an appeal of your claim in accordance with this Subsection 7.3. No legal action shall be brought after the expiration of three (3) years from the time that a claim is required to be submitted.
2. **Who May Request a Review.** A Member or the Member's Authorized Representative may file an appeal to request a review of a claim denial. See Subsection 7.5 concerning the Authorized Representative.
3. **Where and When (Deadline) to Submit an Appeal.** If a claim for benefits is denied either in whole or in part, you will receive a notice explaining the reason or reasons for the denial. See Subsection 7.1.6, above. You may request a review of a denial of benefits for any claim or portion of a claim by sending a request marked "Appeal Request" to Health Advantage, Attention: Member Response Coordinator, Post Office Box 8069, Little Rock, Arkansas 72203. Your request must be made within one hundred eighty (180) days after the initial adverse determination. You may contact the Health Advantage Member Response Coordinator toll free at (800) 843-1329 for assistance in making an appeal.
4. **Appeals Subject to Direct External Review.**
Health Advantage may waive internal review of any claim determination. If Health Advantage waives internal review, Health Advantage shall defer the claim for external review in accordance with Section 7.4 below.
5. **Two Levels of Review.** Health Advantage provides two levels of review.
 - a. **First Level Review.** The First Level Reviewer, a person located at the Health Advantage, conducts the first level review.
 - b. **Second Level Review.** If the outcome of the first level review is adverse, you may appeal to the second level. The request for a second level appeal must be made within 60 days after you have been notified of the result of the first level review. The Second Level Appeal Committee, a committee that meets at the Health Advantage Office located at 320 West Capitol Avenue, Suite 300, Little Rock, Arkansas, conducts the second level review. You have a right to appear in person or attend via teleconference

to supplement the written appeal and respond to the Second Level Appeal Committee's questions.

6. **Documentation.**

- a. **Written Appeals.** You must submit your appeal in writing. However, an appeal related to a claim involving urgent care may initially be submitted orally. Although Health Advantage will immediately commence consideration of an oral appeal, the Health Advantage requires written confirmation of the appeal.
- b. **Appellant's Right to Information.** Health Advantage shall provide you free of charge and sufficiently in advance of the date of the final internal adverse benefit determination to give you a reasonable opportunity to respond, reasonable access to, and copies of, all documents, records or other information that:
 - i. were relied upon in making the benefit determination;
 - ii. were submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record or other information was relied upon in making the benefit determination;
 - iii. demonstrate compliance with the terms of the Plan; or
 - iv. constitute a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for the your diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.
- c. **Appellant's Right to Submit Information.** You may submit with your request for review any additional written comments, issues, documents, records and other information relating to your claim.
- d. **Appeals Reviewer's Right to Information.** You and the treating health care professional are required to provide the Appeals Reviewer, upon request, access to information necessary to determine the appeal. Such information should be provided not later than five (5) days after the date on which the Appeals Reviewer's request for information is received, or, in the case of a claim involving urgent care or concurrent review, at such earlier time as may be necessary to comply with the applicable timelines. See Subsections 7.3.8.c. and d. Your failure to provide access to such information shall not remove the obligation of the Appeals Reviewer to make a determination on the appeal, but the Appeals Reviewer determination may be affected if such requested information is not provided.

7. **Conduct of Review.**

- a. **Scope of Review.** The Appeals Reviewer shall conduct a complete review of all information relating to the claim and shall not afford deference to the initial claim determination in conducting the review.
- b. **Qualifications of Appeals Reviewer.** The Appeals Reviewer is an individual or committee with appropriate expertise who is neither the individual who denied the claim that is the subject of the appeal, nor the subordinate of such individual.
- c. **Review of Medical Judgment.** When reviewing a claim in which the determination was based in whole or in part on medical judgment, including determinations with regard to the application of the Primary Coverage Criteria or a Coverage Policy, the Appeals Reviewer shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. Such health care professional shall not be an individual that was consulted in the initial claim determination, nor the subordinate of such individual. The Appeals Reviewer shall, upon request, provide the identity of health care professional(s) consulted in conducting the review, without regard to whether the health care professional's advice was relied upon in making the benefit determination.

8. **Timing of Appeal Determination.**

- a. **Post-Service Claim.** The Appeals Reviewer at each level of appeal shall render a decision on an appeal related to a post-service claim within a reasonable period of time, but notification of the Appeals Reviewer's determination shall be provided to you not later than thirty (30) days after the Health Advantage Member Response Coordinator received the appeal.

- b. **Pre-Service Claim.** The Appeals Reviewer at each level of appeal shall render a decision and provide notification of the decision on an appeal related to a pre-service claim in accordance with the medical exigencies of the case and as soon as possible, but in no case later than fifteen (15) days after the date the Health Advantage Member Response Coordinator received the appeal.
 - c. **Claims Involving Urgent Care.** If you request an expedited review, and a health care professional certifies that determination as a general pre-service claim would seriously jeopardize your life or health or your ability to regain maximum function, the Appeals Reviewer at both levels of appeal shall make a determination on review in accordance with the medical exigencies of the case and as soon as possible, but in no case later than 72 hours after the time the Health Advantage Member Response Coordinator initially receives the request for review. See Subsection 7.3.10., below.
 - d. **Concurrent Care Determination.** The Appeals Reviewer shall administer an appeal involving concurrent care in accordance with Subsections 7.3.8.a., b. or c. depending upon whether the claim is a post-service claim, a pre-service claim or a claim involving urgent care.
9. **Notification of Determination of Appeal to Plan.** The Appeals Reviewer shall provide notice of the review determination in a printed form and written in a manner calculated to be understood by the claimant. The notice shall include:
- a. The specific reason or reasons for the review determination with information sufficient to identify the claim involved (including the date of service, the health care provider, the claim amount and a way that the Member may learn the diagnosis and treatment codes and their descriptions);
 - b. reference to the specific plan provision(s) on which the review determination is based;
 - c. a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of all documents, records, and other information Relevant to the Claim for benefits;
 - d. a statement that any internal rule, guideline, protocol or other similar criterion relied upon by the Plan is available upon request and free of charge;
 - e. a statement describing the voluntary external review procedures offered by the Plan; and
 - f. a statement of the claimant's right to bring an action under the Employee Retirement Income Security Act of 1974.
10. **Expedited Appeal Procedure.** An appeal of a claim involving urgent care or of a claim involving ongoing care is conducted in accordance with this Subsection 7.3.10. Note that submission to the Appeals Reviewer may be done electronically, FAX No. (501) 212-8518, e-mail: APPEALS@HEALTHADVANTAGE-HMO.COM. In accordance with Subsection 7.3.6.a., an expedited appeal may be submitted by telephone, toll free (800) 843-1329, followed by a written confirmation. Please refer to Subsection 7.3.6.d. with respect to submission of information concerning a claim involving urgent care or concurrent review to the Appeals Reviewer. In accordance with Subsection 7.3.8.c., the Appeals Reviewer will notify you and your treating health care professional of the determination of your expedited appeal in accordance with the medical exigencies of the case and soon as possible, but in no case later than 72 hours after the Appeals Reviewer receives the expedited appeal.

7.4 Independent Medical Review of Claims (External Review)

- 1. **Claim Appeals Subject to External Review.**
 - a. **Waiver of Internal Review.** If we have waived internal review, your appeal shall be to external review in accordance with this Section 7.4.
 - b. **Application of Primary Coverage.** If your claim has not been the subject of a prior external review and if we have denied your claim in whole or in part because the intervention did not meet the Primary Coverage Criteria (other than under the conditions outlined in Subsections 2.4.1.a., b., c. or d.) or because of the application of a Coverage Policy, you may request an independent medical review by an Independent Review Organization in accordance with the provisions of this Subsection 7.4 provided:
 - i. The claim denial was upheld in whole or in part as a result of the Plan's internal review process, or

- ii. You have not requested or agreed to a delay in the Plan's internal review process and the Appeals Coordinator has not given you notification of the determination involving a pre-service claim appeal within thirty (30) days following receipt of your appeal to the Plan; or
 - iii. You have not requested or agreed to a delay in the Plan's internal review process and the Appeals Coordinator has not given you notification of the determination involving a post-service claim appeal within sixty (60) days following receipt of your appeal to the Plan; or
 - iv. Your claim meets the requirements for expedited external review, (see Subsection 7.3.10) and you have simultaneously submitted an appeal to the Plan.
- 2. **Where and When to Submit External Review Appeal.** You may request external review by submitting a request for external review to the Arkansas Insurance Commissioner, 1200 West Third Street, Little Rock, Arkansas 72201 or by calling 1-800-282-9134. Your request must be made within four (4) months after you were notified that the claim denial was upheld in whole or in part as a result of the Plan's internal review process. If Subsection 7.4.1.b.ii. or 7.4.1.b.iii. apply, your request may be made at the end of the thirty (30) day period or sixty (60) day period. If Subsection 7.4.1.b.iv. applies, you must file your request for external review at the same time you file your appeal to the Plan.
- 3. **Independent Review Organization and Independent Medical Reviewer**
 - a. **The Arkansas Insurance Commissioner** shall determine if the claim is subject to external review, and if he so determines, assign an Independent Review Organization from the list of approved Independent Review Organizations compiled and maintained by the Commissioner.
 - b. **The Independent Review Organization** is not affiliated with, owned by or controlled by Health Advantage. Health Advantage pays a reasonable fee to the Independent Review Organization to conduct the review, but such fee is not contingent upon the determination of the Independent Review Organization or Independent Medical Reviewer.
 - c. **An Independent Medical Reviewer** is a physician that is licensed in one or more States to deliver health care services and typically treats the condition or illness that is the subject of the claim under review. The Independent Medical Reviewer is not a Subscriber of Health Advantage and does not provide services exclusively for Health Advantage or for individuals holding insurance coverage with Health Advantage. The Independent Medical Reviewer has no material financial, familial or professional relationship with Health Advantage, with the Plan Administrator, with an officer or director of Health Advantage or the Plan Administrator, with the claimant or the claimant's Authorized Representative, with the health care professional that provided the intervention involved in the denied claim; with the institution at which the intervention involved in the denied claim was provided; with the manufacturer of any drug or other device used in connection with the intervention involved in the denied claim; or with any other party having a substantial interest in the denied claim.
- 4. **Documentation**
 - a. **Written Appeals.** You must submit your appeal in writing in a form and in a manner determined by the Arkansas Insurance Commissioner. You may submit with your request for review any additional written comments, issues, documents, records and other information relating to your claim.
 - b. **Authorization to Release Information.** In filing your request for external review, you must include the following authorization: "I, [Member's name], authorize HMO Partners Inc. d/b/a Health Advantage and my healthcare Provider(s) to release all medical information or records pertinent to this claim to the Independent Review Organization that is designated by Health Advantage. I further authorize such Independent Review Organization to release such medical information to any Independent Medical Reviewer(s) selected by the Independent Review Organization to conduct the review."
- 5. **Referral of Review Request to an Independent Review Organization.** Upon receipt of the documentation set out in Subsection 7.4.4, the Arkansas Insurance Commissioner shall

- immediately refer the request for external review, along with Health Advantage's initial determination of the claim and the Appeals Coordinator's internal review determination (if applicable) to an Independent Review Organization.
6. **Independent Review Organization Right to Information.** You and your treating health care professional are required to provide the Independent Review Organization and the Independent Medical Reviewer(s), upon request, access to information necessary to determine the appeal. Access to such information shall be provided not later than seven (7) business days after the date on which the request for information is received.
 7. **Rejection of Request for Review by the Independent Review Organization.** The Independent Review Organization shall reject a request for review and notify you, your Authorized Representative and the Appeals Reviewer in writing within five (5) business days (or within 72 hours for an Expedited Appeal) of its determination, if it determines that the appeal does meet the standards for an appeal for external review. See Subsections 7.4.1.
 8. **Rejection of the Review for Failure to Submit Requested Information.** The Independent Review Organization may reject a request for review if:
 - a. you have not provided the authorization for release of medical records or information pertinent to the claim required by Subsection 7.4.4.b; or
 - b. you or your health care professional have not provided information requested by the Independent Review Organization in accordance with Subsection 7.4.6.
 9. **Independent Medical Review Determination.** If the Independent Review Organization does not reject the request for review in accordance with Subsections 7.4.7 or 7.4.8, it shall assign the request for review to an Independent Medical Reviewer. Such Independent Medical Reviewer shall make a determination after reviewing the documentation submitted by you, your health care professional and Health Advantage. The Independent Medical Reviewer shall consider the terms of the Evidence of Coverage to assure that the reviewer's decision is not contrary to the terms of the Plan. In making the determination the reviewer need not give deference to the determinations made by Health Advantage or the recommendations of the treating health care professional (if any).
 10. **Timing of Appeal Determination.**
 - a. **Standard Review.** The Independent Medical Reviewer shall complete a review on an appeal within a reasonable period of time, but in no case later than forty five (45) days after the Independent Review Organization received the appeal.
 - b. **Expedited Review.** If you request an expedited review, and a health care professional certifies that the time for a standard review would seriously jeopardize your life or health or your ability to regain maximum function, the Independent Medical Reviewer shall make a determination on review in accordance with the medical exigencies of the case and as soon as possible, but in no case later than 72 hours after the time the Independent Review Organization received the request for review.
 11. **Notification of Determination of Independent Medical Review.**
 - a. **Recipients of Notice.** Upon receipt of the determination of the Independent Medical Reviewer, the Independent Review Organization shall provide written notification of the determination to you, you health care Provider and Health Advantage.
 - b. **The Notification shall include.**
 - i. A general description of the reason for the request for external review;
 - ii. The date the Independent Review Organization was notified by Health Advantage to conduct the review;
 - iii. The date the external review was conducted;
 - iv. The date of the Independent Medical Reviewer's determination;
 - v. The principal reason(s) for the determination;
 - vi. The rationale for the determination; and
 - vii. References to the evidence or documentation, including practice guidelines, considered in the determination.
 12. **Expedited External Review.**
 - a. **Requirement for Expedited Review.** You may submit a pre-service claim denial or a denial of a claim involving concurrent care for an expedited external review provided

your health care professional certifies that the time to complete a standard review would seriously jeopardize your life or health or your ability to regain maximum function.

- b. **Expedited External Review without prior Appeal to Plan (internal review).** You may request an expedited review at the same time you submit a request for an appeal to the Plan (internal review) if your health care professional certifies that the time to complete the Plan's expedited appeal process would seriously jeopardize your life or health or your ability to regain maximum function. If you make such a request, the Independent Review Organization may determine and notify you in accordance with Subsections 7.4.10.b and 7.4.11 whether you will be required to complete the internal review process.
 - c. **Same procedures as standard external review.** Unless otherwise specified, the provisions of this Section 7.4 applicable to independent medical review of claims apply to expedited external review of claims.
13. **Other Rights under Plan.** Your decision to submit an appeal to external review will have no effect on your other rights and benefits under the Plan.
 14. **Arkansas Insurance Commissioner.** You may contact the Arkansas Insurance Commissioner for assistance. The mailing address is Arkansas Insurance Department, Attention External Review Assistance, 1200 West Third Street, Little Rock, Arkansas 72201. The telephone number is 501-371-2640 or toll free 800-282-9134. The e-mail address is insurance.consumers@arkansas.gov.
 15. **Binding on the Plan.** The determination of an Independent Review Organization and an Independent Medical Reviewer is binding on both the Plan and you, except to the extent that other remedies are available under applicable federal or state law.

7.5 Authorized Representative

1. **One Authorized Representative.** A Member may have one representative, and only one representative at a time, to assist in submitting a claim or appealing an unfavorable claim determination.
2. **Authority of Authorized Representative.** An Authorized Representative shall have the authority to represent the Member in all matters concerning the Member's claim or appeal of a claim determination. If the Member has an Authorized Representative, references to "You" or "Member" in this document refer to the Authorized Representative.
3. **Designation of Authorized Representative.** One of the following persons may act as a Member's Authorized Representative:
 - a. An individual designated by the Member in writing in a form approved by Health Advantage;
 - b. The treating Provider, if the claim is a claim involving urgent care, or if the Member has designated the Provider in writing in a form approved by Health Advantage;
 - c. A person holding the Member's durable power of attorney;
 - d. If the Member is incapacitated due to illness or injury, a person appointed as guardian to have care and custody of the Member by a court of competent jurisdiction; or
 - e. If the Member is a minor, the Member's parent or legal guardian, unless Health Advantage is notified that the Member's claim involves health care services where the consent of the Member's parent or legal guardian is or was not required by law and the Member shall represent himself or herself with respect to the claim.
4. **Communication with Authorized Representative.**
 - a. If the Authorized Representative represents the Member because the Authorized Representative is the Member's parent or legal guardian or attorney in fact under a durable power of attorney, Health Advantage shall send all correspondence, notices and benefit determinations in connection with the Member's claim to the Authorized Representative.
 - b. If the Authorized Representative represents the Member in connection with the submission of a pre-service claim, including a claim involving urgent care, or in connection with an appeal, Health Advantage shall send all correspondence, notices and benefit determinations in connection with the Member's claim to the Authorized Representative.

- c. If the Authorized Representative represents the Member in connection with the submission of a post-service claim, Health Advantage will send all correspondence, notices and benefit determinations in connection with the Member's claim to the Member, but Health Advantage will provide copies of such correspondence to the Authorized Representative upon request.
5. **Term of the Authorized Representative.** The authority of an Authorized Representative shall continue until
- a. the claim(s) or appeal(s) for which the Authorized Representative was designated has been fully adjudicated; or
 - b. the Member is legally competent to represent himself or herself and notifies Health Advantage that the Authorized Representative is no longer required.

8.0 NOTICE OF PHYSICIAN INCENTIVES

Health Advantage regularly enters into contracts with In-Network Physicians to provide Professional Services to Members. The purpose of this Section 8.0 is to provide Members information about the incentive arrangements between Health Advantage and In-Network Physicians.

8.1 **Definitions.** The following definitions are used in this Section 8.0:

- 1. **"Negotiated Fee-For-Service"** means a pre-determined amount for each service an In-Network Provider provides. In-Network Providers and Health Advantage agree to the Negotiated Fee-For-Service. This amount may be different from the amount the In-Network Provider usually receives from other payers.
- 2. **"Capitation"** means a set dollar payment per patient per unit of time (usually per month) paid to a Physician to cover a specified set of services and administrative costs without regard to the actual number of services provided. Services to which Capitation may be applied include a Physician's own services, referral services and other services. At present, Health Advantage Capitation is limited to services provided directly by In-Network Physicians, i.e. there is no Capitation for referral services.
- 3. **"Medical Trends"** means the percentage increase or decrease in total medical claims (excluding pharmacy claims) received by Health Advantage in a given year, as compared to the previous year, actuarially adjusted for changes in benefits and sex/age ratios.

8.2 **Health Advantage In-Network Provider Incentives.** Health Advantage pays providers using both Capitation and Negotiated Fee-For-Service arrangements. At the end of each year, if medical costs are below what was budgeted by agreement between Health Advantage and participating In-Network Providers, then Health Advantage, In-Network Physicians and In-Network Hospitals share in the surplus, based upon a settlement formula described in the applicable provider contracts.

8.3 **Individual Physician's Incentives Not Tied to Referral Practices.** An individual In-Network Physician does not make or lose money under his or her contract with Health Advantage based upon referral practices. Referral practices are evaluated as part of an overall reimbursement plan for groups of In-Network Physicians, and thus, referral practices could indirectly affect the level of reimbursement for a group of In-Network Physicians in some cases. For example, if, as a group, all In-Network Physicians in a given geographic area have fewer expenses than expected, they may share in any surplus amount. If, however, the In-Network Physicians incur more expense than the budgeted amount, they are not required to "make up" the difference; Health Advantage would absorb this loss.

8.4 **Medical Trends Physician Incentives.** In some parts of Arkansas, but not necessarily in the whole State, Health Advantage may offer incentives to encourage Physicians to practice medicine in a cost-effective manner. Physicians located in part of the Service Area may be entitled to incentive payments in the event that Medical Trends for that part of the Service Area are lower than Medical Trends for the Service Area as a whole for a given year. The incentive payments will be calculated based on a percentage of the total medical claims received from the Physicians practicing in that part of the Service Area and will reflect the lower Medical Trends for that part of the Service Area.

8.5 **Incentive Arrangements Subject to Change.** The incentive arrangements described here concern the provider contracts in place and regularly used by Health Advantage at the time this Evidence of Coverage was issued. Because of the rapid pace of change in health care financing in today's marketplace, physician negotiating positions, regulatory changes, or other developments, the precise content of Health Advantage provider reimbursement and incentive plans may change significantly in the future.

- 8.6 **Pharmacy Incentives.** In some parts of the Service Area, but not necessarily in the whole Service Area, Health Advantage may offer incentives to encourage In-Network Physicians to inform and educate patients regarding the costs of Prescription Medications and, where appropriate in the physician's independent medical judgment, to write prescriptions for Prescription Medications listed as Second Tier on the Health Advantage Formulary or for Generic Medications (First Tier), in lieu of other Prescription Medications. Physicians will be encouraged to discuss available alternatives with their patients, including First Tier or Second Tier medications, use of which will reduce the patient's out-of-pocket costs for Copayments and/or Coinsurance.
- 8.7 **For Further Information.** You may ask your Physician's administrative staff about compensation methods, including incentives, which apply to the services provided by their Physician or request information from Health Advantage by writing to Health Advantage, Post Office Box 8069, Little Rock, Arkansas 72203.

9.0 OTHER PROVISIONS

The following information is important in the administration of the Plan.

- 9.1 **Assignment of Benefits.** No assignment of benefits under this Evidence of Coverage shall be valid until approved and accepted by Health Advantage. Health Advantage reserves the right to make payment of benefits, in its sole discretion, directly to the Provider of service or to you.
- 9.2 **Right of Rescission.** The performance of an act or practice constituting fraud or intentional misrepresentation of material fact may be used by Health Advantage as the basis for rescission of coverage of the Contract Holder, any Subscriber or any Dependent.
- 9.3 **Claim Recoveries.** There may be circumstances in which Health Advantage recovers amounts paid as claims expense from a Provider of services, from a Member or from a third party. Such circumstances include rebates paid to Health Advantage by pharmaceutical manufacturers based upon amounts of claims paid by Health Advantage for certain specified pharmaceuticals, amounts recovered by Health Advantage from health care Providers or pharmaceutical manufacturers through certain legal actions instituted by Health Advantage relating to the claims expense of more than one Member, recoveries by Health Advantage of overpayments made to health care Providers or to Members, and recoveries from other parties with whom Health Advantage contracts or otherwise relies upon for payment or pricing of claims. The following rules govern Health Advantage's actions with respect to such recoveries:
1. In the event that such a recovery relates to a claim paid more than two years before the recovery, no adjustment will be made to any Deductible or Coinsurance paid by a Member and Health Advantage shall be entitled to retain such recoveries for its own use.
If the recovery relates to a claim paid within two years and is not otherwise addressed in this subsection, Deductibles and Coinsurance amounts for a Member will be adjusted if affected by the recovery.
 2. Only recoveries made within two years of the date of the error by Health Advantage or overpayments to health care Providers or to Members by Health Advantage will be applied for the purpose of group rating or divisible surplus calculation, if applicable. The cost actually paid by Health Advantage to procure such recoveries will be treated as an administrative expense in considering group rating or divisible surplus, if applicable.
 3. In the event Health Advantage receives from pharmaceutical manufacturers rebates based upon amounts of claims paid for certain specified pharmaceuticals, Health Advantage shall be entitled to retain such rebates for its own use, and no adjustments will be made to claims paid or to Deductibles or Coinsurance amounts paid by a Member.
 4. If a Member is no longer covered by Health Advantage at the time of any such recovery, regardless of the amount or of the time of such recovery, Health Advantage shall be entitled to retain such recovery for its own use.
 5. If such recovery amounts cannot be attributed on an individual basis, because of having been paid as a lump sum settlement for less than the total amount of claims expense of Health Advantage or otherwise, no adjustments will be made to any Deductible or Coinsurance amounts paid by the Member and Health Advantage shall be entitled to retain such recovery for its own use.
- 9.4 **Amendment.** Health Advantage reserves the right to change the benefits, conditions and premiums covered under the Group Contract, including the terms of this Evidence of Coverage. If we do so, we will give thirty (30) days written notice to your Employer or its agent and the change will go into effect on

the date fixed in the notice. No agent or employee of Health Advantage may change or modify any benefit, term, condition, limitation or exclusion of this Contract. Any change or amendment must be in writing and signed by an officer of Health Advantage.

10.0 GLOSSARY OF TERMS

These are terms used in this Group Policy and Evidence of Coverage.

- 10.1 **Accidental Injury** is defined as bodily injury (other than intentionally self-inflicted injury) sustained by a Member while the coverage is in force, and which is the direct cause of the loss, independent of disease or bodily infirmity. Injury to a tooth or teeth while eating is not considered an Accidental Injury.
- 10.2 **Advanced Diagnostic Imaging** means Computed tomography scanning ("CT SCAN"), Magnetic Resonance Angiography or Imaging ("MRA/MRI"), Nuclear Cardiology and positron emission tomography scans ("PET SCAN").
- 10.3 **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, the 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, Allowances 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 an 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 the 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.

- 10.4 **Ambulance Service** means surface or air transportation in a regularly equipped ambulance licensed by an appropriate agency and where the use of any other means of transportation is not medically indicated. All services provided by the ambulance personnel, including but not limited to, the administration of oxygen, medications, life support, etc. are included in the specific Evidence of Coverage limitation applied to ambulance benefits per Contract Year.
- 10.5 **Ambulatory Surgery Center** means a distinct entity that operates exclusively for the purpose of providing surgical services to patients not requiring hospitalization
- 10.6 **Annual Coinsurance Maximum** means the amount of the Allowance or Allowable Charges a Member must incur for claims in a Contract Year before the Member is relieved of the obligation to pay Coinsurance for the remainder of the Contract Year. The Annual Coinsurance Maximum is set forth in the Schedule of Benefits.
- 10.7 **Brand Name Medication** means any Prescription Medication that has a patented trade name separate from its generic or chemical designation.

- 10.8 **Case Management** is a program in which a registered nurse employed by Health Advantage, known as a Case Manager, assists a Member through a collaborative process that assesses, plans, implements, coordinates, monitors and evaluates options and health care benefits available to a Member. Case management is instituted at the sole option of Health Advantage when mutually agreed to by the Member and the Member's Physician.
- 10.9 **Chemotherapy** means therapy for the treatment of a malignant neoplastic disease by chemical agents. High dose Chemotherapy is Chemotherapy several times higher than the standard dose for malignant disease (as determined in recognized medical compendia) and which would automatically require the addition of drugs and procedures (e.g., Granulocyte Colony-Stimulating Factor, Granulocyte-Macrophage Colony-Stimulating Factor, re-infusion of stem cells, re-infusion of autologous bone marrow transplantation, or allogeneic bone marrow transplantation) in any patient who received this high dose Chemotherapy, to prevent life-threatening complications of the Chemotherapy on the patient's own progenitor blood cells.
- 10.10 **Child** means a Subscriber's natural Child, legally adopted Child or Stepchild. "Child" also means a Child that has been placed with the Subscriber for adoption. "Child" also means a Child for whom the Subscriber must provide medical support under a qualified medical child support order or for whom the Subscriber has been appointed the legal guardian.
- 10.11 **Cognitive Rehabilitation** means a treatment modality designed specifically for the remediation of disorders of perception, memory and language in brain-injured persons. Services or supplies provided as or in conjunction with, Cognitive Rehabilitation are not covered. See Subsection 4.3.14.
- 10.12 **Coinsurance** means the obligation of a Member to pay a portion of an Allowance or Allowable Charge. Coinsurance is expressed as a percentage in the Schedule of Benefits. The Schedule of Benefits sets forth the Coinsurance for services or supplies received from an In-Network Provider and the Coinsurance for services and supplies from Out-of-Network Providers. NOTE: Because the contract between Health Advantage and an In-Network Provider may include risk sharing arrangements that may involve a portion of the In-Network Provider's compensation or fees being withheld at the time the claim is paid the actual Coinsurance percentage for which a Member is responsible on any given claim may be higher than the percentages stated in the Schedule of Benefits. The actual Coinsurance percentage is dependent upon the year-end settlement or periodic adjustments between the In-Network Provider and Health Advantage.
- 10.13 **Compound Medication** means a non FDA approved medication prescribed by a Physician that is admixed by a pharmacist using multiple ingredients which may or may not be FDA approved individually. FDA approved medications that exist as separate components and are intended for reconstitution prior to administration are not Compound Medications.
- 10.14 **Contract Holder** means the Employer that established and maintains the Plan, as shown in the Application of the Group Enrollment Contract.
- 10.15 **Contract Month** means a month commencing on the first day of a calendar month and expiring on the last day of that calendar month or commencing on the fifteenth day of a month and expiring on the fourteenth day of the following month, depending upon the billing cycle applied by Health Advantage.
- 10.16 **Contract Year** means the twelve consecutive month period commencing on the Group Contract effective date and ending on the day before the anniversary of that effective date.
- 10.17 **Copayment** means the amount required to be paid to an In-Network Provider by or on behalf of a Member in connection with Covered Services. Copayments are listed in the Schedule of Benefits.
- 10.18 **Cosmetic Service** means any treatment or corrective surgical procedure performed to reshape structures of the body in order to alter the individual's appearance or to alter the manifestation of the aging process. Breast augmentation, mastopexy, breast reduction for cosmetic reasons, otoplasty, rhinoplasty, collagen injection and scar reversals are examples of Cosmetic Services. Cosmetic Services also includes any procedure required to correct complications caused by or arising from prior Cosmetic Services. Cosmetic Services do not include the following services in connection with a mastectomy resulting from cancer: (a) reconstruction of the breast on which the cancer-related surgery has been performed, and (b) surgery to reconstruct the other breast to produce a symmetrical appearance. The following procedures performed on a child age 12 years and under are not considered Cosmetic Services: correction of a cleft palate or cleft lip, removal of a port-wine stain or hemangioma on the face, correction of a non-dental congenital abnormality.
- 10.19 **Coverage Policy** means a statement developed by Health Advantage that sets forth the medical criteria for coverage under a Health Advantage Evidence of Coverage. Some limitations of benefits related to

coverage, of a drug, treatment, service equipment or supply are also outlined in the Coverage Policy. A copy of a Coverage Policy is available from Health Advantage, at no cost, upon request, or a Coverage Policy can be reviewed on Health Advantage's web site at WWW.HEALTHADVANTAGE-HMO.COM.

- 10.20 **Covered Services** means services for which a Member is entitled to benefits under the terms of this Group Policy and Evidence of Coverage.
- 10.21 **Custodial Care** means care rendered to a Member (1) who is disabled mentally or physically and such disability is expected to continue and be prolonged, and (2) who requires a protected, monitored, or controlled environment whether in an institution or in a home, and (3) who requires assistance to support the essentials of daily living, and (4) who is not under active and specific medical, surgical, or psychiatric treatment that will reduce the disability to the extent necessary to enable the patient to function outside the protected, monitored, or controlled environment. A custodial determination is not precluded by the fact that a Member is under the care of a supervising or attending Physician and that services are being ordered or prescribed to support and generally maintain the Member's condition, or provide for the Member's comfort, or ensure the manageability of the Member. Further, a Custodial Care determination is not precluded because the ordered and prescribed services and supplies are being provided by an R.N., L.P.N., or L.V.N. or the ordered and prescribed services and supplies are being performed in a Hospital, Nursing Home, a skilled nursing facility, an extended care facility or in the home. The determination of Custodial Care in no way implies that the care being rendered is not required by the Member; it only means that it is a type of care that is not covered under this Evidence of Coverage.
- 10.22 **Deductible** means the amount of out of pocket expense a Member must incur for Covered Services each Contract Year before any expenses are paid by Health Advantage under the Plan. This amount is calculated from Allowance or Allowable Charges, not the billed charges. Once the Deductible has been met, subject to all other terms, conditions, limitations and exclusions in the Plan, payment for Covered Services begins.
- 10.23 **Dental Care** means the treatment or repair of the teeth, bones and tissues of the mouth and defects of the human jaws and associated structures and shall include surgical procedures involving the mandible and maxilla where such is done for the purpose of correcting malocclusion of the teeth or for the purpose, at least in part, of preparing such bony structure for dentures or the attachment of teeth, artificial or natural. Generally, hospital services and administration of anesthetic in connection with Dental Care are not covered except in limited circumstances, as provided in Subsection 3.3.3.
- 10.24 **Dependent** means any member of a Subscriber's family who meets the eligibility requirements of Section 6.0, who is enrolled in the Group, and for whom Health Advantage has received premium.
- 10.25 **Diabetes Self-Management Training** means instruction, including medical nutrition therapy relating to diet, caloric intake and diabetes management (excluding programs the primary purpose of which is weight reduction) which enables diabetic patients to understand the diabetic management process and daily management of diabetic therapy as a means of avoiding frequent hospitalizations and complications when the instruction is provided in accordance with a program in compliance with the National Standards for Diabetes Self-Management Education Program as developed by the American Diabetes Association.
- 10.26 **Dose Limitation** means a limitation in the number of doses of a Prescription Medication in a single prescription or a limit in the number of doses over a defined period of time. For example, a Dose Limitation for a particular medication may be set at no more than 10 doses in a dispensed prescription and no more than 20 doses during a 30-day period.
- 10.27 **Durable Medical Equipment (DME)** means equipment which (1) can withstand repeated use; and (2) is primarily and customarily used to serve a medical purpose; and (3) generally is not useful to a person in the absence of an illness or injury; and (4) is appropriate for use in the home.
- 10.28 **Electronic Data Exchange Enrollment** means the process by which a Group submits eligibility data electronically to Health Advantage for the purposes of adding, deleting or modifying Health Advantage's enrollment records. Electronic data submitted to Health Advantage will be relied upon in determining eligibility, effective dates and termination dates of coverage under the terms of the employee health benefit plan.
- 10.29 **Eligibility Date** means:
For a Subscriber, the latest of the following dates:
1. the policy effective date for a Subscriber who has selected coverage; or
 2. the date the required Waiting Period is completed for any Subscriber added after the policy

effective date.

For a Dependent, the latest of the following dates:

1. the date the Subscriber becomes eligible for coverage under the Plan;
2. the date a person becomes a Dependent; or
3. the date this policy is amended to include the Subscriber's class as being eligible for Dependent coverage.

- 10.30 **Emergency Care** means health care services required to evaluate and treat medical conditions of a recent onset and severity, including, but not limited to, severe pain that would lead a prudent lay person, possessing an average knowledge of medicine and health, to believe that a condition, sickness, or injury is of such a nature that failure to get immediate medical care could result in (i) placing the patient's health in serious jeopardy; (ii) serious impairment to bodily functions; or (iii) serious dysfunction of any bodily organ or part. In order to qualify as Emergency Care, health care services must be sought within forty-eight (48) hours of the onset of the illness or Accidental Injury.
- 10.31 **Emergency Prescription** means any Prescription Medication prescribed in conjunction with Emergency Care and deemed necessary by a Physician to be immediately needed by the Member.
- 10.32 **Employer** means a sole proprietorship, partnership, or corporation which is the Contract Holder. Employer and Group shall have a common meaning when used herein.
- 10.33 **Evidence of Coverage** means this document containing the benefits, conditions, limitations and exclusions of the Group Contract plus the Schedule of Benefits and any amendments signed by an Officer of Health Advantage.
- 10.34 **Formulary** means a specified list of Prescription Medications covered by Health Advantage. The Formulary is established by Health Advantage based upon recommendations from the Pharmacy and Therapeutics Committee, a committee including practicing Arkansas Physicians and practicing Arkansas pharmacists, as well as the medical director and pharmacy director of Health Advantage. Prescription Medications on the Formulary are classified into one of three tiers. Prescription Medications in the first tier are Generic Medications. Prescription Medications in the second and third tiers are Brand Name Medications. The list of Prescription Medications that make up the Formulary and the tier classification of a Prescription Medication on the Formulary are subject to change by Health Advantage. In determining whether to place a Prescription Medication on the Formulary or to place a Prescription Medication in a tier classification in the Formulary, Health Advantage compares a Prescription Medication's safety, effectiveness, cost efficiency and uniqueness with other Prescription Medications in the same category. **Prescription Medications including new Prescription Medications approved by the FDA are not covered under this Evidence of Coverage unless or until Health Advantage places the medication on the Formulary.**
- 10.35 **Freestanding Facility** means an entity that furnishes health care services and that is neither integrated with, nor a department of, a Hospital. Physically separate facilities on the campus of a Hospital are considered freestanding unless they are integrated with, or a department of, the Hospital. Examples of Freestanding Facilities include, but are not limited to, Free-Standing Cardiac Care Facilities and Free-Standing Residential Treatment Centers. Ambulatory Surgery Centers performing covered services provided in 3.4 are not considered Freestanding Facilities. Laboratories are not considered Freestanding Facilities.
- 10.36 **Full-Time Employment**, full-time active Subscriber, and like terms, mean a job with the Employer:
1. on a permanent and active basis;
 2. for compensation; and
 3. for at least thirty (30) hours a week, forty-eight (48) weeks per year.
- 10.37 **Generic Medication** means any US Food and Drug Administration ("FDA") approved, chemically identical, reproduction of a Brand Name Medication for which the patent has expired. A Prescription Medication must have a price at least twenty percent (20%) lower than the Brand Name Medication in order to qualify as a Generic Medication for reimbursement purposes.
- 10.38 **Group** means the Employer or party that has entered into a Group Contract with Health Advantage under which Health Advantage will cover Health Interventions for eligible Subscriber's and their Dependents.
- 10.39 **Group Contract** or **Contract** means the contract between Health Advantage and the Employer and any attachments thereto, including this Evidence of Coverage, the Group Application, the Enrollment Application, Change Forms and any attachments, riders, endorsements or amendments, whereby

Health Advantage coverage for Subscribers and their Dependents is elected.

- 10.40 **Health Intervention or Intervention** means an item, Medication or service delivered or undertaken primarily to diagnose, detect, treat, palliate or alleviate a medical condition or to maintain or restore functional ability of the mind or body.
- 10.41 **Home Health Agency** means an organization, licensed by the appropriate regulatory authority, which has entered into an agreement with Health Advantage to render home health services to Members.
- 10.42 **Homeopathic** means healing the underlying cause of disease not simply eliminating the symptoms caused by the disease. Some forms of homeopathic treatment may include, but are not limited to diet therapy, environment services, minimum doses of natural medications. Homeopathic treatments are not covered. See Subsection 4.3.54.
- 10.43 **Hospice Care** means an autonomous, centrally administered, medically directed, coordinated program providing a continuum of home, outpatient and home-like inpatient care for the terminally ill patient and family. Hospice Care provides palliative and supportive care to meet the special needs arising out of the physical, emotional, spiritual, social and economic stresses which are experienced during the final stages of illness and during dying and bereavement.
- 10.44 **Hospital** means an acute general care Hospital, a Psychiatric Hospital and a Rehabilitation Hospital licensed as such by the appropriate state agency. It does not include any of the following, unless required by applicable law or approved by the Board of Directors of Health Advantage: Hospitals owned or operated by state or federal agencies, convalescent homes or Hospitals, homes for the aged, sanitariums, long term care facilities, infirmaries, or any institution operated mainly for treatment of long-term chronic diseases.
- 10.45 **Imperative Care** means care for an unexpected illness or injury that can not be delayed until the Member consults with his or her Primary Care Physician.
- 10.46 **In-Network Provider** means a Provider who has signed a Contract with Health Advantage to provide the services covered by this Evidence of Coverage to Health Advantage Members. Health Advantage pays an In-Network Provider directly.
- 10.47 **Laboratory** means an entity furnishing biological, microbiological, serological, chemical, immunohematological, hematological, biophysical, cytological, pathological or other examination of materials derived from the human body for the purpose of providing information for the diagnosis, prevention, or treatment of any disease or impairment of, or the assessment of the health of, human beings. These examinations also include procedures to determine, measure or otherwise describe the presence or absence of various substances or organisms in the body. Entities only collecting or preparing specimens (or both) or only serving as a mailing service and not performing testing are not considered laboratories.
- 10.48 **Late Enrollee** means a Member whose electronic data submitted by the Group for coverage was received by Health Advantage other than during:
1. the first period in which the Member is eligible to enroll in the Plan; or
 2. a Special Enrollment Period.
- 10.49 **Long Term Acute Care** means the medical and nursing care treatment of medically stable but fragile patients over an extended period of time, anticipated to be at least 25 days. Long Term Acute Care includes, but is not limited to treatment of chronic cardiac disorders, ventilator dependent respiratory disorder, post-operative complications and total parenteral nutrition (TPN) issues.
- 10.50 **Low Protein Modified Food Products** means a food product that is specifically formulated to have less than one (1) gram of protein per serving and intended to be used under the direction of a Physician for the dietary treatment of phenylketonuria, galactosemia, organic acidemias and disorders of amino acid metabolism.
- 10.51 **Maintenance Medication** means a specific Prescription Medication: 1.) for ongoing therapy of a chronic illness; and 2.) that has been designated as a Maintenance Medication by Health Advantage. You may obtain a list of Maintenance Medications by calling Customer Service.
- 10.52 **Medical Food** means a food that is intended for the dietary treatment of phenylketonuria, galactosemia, organic acidemias and disorders of amino acid metabolism for which nutritional requirements are established by recognized scientific principles and formulated to be consumed or administered enterally under the direction of a Physician.
- 10.53 **Medical Supply or Supplies** means an item which (1) is consumed or diminished with use so that it cannot withstand repeated use; and (2) is primarily or customarily used to serve a medical purpose; and (3) generally is not useful to a person in the absence of an illness or injury.

- 10.54 **Medicare** means the two programs cited as the "Health Insurance for the Aged Act," Title I, Part I, of Public Law 89-97, as amended. Part A refers to Hospital insurance. Part B refers to supplementary medical insurance.
- 10.55 **Member** means a Subscriber or Dependent who is covered under the Group Contract.
- 10.56 **Mental Illness** means and includes (whether organic or non-organic, whether of biological, non-biological, chemical or non-chemical origin, and irrespective of cause, basis or inducement) mental disorders, mental illnesses, psychiatric illnesses, mental conditions, and psychiatric conditions. This includes, but is not limited to, psychoses, neurotic disorders, schizophrenic disorders, affective disorders, personality disorders, and psychological or behavioral abnormalities associated with transient or permanent dysfunction of the brain or related neurohormonal systems. (This is intended to include only illnesses classified on Axes I and II in the current edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association, Washington, D.C.)
- 10.57 **Naturopathic** means a system of therapeutics in which neither surgical or medicine agents are used, dependence placed only on natural (non-medicinal) focus. Naturopathic treatments are not covered. See Subsection 4.3.54.
- 10.58 **Neurologic Rehabilitation Facility** means an institution licensed as such by the appropriate state agency. A Neurological Rehabilitation Facility must:
1. be operated pursuant to law;
 2. be accredited by the Joint Commission on Accreditation of Healthcare Organizations and the Commission on Accreditation of Rehabilitation Facilities;
 3. be primarily engaged in providing, in addition to room and board accommodations, rehabilitation services for Severe Traumatic Brain Injury under the supervision of a duly licensed Physician (M.D. or D.O.); and
 4. maintain a daily progress record for each patient.
- 10.59 **Non-Diseased Tooth** means a tooth that is whole or properly restored, and is free of decay and/or periodontal conditions.
- 10.60 **Open Enrollment Period** means the time period annually, during the month designated by the Employer and set forth in the Group Contract when employees who are eligible for coverage may enroll in the Plan. During the Open Enrollment Period, Subscribers covered in the Plan may change their coverage, and that of their covered Dependents. If the Open Enrollment Period is not designated in the Group Contract, it is the month period preceding the anniversary date of the Group Contract.
- 10.61 **Outpatient Care** means all care received including services, supplies and Medications in a Physician's office, Outpatient Surgery Center, x-ray or Laboratory, the Member's home or at a Hospital where the Member receives services but is not admitted to the Hospital.
- 10.62 **Outpatient Hospital** means a portion of a Hospital which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services by, or under the supervision of, a Physician to patients admitted for a variety of medical conditions.
- 10.63 **Outpatient Psychiatric Center** means a facility licensed by the appropriate state agency as such.
- 10.64 **Outpatient Surgery Center or Radiation Therapy Center** means a facility licensed as such by the appropriate state agency.
- 10.65 **Outpatient Therapy Visit** means one unit of therapeutic service (usually one hour or less) provided by licensed Provider(s). An Outpatient Therapy Visit may include services provided by more than one Provider and in the case of physical therapy. Any physical therapy or occupational therapy modality, regardless of who provides the service, is included in the visit limit. Outpatient therapy visit applies to therapy provided in a physician's office or in a physical therapy setting.
- 10.66 **Out-of-Area Services** mean those services provided outside the Service Area in a location outside the state of Arkansas where covered medical services are not available through In-Network Providers. See Subsection 7.1.10 Out of Service Area Services.
- 10.67 **Out-of-Network Provider** means a Provider who does not have a contract with Health Advantage to provide to Members services covered by this Evidence of Coverage. Out-of-Network Providers are free to bill and collect from you charges for covered services which are in excess of Health Advantage's Allowance or Allowable Charge.
- 10.68 **Partial Hospitalization** means continuous treatment for a Member who requires care or support, or both, in a Hospital but who does not require 24-hour supervision. A Physician must prescribe services for at least 4 hours, but not more than 16 hours in any 24-hour period.

- 10.69 **Participating Pharmacy** means a licensed pharmacy that has contracted directly or indirectly with Health Advantage to provide pharmacy services to Members subject to all terms, conditions, exclusions and limitations of the Plan set forth in this Evidence of Coverage.
- 10.70 **Period of Creditable Coverage** means the period of time a Member was covered by a health Plan or insurance contract defined as creditable coverage in the provisions of the Health Insurance Portability and Accountability Act of 1996. Common health Plans and insurance contracts providing creditable coverage include: Employer Group Health Insurance, Individual Comprehensive Health Insurance, Medicare, Medicaid, CHAMPUS and a State Health Benefits Risk Pool. Any continuous sixty-three (63) day period during which the Member was not covered will start a new Period of Creditable Coverage.
- 10.71 **Physician** means a Doctor of Medicine (M.D.) or a Doctor of Osteopathy (D.O.) duly licensed and qualified to practice medicine and perform surgery at the time and place a claimed Intervention is rendered. Physician also means a Doctor of Podiatry (D.P.M.), a Chiropractor (D.C.), a Psychologist (Ph.D.), an Oral Surgeon (D.D.S.) or an Optometrist (O.D.) duly licensed and qualified to perform the claimed Health Intervention at the time and place such Intervention is rendered.
- 10.72 **Physician Service** means such services as are rendered by a licensed Physician within the scope of his license.
- 10.73 **Placement, or being placed, for adoption** means the assumption and retention of a legal obligation for total or partial support of a Child by a person with whom the Child has been placed in anticipation of the Child's adoption. The Child's Placement for adoption with such person terminates upon the termination of such legal obligation.
- 10.74 **Plain Film Radiograph** means a routine film x-ray performed in a Specialty Care Provider's office and provided in accordance with Coverage Policy established by Health Advantage.
- 10.75 **Plan** means the Subscriber health benefit Plan established by your Employer. The terms of the Plan are set forth in the Group Contract between Health Advantage and your Employer.
- 10.76 **Plan Administrator** means the Employer.
- 10.77 **Plan Year** means the Plan Year stated in the Subscriber Health Benefit Plan Summary Plan Description, or if not stated in that document, or if that document does not exist, the twelve month period ending on the day before the anniversary date of the effective date of this Group Contract.
- 10.78 **Prescription** means an order for Medications by a Physician or health care Provider authorized by applicable law to issue a Prescription, to a pharmacy for the benefit of and use by a Member.
- 10.79 **Prescription Medication or Medication** means any pharmaceutical that has been approved by the FDA and can be obtained only through a Prescription. Health Advantage has classified selected Prescription Medications, primarily Medications intended for self-administration as "A Medications." Health Advantage has classified Intra-muscular injections, Intravenous injections and other pharmaceuticals that are primarily intended for professional administration as "B Medications."
- 10.80 **Primary Care Physician** means an In-Network M.D. or D.O. Physician who provides primary medical care in one of these medical specialties: General Practice, Pediatrics, Family Practice, Obstetrics/Gynecology or Internal Medicine. This also includes advanced practice nurses or physician's assistants who provide primary medical care in these medical specialties and are performed in the Primary Care Physician's office.
- 10.81 **Prior Approval** means the process by which Health Advantage determines in advance of the Member obtaining a requested medical service, Medication, supply, test or equipment that such medical service, Medication, supply, test or equipment meets Primary Coverage Criteria.
- 10.82 **Professional Services** means those Covered Services rendered by Physician and other health care provided in accordance with this Evidence of Coverage. Except for Emergency Care, all services must be performed, prescribed, directed, or authorized in advance by the Member's Primary Care Physician.
- 10.83 **Provider** means an advance practice nurse; an athletic trainer; an audiologist; a certified orthotist; a chiropractor; a community mental health center or clinic; a dentist, a Hospital; a licensed ambulatory surgery center; a licensed certified social worker; a licensed dietician; a licensed durable medical equipment provider; a licensed professional counselor; a licensed psychological examiner; a long-term care facility; a non-hospital based medical facility providing clinical diagnostic services for sleep disorders; a non-hospital based medical facility providing magnetic resonance imagining, computed axial tomography, or other imaging diagnostic testing; an occupational therapist; an optometrist; a pharmacist; a physical therapist; a physician or surgeon (M.D. and D.O.); a podiatrist; a prosthetist; a psychologist; a respiratory therapist; a rural health clinic; a speech pathologist and any other type of

health care Provider which Health Advantage, in its sole discretion, approves for reimbursement for services rendered.

- 10.84 **Psychiatric Residential Treatment Center** means a facility, or a distinct part of a facility, for psychiatric care which provides a total 24-hour therapeutically planned and professionally staffed group living and learning environment.
- 10.85 **Referral** means an authorization to cover services issued by the Member's Primary Care Physician.
- 10.86 **Relevant to the Claim** means a document, record or other information that:
1. was relied upon in making the benefit determination;
 2. was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record or other information was relied upon in making the benefit determination;
 3. demonstrates compliance with the administrative processes and safeguards required by 7.2.5.b.; and
 4. constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for the Member's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.
- 10.87 **Retransplantation** means a second transplant performed within sixty (60) days of the failure of an initial transplant.
- 10.88 **Severe Traumatic Brain Injury** means a sudden trauma causing damage to the brain as a result of the head suddenly and violently hitting an object or an object piercing the skull and entering brain tissue with an extended period of unconsciousness or amnesia after the injury or a Glasgow Coma Scale below 9 within the first 48 hours of injury.
- 10.89 **Service Area** is the state of Arkansas.
- 10.90 **Skilled Nursing Facility** means an institution licensed as such by the appropriate state agency. A Skilled Nursing Facility must:
1. be operated pursuant to law;
 2. be approved for payment of Medicare benefits or be qualified to receive such approval, if so requested;
 3. be primarily engaged in providing, in addition to room and board accommodations, skilled nursing care under the supervision of a duly licensed Physician (M.D. or D.O.);
 4. provide continuous 24 hours a day nursing service by or under the supervision of a registered graduate professional nurse (R.N.) for at least 8 hours per day and a registered graduate professional nurse (R.N.) or licensed practical nurse (L.P.N.) for the remaining 16 hours; and
 5. maintain a daily medical record of each patient.
- However, a Skilled Nursing Facility does not include:
1. any home, facility or part thereof used primarily for rest;
 2. a home or facility for the aged or for the care of drug addicts or alcoholics; or
 3. a home or facility primarily used for the care and treatment of mental diseases, or disorders, or Custodial Care or educational care.
- 10.91 **Special Enrollment Period** means a thirty (30) day period during which time a Subscriber or Subscriber's Dependent may enroll in the Plan, after his or her initial Waiting Period (Eligibility Period or Eligibility Date) and not be a Late Enrollee. Special Enrollment Periods occur in two instances:
1. AFTER THE TERMINATION OF ANOTHER HEALTH PLAN: A Special Enrollment Period occurs (i) after a Subscriber's or Dependent's coverage under another health plan terminated as a result of Loss of Eligibility or (ii) after the employer providing such other health Plan terminated its contributions.
 2. AFTER THE ADDITION OF A DEPENDENT: A Special Enrollment Period occurs for a Subscriber, Subscriber's Spouse or Subscriber's new Dependent Child (i) after the Subscriber marries; (ii) after a Subscriber's Child is born or (iii) a Subscriber adopts a Child or has a Child placed with the Subscriber for adoption.
- 10.92 **Specialty Care Provider** means a Physician or other health care provider other than a Primary Care Physician.
- 10.93 **Spouse** means a member of the opposite sex who is the husband or wife of a Subscriber as a result of a marriage that is legally recognized in the state of Arkansas.

- 10.94 **Step Therapy** means a process that establishes a required order of use for a specific Prescription Medication. For example, a Step Therapy may require that medication "X" be used for a period of time before medication "Y" or that a weaker strength of a medication be used for a period before a stronger strength of the same medication.
- 10.95 **Stepchild** means a natural or adopted Child of the Spouse of the Subscriber.
- 10.96 **Subscriber** means a person who is directly employed by the Employer for Full-Time Employment. This person must reside in the United States and be paid for full-time work in the conduct of the Employer's regular business. No director or officer of the Employer shall be considered a Subscriber unless he meets the above conditions.
- 10.97 **Substance Abuse** means a maladaptive pattern of substance use manifested by recurrent and significant adverse consequences related to the repeated use of substances.
- 10.98 **Substance Abuse Residential Treatment Center** means a facility that provides treatment for substance (alcohol and drug) abuse to live-in residents who do not require acute medical care. Services include individual and group therapy and counseling, family counseling, laboratory tests, drug and supplies, psychological testing, and room and board.
- 10.99 **Transplant Global Period** means a period of time that begins on or prior to the day of the transplant procedure and extends for a number of days after the transplant procedure. The length of the Transplant Global Period varies, depending upon the type of transplant involved.
- 10.100 **Waiting Period** means the time beginning with the Subscriber's most recent date of continuous employment with the Employer and ending on the date he is eligible for coverage. The Employer establishes the Waiting Period, but for purposes of coverage or eligibility determinations under this Evidence of Coverage, the Waiting Period shall be such period as is reflected in the enrollment records of Health Advantage.
- 10.101 **We, Our and Us** mean Health Advantage.
- 10.102 **Work Hardening** means a highly specialized rehabilitation program that spans the transition from traditional rehabilitation therapies to return to work by simulating the workplace activities and surroundings in a monitored environment. Programs may be developed and carried out by an occupational therapist and/or physical therapist. The goal is to create an environment in which returning workers can rebuild psychological self-confidence and physical reconditioning by replicating their work routine.
- 10.103 **Work Integration (Community)** means training in shopping, transportation, money management, vocational activities and/or work environment/modification analysis, and/or work task analysis. This is not considered medical treatment.
- 10.104 **You and Your** mean a Member.

11.0 YOUR RIGHTS UNDER ERISA

The following information is provided to you in accordance with the Employee Retirement Income Security Act of 1974 (ERISA). This information and the information contained in this Evidence of Coverage, constitute the Summary Plan Description required by ERISA.

11.1 Information about the Plan

As a participant in the Plan described in this Evidence of Coverage, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974, as amended (ERISA). ERISA provides that all plan participants shall be entitled to:

1. Examine, without charge, at the Plan Administrator's office all plan documents, including insurance company contracts, and copies of all documents filed by the plan with the U.S. Department of Labor such as detailed annual reports and plan descriptions.
2. Obtain copies of all applicable plan documents and other plan information upon written request to the Plan Administrator. The administrator may make a reasonable charge for the copies.
3. Receive a summary of the plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

11.2 Continuation of Coverage

The Plan provides an opportunity to continue coverage for yourself, spouse, dependents if there is a loss of coverage under the Plan as a result of a qualifying event. See Subsection 6.4.3.a. You or your

dependents may have to pay for such coverage. Review this Evidence of Coverage, Subsection 6.4.3 and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

11.3 **Creditable Coverage**

The Plan provides a reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to preexisting condition exclusion for 12 months after your enrollment in your coverage.

11.4 **Prudent Actions by Plan Fiduciaries**

1. In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other participants and beneficiaries.
2. No one, including your employer, or any other person, may fire you or otherwise discriminate against you in a way to prevent you from obtaining a benefit or exercising your rights under ERISA.

11.5 **Enforce your Rights**

1. If your claim for a benefit is denied, in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the plan review and reconsider your claim.
2. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you per day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees for example, if it finds your claim is frivolous.

11.6 **Assistance with Your Questions**

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or your rights under ERISA, you should contact the nearest area office of the Employee Benefits Security Administration, U.S. Department of Labor listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

11.7 **Claim and Appeal Procedures**

The Plan rules and procedures for filing claims and seeking review of adverse claim determinations are set forth in Section 7.0 of this Evidence of Coverage.



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



Health Advantage

An Independent Licensee of the Blue Cross and Blue Shield Association

AMENDMENT TO THE HEALTH ADVANTAGE EVIDENCE OF COVERAGE

FOR

Tyson Foods, Inc.

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IMPORTANT INFORMATION

For Residents of States other than the State of Arkansas:

For residents of states other than the State of Arkansas, there is a state-specific benefit that contains provisions which add to or which change your Evidence of Coverage provisions.

NOTE: The provisions identified in your state-specific amendment, incorporated herein, are applicable ONLY to Employees located in that state. The specific state for which the amendment is applicable is identified at the beginning of each individual amendment as part of the "Amendment Eligibility" heading.

READ THE FOLLOWING

NOTE: The provisions identified in each state-specific amendment incorporated herein are specifically applicable ONLY for:

- (a) Benefit plans which have been made available to you and/or your Dependents by your Employer;
- (b) Benefit plans for which you and/or your Dependents are eligible;
- (c) Benefit plans which you have elected for you and/or your Dependents;
- (d) Benefit plans which are currently effective for you and/or your Dependents.

Please refer to the **Table of Contents** for the individual state-specific amendment that is applicable for *your* residence state.

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

AMENDMENT – California Residents

Amendment Eligibility: Each Employee who is located in California; You will become covered on the date you become eligible. This amendment forms a part of the Evidence of Coverage issued to you by Health Advantage. The provisions set forth in this amendment comply with the legislative requirements of California regarding group insurance plans covering Employees located in California. These provisions supersede any provisions in your Evidence of Coverage to the contrary unless the provisions in your Evidence of Coverage result in greater benefits.

BENEFITS AND SPECIFIC LIMITATIONS IN YOUR PLAN, is hereby amended to add the following Subsection.

Subject to all other terms, conditions, exclusions and limitations of the plan as set forth in the Evidence of Coverage, coverage is provided for general anesthesia and associated facility charges for dental procedures rendered in a Hospital or Ambulatory Surgical Facility for: (a) a Child under the age of 7; (b) a Covered Person who is developmentally disabled; or (c) a Covered Person whose health is compromised and general anesthesia meets Primary Coverage Criteria.

BENEFITS AND SPECIFIC LIMITATIONS IN YOUR PLAN, is hereby amended to add the following Subsection.

Subject to all other terms, conditions, exclusions and limitations of the plan as set forth in the Evidence of Coverage, coverage is provided for clinical trials as follows:

1. charges made for routine patient services associated with cancer clinical trials approved and sponsored by the federal government. In addition the following criteria must be met:
 - a. the cancer clinical trial is listed on the NIH web site www.clinicaltrials.gov as being sponsored by the federal government;
 - b. the trial investigates a treatment for terminal cancer and: (i) the person has failed standard therapies for the disease; (ii) cannot tolerate standard therapies for the disease; or (iii) no effective non-experimental treatment for the disease exists;
 - c. the person meets all inclusion criteria for the clinical trial and is not treated “off-protocol”;
 - d. the trial is approved by the Institutional Review Board of the institution administering the treatment; and
2. Coverage will not be extended to clinical trials conducted at nonparticipating facilities if a person is eligible to participate in a covered clinical trial from a Participating Provider.
3. Routine patient services do not include, and reimbursement will not be provided for:
 - a. the investigational service or supply itself;
 - b. services or supplies listed herein as Specific Plan Exclusions;
 - c. services or supplies related to data collection for the clinical trial (i.e., protocol-induced costs);
 - d. services or supplies which, in the absence of private health care coverage, are provided by a clinical trial sponsor or other party (e.g., device, drug, item or service supplied by manufacturer and not yet FDA approved) without charge to the trial participant.

GLOSSARY OF TERMS is hereby amended to add the following new term.

Emergency Services are medical, psychiatric, surgical, Hospital and related health care services and testing, including ambulance service, which are required to treat a sudden, unexpected onset of a bodily Injury or serious Sickness which could reasonably be expected by a prudent layperson to result in serious medical complications, loss of life or permanent impairment to bodily functions in the absence of immediate medical attention. Examples of emergency situations include uncontrolled bleeding, seizures or loss of consciousness,

shortness of breath, chest pains or severe squeezing sensations in the chest, suspected overdose of medication or poisoning, sudden paralysis or slurred speech, burns, cuts and broken bones. The symptoms that led you to believe you needed emergency care, as coded by the provider and recorded by the Hospital on the UB92 claim form, or its successor, or the final diagnosis, whichever reasonably indicated an emergency medical condition, will be the basis for the determination of coverage, provided such symptoms reasonably indicate an emergency.

AMENDMENT – Missouri Residents

Amendment Eligibility: Each Employee who is located in Missouri; You will become covered on the date you become eligible. This amendment forms a part of the Evidence of Coverage issued to you by Health Advantage. The provisions set forth in this amendment comply with the legislative requirements of Missouri regarding group insurance plans covering Employees located in Missouri. These provisions supersede any provisions in your Evidence of Coverage to the contrary unless the provisions in your Evidence of Coverage result in greater benefits.

BENEFITS AND SPECIFIC LIMITATIONS IN YOUR PLAN, is hereby amended to add the following Subsection.

Subject to all other terms, conditions, exclusions and limitations of the plan as set forth in the Evidence of Coverage, coverage is provided for clinical trials as follows:

1. charges made for routine patient services associated with cancer clinical trials approved and sponsored by the federal government. In addition the following criteria must be met:
 - a. the cancer clinical trial is listed on the NIH web site www.clinicaltrials.gov as being sponsored by the federal government;
 - b. the trial investigates a treatment for terminal cancer and: (i) the person has failed standard therapies for the disease; (ii) cannot tolerate standard therapies for the disease; or (iii) no effective non-experimental treatment for the disease exists;
 - c. the person meets all inclusion criteria for the clinical trial and is not treated “off-protocol”;
 - d. the trial is approved by the Institutional Review Board of the institution administering the treatment; and
2. Coverage will not be extended to clinical trials conducted at nonparticipating facilities if a person is eligible to participate in a covered clinical trial from a Participating Provider.
3. Routine patient services do not include, and reimbursement will not be provided for:
 - a. the investigational service or supply itself;
 - b. services or supplies listed herein as Specific Plan Exclusions;
 - c. services or supplies related to data collection for the clinical trial (i.e., protocol-induced costs);
 - d. services or supplies which, in the absence of private health care coverage, are provided by a clinical trial sponsor or other party (e.g., device, drug, item or service supplied by manufacturer and not yet FDA approved) without charge to the trial participant.

BENEFITS AND SPECIFIC LIMITATIONS IN YOUR PLAN, is hereby amended to add the following Subsection.

Subject to all other terms, conditions, exclusions and limitations of the plan as set forth in the Evidence of Coverage, coverage is provided for genetic testing as follows:

1. charges made for genetic testing that uses a proven testing method for the identification of genetically-linked inheritable disease. Genetic testing is covered only if:
 - a. a person has symptoms or signs of a genetically-linked inheritable disease;
 - b. it has been determined that a person is at risk for carrier status as supported by existing peer-reviewed, evidence-based, scientific literature for the development of a genetically-linked inheritable disease when the results will impact clinical outcome; or

2. the therapeutic purpose is to identify specific genetic mutation that has been demonstrated in the existing peer-reviewed, evidence-based, scientific literature to directly impact treatment options.
3. Pre-implantation genetic testing, genetic diagnosis prior to embryo transfer, is covered when either parent has an inherited disease or is a documented carrier of a genetically-linked inheritable disease.
4. Genetic counseling is covered if a person is undergoing approved genetic testing, or if a person has an inherited disease and is a potential candidate for genetic testing. Genetic counseling is limited to 3 visits per contract year for both pre and post genetic testing.

BENEFITS AND SPECIFIC LIMITATIONS IN YOUR PLAN, is hereby amended to add the following Subsection.

Subject to all terms, conditions, exclusions and limitations of the Plan set forth in this Evidence of Coverage, coverage is provided for a Member to undergo human leukocyte antigen testing utilized for participation in the National Marrow Donor Program. The testing, also known as histocompatibility locus antigen testing, for A, B and DR antigens, must be performed in a facility accredited by the American Association of Blood Banks or its successors, and licensed under the federal Clinical Laboratory Improvement Act. Benefits will be payable on the same basis as for other covered Health Interventions. Benefits will be limited to one test per Member per lifetime, subject to a maximum benefit of \$75.

BENEFITS AND SPECIFIC LIMITATIONS IN YOUR PLAN, is hereby amended to add the following Subsection.

Subject to all terms, conditions, exclusions and limitations of the Plan set forth in this Evidence of Coverage, coverage is provided for the diagnosis, treatment and appropriate management of osteoporosis for Members with a condition or medical history for which bone mass measurement meets Primary Coverage Criteria, provided such services are received by a Physician licensed to practice medicine and surgery in Missouri.

BENEFITS AND SPECIFIC LIMITATIONS IN YOUR PLAN, is hereby amended to add the following Subsection.

Subject to all terms, conditions, exclusions and limitations of the Plan set forth in this Evidence of Coverage, coverage is provided for charges made by a Hospital or other facility that provides obstetrical care for inpatient Hospital services will include covered expenses for a mother and her newborn child for 48 hours following a vaginal delivery or for 96 hours following a cesarean delivery. A longer stay will be covered if deemed to meet Primary Coverage Criteria. The mother may request an earlier discharge if, after consulting with her Physician, it is determined that less time is needed for recovery. If discharged early, at least 2 post discharge visits will be covered, one of which will be a home visit by either a registered nurse with experience in maternal and child health nursing or a Physician. These visits will include, but are not limited to, a physical assessment of the mother and the newborn; parent education; assistance and training in breast and bottle feeding; education and services for complete childhood immunizations; appropriate clinical tests; and the submission of a metabolic specimen to the state laboratory.

ELIGIBILITY STANDARDS, Subsection 6.4 is hereby amended to add the following new Subsection.

Special Continuation for Surviving Dependents. Subject to all other terms, conditions, exclusions and limitations of the Plan as set forth in this Evidence of Coverage, coverage may be continued in the Plan for any surviving Dependents provided the required premium is paid to the Group. Continuation shall begin only after the continuation required by federal law has expired, provided the Dependent Spouse is at least 55 years of age at such time. Such coverage shall not continue beyond the earliest of the following dates:

- a. Dependent Spouse's 65th birthday;
- b. the last day of the period for which the required contribution has been paid;

- c. the date that your spouse becomes insured under any other group health plan, including Medicare;
- d. with respect to any one Dependent: (1) the date that Dependent becomes eligible for similar group coverage or (2) the date that Dependent ceases to qualify as a Dependent for any reason other than lack of primary support by the Dependent Spouse; or
- e. the date this policy cancels.

For Spouse Upon Legal Separation or Divorce From Employee

Subject to all other terms, conditions, exclusions and limitations of the Plan as set forth in this Evidence of Coverage, if your Dependent Spouse's coverage would otherwise terminate because of legal separation, divorce or annulment of marriage, your Dependent Spouse may continue their health plan coverage, and the coverage of any eligible Dependent children, by paying the required contribution to the Group. Continuation shall begin only after the continuation required by Federal Law has expired, provided your Dependent Spouse is at least 55 years of age at such time.

Such coverage shall not continue beyond the earliest of the following dates:

- a. your Dependent Spouse's 65th birthday;
- b. the last day of the period for which the required contribution has been paid;
- c. the date that your spouse becomes insured under any other group health plan, including Medicare;
- d. with respect to any one Dependent: (1) the date that Dependent becomes eligible for similar group coverage or (2) the date that Dependent ceases to qualify as a Dependent for any reason other than lack of primary support by you; or
- e. the date this policy cancels.

GLOSSARY OF TERMS is hereby amended to add the following new term.

Emergency Services means medical, surgical, hospital, and related health care services and testing, including ambulance service, required to evaluate, stabilize or treat a sudden, unexpected onset of a bodily injury or serious illness which could reasonably be expected by a prudent layperson, possessing an average knowledge of health and medicine, to believe that immediate medical care is required, which may include, but shall not be limited to: (a) placing the person's health in significant jeopardy; (b) serious impairment to a bodily function; (c) serious dysfunction of any bodily organ or part; (d) inadequately controlled pain; or (e) with respect to a pregnant woman who is having contractions that there is inadequate time to effect a safe transfer to another hospital before delivery, or that transfer to another hospital may pose a threat to the health or safety of the woman or unborn child. Included are conditions which produce loss of consciousness, severe pain or excessive bleeding; or which may otherwise be determined by the Medical Director in accordance with generally accepted medical standards, to have been a condition requiring immediate medical attention.

AMENDMENT – North Carolina Residents

Amendment Eligibility: Each Employee who is located in North Carolina; You will become covered on the date you become eligible. This amendment forms a part of the Evidence of Coverage issued to you by Health Advantage.

The provisions set forth in this amendment comply with the legislative requirements of North Carolina regarding group insurance plans covering Employees located in North Carolina. These provisions supersede any provisions in your Evidence of Coverage to the contrary unless the provisions in your Evidence of Coverage result in greater benefits.

BENEFITS AND SPECIFIC LIMITATIONS IN YOUR PLAN, is hereby amended to add the following Subsection.

Subject to all terms, conditions, exclusions and limitations of the Plan set forth in this Evidence of Coverage, coverage is provided for charges made by a Hospital or Ambulatory Surgical Facility for anesthesia and facility charges for services performed in the facility in connection with dental procedures for: (a) Dependent children below age 9; (b) covered persons with

serious mental or physical conditions; or (c) covered persons with significant behavioral problems. The treating provider must certify that hospitalization or general anesthesia is required in order to safely and effectively perform the procedure because of the person's age, condition or problem.

BENEFITS AND SPECIFIC LIMITATIONS IN YOUR PLAN, is hereby amended to add the following Subsection.

Subject to all terms, conditions, exclusions and limitations of the Plan set forth in this Evidence of Coverage, coverage is provided for charges for a qualified person for the diagnosis and evaluation of osteoporosis or low bone mass if at least 23 months have elapsed since the last Bone Mass Measurement was performed. More frequent follow up measurements will be covered when deemed to meet Primary Coverage Criteria. Conditions that would be considered to meet Primary Coverage Criteria include, but are not limited to: (1) monitoring Members on long-term glucocorticoid therapy of more than 3 months; or (2) a central Bone Mass Measurement to determine the effectiveness of adding an additional treatment program for a qualified person with low bone mass as long as the Bone Mass Measurement is performed 12 to 18 months from the start date of the additional program.

Bone Mass Measurement (BMM) means a scientifically proven radiologic, radioisotopic, or other procedure performed on a qualified person to identify bone mass or detect bone loss in order to initiate or modify treatment. A Qualified Person means one who:

1. is estrogen deficient and at clinical risk for osteoporosis or low bone mass;
2. is experiencing radiographic osteopenia anywhere in the skeleton;
3. is receiving long-term glucocorticoid (steroid) therapy;
4. is having primary hyperparathyroidism;
5. is being monitored to assess the response to commonly accepted osteoporosis drug therapies;
6. has a history of low-trauma fractures;
7. has other conditions or is on medical therapies known to cause osteoporosis or low bone mass.

AMENDMENT – Texas Residents

Amendment Eligibility: Each Employee who is located in Texas; You will become covered on the date you become eligible. This amendment forms a part of the Evidence of Coverage issued to you by Health Advantage. The provisions set forth in this amendment comply with the legislative requirements of Texas regarding group insurance plans covering Employees located in Texas. These provisions supersede any provisions in your Evidence of Coverage to the contrary unless the provisions in your Evidence of Coverage result in greater benefits.

IMPORTANT NOTICE

To obtain information or make a complaint:

You may call Health Advantage's toll-free telephone number for information or to make a complaint at

1-800-843-1329

AVISO IMPORTANTE

Para obtener informacion o para someter una queja:

Usted puede llamar al numero de telefono gratis de Health Advantage's para informacion o para someter una queja al

1-800-843-1329

You may also write to Health Advantage at:

**320 West Capitol Avenue
Little Rock, AR 72201**

You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights or complaints at

1-800-252-3439

You may write the Texas Department of Insurance

P.O. Box 149104

Austin, TX 78714-9104

FAX #(512)475-1771

Usted tambien puede escribir a Health Advantage:

**320 West Capitol Avenue
Little Rock, AR 72201**

Puede comunicarse con el Departamento de Seguros de Texas para obtener informacion acerca de companias, coberturas, derechos o quejas al

1-800-252-3439

Puede escribir al Departamento de Seguros de Texas

P.O. Box 149104

Austin, TX 78714-9104

FAX #(512)475-1771

PREMIUM OR CLAIM DISPUTES:

Should you have a dispute concerning your premium or about a claim you should contact Health Advantage first. If the dispute is not resolved, you may contact the Texas Department of Insurance.

ATTACH THIS NOTICE TO YOUR POLICY/CERTIFICATE: This notice is for information only and does not become a part or condition of the attached document.

DISPUTAS SOBRE PRIMAS O

RECLAMOS: Si tiene una disputa concerniente a su prima o a un reclamo, debe comunicarse con el Health Advantage primero. Si no se resuelve la disputa, puede entonces comunicarse con el departamento (TDI).

UNA ESTE AVISO A SU POLIZA/CERTIFICADO:

Este aviso es solo para proposito de informacion y no se convierte en parte o condicion del documento adjunto.

BENEFITS AND SPECIFIC LIMITATIONS IN YOUR PLAN, is hereby amended to add the following Subsection.

Subject to all other terms, conditions, exclusions and limitations of the plan as set forth in the Evidence of Coverage, coverage is provided for charges for a service provided through Telemedicine for diagnosis, consultation, treatment, transfer of medical data, and medical education. These benefits may not be subject to a greater deductible, copayment, or coinsurance than for the same service under this plan provided through a face-to-face consultation. The term Telemedicine means the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and medical education through the use of interactive audio, video, or other electronic media. It does not include the use of telephone or fax.

BENEFITS AND SPECIFIC LIMITATIONS IN YOUR PLAN, is hereby amended to add the following Subsection.

Subject to all other terms, conditions, exclusions and limitations of the plan as set forth in the Evidence of Coverage, coverage is provided for necessary cognitive rehabilitation therapy, cognitive communication therapy, neurocognitive therapy and rehabilitation, neurobehavioral, neurophysiological, neuropsychological and psychophysiological testing or treatment, neurofeedback therapy, remediation, post-acute transition services or community reintegration services as a result of and related to an acquired brain injury.

BENEFITS AND SPECIFIC LIMITATIONS IN YOUR PLAN, is hereby amended to add the following Subsection.

Subject to all other terms, conditions, exclusions and limitations of the plan as set forth in the Evidence of Coverage, coverage is provided for a screening test for hearing loss from birth through the date the child is 30 days old, and necessary diagnostic follow-up care related to the screening test from birth through the date the child is 24 months old without application of a deductible.

BENEFITS AND SPECIFIC LIMITATIONS IN YOUR PLAN, is hereby amended to add the following Subsection.

Subject to all other terms, conditions, exclusions and limitations of the plan as set forth in the Evidence of Coverage, coverage is provided for reconstructive surgery of craniofacial abnormalities for covered Dependents age 18 or younger to improve the function of, or to attempt to create a normal appearance for an abnormal structure caused by congenital defects, developmental deformities, trauma, tumors, infection or disease.

BENEFITS AND SPECIFIC LIMITATIONS IN YOUR PLAN, is hereby amended to add the following Subsection.

Subject to all other terms, conditions, exclusions and limitations of the plan as set forth in the Evidence of Coverage, coverage is provided for reconstructive surgery or therapy to repair or correct a severe physical deformity or disfigurement which is accompanied by functional deficit; (other than abnormalities of the jaw or conditions related to TMJ disorder) provided that: (a) the surgery or therapy restores or improves function; (b) reconstruction is required provided Primary Coverage Criteria are met, (noncosmetic surgery); or (c) the surgery or therapy is performed prior to age 19 and is required as a result of the congenital absence or agenesis (lack of formation or development) of a body part. Repeat or subsequent surgeries for the same condition are covered only when there is the probability of significant additional improvement as determined by the Health Advantage's Medical Director.

BENEFITS AND SPECIFIC LIMITATIONS IN YOUR PLAN, is hereby amended to add the following Subsection.

Mental Health and Chemical Dependency Services

1. **Inpatient Mental Health Services**

Inpatient Mental Health benefits are exchangeable with **Partial Hospitalization** sessions when benefits are provided for not less than 4 hours and not more than 12 hours in any 24-hour period. The benefit exchange will be two partial hospitalization sessions are equal to one day of inpatient care.

2. **Mental Health Residential Treatment services** in a Mental Health Residential Treatment Center for Children and Adolescents, or a Crisis Stabilization Unit are exchanged with Inpatient Mental Health Benefits at a rate of:

- a. 2 days of Mental Health Residential Treatment at a Center for Children and Adolescents being equal to 1 day of Inpatient Mental Health Treatment.
- b. 2 days of Mental Health Services provided through Crisis Stabilization Units being equal to 1 day of Inpatient Mental Health Treatment.

3. **Outpatient Mental Health Services**

Services of Providers who are qualified to treat Mental Health when treatment is provided on an outpatient basis, while you or your Dependent is not Confined in a Hospital, and is provided in an individual, group or Mental Health Intensive Outpatient Therapy Program. Covered services include, but are not limited to, outpatient treatment of conditions such as: anxiety or depression which interfere with daily functioning; emotional adjustment or concerns related to chronic conditions, such as psychosis or depression; emotional reactions associated with marital problems or divorce; child/adolescent problems of conduct or poor impulse control; affective disorders; suicidal or homicidal threats or acts; eating disorders; or acute exacerbation of chronic

Mental Health conditions (crisis intervention and relapse prevention) and outpatient testing and assessment.

A Mental Health Intensive Outpatient Therapy Program consists of distinct levels or phases of treatment that are provided by a certified/licensed Mental Health program. Intensive Outpatient Therapy Programs provide a combination of individual, family and/or group therapy in a day, totaling 9 or more hours in a week. Mental Health Intensive Outpatient Therapy Program services are exchanged with Outpatient Mental Health services at a rate of 1 visit of Mental Health Intensive Outpatient Therapy being equal to 1 visit of Outpatient Mental Health Services.

4. **Inpatient Chemical Dependency Rehabilitation Services**

Services provided for rehabilitation, while you or your Dependent is confined in a Hospital, when required for the diagnosis and treatment of Chemical Dependency. Inpatient Chemical Dependency services are exchangeable with **Partial Hospitalization** sessions when services are provided for not less than 4 hours and not more than 12 hours in any 24-hour period. The exchange for services will be 2 partial hospitalization sessions are equal to 1 day of inpatient care. Chemical Dependency Outpatient Therapy Program benefits are exchanged with Inpatient Chemical Dependency benefits at a rate of 3 days of Chemical Dependency Outpatient Structured Therapy being equal to 1 day of Inpatient Chemical Dependency Rehabilitation Services. Chemical Dependency Residential Treatment benefits are exchanged with Inpatient Chemical Dependency benefits at a rate of 2 days of Chemical Dependency Residential Treatment being equal to 1 day of Inpatient Chemical Dependency Treatment.

5. **Outpatient Chemical Dependency Rehabilitation Services**

Services provided for the diagnosis and treatment of Chemical Dependency, while you or your Dependent is not confined in a Hospital, including outpatient rehabilitation in an individual, group or Chemical Dependency intensive Outpatient Structured Therapy Program.

6. **Chemical Dependency Detoxification Services**

Detoxification and related medical ancillary services provided when required for the diagnosis and treatment of addiction to alcohol and/or drugs. Health Advantage will decide, based on the facts of each situation, whether such services will be provided in an inpatient or outpatient setting.

7. **Exclusions**

The following are specifically excluded from Mental Health and Chemical Dependency Services:

- a. any court ordered treatment or therapy, or any treatment or therapy ordered as a condition of parole, probation or custody or visitation evaluations unless said services meet Primary Coverage Criteria and are otherwise covered under this Evidence of Coverage;
- b. treatment of medical disorders which have been diagnosed as organic mental disorders associated with permanent dysfunction of the brain;
- c. developmental disorders, including but not limited to, developmental reading disorders, developmental arithmetic disorders, developmental language disorders or developmental articulation disorders;
- d. counseling for activities of an educational nature;
- e. counseling for borderline intellectual functioning;
- f. counseling for occupational problems;
- g. counseling related to consciousness raising;
- h. vocational or religious counseling;
- i. I.Q. testing;
- j. custodial care, including but not limited to geriatric day care;
- k. psychological testing on children requested by or for a school system;
- l. occupational/recreational therapy programs even if combined with supportive therapy for age-related cognitive decline.

ELIGIBILITY STANDARDS, Subsection 6.4 is hereby amended to add the following new Subsections.

Special Continuation of Coverage

If coverage for you or your Dependent would otherwise cease for any reason except due to involuntary termination for cause or due to discontinuance in entirety of the policy or an insured class, coverage may be continued if:

1. the person was covered by this Evidence of Coverage and/or a prior policy for the three months immediately prior to the date coverage would otherwise cease, and
2. the person elects continuation coverage and pays the first monthly premium within 31 days of the later of either the date coverage would otherwise cease or the date required notice is provided.
3. Coverage will continue until the earliest of the following:
 - a. 6 months after continuation coverage is elected;
 - b. the end of the period for which premium is paid;
 - c. the date the policy is discontinued and not replaced;
 - d. the date the person becomes eligible for Medicare; and
 - e. the date the person becomes insured under another similar policy or becomes eligible for coverage under a group plan or a state or federal plan.

Special Continuation of Dependent Medical Insurance

1. If your Dependent's coverage would otherwise cease because of your death or retirement, or because of divorce or annulment, his coverage will be continued upon payment of required premium, if: (a) the Member has been covered under the Evidence of Coverage, or a previous policy sponsored by your Employer, for at least one year prior to the date the coverage would cease; or (b) he is a Dependent child less than one year old. The insurance will be continued until the earliest of:
 - a. three years from the date the insurance would otherwise have ceased;
 - b. the last day for which the required premium has been paid;
 - c. with respect to any one Dependent, the earlier of the dates that Dependent: (a) becomes eligible for similar group coverage; or (b) no longer qualifies as a Dependent for any reason other than your death or retirement or divorce or annulment; or
 - d. the date the policy cancels.
2. If, on the day before the Effective Date of the Evidence of Coverage, coverage was being continued for a Dependent under a group medical policy: (a) sponsored by your Employer; and (b) replaced by this Evidence of Coverage, his coverage will be continued for the remaining portion of his period of continuation under this Evidence of Coverage, as set forth above. Your Dependent must provide your Employer with written notice of retirement, death, divorce or annulment within 15 days of such event. Your Employer will, upon receiving notice of the death, retirement, divorce or annulment, notify your Dependent of his right to elect continuation as set forth above. Your Dependent may elect in writing such continuation within 45 days after the date the insurance would otherwise cease, by paying the required premium to your Employer.

GLOSSARY OF TERMS is hereby amended to add the following new terms.

Chemical Dependency is defined as the abuse of or psychological or physical dependence on or addiction to alcohol or a controlled substance that requires diagnosis, care, and treatment. In determining benefits payable, charges made for the treatment of any physiological conditions related to rehabilitation services for Chemical Dependency will not be considered to be charges made for treatment of Chemical Dependency.

Chemical Dependency Outpatient Structured Therapy Program consists of distinct levels or phases of treatment that are provided by a certified/licensed Chemical Dependency program.

Intensive Outpatient Therapy Programs provide a combination of individual, family and/or group therapy in a day, totaling 9 or more hours in a week. Chemical Dependency Intensive Outpatient Therapy Program services are exchanged with Outpatient Chemical Dependency services at a rate of 1 visit of Chemical Dependency Intensive Outpatient Therapy being equal to 1 visit of Outpatient Chemical Dependency Rehabilitation Services.

Chemical Dependency Outpatient Therapy Program consists of distinct levels or phases of treatment that are provided by a certified/licensed Chemical Dependency program. Intensive outpatient structured therapy programs provide a combination of individual, family and/or group therapy in a day, totaling 9 or more hours in a week.

Chemical Dependency Residential Treatment Center means an institution which (a) specializes in the treatment of psychological and social disturbances that are the result of Chemical Dependency conditions; (b) provides a subacute, structured, psychotherapeutic treatment program, under the supervision of Physicians; (c) provided 24-hour care, in which a person lives in an open setting; and (d) is licensed in accordance with the laws of the appropriate legally authorized agency as a residential treatment center. A person is considered Confined in a Chemical Dependency Residential Treatment Center when she/he is a registered bed patient in a Chemical Dependency Residential Treatment Center upon the recommendation of a Physician.

Chemical Dependency Residential Treatment Services are services provided by a Hospital for the evaluation and treatment of the psychological and social functional disturbances that are a result of subacute Substance Abuse conditions.

Controlled Substance means a Toxic Inhalant or a substance designated as a controlled substance in Chapter 481, Health and Safety code.

Crisis Stabilization Unit means a 24-hour residential program that is usually short term in nature and that provides intensive supervision and highly structured activities to individuals who are demonstrating an acute demonstrable psychiatric crisis of moderate to severe proportions.

Dependents include a Child of yours who is

1. less than 26 years old;
2. 26 or more years old and primarily supported by you and incapable of self-sustaining employment by reason of mental or physical handicap. Proof of the child's condition and dependence must be submitted to Health Advantage within 31 days after the date the child ceases to qualify above. During the next two years Health Advantage may, from time to time, require proof of the continuation of such condition and dependence. After that, Health Advantage may require proof no more than once a year.

A child includes your natural child, stepchild, or legally adopted child, or the child for whom you are the legal guardian, or the child who is the subject of a lawsuit for adoption by you, or the child who is supported pursuant to a court order imposed on you (including a qualified medical child support order) or your grandchild who is your Dependent for federal income tax purposes at the time of application for coverage in the Plan.

Emergency Services are a health care item or service furnished or required to evaluate and treat an Emergency Medical Condition, which may include, but shall not be limited to health care services that are provided in a licensed Hospital's emergency facility by an appropriate provider. An Emergency Medical Condition is the sudden and, at the time, unexpected onset of a health condition that manifests itself by symptoms of sufficient severity that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that immediate medical care is required, which may include, but shall not be limited to:

1. Placing the person's health in significant jeopardy;

2. Serious impairment to a bodily function;
3. Serious dysfunction of any bodily organ or part;
4. Inadequately controlled pain; or
5. With respect to a pregnant woman who is having contractions:
 - a. That there is inadequate time to effect a safe transfer to another hospital before delivery; or
 - b. That transfer to another hospital may pose a threat to the health or safety of the woman or unborn child.

Mental Health Services are services that are required to treat a disorder that impairs the behavior, emotional reaction or thought processes. In determining benefits payable, charges made for the treatment of any physiological conditions related to Mental Health will not be considered to be charges made for treatment of Mental Health.

Residential Treatment Center for Children and Adolescents means a child care institution that provides residential care and treatment for emotionally disturbed children and adolescents, and that is accredited as a Residential Treatment Center by the Council on Accreditation, the Joint Commission on Accreditation of Hospitals, or the American Association of Psychiatric Services for Children.

Series of Treatments is a planned, structured and organized program to promote chemical free status which may or may not include different facilities or modalities, and is complete when you are discharged on medical advice from inpatient detoxification, inpatient rehabilitation, partial hospitalization or intensive outpatient, or a series of these levels of treatment without a lapse in treatment, or when you fail to materially comply with the treatment program for a period of 30 days.

Toxic Inhalant means a volatile chemical under Chapter 484, Health and Safety code, or usable glue or aerosol paint under Section 485.001, Health and Safety code.

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

SERFF Tracking #:

HLAD-128857066

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

30-04, 31-16, 34-179 1/13

State:

Arkansas

Filing Company:

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

TOI/Sub-TOI:

HOrg02G Group Health Organizations - Health Maintenance (HMO)/HOrg02G.002B Any Size Group - POS

Product Name:

Tyson Products

Project Name/Number:

GEC, EOC and Amendment/30-04, 31-16, 34-179 1/13

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	01/23/2013
Comments:	Please see attached.		
Attachment(s):	Flesch Certification Form HA, 30-04, 31-16, 34-179 1-13.pdf		

		Item Status:	Status Date:
Bypassed - Item:	Application	Approved-Closed	01/23/2013
Bypass Reason:	Not required.		

		Item Status:	Status Date:
Bypassed - Item:	Health - Actuarial Justification	Approved-Closed	01/23/2013
Bypass Reason:	Not required.		

		Item Status:	Status Date:
Bypassed - Item:	PPACA Uniform Compliance Summary	Approved-Closed	01/23/2013
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. 30-04, 31-16, 34-179 1/13**

FLESCH READING EASE CERTIFICATION

This is to certify that the above referenced document have achieved a Flesch Reading Ease Score average of 40.5 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

January 18, 2013

Date