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)

THIS COVERAGE CONTAINS A PREEXISTING CONDITION. REFER TO THE SCHEDULE OF BENEFITS AND SECTION 4.1.1.

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

TABLE OF CONTENTS

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 Preexisting Condition excluded by the Plan. (See Subsection 4.1.1.) 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 under the Plan. For a description of the amount of these obligations and how they may vary, refer to Section 5.0 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.
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.

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 4.3.89 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.** 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 and related services, provided the Child's coverage becomes effective on his or her date of birth in accordance with the provisions of Section 6.0. However, if such Child is born in an Out-of-Network hospital, the Child's coverage for Out-of-Network services in the first 90 days is limited to the Allowance or Allowable Charges incurred or $2,000, whichever is less. 6.0.

   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 or $2,000, whichever is less.
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. Inpatient stays for therapy are limited to sixty (60) days per Member per Contract Year.

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, speech therapy and chiropractic services is limited to an aggregate maximum of thirty (30) visits per Member per Contract Year. See Subsection 10.64 - Outpatient Therapy Visit.

3. **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 4.3.69.

4. **Cognitive Rehabilitation.** Cognitive Rehabilitation is generally not covered. See Subsections 4.3.14 and 10.11.

5. **Radio-Frequency Thermal Therapy.** The use of radio-frequency thermal therapy for treatment of orthopedic conditions is not covered. See Subsection 4.3.72. 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.

6. **Group Therapy.** Group therapy or group counseling at any time, in any setting and by any Provider is not covered. See Subsection 4.3.37.

3.9 **Mental Health 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 Mental Health, including eating disorders, and substance abuse services when performed or prescribed by a Physician. **The treating facility must be a Hospital.** See Subsection 10.43**.** Treatment received at a Freestanding Residential Substance Abuse Treatment Center or at a Freestanding Psychiatric Residential Treatment Center is not a covered benefit. Coverage is limited to seven (7) inpatient days or thirty (30) outpatient visits per Member per Contract Year. Each Partial Hospitalization day counts as one inpatient day. This benefit is subject to the Deductible, Copayment and Coinsurance specified in the Schedule of Benefits. See Subsection 10.55 Mental Health. Copayments and Coinsurance for Mental Health and substance abuse services are not applied to the Inpatient Admission Maximums and are not applied to Annual Coinsurance Maximums.

1. **Inpatient Mental Health and Substance Abuse Services.** Coverage is provided for inpatient Mental Health and Substance Abuse Services, including professional services, when performed or prescribed by an In-Network Physician. Each Partial Hospitalization day counts as one inpatient day. This benefit is subject to the Deductible, Copayment and Coinsurance specified in the Schedule of Benefits, for each day of inpatient and Partial Hospitalization care.
2. **Outpatient Mental Health and Substance Abuse Services.** Coverage is provided for outpatient Mental Health and Substance Abuse Services when performed by an In-Network Physician. This benefit is subject to the Deductible, Copayment and Coinsurance specified in the Schedule of Benefits, for each outpatient visit.
3. **Substance Abuse Services.** Benefits for treatment of drug addiction and alcoholism are limited to multidisciplinary substance abuse rehabilitation units of Hospitals, in an inpatient setting.

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 Emergency Care Deductible, Copayment 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 10.29 Emergency Care), coverage shall be denied and the emergency room charges will become the Member's liability.

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 $50 maximum Allowance or Allowable Charge.
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 10.52), 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 4.3.40. However, subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Evidence of Coverage, coverage is provided for:

1. cochlear implant (an implantable hearing device inserted into the modiolus of the cochlea and into cranial bone) and its associated speech processor up to a lifetime maximum benefit of $35,000 per Member; and

2. one auditory brain stem implant per lifetime for an individual twelve years of age and older with a diagnosis of Neurofibromatosis Type II (NF2) who has undergone or is undergoing removal of bilateral acoustic tumors; and
3. implantable osseointegrated hearing aid for patients with single-sided deafness and normal hearing in the other ear. Coverage is further limited to Members with
    a. congenital or surgically induced malformations (e.g. atresia) of the external ear canal or middle ear;
    b. chronic external otitis or otitis media, subject to Prior Approval;
    c. tumors of the external canal and/or tympanic cavity; and
    d. sudden, permanent, unilateral hearing loss due to trauma, idiopathic sudden hearing loss, or auditory nerve tumor.

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 10.29 Emergency Care.) The coverage for ground or water Ambulance Services may not exceed $1,000 per trip, subject to the Deductible, Copayment and Coinsurance specified in the Schedule of Benefits. The coverage for air Ambulance Services may not exceed $5,000 per trip, subject to the Deductible, Copayment and Coinsurance specified in the Schedule of Benefits. Air Ambulance Services are further limited to one trip per Member per Contract Year.

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, Coinsurance and benefit limitation 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 pre-treatment dental services. Pre-treatment 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 an In-Network 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 4.3.59. *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 lymphademas.

5. Reduction mammoplasty, if such reduction mammoplasty meets Coverage Criteria and is Prior Approved by Health Advantage is covered subject to a 50% Copayment.

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 4.3.70.

   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 10.33 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. **Autologous Transplants.** The Plan does not generally cover autologous bone marrow transplantation and all related procedures (including high dose Chemotherapy, *with or without radiotherapy*) designed to replace bone marrow or peripheral cells. **There is no coverage for high dose Chemotherapy with stem cell support for diseases that are not either specifically listed as exceptions and therefore covered in subsections 3.23.7 or 3.23.8 of this Evidence of Coverage, or specifically listed as exceptions and therefore covered in specific Coverage Policies.**

Tandem transplants (transplants done within approximately 2 to 24 weeks of the initial transplant, and done to increase the chance of inducing a remission) are covered only for a diagnosis of multiple myeloma or of testicular germ cell tumors.

The only instances in which drugs, services or supplies associated with high dose Chemotherapy and related procedures for autologous stem cell support will be eligible for benefits are in the case of autologous bone marrow, stem cell or progenitor cell transplant with or without radiation therapy for the following diseases under the following circumstances:

a. Acute Lymphocytic Leukemia (ALL); Childhood, if
   i. following first complete remission but at high risk of relapse;
   ii. following second or greater remission; or
   iii. for refractory ALL.

   High-dose Chemotherapy and allogeneic stem-cell support is not covered to treat relapsing ALL after a prior course of high-dose Chemotherapy and autologous stem-cell support.

   Tandem transplants are not covered.

b. Acute Lymphocytic Leukemia (ALL); Adult if following first complete remission but at high risk of relapse.

   High-dose chemotherapy with autologous stem-cell support is not covered to treat adult ALL in second or greater remission or those with refractory disease.

   Tandem transplants are not covered.

c. Acute Myelogenous Leukemia (AML); if
   i. following first complete remission;
   ii. for primary refractory AML; or
   iii. for relapsed AML.

   Allogeneic transplant after previous high-dose Chemotherapy with autologous stem-cell support is not covered.

   Tandem transplants are not covered.

d. Amyloidosis, Primary amyloidosis when there is amyloid deposition two (2) or fewer organs and the member's cardiac left ventricular ejection fraction (EF) is greater than 45%.

   Tandem transplants are not covered.

e. Ewing's Sarcoma for patients 32 years of age or less; if
   i. following recurrent disease;
   ii. for refractory disease;
   iii. to consolidate remissions of poor risk Ewing's sarcoma; or
   iv. as salvage therapy for those with residual, recurrent or refractory disease.

   Allogeneic transplant after previous high-dose Chemotherapy with autologous stem-cell support is not covered.

   Tandem transplants are not covered.

f. Germ Cell Tumor of the Testicle, Ovary, Mediastinum, or Retroperitoneum; if
   i. for incomplete remission following standard chemotherapy;
   ii. for consolidation following second complete remission induced by standard chemotherapy; or
   iii. following second relapse to standard chemotherapy.

   Tandem high-dose chemotherapy with autologous stem-cell support to treat germ cell tumors is covered; only two (2) courses of therapy given in tandem are covered.

g. Hodgkin's Disease; if
   i. for primary refractory disease; or
   ii. for relapsed disease.

   High-dose Chemotherapy and stem-cell rescue is not covered for initial treatment of Hodgkin's Disease.

   Tandem transplants are not covered.

h. Multiple Myeloma, if

i. to treat newly diagnosed or responsive multiple myeloma; or

ii. to treat responsive myeloma that has relapsed after a durable complete or partial remission following an initial autologous transplant.

Tandem high-dose chemotherapy with autologous stem-cell support to treat newly diagnosed or responsive multiple myeloma is covered when medically indicated. Only two (2) courses of therapy given in tandem are covered.

High-dose chemotherapy with autologous stem-cell support to treat multiple myeloma in a refractory relapse does not meet primary coverage criteria.

An initial course of high-dose chemotherapy with autologous stem-cell support followed by non-marrow-ablative chemotherapy and allogeneic stem-cell support (i.e., "mini-transplant") to treat multiple myeloma does not meet primary coverage criteria.

i. Myelodysplastic Syndrome (MDS) (including myelodysplastic syndrome secondary to previous chemotherapy for another malignancy), if:

i. for treatment of MDS in patients with adequate hematopoietic stem cells prior to onset of MDS; or

ii. for treatment of MDS in patients who have complete Chemotherapy remission allowing for harvesting of adequate hematopoietic stem cells.

j. Neuroblastoma; if

i. for initial treatment of high risk disease;

ii. for refractory neuroblastoma; or

iii. for recurrent neuroblastoma.

Tandem high-dose chemotherapy with autologous stem-cell support to treat neuroblastoma is covered when medically indicated. Only three (3) courses of therapy given in tandem are covered.

Salvage allogeneic transplant for neuroblastoma that relapses after autologous transplant or fails to respond is not covered.

k. Non-Hodgkin's Lymphoma

i. International Working Formulation subtypes intermediate or aggressive

1) as salvage therapy for patients who do not achieve a complete remission (CR) after first-line treatment (induction) with a full course of standard-dose chemotherapy;

2) to consolidate a first complete response for patients with an age-adjusted International Prognostic Index score that predicts a high- or high-intermediate risk of relapse; and

3) to achieve or consolidate CR for those in a chemosensitive first or subsequent relapse.

For patients with NHL subtypes the IWF scheme classified as indolent, and for new subtypes defined by the World Health Organization//Revised

ii. European American Lymphoma scheme

1) as salvage therapy for patients who do not achieve a complete remission (CR) after first-line treatment (induction) with a full course of standard-dose chemotherapy;

2) to achieve or consolidate CR for those in a first or subsequent chemosensitive relapse, whether or not their lymphoma has undergone transformation to a higher grade.

Tandem transplants are not covered for the treatment of Non-Hodgkin's Lymphoma.

High dose chemotherapy with autologous stem cell support for chronic lymphocytic leukemia/small lymphocytic lymphoma is not covered.

8. **Allogeneic Transplants.** The Plan does not generally cover allogeneic bone marrow transplantation and all related procedures (including high dose Chemotherapy, *with or without radiotherapy*) designed to replace bone marrow or peripheral cells. **There is no coverage for high dose Chemotherapy with stem cell support for diseases that are not either specifically listed as exceptions and therefore covered in subsections 3.23.7 or 3.23.8 of**

this Evidence of Coverage, or specifically listed as exceptions and therefore covered in specific Coverage Policies.

High dose Chemotherapy with allogeneic stem cell support is not covered when used for any relapsing disease previously treated with high dose Chemotherapy and autologous stem cell support.

The only instances in which services, supplies or drugs associated with allogeneic transplantation and related procedures will be eligible for benefits are the following:

a. Acute Lymphocytic Leukemia (ALL), Childhood, if
   i. in first complete remission but at high risk for relapse;
   ii. in second or greater remission; or
   iii. refractory ALL.

   High-dose chemotherapy and allogeneic stem-cell support is not covered to treat relapsing ALL after a prior course of high-dose chemotherapy and *autologous* stem-cell support.

   Donor leukocyte infusion for relapse following allogeneic transplant for ALL is covered.

   Non-myeloablative allogeneic "mini" transplant as primary treatment of ALL is not covered.

b. Acute Lymphocytic Leukemia (ALL), Adult, if
   i. in first complete remission but at high risk for relapse;
   ii. in second or greater remission;
   iii. relapsed disease; or
   iv. refractory ALL.

   High-dose chemotherapy and allogeneic stem-cell support is not covered to treat relapsing ALL after a prior course of high-dose chemotherapy and autologous stem-cell support.

   Donor leukocyte infusion for relapse following allogeneic transplant for ALL is covered.

   Non-myeloablative allogeneic "mini" transplant as primary treatment of ALL is not covered.

c. Acute Myelogenous Leukemia (AML), if
   i. in first complete remission at high risk for relapse;
   ii. primary refractory AML ;or
   iii. relapsed AML.

   High-dose chemotherapy with allogeneic stem-cell support is **not covered** to treat AML relapsing after prior therapy with high-dose chemotherapy and autologous stem-cell support.

   Donor leukocyte infusion for relapse following allogeneic transplant for AML is covered.

   Non-myeloablative allogeneic "mini" transplant as primary treatment of AML is not covered.

d. Chronic Myelogenous Leukemia (CML) if
   i. primary CML; or
   ii. relapsed CML.

   Donor leukocyte infusion for relapse following allogeneic transplant for CML is covered.

   Non-myeloablative allogeneic "mini" transplant as primary treatment of CML is not covered.

e. Ewing's Sarcoma (allogeneic cells must be syngenetic [from the patient's sibling])
   i. to consolidate remissions for poor-risk Ewing's sarcoma patients; or
   ii. as salvage therapy for those with residual, recurrent, or refractory disease.

f. Hodgkin's Disease
   i. primary refractory disease; or
   ii. relapsed Hodgkin's disease.

   Coverage for high-dose chemotherapy and allogeneic stem-cell support for relapsed Hodgkin's disease following high dose chemotherapy and *autologous* transplantation

will depend on review of medical records by the Company's independent external review organization.

g. Myelodysplastic Syndrome (including primary [e.g. idiopathic] and acquired [e.g. secondary to drug or toxin exposure])
   i. in patients with myelodysplastic syndrome and refractory anemia;
   ii. in patients with myelodysplastic syndrome and refractory anemia with ringed sideroblasts;
   iii. in patients with myelodysplastic syndrome with excess blasts;
   iv. in patients with myelodysplastic syndrome with excess blasts in transformation; or
   v. chronic myelomonocytic leukemia.

   Non-myeloablative allogeneic "mini" transplant as primary treatment of Myelodysplastic Syndrome is covered.

h. Myelodysplastic Disorders
   i. patients diagnosed as Polycythemia Vera
   ii. patients diagnosed as Essential Thrombocytopenia
   iii. patients diagnosed as Agnogenic Myeloid Metaplasia with Myelofibrosis.

   Non-myeloablative allogeneic "mini" transplant as primary treatment of Myelodysplastic Disorders is not covered

I. Neuroblastoma, if
   i. for initial treatment of high risk disease;
   ii. for recurrent disease; or
   iii. for primary refractory disease.

   Non-myeloablative allogeneic "mini" transplant as primary treatment of Neuroblastoma is not covered. Tandem transplants are not covered.

j. Non-Hodgkin's Lymphoma
   i. International Working Formulation subtypes intermediate or aggressive; if
      1) as salvage therapy for patients who do not achieve a complete remission (CR) after first-line treatment (induction) with a full course of standard-dose chemotherapy;
      2) to consolidate a first complete response for patients with an age-adjusted International Prognostic Index score that predicts a high- or high-intermediate risk of relapse;
      3) to achieve or consolidate CR for those in a chemosensitive first or subsequent relapse.
   ii. For patients with NHL subtypes IWF scheme classified as indolent, and for new subtypes defined by the World Health Organization//Revised European American Lymphoma scheme; if
      1) as salvage therapy for patients who do not achieve a complete remission (CR) after first-line treatment (induction) with a full course of standard-dose chemotherapy;
      2) to achieve or consolidate CR for those in a first or subsequent chemosensitive relapse, whether or not their lymphoma has undergone transformation to a higher grade.

   High dose chemotherapy with allogeneic stem cell support for treatment of chronic lymphocytic leukemia/small lymphocytic lymphoma is not covered.

   Non-myeloablative chemotherapy and allogeneic transplant ("mini" transplant) is not covered for treatment of chronic lymphocytic leukemia/small lymphocytic lymphoma.

9. **Allogeneic Stem Cell Transplants for Genetic Diseases and Acquired Anemias.** Allogeneic transplantation with or without the addition of chemotherapy, is covered only for the following genetic diseases and acquired anemias

   a. Aplastic anemia, severe or very severe, including congenital (e.g., Fanconi's anemia or Diamond-Blackfan syndrome) or acquired (e.g., secondary to drug or toxin exposure)

forms. Appropriate patients include those with platelets less than 20 x 10^6/ml, granulocytes less than 0.5 x 10^6/ml, and reticulocytes less than 1% (corrected for hematocrit) and who have failed antithymocyte globulin therapy;

b. Beta-thalassemia, homozygous (i.e., thalassemia major);

c. Hematophagocytic lymphocytosis

d. Infantile malignant osteopetrosis (Albers-Schönberg disease or marble bone disease);

e. Kostmann's syndrome;

f. Leukocyte adhesion deficiencies;

g. Mucolipidoses (e.g., Gaucher's disease, metachromatic leukodystrophy, globoid cell leukodystrophy, adrenoleukodystrophy) for patients who have failed conventional therapy (e.g., diet, enzyme replacement) and who are neurologically intact;

h. Mucopolysaccharidoses (e.g., Hunter's, Hurler's, Sanfilippo, Maroteaux-Lamy variants) in patients who are neurologically intact;

i. Severe combined immunodeficiencies;

j. Sickle cell anemia for children or young adults with either a history of prior stroke or at increased risk of stroke or end-organ damage, and with an HLA-identical, related donor; factors associated with a high risk of stroke or end-organ damage include: recurrent chest syndrome, recurrent vaso-occlusive crises, red blood cell alloimmunization on chronic transfusion therapy;

10. **Nonmyeloablative Allogeneic Stem Cell Transplantation.** Nonmyeloablative allogeneic stem cell transplants consist of infusions of allogeneic stem cells that can engraft in recipients using less intensive conditioning regimens that are sufficiently immunosuppressive to permit graft-host tolerance. Donor leukocyte infusions may be administered as part of this therapy.

The only instances in which these services, supplies or drugs associated with nonmyeloablative allogeneic stem cell transplantation and related procedures will be eligible for benefits are:

a. For patients who would also meet patient selection criteria for high dose chemotherapy and allogeneic stem cell transplantation (see selection criteria in coverage for Non-Hodgkin's lymphoma, myelodysplastic disease, acute myelogenous leukemia, Hodgkin's Disease, chronic myelogenous leukemia, and acute lymphocytic leukemia);

b. For patients with aplastic anemia who fail treatment with immunosuppressive regimens and do not have a sustained response to growth factor therapy.

There is no coverage for nonmyeloablative allogeneic stem cell transplantation for diseases not covered in this subsection 3.23.10., or in a Coverage Policy.

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. **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.
7. **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 4.3.48. 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.
8. **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.
9. **Vision Enhancement.** Vision enhancements are generally not covered, see Subsection 4.3.90. 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. 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.

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 Preexisting and Other Conditions.

1. Preexisting Conditions. No benefits or services of any kind are provided under this Evidence of Coverage for treatment of a Preexisting Condition, for a period of twelve (12) months. This 12 month period is referred to as the "look forward period." If the Member submits an application for coverage during the Waiting Period, the 12 month look forward period starts on the first day of the Waiting Period. If the Member did not apply within the Waiting Period, the look forward period starts on the Member's effective date.
    a. Periods of Creditable Coverage will reduce the Preexisting Condition exclusion period. The notification a Member received from Health Advantage sets out the preexisting condition period. In reaching this determination, Health Advantage considered Certificates of Creditable Coverage provided by the Member's prior health plans and health insurers.
    b. This Preexisting Condition exclusion is not applicable to:
        i. pregnancy; or
        ii. a Member under the age of 19.
    c. How to Appeal A Preexisting Condition Exclusion Period Determination.

i. If a Member disagrees with the Preexisting Condition exclusion period, the Member can ask for a reconsideration of this determination by sending a written request to Health Advantage – Preexisting Condition Period, Post Office Box 8069, Little Rock, Arkansas 72203.

ii. The Member's request for reconsideration should include a written statement of the correct period of time the Member had creditable coverage and relevant evidence to corroborate this statement. Relevant evidence can include certificate(s) of coverage issued by prior health Plans, explanation of benefit notices or other correspondence from a health Plan indicating coverage, pay stubs showing a payroll deduction for health coverage, a health insurance ID card, a benefit certificate, or the current, working telephone number of a prior health plan administrator authorized to verify prior health plan coverage.

iii. When a Member requests reconsideration of the determination of a Preexisting Condition exclusion period, the Member agrees to cooperate with efforts to verify prior coverage. Cooperation includes, but is not limited to, providing written authorization to request a Certificate on the Member's behalf from prior health Plan(s) and insurer(s). It may also include providing information about the Member's prior health Plan(s) and Insurer(s), such as telephone numbers and addresses, and assisting in the efforts to determine the validity of the relevant evidence. Failure to cooperate fully shall constitute grounds for affirming any original Preexisting Condition exclusion period determination. Claims will be denied on that basis.

d. Health Advantage will make the final determination of a Member's Preexisting Condition exclusion period within a reasonable period of time after Health Advantage receives the Member's written request for reconsideration.

2. 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. Recreational Therapist. Services or supplies provided by a recreational therapist are not covered.
8. 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.
9. 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.
    a. 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.

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

c. 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 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.

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. Gastric Electrical Stimulators. Gastric electric neurostimulators, gastric pacemakers or electrogastrography are not covered.

36. 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.

37. Group Therapy. Group therapy or group counseling at any time in any setting by any Provider is not covered.

38. 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.

39. 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.

40. 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. However, subject to all terms, conditions, exclusions and limitations of the Plan set forth in this Evidence of Coverage, coverage is provided for:
    a. cochlear implant (an implantable hearing device inserted into the modiolus of the cochlea and into cranial bone) and its associated speech processor up to a lifetime maximum benefit of $35,000 per Member; and
    b. one auditory brain stem implant per lifetime for an individual twelve years of age and older with a diagnosis of Neurofibromatosis Type II (NF2) who has undergone or is undergoing removal of bilateral acoustic tumors.
    c. implantable osseointegrated hearing aid for patients with single-sided deafness and normal hearing in the other ear. Coverage is further limited to Members with
        i. congenital or surgically induced malformations (e.g. atresia) of the external ear canal or middle ear;
        ii. chronic external otitis or otitis media, subject to Prior Approval;
        iii. tumors of the external canal and/or tympanic cavity; and
        iv. sudden, permanent, unilateral hearing loss due to trauma, idiopathic sudden hearing loss, or auditory nerve tumor.

41. Heat Bandage. Treatment of a wound with a Warm-up Active Wound Therapy device or a noncontact radiant heat bandage is not covered.

42. 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.

43. Hippo Therapy. Hippo therapy is not covered.

44. Home delivery. Services and supplies received in connection with child birth in the home are not covered regardless of the Provider.

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

46. Hypnotherapy. Hypnotherapy is not covered for any diagnosis or medical condition.

47. 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.

48. 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.

49. In Vitro Chemoresistance and Chemosensitivity Assays. In vitro chemoresistance and chemosensivity 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.

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

51. 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.

52. Lost Medications. Replacement of previously filled Prescription Medications because the initial Prescription Medication was lost, stolen, spilled, contaminated, etc. are not covered.

53. Marriage and Family Therapy. Marriage and family therapy or counseling services are not covered.

54. 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.

55. 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.

56. Naturopath/Homeopath Treatment. Naturopathic or Homeopathic treatments of any condition are not covered.

57. 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.

58. Oral, Implantable and Injectable Contraceptives. Oral, implantable and injectable contraceptive drugs, and Prescription barrier methods that are not on the Formulary are not covered.

59. 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.
60. 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.
61. Out-of-Network Infertility. Testing, counseling and planning services for infertility are not covered when provided by Out-of-Network Providers.
62. Out-of-Network Mental Health and Substance Abuse Services. Interventions to treat Mental Health or substance abuse are not covered when rendered by an Out-of-Network Provider.
63. Out-of-Network Reconstructive Surgery. Services rendered for any Reconstructive Surgery, including reduction mammoplasty, are not covered when rendered by an Out-of-Network Provider.
64. Out-of-Network Therapy. Services rendered Out-of-Network for physical, occupational and speech therapy, chiropractic services and cardiac rehabilitation therapy are not covered.
65. Over-the-Counter Medications. Medications (except insulin) which do not by law require a Prescription from a Physician are not covered.
66. Pain Pump, Disposable. Disposable pain pumps following surgery are not covered.
67. 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.
68. Percutaneous Sacroplasty. Percutaneous sacroplasty is not covered.
69. Peripheral Vascular Disease Rehabilitation Therapy. Peripheral vascular disease rehabilitation therapy is not covered.
70. 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.
71. 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.
72. Radio-frequency Thermal Therapy for Treatment of Orthopedic Conditions. The use of radio-frequency thermal therapy for treatment of orthopedic conditions is not covered.
73. Rest cures. Services or supplies for rest cures are not covered.
74. Seasonal Affective Disorder (SAD). Use of photo therapy or light therapy to treat seasonal affective disorder or depression is not covered.
75. Sensory Stimulation for Coma Patients. Sensory stimulation, whether visual, auditory, olfactory, gustatory, cutaneous or kinesthetic, for coma patients is not covered.
76. 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.
77. 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.
78. Short stature syndrome. Any services related to the treatment of short stature syndrome, except for laboratory documented growth hormone deficiency, are not covered.
79. Sleep Apnea, Portable Studies. Studies for the diagnosis, assessment or management of obstructive sleep apnea, not continuously attended by a qualified technician, are not covered.

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

81. 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.

82. Sperm and Embryo Storage. Collecting, storing, freezing or thawing of specimens of sperm or embryos for later use is not covered.

83. Substance Addiction. Medications used to sustain or support an addiction or substance dependency are not covered.

84. Tanning equipment or salon. The purchase or rental of tanning equipment, supplies or the services of a tanning salon are not covered.

85. Temporomandibular Joint. Treatment of disease or dysfunction of the temporomandibular joint is not covered.

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

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

88. 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.

89. Ultrasounds. More than one basic level obstetrical ultrasound during Routine Prenatal Care is not covered.

90. 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 Insitu Keratomileusis (LASIK) and all other related refractive procedures are not covered. Keratoprosthesis is 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 $50 maximum Allowance or Allowable Charge. See Subsection 3.11.3.

91. 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.

92. Vocational rehabilitation. Vocational rehabilitation services, vocational counseling and testing, employment counseling or services to assist a Member in gaining employment, are not covered.

93. 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.

94. Whole body computed tomography. Whole body computed tomography is not covered.

95. 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, 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. IDEA Covered Services. Services and supplies paid or which the Member is entitled to have paid or to obtain without cost by virtue of the Individuals with Disabilities Education Act ("IDEA"), 20 U.S.C. §1401 *et seq.* as amended, are not covered.

12. Postage or Delivery Charges. Charges for shipping, packaging, handling or delivering Medications are not separately covered.

13. 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.

14. 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.
15. 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.
16. 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.
17. War. Services or supplies provided for treatment of disease or injuries sustained while serving in the military forces of any nation are not covered
18. 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 10.29) or Imperative Care (see Subsection 10.44) 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 Allowed Charge for Emergency Care or Imperative Care 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.

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 Out-of-Network 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 for Out-of-Network 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. work on a full-time basis for the Employer;
   b. complete the required Waiting Period, if applicable;
   c. be in a class of employees who are included in the Plan;
   d. regularly and routinely work the minimum number of hours and the minimum number or weeks per year specified in the Group Application; and
   e. live or work in the Service Area.
2. **Dependent Coverage.** Eligible Dependents are the Subscriber's:
   a. Spouse;
   b. Child less than 26 years of age, provided the Child was covered by the Plan or by another Health benefit Plan on May 31, 2010 and 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;
   c. unmarried Child less than 26 years of age; who is:
      i. living with the Subscriber in a parent-child relationship; and
      ii. is claimed as a dependent on the Subscriber's federal income tax return;
   d. Child less than 26 years of age, provided the Child enrolls on or after the anniversary date of the Group Contract after September 23, 2010;
   e. 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 c. 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 Subscriber must submit a written application for coverage for the Subscriber and any Dependents. 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 an enrollment application is completed 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 application 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 of the Contract Month following the date the Subscriber is first eligible for coverage. However, if the date the Subscriber is first eligible for coverage falls on the first day of the Contract Month, the Subscriber's coverage will become effective at 12:01 a.m. on that day.

4. **Coverage in the Case of Late Enrollment**: If an employee or an employee's dependent who is eligible for coverage does not make application for coverage in the Plan when initially eligible for coverage, the employee or dependent cannot subsequently obtain coverage, except during a Special Enrollment Period or Open Enrollment Period.

5. **Open Enrollment Period**: Annually, during the month designated by the Employer and set forth in the Group Contract, employees who are eligible for coverage may enroll in the Plan.

During the Open Enrollment Period, employees covered in the Plan may change their coverage, and that of their covered dependents. Unless otherwise designated in the Group Contract, enrollments and coverage changes made during the Open Enrollment Period become effective on the anniversary date of the Group Contract.

6. **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. Subscriber submits a written application for Dependents' coverage within 30 days of the Subscriber's Effective Date; and
   2. The appropriate premium is timely paid.

   If the Subscriber submits an application for such existing eligible Dependent(s) after 30 days of the Subscriber's effective date, coverage for such Dependent(s) shall begin on the first of the month following Health Advantage's receipt of the application and the Dependent(s) shall be classified as a Late Enrollee. The status of Late Enrollee is important with respect to the Preexisting Condition exclusion.

7. **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 Subscriber shall submit an application or change form within 30 days of the date of marriage. The effective date will be the first of the month following the date of marriage and the Spouse will not be a Late Enrollee. If a Subscriber submits the application or change form 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 Subscriber gives Health Advantage notice by submitting an application or change form 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 Subscriber submits the application or change form 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. **Court Ordered Coverage for a Child.** 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 written notification and satisfactory proof of the court order. If the Subscriber fails to apply to obtain coverage for a Child, Health Advantage shall enroll the Child on the first day of the month following Health Advantage's receipt of a written application from 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 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 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 an application 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 application for coverage is submitted to Health Advantage within 60 days of the Child's birth. If the Subscriber submits the application or change form 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.** Written application 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 first day of the month following the date that application for coverage is received by Health Advantage. Such Dependent will not be a Late Enrollee. If the Subscriber submits the application or change form 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.

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 of the Contract Month 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. 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 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.

b. Coverage shall terminate at 12:00 midnight Central Time on the last day of the Contract Month in which the event occurs when:

i. The Member ceases to be eligible as a Subscriber or Dependent for any reason.

ii. The Member is a Dependent Spouse who becomes legally separated or divorced from the Subscriber.

c. 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.

3. **Continuation Rights under Federal Law.** If Section 10001 of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) applies to the Group, the coverage of a Subscriber or Member whose coverage ends due to a Qualifying Event may be continued while the Group Contract remains in force subject to the terms of this Section and all terms and provisions of this Evidence of Coverage not inconsistent with this Section.

This provision shall not be interpreted to grant to any Member any continuation rights under this Evidence of Coverage in excess of those required by COBRA. If the Group fails to comply with the provisions of the Group Contract and this Evidence of Coverage concerning COBRA or the notice requirements or other standards under COBRA, Health Advantage shall not assume the Group's obligation to provide COBRA continued coverage under the Plan.

a. **Qualifying Events.** The following is a list of events which could result in termination of a Member's coverage under this Evidence of Coverage. If such should occur, for purposes of this Section, the event shall be called a Qualifying Event.

i. A Subscriber's death.

ii. Termination of a Subscriber's employment (other than by reason of the Subscriber's gross misconduct), or of a Subscriber's eligibility due to reduction in the Subscriber's hours of employment.

iii. A Subscriber's and Spouse's divorce or legal separation.

iv. A Subscriber becoming entitled to Medicare.

v. A Dependent Child ceasing to be a Dependent Child as defined in this Evidence of Coverage.

b. **Requirements for COBRA Continuation.** Continuation under this Subsection is subject to a Member requesting it and paying any required premium contributions to the Group within the applicable COBRA election period. In addition, all of the following conditions must be satisfied in order for COBRA continuation coverage to apply:

i. The Group must sponsor and maintain the Plan at the time of the qualifying event, as well as when the Member elects to continue coverage; and

ii. The Group, as Plan Administrator, must have provided the Member an initial notice of COBRA rights at the time coverage commenced under the Plan (this Evidence of Coverage); and

iii. The Plan Administrator must notify the person qualified to elect continuation of coverage under COBRA ("Qualified Insured") of the right to elect coverage within 14 days of receiving notice of the happening of any of the qualifying events listed above; and

iv. The Member must notify the Plan Administrator within 60 days of the happening of Qualifying Event (iii) or (v) in Section 6.4.3.a, above; and

v. The Member must elect to continue coverage under the Plan within 60 days of the later of:

(1) the date the notification of election rights is sent, or

(2) the date coverage under the Plan terminates.

If an election is not made by the Member within this 60-day period, the option to elect COBRA shall end.

If a Subscriber with Dependent coverage requests continuation of coverage under this Section, such request shall include the Dependent coverage, unless the Subscriber asks that it be dropped. In like manner, such a request on the part of the covered Spouse of a Subscriber shall include coverage for all Dependents of the Subscriber who were covered.

c. **Coverage Continued.** The coverage continued for a Member in accordance with this Section shall be the same as otherwise provided under this Evidence of Coverage for other Members in the same benefit class in which such Member would have been covered had his or her coverage not terminated.

d. **Effective date.** The effective date for COBRA continuation is the date coverage under the Plan terminates due to a qualifying event.

e. **Termination.** Once in effect, COBRA continuation coverage for a Member under this Section shall terminate on the earliest to occur of the following applicable dates:

i. The date the Group Contract terminates;

ii. At the end of the last period for which premium contributions for such coverage have been made, if the Member or other responsible person does not make, when due, the required premium contribution to the Group;

iii. The date ending the maximum period. In the Case of Qualifying Event 6.4.3.a.(ii) above (relating to termination of employment or reduction in hours), the date ending the maximum period shall be the date 18 months after the date of that Qualifying Event; unless the Social Security Administration determines that the Covered Person is disabled at the time of, or within 60 days after the Qualifying Event, and the Covered Person provides the notice of Social Security disability determination to the Plan Administrator with 60 days of the date of the Social Security determination and before the end of the initial 18-month period of continuation, in which case this date shall be 29 months after the Qualifying Event. In all other cases, such date shall be the date 36 months after the date of that the applicable Qualifying Event.

iv. The date the Member becomes covered under any other group health plan that provides coverage for Preexisting Conditions;

v. The date the Member becomes entitled to Medicare;

vi. The date the Member's coverage is terminated for cause. See Section 6.3.2 above.

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 polices 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;

   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, upon request and free of charge, 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;

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 Criteria to a Claim involving expenses in excess of five hundred ($500) dollars.** 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; and, as a result, you will incur expenses of five hundred ($500) dollars or more, 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 Reviewer has not given you notification of the determination involving a pre-service claim appeal within fifteen (15) 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 Reviewer has not given you notification of the determination involving a post-service claim appeal within thirty (30) days following receipt of your appeal to the Plan; or

iv. Your claim meets the requirements for expedited external review, (see Subsection 7.4.14) and you have simultaneously submitted an appeal to the Plan.

2. **Claim Appeals Not Subject to External Review.**

a. **Expressed Exclusion.** A claim that was denied because of an expressed exclusion in the Plan, other than 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, is not subject to external review.

b. **Express Limitation.** A claim that was denied because of an express limitation in the Plan with respect to the number of visits, treatments, supplies or services for a covered benefit in a given calendar period or over the lifetime of the Member is not subject to external review.

c. **Dollar Limitation.** A claim that was denied because of an express limitation in the Plan with respect to a maximum dollar limitation with respect to a covered benefit in a given calendar period or over the lifetime of the Member is not subject to external review.

d **Eligibility of Claimant.** A claim that was denied because Health Advantage determined the claimant is not eligible to be a Member is not subject to external review.

e. **Fraud or Material Misrepresentation.** A claim that was denied because Health Advantage determined the treatment, service, or supplies were requested or obtained by a Member through fraud or material misrepresentation is not subject to external review.

f. **Illegal Services.** A claim that was denied because the claimed services, or the means or methods of administering such services were illegal is not subject to external review.

g. **Government Agency Determination.** A claim that was denied because of FDA or other government agency determinations, reports or statements is not subject to external review.

h. **Provider License.** A claim that was denied because of the licensure, permit or accreditation status of a health care Provider is not subject to external review.

i. **Provider Access.** A claim that was denied because of the Plan's procedure for determining the Member's access to a health care Provider is not subject to external review.

3. **Where and When to Submit External Review Appeal.** You may request external review by sending a request marked "External Review Request" to Member Response Coordinator, Post Office Box 8069, Little Rock, Arkansas 72203. Alternatively, you may e-mail our request to APPEALS@HEALTHADVANTAGE-HMO.COM. Your request must be made within sixty (60) days 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 7.3.1.b.ii. or 7.3.1.b.iii. apply, your request may be made at the end of the fifteen (15) day period or thirty (30) 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.

4. **Filing Fee.** You are required to pay a twenty-five dollar ($25) fee to submit an appeal for external review. When you submit your request, include a check made payable to Health Advantage. If the external review results in a reversal of the claim denial, in whole or in part, Health Advantage will refund your filing fee.

5. **Independent Review Organization and Independent Medical Reviewer**

a. **Health Advantage shall select** an Independent Review Organization from the list of approved Independent Review Organizations compiled and maintained by the Arkansas Insurance 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 an employee of Health Advantage and does not provide services exclusively for Health Advantage or for individuals holding 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.

6. **Documentation**

a. **Written Appeals.** You must submit your appeal in writing via mail or e-mail. 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."

7. **Referral of Review Request to an Independent Review Organization.** Upon receipt of the documentation set out in Subsection 7.3.5, the Appeals Reviewer shall immediately refer the request for external review, along with Health Advantage's initial determination of the claim and the Appeals Reviewer's internal review determination (if applicable) to an Independent Review Organization.

8. **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.

9. **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 7.3.1 and 7.3.2.

10. **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 7.3.5.b; or
    b. you or your health care professional have not provided information requested by the Independent Review Organization in accordance with Subsection 7.3.7.

11. **Independent Medical Review Determination.** If the Independent Review Organization does not reject the request for review in accordance with Subsections 7.3.8 or 7.3.9, 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 this 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).

12. **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.

13. **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 of the Independent Medical Reviewer's determination;
        iv. The principal reason(s) for the determination;
        v. The rationale for the determination; and
        vi. References to the evidence or documentation, including practice guidelines, considered in the determination.

14. **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 7.3.11.b and 7.3.12 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 7.3 applicable to independent medical review of claims apply to expedited external review of claims.

15. **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.

16. **Assistance.** If you have any questions concerning the External Review Process, you may contact the Health Advantage Member Response Coordinator, Post Office Box 8069, Little Rock, Arkansas 72203. Telephone toll free (800) 843-1329.

17. **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 800-852-5494. The e-mail address is iNSURANCE.CONSUMERS@ARKANSAS.GOV.

18. **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 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.

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.**

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 **Eligibility Date** means:

For a Subscriber, the latest of the following dates:

1. the policy effective date for a Subscriber who has selected coverage and is working for the Employer on that date; or
2. the date the required Waiting Period is completed for any Subscriber hired 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.

10.29 **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.

10.30 **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.

10.31 **Employer** means a sole proprietorship, partnership, or corporation which is the Contract Holder. Employer and Group shall have a common meaning when used herein.

10.32 **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.

10.33 **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.**

10.34 **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.

10.35 **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.

10.36 **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.

10.37 **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.

10.38 **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.

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

10.40 **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.

10.41 **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 4.3.56.

10.42 **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.

10.43 **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.

10.44 **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.

10.45 **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.

10.46 **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.

10.47 **Late Enrollee** means a Member who submits an application for coverage other than during:

1. the first period in which the Member is eligible to enroll in the Plan; or
2. a Special Enrollment Period.

10.48 **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.

10.49 **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.

10.50 **Maintenance Therapy** means any therapy where there is no expectation based upon a reasonable degree of medical probability that treatment will result in significant, measurable improvement in the condition in a reasonable, predictable period of time for treatment.

10.51 **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.

10.52 **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.

10.53 **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.

10.54 **Member** means a Subscriber or Dependent who is covered under the Group Contract.

10.55 **Mental Health** 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 disorders, conditions and 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.)

10.56 **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 4.3.56.

10.57 **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.

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

10.59 **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.

10.60 **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.

10.61 **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.

10.62 **Outpatient Psychiatric Center** means a facility licensed by the appropriate state agency as such.

10.63 **Outpatient Surgery Center or Radiation Therapy Center** means a facility licensed as such by the appropriate state agency.

10.64 **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.

10.65 **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.

10.66 **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.

10.67 **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.

10.68 **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.

10.69 **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.

10.70 **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.

10.71 **Physician Service** means such services as are rendered by a licensed Physician within the scope of his license.

10.72 **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.

10.73 **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.

10.74 **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.

10.75 **Plan Administrator** means the Employer.

10.76 **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.

10.77 **Preexisting Condition** means a condition (whether physical or mental) regardless of the cause of the condition, for which medical advice, diagnosis, care and treatment was recommended or received within the six-month period ending on (i) the Member's effective date or (ii) the first day of their Waiting Period (the "six-month look-back period"), whichever applies. If the Member submits an application for coverage during the Waiting Period, the six-month look-back period is calculated by counting back from the first day of the Waiting Period, rather than from the Member's actual effective date. If the Member did not apply within the Waiting Period, the six-month look back period is calculated by counting back from the Member's effective date.

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 provider 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) or Open Enrollment Period 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 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 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.

10.98 **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.

10.99 **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.

10.100 **We, Our and Us** mean Health Advantage.

10.101 **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.

10.102 **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.

10.103 **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.