ARKANSAS UNITED METHODIST

EMPLOYEE BENEFIT PLAN

PLAN DOCUMENT

(January 1, 2013)

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GRANDFATHERED STATUS DISCLOSURE

This **Arkansas United Methodist Conference** Plan believes this ***Plan*** is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that this ***Plan*** may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits. Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the ***plan administrator***.

Covered persons may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.

SUMMARY PLAN DESCRIPTION

Name of Plan:

Arkansas United Methodist Conferences Employee Benefit Plan

Name, Address and Phone Number of Employer/Plan Sponsor:

Arkansas United Methodist Conferences
P.O. Box 3611
800 Daisy Bates Drive
Little Rock, AR 72203
501-324-8003 or 501-324-8040

Employer Identification Number:

71-6163137

Group Number:

ARMET01

Type of Plan:

Welfare Benefit Plan: medical, dental and vision benefits

Type of Administration:

Contract administration: The processing of claims for benefits under the terms of the ***Plan*** is provided through a company contracted by the ***employer*** and shall hereinafter be referred to as the ***claims processor***.

Name, Address and Phone Number of Plan Administrator, Fiduciary, and Agent for Service of Legal Process:

Arkansas United Methodist Conferences
P.O. Box 3611
800 Daisy Bates Drive
Little Rock, AR 72203
501-324-8003 or 501-324-8040

Legal process may be served upon the ***plan administrator***.

Eligibility Requirements:

For detailed information regarding a person's eligibility to participate in the ***Plan,*** refer to the following sections:

Eligibility
Enrollment
Effective Date of Coverage

For detailed information regarding a person being ineligible for benefits through reaching ***maximum benefit*** levels, ***pre-existing conditions***, termination of coverage or ***Plan Exclusions***, refer to the following sections:

Schedule of Benefits
Effective Date of Coverage, Pre-existing Conditions
Termination of Coverage
Plan Exclusions

Source of Plan Contributions:

Contributions for ***Plan*** expenses are obtained from the ***employer*** and from the *covered* ***employees***. The ***employer*** evaluates the costs of the ***Plan*** based on projected ***Plan*** expenses and determines the amount to be contributed by the ***employer*** and the amount to be contributed by the ***covered employees***.

Funding Method:

The ***employer*** pays ***Plan*** benefits and administration expenses directly from general assets. Contributions received from ***covered persons*** are used to cover ***Plan*** costs and are expended immediately.

Ending Date of Plan Year:

July 31st

Procedures for Filing Claims:

For detailed information on how to submit a claim for benefits, or how to file an appeal on a processed claim, refer to the section entitled, *Medical/Dental/Vision Claim Filing Procedure*.

The designated ***claims processor*** is:

For Medical & Vision Claims:
CoreSource, Inc.
Post Office Box 8215
Little Rock, AR 72221-8215

For Prescription Drug Claims:
CareMark
Box 659541
San Antonio, TX 78265-9541

For Dental Claims:
Delta Dental of Arkansas (**DDAR**)
c/o CoreSource, Inc.
Post Office Box 15965
North Little Rock, AR 72231

SCHEDULE OF BENEFITS

The following *Schedule of Benefits* is designed as a quick reference. For complete provisions of the ***Plan's*** benefits, refer to the following sections: *Medical/Dental/Vision Claim Filing Procedure, Medical Expense Benefit, Prescription Drug Program, Dental Expense Benefit, Vision Expense Benefit, Plan Exclusions* and *Preferred Provider or Nonpreferred Provider*.

MEDICAL BENEFITS FOR ACTIVE PARTICIPANTS AND MEDICARE SECONDARY PARTICIPANTS:

Maximum Benefit Per Covered Person While Covered By This Plan For:		
Medical	Unlimited	
Infertility/In-Vitro Fertilization	$15,000	
Maximum Benefit Per Covered Person Per Calendar Year For:		
Medical	$2,000,000	
Chiropractic Care	$1,000	
Skilled Nursing/Extended Care Facility	120 days	
Home Health Care	40 visits	
Deductible Per Calendar Year: (*applies to preferred* and *nonpreferred providers*)		
Individual Deductible (Per Person)	$2,000	
Family Deductible	$4,000	
If two or more covered members of a family are injured in the same ***accident*** and, as a result of that ***accident***, incur ***covered expenses***, only one individual deductible amount will be deducted from the total ***covered expenses*** of all covered family members related to the ***accident*** for the remainder of the calendar year.		
Additional Per Confinement Deductible: (Refer to *Medical Expense Benefit, Deductible*)		
Hospital Admission	$500	
Out-of-Pocket Expense Limit Per Calendar Year: (includes deductible)	***In-Network***	***Out-of-Network***
Individual (Per Person)	$4,000	$8,000
Family	$8,000	$16,000
Refer to *Medical Expense Benefit, Out-of-Pocket Expense Limit* for a listing of charges not applicable to the out-of-pocket expense limit. ***Out-of-Pocket Expense Limits*** **do not contribute toward each other**.		

Coinsurance:
The ***Plan*** pays the percentage listed on the following pages for ***covered expenses incurred*** by a ***covered person*** during a calendar year after the individual or family deductible has been satisfied and until the individual or family out-of-pocket expense limit has been reached. Thereafter, the ***Plan*** pays one hundred percent (100%) of ***covered expenses*** for the remainder of the calendar year or until the ***Essential Health Benefits***/non-***Essential Health Benefits maximum benefit*** has been reached. Refer to *Medical Expense Benefit, Out-of-Pocket Expense Limit*, for a listing of charges not applicable to the one hundred percent (100%) ***coinsurance***. ***This 100% provision will not apply to expenses for any participant who has other medical coverage.***

BENEFIT DESCRIPTION	***Preferred Provider*** (% of ***negotiated rate***, if applicable, otherwise % of ***customary and reasonable amount***)	***Nonpreferred Provider*** (% of ***customary and reasonable amount)***
Inpatient Hospital Additional Deductible Applies.	80%	70%
Preadmission Testing	100%*	100%*
Outpatient Surgery/Ambulatory Surgical Center	80%*	70%*
Emergency Room Services	80%	80%
Primary Care Physician (PCP) Office Visit (General Practitioner, Family Practice, OB/GYN, Internal Medicine and Pediatrician)	$30 Copay then 100%*	70%
Physician's Services (other than PCP Office Visit)	80%	70%
Diagnostic X-rays & Lab Inpatient or Outpatient	80%	70%
Second Surgical Opinion Elective by Covered Person	100%*	100%*
Rehabilitation Facility	80%	70%
Extended Care Facility 50% of the semi-private room rate from which the patient was transferred. Limitation: 120 days ***maximum benefit*** per calendar year	50%	50%
Home Health Care Limitation: 40 visits ***maximum benefit*** per calendar year	80%	70%
Hospice Care Limitation: 15 visits ***maximum benefit*** for family bereavement counseling	80%	70%
Smoking Cessation (for office visits to prescribe and monitor smoking cessation medications)	80%	70%
Durable Medical Equipment	80%	70%
Infertility/In-vitro Fertilization (Limited to $15,000 per lifetime)	80%	70%

* Deductible Waived

BENEFIT DESCRIPTION	***Preferred Provider*** (% of ***negotiated rate***, if applicable, otherwise % of ***customary and reasonable amount***)	***Nonpreferred Provider*** (% of ***customary and reasonable amount)***
Children's Immunizations Limitation: to age eighteen (18) ***maximum benefit***	100%*	100%*
Wellness Benefit Routine Physical Exams, Pap Smears, Immunizations, Mammograms, and Prostate Cancer Exams including office visits and any related laboratory charges. (Wellness Benefit charges over $1,200 will be subject to the regular benefit percentage and coinsurance) *See Routine Preventive Care section.* ***NOTE***: Prostate Cancer Exams are not subject to any deductible.	100%*	100%*
Colorectal Cancer Examinations/Laboratory Tests *See Routine Preventive Care section.*	80%*	70%*
Mental & Nervous Disorders		
Office Visit Services	$30 Copay then 100%*	70%
Inpatient Services	80%	70%
Outpatient Services	80%	70%
Office Visit Services	$30 Copay then 100%*	70%
Inpatient Services	80%	70%
Outpatient Services	80%	70%
Therapy Services (Physical, Speech, Occupational, etc.)	80%	70%
Birthing Facility	80%	70%
Ambulance Services	80%	70%
Chiropractic Care Limitation: $1,000 ***maximum benefit*** per calendar year	80%	70%
Hearing Aids (please refer to *Medical Expense Benefit*, Hearing Aids) Limitation: Per Ear per 3-year period (this benefit is not subject to copays or deductibles)	80%*	70%*
CVS Caremark Specialty Pharmacy Program	See *Medical Expense Benefit, CVS Caremark Specialty Pharmacy Program* section.	
All Other Covered Expenses	80%	70%

* Deductible Waived

ROUTINE VISION BENEFITS FOR ALL COVERED PARTICIPANTS:

Deductible Per Covered Person Per Calendar Year:	None
Percentage Payable:	100%
Examination Maximum Benefit (18 years of age and older)**:** Limitation: One (1) exam per person per calendar year	$40
Examination Maximum Benefit (up to 18 years of age)**:** Limitation: One (1) exam per person per calendar year **Note: Dollar maximums do not apply to dependent children under the age of eighteen (18)**	
Corrective Lenses/Frames OR Contact Lenses Maximum Benefit: Limitation: Per covered person per calendar year **Note: Dollar maximums do not apply to dependent children under the age of eighteen (18)**	$200

Refer to *Vision Expense Benefit* for complete details.

DENTAL BENEFITS FOR ALL COVERED PARTICIPANTS:

Deductible Per Calendar Year: Individual The deductible is waived for diagnostic & preventive dental services.	$100
Maximum Benefit Per Covered Person For: Diagnostic, Preventive & Basic dental services per calendar year for ***covered persons*** <u>eighteen (18) years of age and older</u>) Diagnostic, Preventive & Basic dental services per calendar year for ***covered persons*** <u>under age eighteen (18)</u> (other than Orthodontics)	$500 $2,000,000
Percentage Payable of Maximum Plan Allowance For: Class I - Diagnostic & Preventive Dental Services Class II - Basic Dental Services	100% 80%

Refer to *Dental Expense Benefit* for complete details.

PRESCRIPTION DRUG PROGRAM FOR ALL COVERED PARTICIPANTS:

Retail Deductible Per Calendar Year Per Person:	$100
Retail Pharmacy Option Prescription Drug Card ***Copay*** Limitation: 30 day supply	 100% after ***copay*** Generic: $10 ***copay*** Preferred Brand Name: $40 ***copay*** Nonpreferred Brand Name: $60 ***copay***
Mail Order Option Mail Order Prescription ***Copay*** Limitation: 90 day supply	*Deductible does not apply to Mail Order.* 100% after ***copay*** Generic: $20 ***copay*** Preferred Brand Name: $80 ***copay*** Nonpreferred Brand Name: $120 ***copay***

Refer to *Prescription Drug Program* for complete details.

SPECIAL NOTICE: The ***covered person*** and the prescribing ***physician*** must both agree to change to a drug or medication not included in the drug formulary when the equivalent has been ineffective in treatment or has caused or is expected to cause adverse or harmful reactions to the ***covered person***, as determined by the prescribing ***physician***. The specific drug or medication will be subject to the same benefits as formulary medications, provided the ***covered person*** utilizes an In-Network Pharmacy.

MEDICAL BENEFITS FOR RETIRED PARTICIPANTS:

MEDICAL SCHEDULE OF BENEFITS FOR RETIRED PARTICIPANTS

When Retired Employees or their Dependents become eligible under Medicare, all of the following will happen:

- Medicare pays benefits first.
- All health benefits then in effect for that person stop and are replaced with a new benefit to complement Medicare. The new benefit is a Major Medical Benefit.
- Eligible Charges incurred prior to a person becoming eligible under Medicare in the Calendar Year in which the person becomes eligible under Medicare may be used to satisfy the Cash Deductible under the new Major Medical Benefit for that Calendar Year.
- Payment for any day of confinement or any treatment, services, or supplies given after the date the person becomes eligible under Medicare is made only under the new Major Medical Benefit.
- This new Major Medical Benefit is only for persons eligible under Medicare. It does not apply to any participant unless that participant becomes eligible under Medicare.

The Major Medical Benefit for Retired Employees pays Eligible Charges that are more than the amounts payable for the same expenses under both of the following:

- Medicare Parts A and B.
- Any plan of basic medical benefits sponsored by the Employer for persons eligible under Medicare.

Each participant must satisfy a Cash Deductible of $250 each Calendar Year before any payment is made. The Cash Deductible is the amount of Eligible Charges you must first pay each year for each participant.

If a participant:

- Incurs Eligible Charges during October, November, or December; and
- Uses these Eligible Charges to satisfy the Cash Deductible,

They will also be counted toward that participant's Cash Deductible for the following year.

If two (2) or more family members are hurt in the same accident, only one (1) Cash Deductible will have to be paid for all expenses incurred by the family due to that accident each year.

Then the benefit pays the following percentage of Eligible Charges:

- 80% of the UCR amount for PPO Providers and 70% of the UCR amount for Non-PPO Providers.

The Eligible Charges payable under this Major Medical Benefit for Retired Employees are the same Eligible Charges payable under Medicare with the exception of Prescription Drug charges.

If the provider has agreed to limit charges for services and supplies to the charges allowed by Medicare (participation physicians), this Plan determines the amount of Eligible Charges based on the amount of charges allowed by Medicare.

If the provider has not agreed to limit charges for services and supplies to the charges allowed by Medicare (non-participating physician), this Plan determines the amount of Eligible Charges based on the lesser of the following:

- The Reasonable Charges.
- The amount of the Limiting Charges as defined by Medicare.

OUT-OF-POCKET FEATURE

The Out-of-Pocket Feature does not apply to charges incurred because of cost containment penalties, nor charges incurred due to reduction of UCR nor prescription drug card copays nor Inpatient Hospital Confinement Deductibles. The aforementioned charges will never be paid at 100%, even after the Out-of-Pocket Maximum has been reached.

The amount of Eligible Charges, including the Cash Deductible that you pay, are counted toward the In-Network Out-of-Pocket Maximum or the Out-of-Network Out-of-Pocket Maximum, as applicable. The In-Network Out-of-Pocket Maximum is $2,500 and the Out-of-Network Out-of-Pocket Maximum is $2,500; please note these are separate and do not contribute toward each other. When the Out-of-Pocket Maximum for In-Network is reached for any one person in a Calendar Year, In-Network Eligible Charges, other than those shown above, are payable at 100% for that same person for the rest of that year. When the Out-of-Pocket Maximum for Out-of-Network is reached for any one person in a Calendar Year, Out-of-Network Eligible Charges, other than those shown above, are payable at 100% for that same person for the rest of that year.

MAXIMUM BENEFIT

The Maximum Benefit payable per Calendar Year for each participant is $2,000,000.

The maximum will include any amount paid under the Employer's Comprehensive Medical Benefit for persons eligible under Medicare in effect prior to the Effective Date.

EXCLUSIONS

The exclusions shown in the "Exclusions" section of this Plan Document also apply to this Major Medical Benefit for Retired Employees and includes ineligible charges under Medicare with the exception of Prescription Drug charges.

SCHEDULE OF BENEFITS FOR MEDICARE PRIMARY PARTICIPANTS:

Maximum Benefit Per Covered Person While Covered By This Plan For:		
Medical	Unlimited	
Infertility/In-vitro Fertilization	$15,000	
Maximum Benefit Per Covered Person Per Calendar Year For:		
Medical	$2,000,000	
Chiropractic Care	$1,000	
Skilled Nursing/Extended Care Facility	120 days	
Home Health Care	40 visits	
Deductible Per Calendar Year: (*applies to preferred* and *nonpreferred providers*)		
Individual Deductible (Per Person)	$250	
Family Deductible	$500	
If two or more covered members of a family are injured in the same ***accident*** and, as a result of that ***accident***, incur ***covered expenses***, only one individual deductible amount will be deducted from the total ***covered expenses*** of all covered family members related to the ***accident*** for the remainder of the calendar year.		
Additional Per Confinement Deductible: (Refer to *Medical Expense Benefit, Deductible*)		
Hospital Admission	$200	
Out-of-Pocket Expense Limit Per Calendar Year: (includes deductible)	***In-Network***	***Out-of-Network***
Individual (Per Person)	$2,500	$2,500
Family	$5,000	$5,000
Refer to *Medical Expense Benefit, Out-of-Pocket Expense Limit* for a listing of charges not applicable to the out-of-pocket expense limit. ***Out-of-Pocket Expense Limits*** **do not contribute toward each other**.		

Coinsurance:

The ***Plan*** pays the percentage listed on the following pages for ***covered expenses incurred*** by a ***covered person*** during a calendar year after the individual or family deductible has been satisfied and until the individual or family out-of-pocket expense limit has been reached. Thereafter, the ***Plan*** pays one hundred percent (100%) of ***covered expenses*** for the remainder of the calendar year or until the ***Essential Health Benefits***/non-***Essential Health Benefits maximum benefit*** has been reached. Refer to *Medical Expense Benefit, Out-of-Pocket Expense Limit*, for a listing of charges not applicable to the one hundred percent (100%) ***coinsurance***. ***This 100% provision will not apply to expenses for any participant who has other medical coverage.***

BENEFIT DESCRIPTION	***Preferred Provider*** (% of ***negotiated rate***, if applicable, otherwise % of ***customary and reasonable amount***)	***Nonpreferred Provider*** (% of ***customary and reasonable amount)***
Inpatient Hospital Additional Deductible Applies.	80%	70%
Preadmission Testing	100%*	100%*
Outpatient Surgery/Ambulatory Surgical Center	80%*	70%*
Emergency Room Services	80%	80%
Physician's Services	80%	70%
Diagnostic X-rays & Lab Inpatient or Outpatient	80%	70%
Second Surgical Opinion Elective by Covered Person	100%*	100%*
Rehabilitation Facility	80%	70%
Extended Care Facility 50% of the semi-private room rate from which the patient was transferred. Limitation: 120 days ***maximum benefit*** per calendar year	50%	50%
Home Health Care Limitation: 40 visits ***maximum benefit*** per calendar year	80%	70%
Hospice Care Limitation: 15 visits ***maximum benefit*** for family bereavement counseling	80%	70%
Smoking Cessation (for office visits to prescribe and monitor smoking cessation medications)	80%	70%
Durable Medical Equipment	80%	70%
Infertility/In-vitro Fertilization (Limited to $15,000 per lifetime)	80%	70%

* Deductible Waived

BENEFIT DESCRIPTION	***Preferred Provider*** (% of ***negotiated rate***, if applicable, otherwise % of ***customary and reasonable amount***)	***Nonpreferred Provider*** (% of ***customary and reasonable amount)***
Children's Immunizations Limitation: to age eighteen (18) ***maximum benefit***	100%*	100%*
Wellness Benefit Routine Physical Exams, Pap Smears, Immunizations, Mammograms, and Prostate Cancer Exams including office visits and any related laboratory charges. (Wellness Benefit charges over $1,200 will be subject to the regular benefit percentage and coinsurance.) *See Routine Preventive Care section.* ***NOTE***: Prostate Cancer Exams are not subject to any deductible.	100%*	100%*
Colorectal Cancer Examinations/Laboratory Tests *See Routine Preventive Care section.*	80%*	70%*
Mental & Nervous Disorders		
Office Visit Services	80%	70%
Inpatient Services	80%	70%
Outpatient Services	80%	70%
Chemical Dependency		
Office Visit Services	80%	70%
Inpatient Services	80%	70%
Outpatient Services	80%	70%
Therapy Services (Physical, Speech, Occupational, etc.)	80%	70%
Birthing Facility	80%	70%
Ambulance Services	80%	70%
Chiropractic Care Limitation: $1,000 ***maximum benefit*** per calendar year	80%	70%
Hearing Aids (please refer to *Medical Expense Benefit*, Hearing Aids) Limitation: Per Ear per 3-year period (this benefit is not subject to copays or deductibles)	80%*	70%*
All Other Covered Expenses	80%	70%
CVS Caremark Specialty Pharmacy Program	See *Medical Expense Benefit, CVS Caremark Specialty Pharmacy Program* section.	

* Deductible Waived

PREFERRED PROVIDER OR NONPREFERRED PROVIDER

Covered persons have the choice of using either a ***preferred provider*** or a ***nonpreferred provider***.

PREFERRED PROVIDERS

A ***preferred provider*** is a ***physician***, ***hospital*** or ancillary service provider which has an agreement in effect with the ***Preferred Provider Organization*** (PPO) to accept a reduced rate for services rendered to ***covered persons***. This is known as the ***negotiated rate***. The ***preferred provider*** cannot bill the ***covered person*** for any amount in excess of the ***negotiated rate***. ***Covered persons*** should contact the ***employer's*** Human Resources Department for a current listing of ***preferred providers***.

NONPREFERRED PROVIDERS

A ***nonpreferred provider*** does not have an agreement in effect with the ***Preferred Provider Organization***. This ***Plan*** will allow only the ***customary and reasonable amount*** as a ***covered expense***. The ***Plan*** will pay its percentage of the ***customary and reasonable amount*** for the ***nonpreferred provider*** services, supplies and treatment. The ***covered person*** is responsible for the remaining balance. This results in greater out-of-pocket expenses to the ***covered person***.

EXCEPTIONS

The following listing of exceptions represents services, supplies or treatments rendered by a ***nonpreferred provider*** where ***covered expenses*** shall be payable at the ***preferred provider*** level of benefits:

1. ***Emergency*** treatment rendered at a ***nonpreferred provider facility*** or at a ***preferred provider facility*** by a ***nonpreferred provider***. If the ***covered person*** is admitted to the ***hospital*** on an ***emergency*** basis, ***covered expenses*** shall be payable at the ***preferred provider*** level.

2. ***Nonpreferred*** anesthesiologist and/or assistant surgeon if the operating surgeon is a ***preferred provider*** and when the ***facility*** rendering such services is a ***preferred provider***.

3. Radiologist or pathologist services for interpretation of x-rays and diagnostic laboratory and surgical pathology tests rendered by a ***nonpreferred provider*** when the ***facility*** rendering such services is a ***preferred provider***.

4. Diagnostic laboratory and surgical pathology tests referred to a ***nonpreferred provider*** by a ***preferred provider***.

5. While the covered person is confined to a ***preferred provider hospital***, the ***preferred provider physician*** requests a consultation from a ***nonpreferred provider*** or a newborn visit as performed by a ***nonpreferred provider***.

6. ***Medically necessary*** services, supplies and treatments not available through any ***preferred provider***.

7. When a covered ***dependent*** resides outside the service area of the ***Preferred Provider Organization***, for example a ***full-time student***, ***covered expenses*** shall be payable at the ***preferred provider*** level of benefits.

8. ***Covered persons*** who do not have access to ***preferred providers*** within thirty (30) miles of their place of residence, or for ***emergency*** treatment rendered while traveling out-of-area.

9. Treatment rendered at a ***facility*** of the uniformed services.

10. Treatment provided by a ***preferred provider*** who terminates participation in the ***Preferred Provider Organization***, until the earlier of; the current treatment of an acute condition is completed or ninety (90) days following the provider's termination date, whichever comes first.

11. Treatment provided by a ***nonpreferred provider*** to a newly ***covered person*** under the ***Plan***, until the earlier of; current treatment of an acute condition is completed or ninety (90) days following the ***covered person's effective date***, whichever comes first.

EXCEPTIONS ONLY APPLICABLE TO CVS CAREMARK SPECIALTY PHARMACY PROGRAM

1. ***Covered person*** who is identified, as under hospice care is not required to participate in this program.

2. ***Covered person*** is unable to administer the specialty drug or locate a contracted service.

3. In cases where the ***covered person*** has an immediate need for a specialty medication through a retail provider.

MEDICAL EXPENSE BENEFIT

This section describes the ***covered expenses*** of the ***Plan***. All ***covered expenses*** are subject to applicable ***Plan*** provisions including, but not limited to: deductible, ***copay***, ***coinsurance*** and ***maximum benefit*** provisions as shown on the *Schedule of Benefits*, unless otherwise indicated. Any portion of an expense ***incurred*** by the ***covered person*** for services, supplies or treatment, that is greater than the ***customary and reasonable amount*** for ***nonpreferred providers*** or ***negotiated rate*** for ***preferred providers*** will not be considered a ***covered expense*** by this ***Plan***.

COPAY

The ***copay*** is the amount payable by the ***covered person*** for certain services, supplies or treatment rendered by a ***preferred provider***. The service and applicable ***copay*** are shown on the *Schedule of Benefits*. The ***covered person*** selects a ***preferred provider*** and pays the ***preferred provider*** the ***copay***. The ***Plan*** pays the remaining ***covered expenses*** at the ***negotiated rate***. The ***copay*** must be paid each time a treatment or service is rendered. The ***copay*** will not be applied toward the following:

1. The calendar year deductible.
2. The maximum out-of-pocket expense.
3. The deductible carry-over.
4. The common accident deductible.
5. Multiple birth deductible.
6. Hospital deductible.

DEDUCTIBLES

Hospital Deductible

For each ***inpatient hospital confinement***, the ***covered person*** is responsible for an additional ***hospital*** deductible as specified on the *Schedule of Benefits*. The ***hospital*** deductible shall be applied to ***covered expenses*** first, then any applicable calendar year deductible shall be applied.

Individual Deductible

The individual deductible is the dollar amount of ***covered expense*** that each ***covered person*** must have incurred during each calendar year before the ***Plan*** pays applicable benefits. The individual deductible amount is shown on the *Schedule of Benefits.*

Family Deductible

If, in any calendar year, covered members of a family incur ***covered expenses*** that are subject to the deductible that are equal to or greater than the dollar amount of the family deductible shown on *the Schedule of Benefits*, then the family deductible will be considered satisfied for all family members for that calendar year. Any number of family members may help to meet the family deductible amount, but no more than each person's individual deductible amount may be applied toward satisfaction of the family deductible by any family member.

Common Accident

If two or more covered members of a family are ***injured*** in the same ***accident*** and, as a result of that ***accident***, incur ***covered expenses***, only one individual deductible amount will be deducted from the total ***covered expenses*** of all covered family members related to the ***accident*** for the remainder of the calendar year.

Deductible Carry-Over

Amounts ***incurred*** during October, November and December and applied toward the individual deductible of any ***covered person***, will also be applied to the individual deductible of that ***covered person*** in the next calendar year.

Multiple Birth Deductible

When two (2) or more ***dependents*** are born in a multiple birth, only one individual deductible will be taken from the total ***covered expenses incurred*** in a calendar year for those ***dependents*** if the ***covered expenses*** are ***incurred*** in the same calendar year as the birth and are due to:

1. Premature birth; or

2. Abnormal congenital conditions; or

3. ***Injury*** which is ***incurred*** or ***illness*** which starts not more than thirty (30) days after birth.

COINSURANCE

The ***Plan*** pays a specified percentage of ***covered expenses*** at the ***customary and reasonable amount*** for ***nonpreferred providers***, or the percentage of the ***negotiated rate*** for ***preferred providers***. That percentage is specified on *the Schedule of Benefits*. For ***nonpreferred providers***, the ***covered person*** is responsible for the difference between the percentage the ***Plan*** paid and 100% of the billed amount. The ***covered person's*** portion of the ***coinsurance*** represents the out-of-pocket expense limit.

OUT-OF-POCKET EXPENSE LIMIT

After the ***covered person*** has ***incurred*** an amount equal to the out-of-pocket expense limit listed on the *Schedule of Benefits* for ***covered expenses***, the ***Plan*** will begin to pay 100% for ***covered expenses*** for the remainder of the calendar year.

After a covered family has ***incurred*** a combined amount equal to the family out-of-pocket expense limit shown on the *Schedule of Benefits*, the ***Plan*** will pay 100% of ***covered expenses*** for all covered family members for the remainder of the calendar year.

This 100% provision will not apply to expenses for any participant who has other group medical coverage.

Out-of-Pocket Expense Limit Exclusions

The following items do not apply toward satisfaction of the calendar year out-of-pocket expense limit:

1. Expenses for services, supplies and treatments not covered by this ***Plan***, to include charges in excess of the ***customary and reasonable amount***.

2. ***Copays***.

3. Expenses ***incurred*** as a result of failure to obtain precertification.

4. In-Network Out-of-Pocket Expense Limits **DO NOT** contribute toward Out-of-Network Out-of-Pocket Expense Limits and vice versa.

MAXIMUM BENEFIT

The *Schedule of Benefits* contains a separate annual ***maximum benefit***. The *Schedule of Benefits* may also contain separate ***maximum benefit*** limitations for specified conditions and/or services. Any separate ***maximum benefit*** will include all such benefits paid by the ***Plan*** for the ***covered person*** during any and all periods of coverage under this ***Plan***. No more than the ***maximum benefit*** will be paid for any ***covered person*** while covered by this ***Plan***.

Notwithstanding any provision of the ***Plan*** to the contrary, all benefits received by an individual under any benefit option, package or coverage under the ***Plan*** shall be applied toward the ***Essential Health Benefits/***non-***Essential Health Benefits maximum benefit*** paid by the ***Plan*** for any one ***covered person*** for such option, package or coverage under the ***Plan***, and also toward the ***Essential Health Benefits/***non-***Essential Health Benefits maximum benefit*** under any other options, packages or coverages under the ***Plan*** in which the individual may participate in the future.

The ***maximum benefit*** for ***Essential Health Benefits*** and non-***Essential Health Benefits*** is tracked separately.

HOSPITAL/AMBULATORY SURGICAL FACILITY

Inpatient hospital admissions are subject to precertification. Failure to obtain precertification will result in a reduction of benefits (refer to *Medical Claim Filing Procedure*).

Covered expenses shall include:

1. ***Room and board*** for treatment in a ***hospital,*** including ***intensive care units,*** cardiac care units and similar ***medically necessary*** accommodations. ***Covered expenses*** for ***room and board*** shall be limited to the ***hospital's semiprivate*** rate except room and board in an all-private room facility will be allowed at 90% of the ***customary and reasonable amount***. ***Covered expenses*** for ***intensive care*** or cardiac care units shall be the ***customary and reasonable amount*** for ***nonpreferred providers*** and the percentage of the ***negotiated rate*** for ***preferred providers***. (**NOTE:** A full private room rate is covered if the private room is necessary for isolation purposes and is not for the convenience of the ***covered person***.)

2. Miscellaneous ***hospital*** services, supplies, and treatments including, but not limited to:

    a. Admission fees, and other fees assessed by the ***hospital*** for rendering services, supplies and treatments;
    b. Use of operating, treatment or delivery rooms;
    c. Anesthesia, anesthesia supplies and its administration by an employee of the ***hospital***;
    d. Medical and surgical dressings and supplies, casts and splints;
    e. Blood transfusions, including the cost of whole blood, the administration of blood, blood processing and blood derivatives (to the extent blood or blood derivatives are not donated or otherwise replaced);
    f. Drugs and medicines (except drugs not used or consumed in the ***hospital***);
    g. X-ray and diagnostic laboratory procedures and services;
    h. Oxygen and other gas therapy and the administration thereof;
    i. Therapy services.

3. Services, supplies and treatments described above furnished by an ***ambulatory surgical facility***, including follow-up care provided within seventy-two (72) hours of a procedure.

4. Charges for preadmission testing (x-rays and lab tests) performed within seven (7) days prior to a ***hospital*** admission which are related to the condition which is necessitating the ***confinement***. Such tests shall be payable even if they result in additional medical treatment prior to ***confinement*** or if they show that ***hospital confinement*** is not ***medically necessary***. Such tests shall not be payable if the same tests are performed again after the ***covered person*** has been admitted.

EMERGENCY SERVICES/EMERGENCY ROOM SERVICES

Covered expenses for ***emergency services*** in the emergency department of a ***hospital*** shall be paid in accordance with the *Schedule of Benefits*.

FACILITY PROVIDERS

Services of ***facility*** providers if such services would have been covered if performed in a ***hospital*** or ***ambulatory surgical facility***.

AMBULANCE SERVICES

Ambulance services must be by a regularly scheduled airline or by a licensed air or ground ambulance.

Covered expenses shall include:

1. Ambulance services for air or ground transportation for the ***covered person*** from the place of ***injury*** or serious medical incident to the nearest ***hospital*** where treatment can be given.

2. Ambulance service is covered in a non-emergency situation only to transport the ***covered person*** to or from a ***hospital*** or between ***hospitals*** for required treatment when such transportation is certified by the attending ***physician*** as ***medically necessary***. Such transportation is covered only from the initial ***hospital*** to the nearest ***hospital*** qualified to render the special treatment.

3. ***Emergency*** services actually provided by an advance life support unit, even though the unit does not provide transportation.

If the ***covered person*** is admitted to a ***nonpreferred hospital*** after ***emergency*** treatment, ambulance service is covered to transport the ***covered person*** from the ***nonpreferred hospital*** to a ***preferred hospital*** after the patient's condition has been stabilized, provided such transport is certified by the attending physician as ***medically necessary***.

PHYSICIAN SERVICES

Covered expenses shall include:

1. Medical treatment, services and supplies including, but not limited to: office visits, ***inpatient*** visits, home visits.

2. Surgical treatment. Separate payment will not be made for ***inpatient*** pre-operative or post-operative care normally provided by a surgeon as part of the surgical procedure.

3. For related operations or procedures performed through the same incision or in the same operative field, ***covered expenses*** shall include the surgical allowance for the highest paying procedure, plus fifty (50) percent of the surgical allowance for second highest paying procedure and twenty-five (25) percent of the surgical allowance for each additional procedure.

4. Surgical assistance provided by a ***physician*** if it is determined that the condition of the ***covered person*** or the type of surgical procedure requires such assistance.

5. Furnishing or administering anesthetics, other than local infiltration anesthesia, by other than the surgeon or his assistant.

6. Consultations requested by the attending ***physician*** during a ***hospital confinement***. The ***Plan*** will pay for one such consultation per ***illness*** or ***injury***. Consultations do not include staff consultations which are required by a ***hospital's*** rules and regulations.

7. Radiologist or pathologist services for interpretation of x-rays and laboratory tests necessary for diagnosis and treatment.

8. Radiologist or pathologist services for diagnosis or treatment, including radiation therapy and chemotherapy.

9. Allergy testing consisting of percutaneous, intracutaneous and patch tests.

SECOND SURGICAL OPINION

The second surgical opinion benefit is not subject to any deductible.

1. Benefits for a second surgical opinion will be payable according to the *Schedule of Benefits* if an elective surgical procedure (non-emergency surgery) is recommended by the ***physician***.

2. The ***physician*** rendering the second opinion regarding the ***medical necessity*** of such surgery must be a board certified specialist in the treatment of the ***covered person's illness*** or ***injury*** and must not be affiliated in any way with the ***physician*** who will be performing the actual surgery.

3. In the event of conflicting opinions, a request for a third opinion may be obtained. The ***Plan*** will consider payment for a third opinion the same as a second surgical opinion.

4. The second surgical opinion benefit includes ***physician*** services and any diagnostic services as may be required.

DIAGNOSTIC SERVICES AND SUPPLIES

Covered expenses shall include services and supplies for diagnostic laboratory, pathology, ultrasound, nuclear medicine, magnetic imaging and x-ray.

TRANSPLANT

Transplant procedures are subject to precertification. Failure to obtain precertification will result in a reduction of benefits to your hospital confinement as outlined in the ***Medical Claim Filing Procedure*** section of this document.

Services, supplies and treatments in connection with human-to-human organ and tissue transplant procedures will be considered ***covered expenses*** subject to the following conditions:

1. When the recipient is covered under this ***Plan***, the ***Plan*** will pay the recipient's ***covered expenses*** related to the transplant.

2. When the donor is covered under this ***Plan***, the ***Plan*** will pay the donor's ***covered expenses*** related to the transplant.

3. Expenses ***incurred*** by the donor who is not ordinarily covered under this ***Plan*** according to *Eligibility* requirements will be ***covered expenses*** to the extent that such expenses are not payable by any other form of health coverage, including any government plan or individual policy of health coverage, and provided the recipient is covered under this ***Plan***. The donor's expense shall be applied to the recipient's ***maximum benefit***. In no event will benefits be payable in excess of the ***maximum benefit*** still available to the recipient.

4. Surgical, storage and transportation costs directly related to procurement of an organ or tissue used in a transplant procedure will be covered for each procedure completed. If an organ or tissue is sold rather than donated, the purchase price of such organ or tissue shall not be considered a ***covered expense*** under this ***Plan***.

If a ***covered person's*** transplant procedure is not performed as scheduled due to the intended recipient's medical condition or death, benefits will be paid for organ or tissue procurement as described above.

Centers of Excellence Program

In addition to the above Transplant benefits, the ***covered person*** may be eligible to participate in a Centers of Excellence Program. ***Covered persons*** should contact the ***Health Care Management Organization*** to discuss this benefit by calling:

1-866-292-8108

A Center of Excellence is a facility within a Centers of Excellence Network that has been chosen for their proficiency in performing one or more transplant procedures. Usually located throughout the United States, the Centers of Excellence facilities have greater transplant volumes and surgical team experience than other similar facilities.

Through regular recredentialing, the Network sponsoring the Centers of Excellence Program determines whether each hospital within their Network maintains high quality standards to include transplant services and the transplant team composition. Transplant volumes and outcomes are regularly monitored by the Network Credentialing Committee to assure continued compliance with strict established credentialing criteria.

Transplant procedures are subject to precertification. Failure to obtain precertification will result in a reduction of benefits to your hospital confinement as outlined in the *Medical Claim Filing Procedure* section of this document.

PREGNANCY

Covered expenses for ***pregnancy*** or ***complications of pregnancy*** shall be provided for a covered female ***employee***, a covered female spouse of a covered ***employee***, and ***dependent*** female children.

In the event of early discharge from a ***hospital*** or ***birthing center*** following delivery, the ***Plan*** will cover two (2) Registered Nurse home visits.

The ***Plan*** shall cover services, supplies and treatments for ***medically necessary*** abortions when the life of the mother would be endangered by continuation of the ***pregnancy***, or when the fetus has a known condition incompatible with life, or when the ***pregnancy*** is a result of rape or incest.

Complications from an abortion shall be a ***covered expense*** whether or not the abortion is a ***covered expense***.

BIRTHING CENTER

Covered expenses shall include services, supplies and treatments rendered at a ***birthing center*** provided the ***physician*** in charge is acting within the scope of his license and the ***birthing center*** meets all legal requirements. Services of a midwife acting within the scope of his license or registration are a ***covered expense*** provided that the state in which such service is performed has legally recognized midwife delivery.

STERILIZATION

Covered expenses shall include elective sterilization procedures for the covered ***employee*** or covered spouse. Reversal of sterilization is not a ***covered expense***.

INFERTILITY SERVICES

Covered expenses shall include expenses for infertility testing, and infertility treatment for ***employees*** and their covered spouse.

The following conditions must all be met:

1. The patient and patient's spouse must have a history of infertility of at least two (2) years and;
2. The patient's oocytes must be fertilized with her spouse's sperm and;
3. The infertility must be associated with one or more of the following medical conditions:
   a. Endometriosis;
   b. Exposure in utero to Diethylstilbestrol;
   c. Blockage of, or removal of, one or both fallopian tubes except if due to voluntary sterilization and;
   d. Abnormal male factors contributing.
4. The patient must have been unable to attain a successful pregnancy through other applicable treatments for which coverage is provided and;
5. The in-vitro fertilization procedures must be performed at:
   a. A facility licensed or certified by the state as an in-vitro fertilization clinic; or
   b. A medical facility that conforms to the American College of Obstetric and Gynecology guidelines for in-vitro fertilization clinics or the American Fertility Society minimal standards for programs of in-vitro fertilization.

Cryopreservation shall be included as an in-vitro fertilization procedure. Any pre-existing limitation for infertility shall not exceed a period of twelve (12) months.

Treatment of infertility shall be subject to the ***maximum benefit*** as shown on the *Schedule of Benefits*.

WELL NEWBORN CARE

The ***Plan*** shall cover well newborn care for covered newborn dependents while the mother is confined for delivery.

Such care shall include, but is not limited to:

1. ***Physician*** services

2. ***Hospital*** services

3. Circumcision

CHILDREN'S IMMUNIZATIONS

Charges for routine immunizations for children up to the age of eighteen (18) and payable according to the *Schedule of Benefits*

ROUTINE PREVENTIVE CARE/WELLNESS BENEFITS

Covered expenses for ***routine examinations*** include services such as a routine physical examination and related lab per year, one (1) pap smear per calendar year per covered participant, immunizations, one (1) mammogram per year, and one (1) prostate cancer screening which is subject to the following state regulations:

- Prostate cancer screenings and related charges are not subject to any deductible;
- Prostate cancer screenings shall be performed by a qualified medical professional;
- One screening per year for covered men who are forty (40) years of age or older;
- Prostate cancer screening required under this section does not diminish or limit diagnostic benefits otherwise allowable under the ***Plan*** and;
- Prostate cancer screenings may not be denied based on the ***covered person*** having a previous digital rectal examination that was negative.

Includes office visits and any related laboratory charges.

Routine Preventive Care/Wellness Benefits are payable as specified on the *Schedule of Benefits.*

The ***Plan*** will apply reasonable medical management techniques to determine the appropriate frequency, method, treatment, or setting for a preventive item or service to the extent that such techniques are not specified in the recommendations or guidelines.

COLORECTAL CANCER EXAMINATIONS

Covered expenses shall include colorectal cancer examinations and appropriate laboratory tests for ***covered persons*** age fifty (50) and over; ***covered persons*** who are less than fifty (50) years of age who are at high risk for colorectal cancer according to the American Cancer Society colorectal cancer screening guidelines as they exist; and ***covered persons*** experiencing the following symptoms of colorectal cancer as determined by a ***physician*** licensed under the Arkansas Medical Practices Act, which are:

- Bleeding from the rectum or blood in the stool; or
- A change in bowel habits, such as diarrhea, constipation, or narrowing of the stool, that lasts more than five (5) days.

The colorectal screening should involve an examination of the entire colon, including the following exams or laboratory tests, or both:

- An annual fecal occult blood test utilizing the take-home multiple sample method, or an annual fecal immunochemical test in conjunction with a flexible sigmoidoscopy every five (5) years; or
- A double-contrast barium enema every five (5) years; or
- A colonoscopy every five (5) years; AND
- Any additional medically recognized screening test for colorectal cancer required by the Director of Health, determined in consultation with appropriate health care organizations.

Screening shall be limited to the following guidelines for the management or subsequent need for follow-up colonoscopy:

- If the initial colonoscopy is normal, follow-up is recommended in ten (10) years;
- For ***covered persons*** with one or more neoplastic polyps or adenomatous polyps, assuming that the initial colonoscopy was complete to the cecum and adequate preparation and removal of all visualized polyps, follow-up is recommended in three (3) years;
- If single tubular adenoma of less than one (1) centimeter (1cm) is found, follow-up is recommended in five (5) years; and
- For patients with large sessile adenomas greater than three (3) centimeters (3cm), especially if removed in piecemeal fashion, follow-up is recommended in six (6) months or until complete polyp removal is verified by colonoscopy.

THERAPY SERVICES

Therapy services must be ordered by a ***physician*** to aid restoration of normal function lost due to ***illness*** or ***injury***, for congenital anomaly, or for prevention of continued deterioration of function. ***Covered expenses*** shall include:

1. Services of a ***professional provider*** for physical therapy, occupational therapy, speech therapy or respiratory therapy.

2. Radiation therapy and chemotherapy.

3. Dialysis therapy or treatment.

4. Infusion therapy.

EXTENDED CARE FACILITY

Extended care facility confinement is subject to precertification. Failure to obtain precertification shall result in a reduction of benefits to your hospital confinement as outlined in the ***Medical Claim Filing Procedure*** section.

Extended care facility services, supplies and treatments shall be a ***covered expense*** provided:

1. The ***covered person*** was first confined in a ***hospital*** for at least three (3) consecutive days;

2. The attending ***physician*** recommends extended care ***confinement*** for a convalescence from a condition which caused that ***hospital confinement***, or a related condition;

3. The extended care ***confinement*** begins within fourteen (14) days after discharge from that ***hospital confinement***; and

4. The ***covered person*** is under a ***physician's*** continuous care and the ***physician*** certifies that the ***covered person*** must have twenty-four (24) hours-per-day nursing care.

Covered expenses shall include:

1. ***Room and board*** (including regular daily services, supplies and treatments furnished by the ***extended care facility***) limited to the ***facility's*** average ***semiprivate*** room rate; and

2. Other services, supplies and treatment ordered by a ***physician*** and furnished by the ***extended care facility*** for ***inpatient*** medical care.

Extended care facility benefits are limited as shown the *Schedule of Benefits*.

HOME HEALTH CARE

Home health care enables the ***covered person*** to receive treatment in his home for an ***illness*** or ***injury*** instead of being confined in a ***hospital*** or ***extended care facility***. ***Covered expenses*** shall include:

1. Part-time or intermittent nursing care by a Registered Nurse, Licensed Practical Nurse or a Licensed Vocational Nurse;

2. Physical, respiratory, occupational or speech therapy;

3. Part-time or intermittent ***home health aide services*** for a ***covered person*** who is receiving covered nursing or therapy services;

4. Medical social service consultations;

5. Nutritional guidance by a registered dietitian and nutritional supplements such as diet substitutes administered intravenously or through hyperalimentation as determined to be ***medically necessary***.

Covered expenses shall be subject to the ***maximum benefit*** specified on the *Schedule of Benefits*.

A visit by a member of a ***home health care*** team and four (4) hours of ***home health aide service*** will each be considered one (1) ***home health care*** visit.

No ***home health care*** benefits will be provided for dietitian services, homemaker services (except as may be specifically provided herein), maintenance therapy, dialysis treatment, food or home delivered meals, rental or purchase of ***durable medical equipment*** or prescription or non-prescription drugs or biologicals.

HOSPICE CARE

Hospice care is subject to precertification. Failure to obtain precertification shall result in a reduction of benefits to your ***hospital*** confinement as outlined in the *Medical Claim Filing Procedure* section.

Hospice care is a health care program providing a coordinated set of services rendered at home, in ***outpatient*** settings, or in ***facility*** settings for a ***covered person*** suffering from a condition that has a terminal prognosis.

Hospice benefits will be covered only if the ***covered person's*** attending ***physician*** certifies that:

1. The ***covered person*** is terminally ill, and

2. The ***covered person*** has a life expectancy of six (6) months or less.

Covered expenses shall include:

1. ***Confinement*** in a ***hospice*** to include ancillary charges and ***room and board***.

2. Services, supplies and treatment provided by a ***hospice*** to a ***covered person*** in a home setting.

3. ***Physician*** services and/or nursing care by a Registered Nurse, Licensed Practical Nurse or a Licensed Vocational Nurse.

4. Physical therapy, occupational therapy, speech therapy or respiratory therapy.

5. Nutrition services to include nutritional advice by a registered dietitian, and nutritional supplements such as diet substitutes administered intravenously or through hyperalimentation as determined to be ***medically necessary***.

6. Counseling services provided through the ***hospice***.

7. Respite care by an aide who is employed by the ***hospice*** for up to four (4) hours per day. (Respite care provides care of the ***covered person*** to allow temporary relief to family members or friends from the duties of caring for the ***covered person***).

8. Bereavement counseling is a supportive service to ***covered persons*** in the terminally ill ***covered person's*** immediate family. Benefits will be payable up to the ***maximum benefit*** shown on the *Schedule of Benefits*, provided:

    a. On the date immediately before death, the terminally ill person was covered under the ***Plan*** and receiving ***hospice*** care benefits; and

    b. Services are ***incurred*** by the ***covered person*** within six (6) months of the terminally ill person's death and shall be limited to a maximum of fifteen (15) visits.

Charges ***incurred*** during periods of remission are not eligible under this provision of the ***Plan***. Any ***covered expense*** paid under ***hospice*** benefits will not be considered a ***covered expense*** under any other provision of this ***Plan***.

DURABLE MEDICAL EQUIPMENT

Rental or purchase, whichever is less costly, of ***medically necessary durable medical equipment*** which is prescribed by a ***physician*** and required for therapeutic use by the ***covered person*** shall be a ***covered expense***. Repair or replacement of purchased ***durable medical equipment*** that is medically necessary due to normal use or growth of a child will be considered a ***covered expense***

Equipment containing features of an aesthetic nature or features of a medical nature which are not required by the ***covered person's*** condition, or where there exists a reasonably feasible and medically appropriate alternative piece of equipment which is less costly than the equipment furnished, will be covered based on the usual charge for the equipment which meets the ***covered person's*** medical needs.

PROSTHESES

The initial purchase of a prosthesis (other than dental) provided for functional reasons when replacing all or part of a missing body part (including contiguous tissue) or to replace all or part of the function of a permanently inoperative or malfunctioning body organ shall be a ***covered expense***. Repair or replacement of a prosthesis that is ***medically necessary*** due to normal use or growth of a child will be considered a ***covered expense***.

Replacement penile implants or future reconstructive surgeries are not covered. Repairs to a penile implant shall be covered when made necessary due to an accident, provided repairs are initiated within ninety (90) days of the accident.

ORTHOTICS

Orthotic devices and appliances (a rigid or semi-rigid supportive device which restricts or eliminates motion for a weak or diseased body part), including initial purchase, fitting and repair shall be a ***covered expense***. Orthopedic shoes or corrective shoes, unless they are an integral part of a leg brace, and other supportive devices for the feet

shall not be covered, not to include ***medically necessary*** diabetic foot care. Replacement will be covered only after five (5) years from the date of original placement, unless growth and development of a child necessitates earlier replacement.

DENTAL SERVICES

Covered expenses shall include repair of sound natural teeth or surrounding tissue provided it is the result of an ***injury***. Treatment must begin within twelve (12) months of the date of such ***injury***. Damage to the teeth as a result of chewing or biting shall not be considered an ***injury*** under this benefit.

Covered expenses shall include charges for oral surgery such as the excision of partially or completely unerupted impacted teeth, excision of the entire tooth, closed or open reduction of fractures or dislocations of the jaw, and other incision or excision procedures performed on the gums and tissues of the mouth when not performed in conjunction with the extraction of teeth.

TEMPOROMANDIBULAR JOINT DYSFUNCTION

Surgical treatment of temporomandibular joint (TMJ), myofascial pain syndrome or orthognathic treatment shall be a ***covered expense***, but shall not include orthodontia or prosthetic devices prescribed by a ***physician*** or ***dentist***. This limitation shall apply whether surgical treatment is provided by a ***hospital***, ***physician***, ***dentist***, physical therapist or oral surgeon.

If a ***physician*** or ***dentist*** recommends a course of surgical treatment for or in connection with TMJ, myofascial pain syndrome or orthognathic treatment, a ***covered person*** may submit the treatment plan, including x-rays and study models, for predetermination of benefits under the ***Plan***.

The ***claims processor*** will determine if the surgical treatment is a ***covered expense*** and will notify the ***covered person*** in writing.

SPECIAL EQUIPMENT AND SUPPLIES

Covered expenses shall include ***medically necessary*** special equipment and supplies including, but not limited to: casts; splints; braces; trusses; surgical and orthopedic appliances; colostomy and ileostomy bags and supplies required for their use; catheters; syringes and needles for diabetes; other diabetic supplies, including insulin, test strips and blood sugar measurement devices; allergy serums; crutches; electronic pacemakers; gastric pacemakers; oxygen and the administration thereof; the initial pair of eyeglasses or contact lenses due to cataract surgery; soft lenses or sclera shells intended for use in the treatment of ***illness*** or ***injury*** of the eye; support stockings, such as Jobst stockings, shall be limited to two (2) pairs per calendar year; surgical dressings and other medical supplies ordered by a ***professional provider*** in connection with medical treatment, but not common first aid supplies.

HEARING AIDS

This ***Plan*** shall offer coverage for a hearing aid or hearing instrument sold on or after January 1, 2011, by a professional licensed by the state of Arkansas, to dispense a hearing aid or hearing instrument. This benefit includes repair and replacement parts and can be worn in or on the body.

This ***Plan*** shall provide coverage per ear for each three-year period, beginning on the first day of coverage and is not subject to any copays, or deductibles.

COSMETIC SURGERY

Cosmetic surgery or ***reconstructive surgery*** shall be a ***covered expense*** provided:

1. A ***covered person*** receives an ***injury*** as a result of an ***accident*** and as a result requires surgery. ***Cosmetic*** or ***reconstructive surgery*** and treatment must be for the purpose of restoring the ***covered person*** to his normal function immediately prior to the ***accident***.

2. It is required to correct a congenital anomaly, for example, a birth defect, for a child.

MASTECTOMY (WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998)

This ***Plan*** intends to comply with the provisions of the federal law known as the Women's Health and Cancer Rights Act of 1998.

Covered expenses will include eligible charges related to ***medically necessary*** mastectomy.

For a ***covered person*** who elects breast reconstruction in connection with such mastectomy, ***covered expenses*** will include:

a. reconstruction of a surgically removed breast; and

b. surgery and reconstruction of the other breast to produce a symmetrical appearance.

c. An external breast prosthesis shall be covered once every three (3) calendar years, unless recommended more frequently by a ***physician***. The first permanent internal breast prosthesis necessary because of a mastectomy shall also be a ***covered expense***.

Prostheses (and ***medically necessary*** replacements) and physical complications from all stages of mastectomy, including lymphedemas will also be considered ***covered expenses*** following all ***medically necessary*** mastectomies.

MENTAL AND NERVOUS DISORDERS

Inpatient Confinement

Subject to the precertification provisions of the ***Plan***, the ***Plan*** will pay the applicable ***coinsurance***, as shown on the *Schedule of Benefits*, for ***confinement*** in a ***hospital*** or ***treatment center*** for treatment, services and supplies related to the treatment of ***mental and nervous disorders***. The ***Plan*** will pay for treatment of ***mental and nervous disorders*** as any other ***illness***, to include screening, diagnosis and treatment of autism spectrum disorders.

Covered expenses shall include:

1. ***Inpatient hospital*** confinement;

2. Individual psychotherapy;

3. Group psychotherapy;

4. Psychological testing;

5. Electro-Convulsive therapy (electroshock treatment) or convulsive drug therapy, including anesthesia when administered concurrently with the treatment by the same ***professional provider***;

Outpatient

The ***Plan*** will pay the applicable ***coinsurance***, as shown on the *Schedule of Benefits*, for ***outpatient*** treatment, services and supplies related to the treatment of ***mental and nervous disorders.*** Prescription drugs for the treatment of ***mental and nervous disorders*** shall be included in this ***mental and nervous disorder*** care benefit.

CHEMICAL DEPENDENCY

The ***Plan*** will pay for covered treatment of ***chemical dependency*** the same as treatment of any ***illness***. Benefits shall be payable for ***inpatient*** or ***outpatient*** treatment in a ***hospital*** or ***treatment center*** by a ***physician*** or ***professional provider***.

PRESCRIPTION DRUGS

The ***Plan*** shall cover prescription drugs as specified on the *Schedule of Benefits*. Such drugs must be approved by the Food and Drug Administration and must be dispensed by a licensed pharmacist, ***physician*** or ***dentist***. Antigen and allergy vaccine dispensed by a ***physician*** or certified laboratory shall be a ***covered expense***. Covered prescription expense shall include contraceptive implants and Depo-provera birth control shots. Vitamins, which require a prescription by law, and are used to treat a specific ***illness*** shall be considered a ***covered expense***.

CVS CAREMARK SPECIALTY PHARMACY PROGRAM

The CVS Caremark Specialty Pharmacy Program is available for some specialty drugs. Specialty drugs are often high cost pharmaceuticals used in the management of chronic and/or complex conditions. To receive these specialty drugs, CVS Caremark Specialty Pharmacy will contact the ***covered person*** and the ***covered person's physician*** to arrange for the distribution of the specialty drug directly from the CVS Caremark Specialty Pharmacy. Refer to the *Schedule of Benefits*, *Prescription Drug Program, CVS Caremark Specialty Pharmacy Program* section for benefit information, regarding specialty drugs.

OFF-LABEL DRUG USAGE/PHASE III CLINICAL TRIALS

OFF-LABEL DRUG USE. Charges for the use of an FDA-approved Drug for a purpose other than that for which it is approved. but only when the Drug is not excluded by the Plan and the Plan Sponsor determines in its sole discretion that the Drug is appropriate and generally accepted for the condition being treated.

ONCOLOGY CLINICAL TRIALS. Charges for a Drug, device, supply, treatment, procedure or service that is part of a scientific study of cancer therapy in a phase III clinical trial sponsored by the National Cancer Institute or institution of similar stature. Trials must have Institutional Review Board (IRB) approval by a qualified IRB. Charges that are not covered include:

a. Costs for services that are not primarily for the care of the patient (such as lab services performed solely to collect data for the trial).
b. Costs for services provided in a clinical trial that are funded by another source.

PODIATRY SERVICES

Covered expenses shall include surgical podiatry services, including incision and drainage of infected tissues of the foot, removal of lesions of the foot, removal or débridement of infected toenails, surgical removal of nail root, and treatment of fractures or dislocations of bones of the foot.

PRIVATE DUTY NURSING

Medically necessary services of a private duty ***nurse*** shall be a ***covered expense***.

CHIROPRACTIC CARE

Covered expenses include initial consultation, x-rays and treatment (but not maintenance care), subject to the ***maximum benefit*** shown on the *Schedule of Benefits*.

PATIENT EDUCATION

Covered expenses shall include ***medically necessary*** patient education programs including, but not limited to diabetic education and ostomy care.

SURCHARGES

Any excise tax, sales tax, surcharge, (by whatever name called) imposed by state or federal law, a governmental entity for services, supplies and/or treatments rendered by a ***professional provider***; ***physician***; ***hospital***; ***facility*** or any other health care provider shall be a ***covered expense*** under the terms of the ***Plan***.

ROUTINE VISION

Covered expenses shall include charges for routine vision examinations, glasses and contact lenses, as specified in the *Vision Expense Benefit*.

MEDICAL EXCLUSIONS

In addition to *Plan Exclusions,* no benefit will be provided under this ***Plan*** for medical expenses for the following:

1. Charges for ***pre-existing conditions*** as specified in *Pre-existing Conditions* and *Certificates of Coverage*.

2. Charges for services, supplies or treatment for the reversal of sterilization procedures.

3. Charges for services, supplies or treatment related to the diagnosis or treatment of infertility and artificial reproductive procedures, including, but not limited to: artificial insemination, surrogate mother, embryo implantation, or gamete intrafallopian transfer (GIFT), except as otherwise specified.

4. Charges for services, supplies or treatment for transsexualism, gender dysphoria or sexual reassignment or change, including medications, implants, hormone therapy, surgery, medical or psychiatric treatment.

5. Charges for treatment or surgery for sexual dysfunction, except due to loss of prostate, tissue or organ, to include penile implants. Replacement penile implants or future reconstructive surgeries are not covered. Repairs to a penile implant shall be covered when made necessary due to an accident, provided repairs are initiated within ninety (90) days of the accident.

6. Charges for ***hospital*** admission on Friday, Saturday or Sunday unless the admission is an ***emergency*** situation, or surgery is scheduled within twenty-four (24) hours. If neither situation applies, ***hospital*** expenses will be payable commencing on the date of actual surgery.

7. Charges for ***inpatient room and board*** in connection with a ***hospital confinement*** primarily for diagnostic tests, unless it is determined by the ***Plan*** that ***inpatient*** care is ***medically necessary***.

8. Charges for biofeedback therapy.

9. Charges for services, supplies or treatments which are primarily educational in nature; except as specified in *Medical Expense Benefit, Patient Education;* charges for services for educational or vocational testing or training and work hardening programs regardless of diagnosis or symptoms; charges for self-help training or other forms of non-medical self-care.

10. Charges for marital counseling.

11. Except as specifically stated in *Medical Expense Benefit, Dental Services*, charges for or in connection with: treatment of ***injury*** or disease of the teeth; oral surgery; treatment of gums or structures directly supporting or attached to the teeth; removal or replacement of teeth; or dental implants.

12. Charges for routine vision examinations and eye refractions; orthoptics; eyeglasses or contact lenses and dispensing optician's services, except as specifically stated in the *Vision Expense Benefit.*

13. Charges for any eye surgery solely for the purpose of correcting refractive defects of the eye, such as near-sightedness (myopia) and astigmatism including radial keratotomy by whatever name called; contact lenses and eyeglasses required as a result of such surgery.

14. Except as ***medically necessary*** for the treatment of metabolic or peripheral-vascular ***illness,*** charges for routine, palliative or cosmetic foot care, including, but not limited to: treatment of weak, unstable, flat, strained or unbalanced feet; subluxations of the foot; treatment of corns or calluses; non-surgical care of toenails.

15. Charges for services, supplies or treatment which constitute personal comfort or beautification items, whether or not recommended by a ***physician***, such as: television, telephone, air conditioners, air purifiers, humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, elastic bandages, non-hospital adjustable beds, exercise equipment.

16. Charges for nonprescription drugs, such as vitamins, cosmetic dietary aids, and nutritional supplements, except as provided in *Medical Expense Benefit, Prescription Drugs.*

17. Charges for orthopedic shoes (except when they are an integral part of a leg brace and the cost is included in the orthotist's charge or prescribed for diabetic foot care) or shoe inserts, or the purchase of orthotic services or appliances.

18. Expenses for a ***cosmetic surgery*** or procedure and all related services, except as specifically stated in *Medical Expense Benefit, Cosmetic Surgery*.

19. Charges ***incurred*** as a result of, or in connection with, any procedure or treatment excluded by this ***Plan*** which has resulted in medical complications.

20. Charges related to newborns of dependent children.

21. Charges for services provided to a ***covered person*** for an elective abortion (See *Pregnancy* for specifics regarding the coverage of abortions), except for complications from a non-covered abortion as specified

herein.

22. Charges for services, supplies or treatment primarily for weight reduction or treatment of obesity, including, but not limited to: exercise programs or use of exercise equipment; special diets or diet supplements; appetite suppressants; Nutri/System, Weight Watchers or similar programs; and ***hospital confinements*** for weight reduction programs, except as specifically provided herein.

23. Charges for surgical weight reduction procedures and all related charges, even if resulting from morbid obesity.

24. Any prescription refilled in excess of the number specified by the ***physician*** or any refill dispensed after one year from the ***physician's*** original order.

25. Charges for examination to determine hearing loss or the fitting, purchase, repair or replacement of a hearing aid, unless otherwise specified in the *Schedule of Benefits*.

26. Charges related to acupuncture treatment.

27. Charges for non-surgical treatment of temporomandibular joint syndrome and myofascial pain syndrome including, but not limited to: charges for treatment to alter vertical dimension or to restore abraded dentition, orthodontia and intra-oral prosthetic devices.

28. Charges for methods of treatment to alter vertical dimension.

29. Charges for ***custodial care***, domiciliary care or rest cures.

30. Charges for travel or accommodations, whether or not recommended by a ***physician***, except as specifically provided herein.

31. Charges for wigs, artificial hair pieces, artificial hair transplants, or any drug - prescription or otherwise - used to eliminate baldness or stimulate hair growth. This exclusion does not apply when baldness is the result of burns, chemotherapy, radiation therapy, or surgery.

32. Charges for expenses related to hypnosis.

33. Charges for professional services billed by a ***physician*** or Registered Nurse, Licensed Practical Nurse or Licensed Vocational Nurse who is an employee of a ***hospital*** or any other ***facility*** and who is paid by the ***hospital*** or other ***facility*** for the service provided.

34. Charges for environmental change including ***hospital*** or ***physician*** charges connected with prescribing an environmental change.

35. Charges for ***room and board*** in a ***facility*** for days on which the ***covered person*** is permitted to leave (a weekend pass, for example).

36. Charges for any services, supplies or treatment not specifically provided herein.

37. Charges for Drugs, devices, supplies, treatments, procedures or services that are considered experimental or investigational by the Plan. The Plan will consider a Drug, device, supply, treatment, procedure or service to be "experimental" or "investigational":
    a. if, in the case of a device or supply, the device or supply cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the device or supply is furnished; or

b. if the Drug, device, supply, treatment, procedure or service, or the patient's informed consent document utilized with respect to the Drug, device, supply, treatment, procedure or service was reviewed and approved by the treating facility's institutional review board or other body serving a similar function, or if federal law requires such review or approval; or

c. if the Plan Sponsor determines in its sole discretion that the Drug, device, supply, treatment, procedure or service is the subject of on-going phase I or phase II clinical trials; is the research, experimental, study or investigational arm of on-going phase III clinical trials, or is otherwise under study to determine maximum tolerated dose, toxicity, safety or efficacy, however, a Drug, device, supply, treatment, procedure or service that meets the standards set in "Oncology Clinical Trials" or "Off-Label Drug" Use under Covered Expenses will not be deemed experimental or investigational solely by reason of this subparagraph; or

d. if the Plan Sponsor determines in its sole discretion based on documentation in one of the standard reference compendia or in substantially accepted peer-reviewed medical literature that the prevailing opinion among experts regarding the Drug, device, supply, treatment, procedure or service is that further studies or clinical trials are necessary to determine its maximum tolerated dose, toxicity, safety or efficacy.

PRESCRIPTION DRUG PROGRAM

RETAIL PRESCRIPTION DRUG DEDUCTIBLE

Individual Deductible For Retail Prescriptions

The individual prescription drug deductible for Retail Prescriptions is the dollar amount of ***covered expense*** that **each** ***covered person*** must have ***incurred*** for the purchase of Retail prescription drugs during each calendar year before the ***Plan*** pays applicable benefits. The individual prescription drug deductible amount for Retail Prescriptions is shown on the *Schedule of Benefits*. (Mail Order Prescriptions are not subject to a deductible.)

PHARMACY OPTION

Participating pharmacies have contracted with the ***Plan*** to charge ***covered persons*** reduced fees for covered prescription drugs.

SPECIAL NOTICE: The ***covered person*** and the prescribing ***physician*** must both agree to change to a drug or medication not included in the drug formulary when the equivalent has been ineffective in treatment or has caused or is expected to cause adverse or harmful reactions to the ***covered person***, as determined by the prescribing ***physician***. The specific drug or medication will be subject to the same benefits as formulary medications, provided the ***covered person*** utilizes an In-Network Pharmacy.

PHARMACY OPTION COPAY

The ***copay*** is applied to each covered pharmacy drug charge and is shown on the *Schedule of Benefits*. The ***copay*** amount is not a ***covered expense*** under the *Medical Expense Benefit*. Any one prescription is limited to a thirty (30) day supply.

If a drug is purchased from a ***nonparticipating pharmacy*** or a ***participating pharmacy*** when the ***covered person's*** ID card is not used, the ***covered person*** must pay the entire cost of the prescription, including ***copay***, and then submit the receipt to the prescription drug card vendor for reimbursement. If a ***nonparticipating pharmacy*** is used, the ***covered person*** will be responsible for the ***copay***, plus the difference in cost between the ***participating pharmacy*** and ***nonparticipating pharmacy***.

MAIL ORDER OPTION

The mail order drug benefit option is available for maintenance medications (those that are taken for long periods of time, such as drugs which may be prescribed for heart disease, high blood pressure, asthma, etc.).

MAIL ORDER OPTION COPAY

The ***copay*** is applied to each covered mail order prescription charge and is shown on the *Schedule of Benefits*. The ***copay*** is not a ***covered expense*** under the *Medical Expense Benefit*. Any one prescription is limited to a ninety (90) day supply.

COVERED PRESCRIPTION DRUGS

1. Drugs prescribed by a ***physician*** that require a prescription either by federal or state law, except injectables (other than insulin) and drugs excluded by the ***Plan***, unless otherwise specified.

2. Compounded prescriptions containing at least one prescription ingredient with a therapeutic quantity.

3. Insulin, insulin needles and syringes and diabetic supplies when prescribed by a ***physician***.

4. Allergy serums.

5. Oral contraceptives, regardless of the reason prescribed.

6. Certain contraceptive devices.

7. Any other drug which, under the applicable state law, may be dispensed only upon the written prescription of a ***qualified prescriber***.

8. Erectile dysfunction medications according to industry recommended standards.

LIMITS TO THIS BENEFIT

This benefit applies only when a ***covered person*** incurs a covered prescription drug charge. The covered drug charge for any one prescription will be limited to:

1. Refills only up to the number of times specified by a ***physician***.

2. Refills up to one year from the date of order by a ***physician***.

EXPENSES NOT COVERED

1. A drug or medicine that can legally be purchased without a written prescription. This does not apply to injectable insulin.

2. Devices of any type, even though such devices may require a prescription. These include, but are not limited to: therapeutic devices, artificial appliances, braces, support garments, or any similar device.

3. Immunization agents or biological sera, blood or blood plasma.

4. A drug or medicine labeled: “Caution - limited by federal law to ***investigational*** use.”

5. ***Experimental*** drugs and medicines, even though a charge is made to the ***covered person***, including DESI drugs (drugs determined by the FDA as lacking substantial evidence of effectiveness).

6. Any charge for the administration of a covered prescription drug.

7. Any drug or medicine that is consumed or administered at the place where it is dispensed.

8. A drug or medicine that is to be taken by the ***covered person***, in whole or in part, while ***hospital*** confined. This includes being confined in any institution that has a ***facility*** for dispensing drugs.

9. A charge for prescription drugs which may be properly received without charge under local, state or federal programs.

10. A charge for hypodermic syringes and/or needles, injectables or any prescription directing administration by injection (other than insulin), unless otherwise specified.

11. A charge for infertility medication.

12. A charge for legend vitamins, except pre-natal legend vitamins and vitamins prescribed for a specific medical condition.

13. A charge for minerals.

14. A charge for fluoride supplements.

15. A charge for medications that are cosmetic in nature (*i.e.*, treating hair loss, wrinkles, etc.).

16. A charge for growth hormones, except through the CareMark Specialty RX Program.

17. A charge for weight loss drugs.

18. A charge for Tretinoins.

19. A charge for non-legend drugs, other than as specifically listed herein.

20. A charge for Levonorgestrel (Norplant implants).

21. A charge for Hematinics.

Any prescription drug covered under the *Prescription Drug Program* will not be covered under the *Medical Expense Benefit*, except as specified in *Medical Expense Benefit, Prescription Drugs*.

CVS CAREMARK SPECIALTY PHARMACY PROGRAM

The Specialty Pharmacy Program is available for select specialty drugs including select injectible and oral medications including but not limited to, the following conditions:

1. Allergic Asthma

2. Crohn's disease

3. Enzyme replacement for Lysosomal Storage Disorder

4. Gaucher disease

5. Growth hormone disorders

6. Hematopoietics

7. Hemophilia, Von Willebrand disease and related bleeding disorders

8. Hepatitis C
9. Hormonal therapies
10. Immune deficiencies
11. Multiple Sclerosis
12. Oncology
13. Osteoarthritis
14. Psoriasis
15. Pulmonary Arterial Hypertension
16. Pulmonary disease
17. Renal disease
18. Respiratory Syncytial Virus
19. Rheumatoid Arthritis
20. Other Disorders

To take advantage of this program, the ***covered person*** will need to transfer the related prescription to Caremark. To transfer a prescription, call **1-800-237-2767**. A representative of Caremark will call the ***covered person's physician*** and take care of the appropriate paperwork.

NOTICE OF AUTHORIZED REPRESENTATIVE

The ***covered person*** may provide the ***plan administrator*** (or its designee) with a written authorization for an authorized representative to represent and act on behalf of a ***covered person*** and consent to release of information related to the ***covered person*** to the authorized representative with respect to a claim for benefits or an appeal. Authorization forms may be obtained from the Human Resource Department.

APPEALING A DENIED POST-SERVICE PRESCRIPTION DRUG CLAIM

The "***named fiduciary***" for purposes of an appeal of a denied Post-Service Prescription Drug Claim, as described in U. S. Department of Labor Regulations 2560.503-1 (issued November 21, 2000), is the ***claims processor*** (when there is no prior authorization for drugs) for medical/dental/vision claims (when prior authorization is required) Prescription Benefits Manager.

A ***covered person***, or the ***covered person's*** authorized representative, may request a review of a denied claim by making written request to the ***named fiduciary*** within one hundred eighty (180) calendar days from receipt of notification of the denial and stating the reasons the ***covered person*** feels the claim should not have been denied.

The following describes the review process and rights of the ***covered person***:

1. The ***covered person*** has a right to submit documents, information and comments.

2. The ***covered person*** has the right to access, free of charge, ***relevant information*** to the claim for benefits.

3. The review takes into account all information submitted by the ***covered person***, even if it was not considered in the initial benefit determination.

4. The review by the ***named fiduciary*** will not afford deference to the original denial.

5. The ***named fiduciary*** will not be:

    a. The individual who originally denied the claim, nor
    b. Subordinate to the individual who originally denied the claim.

6. If original denial was, in whole or in part, based on medical judgment:

    a. The ***named fiduciary*** will consult with a ***professional provider*** who has appropriate training and experience in the field involving the medical judgment; and
    b. The ***professional provider*** utilized by the ***named fiduciary*** will be neither:
        (i.) An individual who was consulted in connection with the original denial of the claim, nor
        (ii.) A subordinate of any other ***professional provider*** who was consulted in connection with the original denial.

7. If requested, the ***named fiduciary*** will identify the medical or vocational expert(s) who gave advice in connection with the original denial, whether or not the advice was relied upon.

NOTICE OF BENEFIT DETERMINATION ON A POST-SERVICE PRESCRIPTION DRUG CLAIM APPEAL

The ***plan administrator*** (or its designee) shall provide the ***covered person*** (or authorized representative) with a written notice of the appeal decision within sixty (60) calendar days of receipt of a written request for the appeal.

If the appeal is denied, the Notice of Appeal Decision will contain an explanation of the Decision, including:

1. The specific reasons for the denial.

2. Reference to specific ***Plan*** provisions on which the denial is based.

3. A statement that the ***covered person*** has the right to access, free of charge, ***relevant information*** to the claim for benefits.

4. If an internal rule, guideline, protocol or other similar criterion was relied upon, the Notice of Appeal Decision will contain either:

    a. A copy of that criterion, or
    b. A statement that such criterion was relied upon and will be supplied free of charge, upon request.

5. If the denial was based on ***medical necessity***, ***experimental/investigational*** treatment or similar exclusion or limit, the ***Plan*** will supply either:

    a. An explanation of the scientific or clinical judgment, applying the terms of the ***Plan*** to the claimant's medical circumstances, or
    b. A statement that such explanation will be supplied free of charge, upon request.

DENTAL EXPENSE BENEFIT

Subject to all the terms of the ***Plan,*** the ***Plan*** will pay a dental benefit for covered dental expenses. The dental benefit is a percentage of the ***Maximum Plan Allowance*** for covered dental expenses, as shown on the *Schedule of Benefits*.

PREDETERMINATION OF BENEFITS

"Predetermination of benefits" allows the patient to learn an estimate of the amount the ***Plan*** will pay for extensive work the ***dentist*** recommends before the work is performed. A ***dentist*** may file a ***dental claim form*** showing the services he recommends. The ***Dental Claims Processor*** will then pre-determine the *dental* ***benefits*** payable under the ***Plan***. Payment will only be made for pre-determined services if the ***covered person*** receives ***dental treatment*** for which ***dental benefits*** are payable, remains eligible, and has not exceeded his ***Annual Dental Maximum***. A ***dental claim form*** requesting a ***pre-determination*** may be submitted electronically. A ***covered person***, however, is not required to seek a ***pre-determination*** for any ***dental treatment*** under the ***Plan***.

DEDUCTIBLE

Individual Deductible

The individual deductible is the dollar amount of ***covered expense*** which each ***covered person*** must incur during each calendar year before the ***Plan*** pays applicable benefits. The individual deductible amount is shown on the *Schedule of Benefits* and does not apply toward diagnostic/preventive services.

COINSURANCE

The ***Plan*** pays a specified percentage of the ***Maximum Plan Allowance or MPA*** for ***covered expenses***. That percentage is listed on the *Schedule of Benefits*. The ***covered person*** is responsible for the difference.

The ***Dental Claims Processor*** will only pay the ***Dental Benefits*** stated for each type of dental service set out in the *Schedule of Benefits*. **Not all dental services are BENEFITS under this PLAN.** ***Dental Benefits*** will only be provided for ***covered persons*** who are enrolled on the date of treatment. ***Dental Benefits*** will be determined based on the date services were rendered. Dental services must be provided by a ***Dentist*** or properly licensed employee of the ***Dentist***. Dental services must be necessary and provided following generally accepted dental practice standards as determined by the dental profession to be a paid benefit. The ***Dental Claims Processor*** will pay allowable Dental Benefits based upon the percentages and subject to the ***maximum benefit*** as stated on the *Schedule of Benefits.* Such percentages will be applied to the lesser of the ***Maximum Plan Allowance (MPA)*** or the fees the ***Dentist*** charges for the services. Payments for ***covered expenses*** performed by ***Non-Participating Dentists*** will be sent to the ***participant.*** ***Non-Participating Dentists*** may balance-bill patients for the difference of their charges and the ***Dental Claims Processor's*** payment; ***Participating Dentists*** shall not balance-bill patients for charges exceeding the ***MPA*** for ***covered benefits*** under this ***Plan***.

MAXIMUM BENEFIT

The maximum calendar year benefit payable on behalf of a ***covered person*** for covered dental expense is stated on the *Schedule of Benefits.* If the ***covered person's*** coverage under the ***Plan*** terminates and he subsequently returns to coverage under the ***Plan*** during the calendar year, the ***maximum benefit*** will be calculated on the sum of benefits paid by the ***Plan***.

ALTERNATIVE TREATMENT

In the event the ***dentist*** recommends a particular course of treatment and a lower-cost alternative would be as effective, benefits shall be limited to the lower-cost alternative. Any balance remaining, as a result of the ***covered person's*** choice to obtain the higher-cost treatment will be the ***covered person's*** responsibility.

DENTAL INCURRED DATE

A dental procedure will be deemed to have commenced on the date the covered dental expense is ***incurred,*** except as follows:

1. For endodontic treatment, on the date the pulp chamber is opened.

COVERED DENTAL EXPENSES

Subject to the limitations and exclusions, covered dental expenses shall include the necessary services, supplies, or treatment listed below and on the following pages. No dental benefit will be paid for any dental service, supply or treatment which is not on the following list of covered dental expenses.

Class I—Diagnostic and Preventive Dental Services

1. Routine periodic and specialty oral examination: Initial or periodic, limited to twice per calendar year.

2. Prophylaxis: Scaling and cleaning of teeth, limited to twice per calendar year.

3. Dental x-rays as follows:

    a. Bitewing and periapical X-rays as required.
    b. Panorex and/or full mouth series, limited to once in any five (5) year period.

4. Topical application of fluoride, limited to once per calendar year for dependent children to age nineteen (19).

5. Topical application of sealant, limited to once per tooth for dependent children to age sixteen (16).

Class I—Diagnostic and Preventive Dental Services Limitations and Exclusions

a. DDAR will pay for two (2) oral examinations and cleanings per person per calendar year.
b. Diagnostic casts, photographs, and cephalometric films are not covered.
c. Full-mouth debridement is limited to once in a lifetime.
d. DDAR will pay for full mouth x-rays once within five (5) years. A combination of periapical and bitewing x-rays (ten [10] or more films) or a panoramic film and additional x-rays make up a full mouth series.
e. A sealant is a benefit only on the unrestored, decay free chewing surface (occlusal surface) of the maxillary (upper) and mandibular (lower) first and second molars. Sealants are a benefit for dependent children to age sixteen (16). Sealants are payable once per tooth.
f. Preventative control programs (oral hygiene instructions, carries susceptibility tests, dietary control, tobacco counseling, etc.) are not a covered benefit.
g. DDAR will pay for one (1) topical application of fluoride in a calendar year for dependent children to age nineteen (19). Fluoride rinses or self-applied fluorides are not a covered benefit.
h. DDAR will not pay for adult cleanings for covered person(s) to age fourteen (14).

i. Pulp vitality tests are payable per visit, not per tooth, and only for the diagnosis of emergency conditions.

Class II—Basic Dental Services

1. Palliative emergency treatment—Minor emergency treatment for relief of pain as needed by the covered person.

2. Fillings—Amalgam (silver) and composite/resin (white) fillings (Composites are not a covered benefit on molars. See "b" below under *Class II—Basic Dental Services Limitations and Exclusions*.)

3. Endodontics—Includes pulpal therapy; root canal filling.

4. Extractions—Simple extractions.

5. Oral Surgery—Oral surgery, including pre- and post-operative care and surgical extractions, except TMJ surgery.

6. Space Maintainers—For prematurely lost teeth of eligible dependent children to age thirteen (13).

7. Stainless Steel Crowns—Used as a restoration to natural teeth for dependent children to age sixteen (16) when teeth cannot be restored with a filling material.

Class II—Basic Dental Services Limitations and Exclusions

a. Palliative emergency treatment is payable on a per visit basis, once on the same date.
b. Restorative benefits are allowed once per surface per tooth in a twenty-four (24) month period. This is allowed irrespective of the number of combinations of procedures requested or performed. Composites on molars are not covered. An amalgam allowance will be made for molars with any fee difference the responsibility of the patient.
c. Payment for root canal treatment includes charges for temporary restorations. Root canal treatment is limited to once in a lifetime, per tooth by the same dentist or dental office. Retreatment of root canal by the same dentist or dental office will be considered after twenty-four (24) months have lapsed since initial treatment. Root canals on deciduous teeth are not a benefit, unless there is no permanent successor. Pulpal therapy is limited to primary teeth and therapeutic pulpotomy is limited to primary teeth once in a lifetime.
d. Extractions, surgical extractions, root removal, alveoplasty, surgical exposure of impacted or unerupted teeth, tooth reimplantation and/or stabilization, transseptal fiberotomy, and oroantral fistula closure are limited to once per lifetime.
e. Charges for general anesthesia/intravenous sedation are not covered except when administered in conjunction with covered oral surgery, excluding single tooth extractions (ADA procedure code 7140) and for children three (3) years of age and under.
f. Analgesia, anxiolysis, inhalation of nitrous oxide, therapeutic drug injection, other drugs and/or medicines, and desensitizing medicines are not covered.
g. Composite resin crowns are not a benefit on primary teeth. A stainless steel crown allowance will be made with any fee difference the responsbility of the patient.
h. A space maintainer is a benefit when used to replace prematurely lost or extracted teeth for children to age thirteen (13), limited to once in a sixty (60) consecutive month period. Recementation of a space mainainer is limited to once in five (5) years. Recementation of a space maintainer within six (6) months of the seating date is part of the original procedure. A space maintainer is not considered an orthodontic appliance.
i. DDAR will not pay for the replacement of a stainless steel crown within a sixty (60) month period of the initial placement.

j. Treatment of complications (post-surgical) or unusual circumstances are a benefit once in three (3) months (i.e. treatment of a dry-socket).

General Limitations and Exclusions

DDAR does not pay benefits for the following:

1. Benefits or services for injuries or conditions covered under Worker's Compensation or Employer's Liability Laws. Benefits or services available from any federal or state government agency; municipality, county, other political subdivision; or community agnecy; or from any foundation or similar entity.
2. Charges for services or supplies received as a result of dental disease, defect, or injury due to an act of war, declared or undeclared.
3. Charges for services or supplies for which no charge is made that the covered person is legally obligated to pay. Charges for which no charge would be made in the absence of dental coverage.
4. Charges for treatment by other than a licensed dentist except that a licensed hygienist may perform services in accordance with applicable law. Services must be under the supervision and guidance of the licensed dentist in accordance with generally accepted dental standards.
5. Charges for the completion of forms and/or submission of supportive documentation required by DDAR for a benefit determination. A charge for these services is not to be made to a DDAR-***covered person*** by a participating dentist.
6. Benefits to correct congenital or developmental malformations.
7. Services for the purpose of improving appearance when form and function are satisfactory, and there is insufficient pathological condition evident to warrant the treatment (cosmetic dentistry).
8. Benefits for services or appliances started prior to the date the patient became eligible under this plan.
9. Services with respect to diagnosis and treatment of disturbances of the temporomandibular joint (TMJ).
10. Services for increasing the vertical dimension or for restoring tooth structure lost by attrition, for rebuilding or maintaining occlusal services, or for stabilizing the teeth.
11. Experimental and/or investigational services, supplies, care and treatment which does not constitute accepted medical practice properly within the range of appropriate medical practice under the standards of the case and by the standards or a reasonably substantial, qualified, responsible, relevant segment of the medical and dental community or government oversight agencies at the time services were rendered. The ***Claims Administrator*** must make an independent evaluation of the experimental or non-experimental standings of specific technologies. The ***Claims Administrator's*** decision will be final and binding. Drugs are considered experimental if they are not commercially available for purchase and/or are not approved by the Food and Drug Administration for general use.
12. Implant techniques and procedures related to implants.
13. Charges for replacement of lost, missing, or stolen appliances/devices.
14. Charges for services when a claim is received for payment more than twelve (12) months after services are rendered.
15. Charges for complete occlusal adjustments, occlusal guards, occlusion analysis, enamel microabrasion, odontoplasty, bleaching and athletic mouthguards.

16. Specialized techniques that entail procedure and process over and above that which is normally adequate. Any additional fee is the patient's responsibility.
17. Behavior management.
18. Those services and benefits excluded by the rules and regulations of DDAR, including DDAR's processing policies.
19. Removable appliances for control of harmful habits, including but not limited to tongue thrust appliances.
20. Charges for general anesthesia/intravenous sedation are not covered except when administered in conjunction with covered oral surgery, excluding single tooth extractions (ADA procedure code 7140) and for children three (3) years of age and under.
21. Procedures that do not comply with DDAR's guidelines.
22. Charges for precision attachments, provisional splinting, desensitizing medicines, home care medicines, premedications, stress breakers, coping, office visits during or after regularly scheduled hours, case presentations and hospital-related services.
23. All other benefits and services not specifically covered by the ***Plan***.

VISION EXPENSE BENEFIT

Vision benefits will be paid for the charges for covered vision expenses for ***covered persons*** as shown on the *Schedule of Benefits*. The benefits will apply when charges are ***incurred*** for vision care by a legally licensed ***physician*** or ***professional provider***.

COVERED VISION EXPENSES

The ***Plan*** provides coverage for services, supplies and treatment for the following:

1. One (1) examination and refraction for each ***covered person*** per calendar year limited to the ***maximum benefit*** as specified in the *Vision Schedule of Benefits*.

2. Corrective lenses/frames or contacts limited to the ***maximum benefit*** per calendar year as specified in the *Vision Schedule of Benefits*.

VISION EXCLUSIONS

In addition to *Plan Exclusions*, no benefit will be provided under this ***Plan*** for vision expenses ***incurred*** by a ***covered person*** for the following:

1. Services or supplies required as a condition of employment or by any governmental body.

2. Sunglasses (plain or prescription), safety lenses, or goggles.

3. Medical or surgical care of the eye.

4. Any lenses not prescribed by a legally licensed ***physician*** or optometrist.

5. Any service performed or supplies provided for special procedures such as orthoptics or any aids for sub-normal vision.

PLAN EXCLUSIONS

The ***Plan*** will not provide benefits for any of the items listed in this section, regardless of ***medical necessity*** or recommendation of a ***physician*** or ***professional provider***.

1. Charges for services, supplies or treatment from any ***hospital*** owned or operated by the United States government or any agency thereof or any government outside the United States, or charges for services, treatment or supplies furnished by the United States government or any agency thereof or any government outside the United States, unless payment is legally required.

2. Charges for an ***injury*** sustained or ***illness*** contracted while on active duty in military service, unless payment is legally required.

3. Charges for services, treatment or supplies for treatment of ***illness*** or ***injury*** which is caused by or attributed to by war or any act of war, participation in a riot, civil disobedience or insurrection. "War" means declared or undeclared war, whether civil or international, or any substantial armed conflict between organized forces of a military nature.

4. Employees: Treatment or service due to illness or injury which occurred from any act for wage or profit provided the charges for the illness or injury are reimbursed by a policy of Workers' Compensation Insurance; or

   Dependents: Treatment or services due to illness or injury which is covered by Workers' Compensation Insurance or which occurred from any act for wage or profit.

5. Charges in connection with any ***illness*** or ***injury*** arising out of or in the course of any employment intended for wage or profit, including self-employment.

6. Charges made for services, supplies and treatment which are not ***medically necessary*** for the treatment of ***illness*** or ***injury***, or which are not recommended and approved by the attending ***physician***, except as specifically stated herein, or to the extent that the charges exceed ***customary and reasonable amount*** or exceed the ***negotiated rate*** as applicable.

7. Charges in connection with any ***illness*** or ***injury*** of the ***covered person*** resulting from or occurring during commission or attempted commission of a criminal battery or felony by the ***covered person*** if the ***covered person*** is charged with such crime. This exclusion will not apply to ***illness*** and/or ***injury*** sustained due to a medical condition (physical or mental) or domestic violence.

8. To the extent that payment under this ***Plan*** is prohibited by any law of any jurisdiction in which the ***covered person*** resides at the time the expense is incurred.

9. Charges for services rendered and/or supplies received prior to the ***effective date*** or after the termination date of a person's coverage, except as specifically provided herein.

10. Any services, supplies or treatment for which the ***covered person*** is not legally required to pay; or for which no charge would usually be made; or for which such charge, if made, would not usually be collected if no coverage existed; or to the extent the charge for the care exceeds the charge that would have been made and collected if no coverage existed.

11. Charges for services, supplies or treatment that are considered ***experimental/investigational***.

12. Charges ***incurred*** outside the United States if the ***covered person*** traveled to such a location for the sole purpose of obtaining services, supplies or treatment.

13. Charges for services, supplies or treatment rendered by any individual who is a ***close relative*** of the ***covered person*** or who resides in the same household as the ***covered person***.

14. Charges for services, supplies or treatment rendered by physicians or ***professional providers*** beyond the scope of their license; for any treatment, ***confinement*** or service which is not recommended by or performed by an appropriate ***professional provider***.

15. Charges for ***illnesses*** or ***injuries*** suffered by a ***covered person*** due to the action or inaction of any party if the ***covered person*** fails to provide information as specified in *Subrogation.*

16. Claims not submitted within the ***Plan's*** filing limit deadlines as specified in *Claim Filing Procedures*.

17. Charges for telephone consultations, completion of claim forms, charges associated with missed appointments.

18. Charges for drugs, devices, supplies, treatments, procedures or services that are considered ***experimental/investigational*** by the ***Plan***. The ***Plan*** will consider a drug, device, supply, treatment, procedure or service to be "***experimental***" or "***investigative***":

    a. if, in the case of a device or supply, the device or supply cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug, device or supply is furnished; or

    b. if the drug, device, supply, treatment, procedure or service, or the patient's informed consent document utilized with respect to the drug, device, supply, treatment, procedure or service was reviewed and approved by the treating ***facility's*** institutional review board or other body serving a similar function, or if federal law requires such review or approval; or

    c. if the ***plan sponsor*** (or its designee) determines in its sole discretion that the drug, device, supply, treatment, procedure or service is the subject of on-going Phase I or Phase II clinical trials; is the research, ***experimental***, study or ***investigational*** arm of on-going Phase III clinical trials, or is otherwise under study to determine maximum tolerated dose, toxicity, safety or efficacy, however, a drug, device, supply, treatment, procedure or service that meets the standards set in the section *Medical Expense Benefit, Off-Label Drug Use* or *Phase III Oncology Clinical Trials* will not be deemed ***experimental*** or ***investigational*** solely by reason of this subparagraph; or

    d. if the ***plan sponsor*** (or its designee) determines in its sole discretion based on documentation in one of the standard reference compendia or in substantially accepted peer-reviewed medical literature that the prevailing opinion among experts regarding the drug, device, supply, treatment, procedure or service is that further studies or clinical trials are necessary to determine its maximum tolerated dose, toxicity, safety or efficacy.

ELIGIBILITY, ENROLLMENT AND EFFECTIVE DATE

This section identifies the ***Plan's*** requirements for a person to participate in the ***Plan***.

EMPLOYEE ELIGIBILITY

An ***Employee*** is defined as a Bishop, ministerial member, full-time lay pastor or layperson employed by The United Methodist Church or an Annual Conference, local Church, or an agency or institution of such Church.

You are eligible if you are a:

1. Full-Time Active Employee of participating Annual Conferences, local churches, agencies, or institutions of The United Methodist Church. (Non-Clergy employees who perform active work thirty (30) or more hours per week are considered full-time Employees.)

2. Retired Employee of the above participating groups.

3. Surviving Spouse of a deceased ***employee*** who was an active ***employee*** at time of death.

4. Disabled Clergy Employee not currently assigned to a church and will remain eligible under this Plan until they are reassigned to a church or become classified as a retired employee.

A Retired Employee is defined as a former Employee retired by a participating group who is receiving a pension financed by the Employer and was covered under the ***Plan*** prior to retirement.

Surviving Spouse of a deceased employee of the above participating groups.

A Surviving Spouse is defined as the wife or husband of a deceased Employee of a participating group included under this ***Plan*** who was covered under the ***Plan*** prior to the ***employee's*** death and/or retirement.

Retired ***employees*** may continue coverage by paying the applicable contribution for ***employee*** and/or ***dependent*** coverage. While the ***employer*** expects ***retiree*** coverage to continue, the ***employer*** reserves the right to modify or discontinue ***retiree*** coverage or any other provision of the ***Plan*** at any time.

EMPLOYEE ENROLLMENT

An ***employee*** must file a written application with the ***employer*** for coverage hereunder for himself within thirty-one (31) days of becoming eligible for coverage. The ***employee*** shall have the responsibility of timely forwarding to the ***employer*** all applications for enrollment hereunder.

EMPLOYEE(S) EFFECTIVE DATE

Eligible ***employees***, as described in *Employee Eligibility*, are covered under the ***Plan*** on the first day of ***full-time employment.***

DEPENDENT(S) ELIGIBILITY

The following describes ***dependent*** eligibility requirements. The ***employer*** will require proof of ***dependent*** status.

1. The term "spouse" means the spouse of the ***employee*** under a legally valid existing marriage between person's of the opposite sex, unless court ordered separation exists. This also includes a valid marriage entered into in another state between persons of the opposite sex, unless court ordered separation exists.

2. The term "child" means the ***employee's*** natural child, stepchild, legally adopted child, child ***placed for adoption***, foster child, and a child for whom the ***employee*** or covered spouse has been appointed legal guardian, provided the child is less than twenty-six (26) years of age and is not eligible to enroll in any other employer sponsored group health plan, other than through a parent.

3. An eligible child shall also include any other child of an ***employee*** or their spouse who is recognized in a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN) which has been issued by any court judgment, decree, or order as being entitled to enrollment for coverage under this ***Plan***. Such child shall be referred to as an ***alternate recipient***. ***Alternate recipients*** are eligible for coverage regardless of whether the ***employee*** elects coverage for himself. An application for enrollment must be submitted to the ***employer*** for coverage under this ***Plan***. The ***employer/plan administrator*** shall establish written procedures for determining whether a medical child support order is a QMCSO or NMSN and for administering the provision of benefits under the ***Plan*** pursuant to a valid QMCSO or NMSN. Within a reasonable period after receipt of a medical child support order, the ***employer/plan administrator*** shall determine whether such order is a QMCSO, as defined in Section 609 of ERISA, or a NMSN, as defined in Section 401 of the Child Support Performance and Incentive Act of 1998.

   The ***employer/plan administrator*** reserves the right, waivable at its discretion, to seek clarification with respect to the order from the court or administrative agency which issued the order, up to and including the right to seek a hearing before the court or agency.

4. A ***dependent*** child who was covered under the ***Plan*** prior to reaching the maximum age limit of twenty-six (26) years and who lives with the ***employee***, is unmarried, incapable of self-sustaining employment and dependent upon the ***employee*** for support due to a mental and/or physical disability, will remain eligible for coverage under this ***Plan*** beyond the date coverage would otherwise terminate.

   Proof of incapacitation must be provided within thirty-one (31) days of the child's loss of eligibility and thereafter as requested by the ***employer*** or ***claims processor***, but not more than once every two (2) years. Eligibility may not be continued beyond the earliest of the following:

   a. Cessation of the mental and/or physical disability;
   b. Failure to furnish any required proof of mental and/or physical disability or to submit to any required examination.

Every eligible ***employee*** may enroll eligible ***dependents***. However, if both the husband and wife are ***employees***, they may choose to have one covered as the ***employee***, and the spouse covered as the ***dependent*** of the ***employee***, or they may choose to have both covered as ***employees***. Eligible children may be enrolled as ***dependents*** of one spouse, but not both.

DEPENDENT ENROLLMENT

An ***employee*** must file a written application with the ***employer*** for coverage hereunder for his eligible ***dependents*** within thirty-one (31) days of becoming eligible for coverage; within thirty (30) days of marriage or the acquiring of children; and within ninety (90) days of the birth of a child. The ***employee*** shall have the responsibility of timely forwarding to the ***employer*** all applications for enrollment hereunder.

DEPENDENT(S) EFFECTIVE DATE

Eligible ***dependent(s)***, as described in *Eligibility*, will become covered under the ***Plan*** on the later of the dates listed below, provided the ***employee*** has enrolled them in the ***Plan*** within thirty-one (31) days of meeting the ***Plan's*** eligibility requirements.

1. The date the ***employee's*** coverage becomes effective.

2. The date the ***dependent*** is acquired, provided any required contributions are made and the ***employee*** has applied for ***dependent*** coverage within thirty (30) days of the date acquired.

3. Newborn children shall be covered from birth, regardless of confinement, provided the ***employee*** has applied for ***dependent*** coverage within ninety (90) days of birth.

4. Coverage for a newly or to be adopted child shall be effective on the date the child is ***placed for adoption***.

SPECIAL ENROLLMENT PERIOD (OTHER COVERAGE)

An ***employee*** or ***dependent*** who did not enroll for coverage under this ***Plan*** because he was covered under other group coverage or had health insurance coverage at the time he was initially eligible for coverage under this ***Plan***, may request a special enrollment period if he is no longer eligible for the other coverage. Special enrollment periods will be granted if the individual's loss of eligibility is due to:

1. Termination of the other coverage (including exhaustion of COBRA benefits)

2. Cessation of employer contributions toward the other coverage

3. Legal separation or divorce

4. Termination of other employment or reduction in number of hours of other employment

5. Death of ***dependent*** or spouse

6. Cessation of other coverage because ***employee*** or ***dependent*** no longer resides or works in the service area and no other benefit package is available to the individual.

7. Cessation of ***dependent*** status under other coverage and ***dependent*** is otherwise eligible under ***employee's Plan***.

8. An incurred claim that would exceed the other coverage's maximum benefit limit. The maximum benefit limit is all-inclusive and means that no further benefits are payable under the other coverage because the specific total benefit pay out maximum has been reached under the other coverage. The right for special enrollment continues for thirty (30) days after the date the claim is denied under the other coverage.

   The *Schedule of Benefits* contains a separate annual ***maximum benefit***. The *Schedule of Benefits* may also contain separate ***maximum benefit*** limitations for specified conditions and/or services. Any separate ***maximum benefit*** will include all such benefits paid by the ***Plan*** for the ***covered person*** during any and all periods of coverage under this ***Plan***. No more than the ***maximum benefit*** will be paid for any ***covered person*** while covered by this ***Plan***.

   Notwithstanding any provision of the ***Plan*** to the contrary, all benefits received by an individual under any benefit option, package or coverage under the ***Plan*** shall be applied toward the ***Essential Health***

Benefits/non-***Essential Health Benefits maximum benefit*** paid by the ***Plan*** for any one ***covered person*** for such option, package or coverage under the ***Plan***, and also toward the ***Essential Health Benefits/***non-***Essential Health Benefits maximum benefit*** under any other options, packages or coverages under the ***Plan*** in which the individual may participate in the future.

The ***maximum benefit*** for ***Essential Health Benefits*** and non-***Essential Health Benefits*** is tracked separately.

The end of any extended benefits period, which has been provided due to any of the above, will also be considered a loss of eligibility.

However, loss of eligibility does not include a loss due to failure of the individual to pay premiums or contributions on a timely basis or termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the other coverage).

The ***employee*** or ***dependent*** must request the special enrollment and enroll no later than thirty (30) days from the date of loss of other coverage.

The ***effective date*** of coverage as the result of a special enrollment shall be the date of loss of other coverage.

SPECIAL ENROLLMENT PERIOD (DEPENDENT ACQUISITION)

An ***employee*** who is currently covered or not covered under the ***Plan***, but who acquires a new ***dependent*** may request a special enrollment period for himself and all his/her eligible ***dependents*** that are otherwise eligible for coverage.

For the purposes of this provision, the acquisition of a new ***dependent*** includes:

- marriage
- birth of a ***dependent*** child
- adoption or placement for adoption of a ***dependent*** child

The ***employee*** must request the special enrollment within thirty (30) days of the acquisition of the ***dependent***.

The effective date of coverage as the result of a special enrollment shall be:

1. in the case of marriage, the date of such marriage;

2. in the case of a ***dependent's*** birth, the date of such birth;

3. in the case of adoption or placement for adoption, the date of such adoption or placement for adoption.

SPECIAL ENROLLMENT PERIOD (CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP) REAUTHORIZATION ACT OF 2009)

Effective January 1, 2009, this ***Plan*** intends to comply with the Children's Health Insurance Program Reauthorization Act of 2009.

An ***employee*** who is currently covered or not covered under the ***Plan*** may request a special enrollment period for himself, if applicable, and his ***dependent***. Special enrollment periods will be granted if:

1. the individual's loss of eligibility is due to termination of coverage under a state children's health insurance program or Medicaid; or,

2. the individual is eligible for any applicable premium assistance under a state children's health insurance program or Medicaid.

The ***employee*** or ***dependent*** must request the special enrollment and enroll no later than sixty (60) days from the date of loss of other coverage or from the date the individual becomes eligible for any applicable premium assistance.

The ***effective date*** of coverage as the result of a special enrollment shall be the first day of the first calendar month following the ***plan administrator's*** receipt of the completed enrollment form.

SPECIAL ENROLLMENT PERIOD (PATIENT PROTECTION AND AFFORDABLE CARE ACT)

*Effective for **Plan** years renewing after September 23, 2010,* and pursuant to the Patient Protection and Affordable Care Act, an ***employee*** who is currently covered or not covered under the ***Plan*** may enroll for coverage for himself and his ***dependent***. Special enrollment will be granted if:

1. the ***dependent's*** coverage under this ***Plan*** ended or the ***dependent*** was not eligible or was denied coverage under this ***Plan*** because the ***Plan*** did not provide coverage to age twenty-six (26).
2. the ***dependent*** is not eligible to enroll in any other employer sponsored group health plan, other than through a parent.

The ***employee*** or ***dependent*** must enroll no later than thirty (30) days from receipt of notice of the special enrollment period.

OPEN ENROLLMENT

Open enrollment is the period designated by the ***employer*** during which the ***employee*** may change benefit plans or enroll in the ***Plan*** if he did not do so when first eligible or does not qualify for a special enrollment period. An open enrollment will be permitted once in each calendar year during the month of September. A covered ***employee*** who fails to make an election or to change enrollment during the open enrollment period will automatically retain his or her present coverage.

During this open enrollment period, an ***employee*** and his ***dependents*** that are covered under this ***Plan*** or covered under any ***employer*** sponsored health plan may elect coverage or change coverage under this ***Plan*** for himself and his eligible ***dependents***. An ***employee*** must make written application as provided by the ***employer*** during the open enrollment period to change benefit plans.

Any person enrolling in this ***Plan*** for the <u>first time</u> at open enrollment (not transferring from another employer-sponsored health plan) will be treated as a late enrollee.

The ***effective date*** of coverage as the result of an open enrollment period will be the following October 1st.

Except for a status change listed below or as described below in *Effect of an HMO Plan*, the open enrollment period is the only time an ***employee*** may change benefit options or modify enrollment. Status changes include:

1. Change in family status. A change in family status shall include only:
   a. Change in ***employee's*** legal marital status;
   b. Change in number of ***dependents***;
   c. Termination or commencement of employment by the ***employee***, spouse or ***dependent***;
   d. Change in work schedule;

e. ***Dependent*** satisfies (or ceases to satisfy) ***dependent*** eligibility requirements;
f. Change in residence or worksite of ***employee***, spouse or ***dependent***.

2. Significant change in the cost of coverage under the ***employer's*** group medical plan.

3. Cessation of required contributions.

4. Taking or returning from a ***leave of absence*** under the Family and Medical Leave Act.

5. Significant change in the health coverage of the ***employee*** or spouse attributable to the spouse's employment.

6. A Special Enrollment Period as mandated by the Health Insurance Portability and Accountability Act.

7. A court order, judgment or decree.

8. Entitlement to ***Medicare*** or Medicaid or enrollment in a state child health insurance program (CHIP).

9. A COBRA qualifying event.

Effect of an HMO Plan

If an ***employee*** transfers from an HMO plan sponsored by the ***employer*** to this ***Plan*** under circumstances described in 1, 2 or 3 below, the coverage under this ***Plan*** will become effective on the day following the date the HMO coverage terminates.

1. During the open enrollment period; or

2. Because the HMO ceased operation; or

3. Because the ***employee*** changed residence and is no longer eligible for coverage under the HMO.

The ***pre-existing conditions*** provisions will not apply to those persons whose coverage is being transferred from the HMO plan, provided enrollment occurs within thirty (30) days. These provisions will <u>not</u> be waived if an ***employee*** transfers coverage to this ***Plan*** at any other time than specified in 1, 2, or 3.

PRE-EXISTING CONDITIONS

A ***pre-existing condition*** is an ***illness*** or ***injury*** that existed within one hundred eighty (180) days before the ***covered person's enrollment date*** for coverage under this ***Plan***. An ***illness*** or ***injury*** is considered to have existed when the ***covered person***:

1. Sought or received professional advice for that ***illness*** or ***injury***, or

2. Received medical care or treatment for that ***illness*** or ***injury***, or

3. Received medical supplies, drugs, or medicines for that ***illness*** or ***injury***.

Benefits will be provided for ***pre-existing conditions*** after the completion of a period of 365 days (545 days for a ***late enrollee***) from the ***covered person's enrollment date*** for coverage under this ***Plan***, except pre-existing for infertility of a ***late enrollee*** shall be limited to three hundred and sixty-five (365) days only. The ***enrollment date*** shall mean the first day of any applicable service waiting period or the date of hire or, in the case of a Special Enrollment Period or Open Enrollment Period, the date the enrollment form is executed.

This ***pre-existing condition*** limitation shall not apply to a child born to or ***placed for adoption*** under the Special Enrollment provisions of the ***Plan*** for ***dependent*** acquisitions, nor to ***pregnancy*** under any circumstances. ***Pre-existing conditions*** will be waived for a minister and eligible ***dependents*** who have been given a first-time appointment in the Arkansas Conferences, if enrollment is made within thirty (30) days of the appointment.

This ***pre-existing condition*** limitation shall not apply to an ***employee*** or ***dependent*** less than nineteen (19) years of age, or to ***pregnancy*** under any circumstances.

Precertification from the ***Health Care Management Organization*** does not constitute ***Plan*** liability for any ***pre-existing condition*** charges during this ***pre-existing condition*** limitation period.

The ***covered person*** has a right to appeal the determination of coverage for ***pre-existing conditions***. See *Claim Filing Procedures*.

For the purpose of determining whether this ***pre-existing condition*** provision of the ***Plan*** will be applied to claims for any individual, the ***plan administrator*** will look not only to the period of time the individual has been covered under this ***Plan***, but also to any period of previous creditable coverage the individual has earned. Creditable coverage shall include, but is not limited to, coverage the individual may have had under a prior employer's benefit plan or COBRA, individual or group insurance, ***Medicare*** or Medicaid, a state risk pool, or CHAMPUS/TRICARE. Other types of coverage may also be considered creditable coverage. However, creditable coverage will only be applied to this ***Plan's pre-existing condition*** time periods if there has been no break in coverage of the individual for sixty-three (63) days or more. If there has been a break in coverage of sixty-three (63) days or more, the ***plan administrator*** will not apply previous coverage towards this ***Plan's pre-existing condition*** limitation. Waiting periods for coverage do not count as a break in coverage.

It is the ***employee's*** responsibility to provide the ***plan administrator*** with evidence of creditable coverage. Such evidence may be in the form of a Certificate of Coverage or in any other form acceptable to the ***plan administrator***.

TERMINATION OF COVERAGE

Except as provided in the ***Plan's*** *Continuation of Coverage* (COBRA) or *Extension of Benefits* provision, coverage will terminate on the earliest of the following dates:

TERMINATION OF EMPLOYEE COVERAGE

1. The date the ***employer*** terminates the ***Plan*** and offers no other group health plan.

2. The date the ***employee*** ceases to meet the eligibility requirements of the ***Plan***.

3. The date employment terminates, as defined by the ***employer's*** personnel policies.

4. The date the ***employee*** becomes a full-time***,*** active member of the armed forces of any country.

5. The date the ***employee*** ceases to make any required contributions.

If an ***employee*** elects to become covered under another ***employer***-sponsored health plan, coverage under this ***Plan*** will terminate on the day before the ***effective date*** of the other coverage. Any provisions that would extend or continue benefits beyond that date will not apply.

TERMINATION OF DEPENDENT(S) COVERAGE

1. The date the ***employer*** terminates the ***Plan*** and offers no other group health plan.

2. The date the ***employee's*** coverage terminates. However, if the ***employee*** remains eligible for the ***Plan***, but elects to discontinue coverage, coverage may be extended for ***alternate recipients***.

3. The date such person ceases to meet the eligibility requirements of the ***Plan***.

4. The date the ***employee*** ceases to make any required contributions on the ***dependent's*** behalf.

5. The date the ***dependent*** becomes a full-time, active member of the armed forces of any country.

6. The date the ***Plan*** discontinues ***dependent*** coverage for any and all ***dependents***.

7. The date the ***dependent*** becomes eligible as an ***employee***.

LEAVE OF ABSENCE

Coverage may be continued for a limited time, contingent upon payment of any required contributions for ***employees*** and/or ***dependents***, when the ***employee*** is on an authorized ***leave of absence*** from the ***employer***. In no event will coverage continue for more than three (3) months after the ***employee's*** active service ends.

LAYOFF

Coverage may be continued for a limited time, contingent upon payment of any required contributions for ***employees*** and/or ***dependents***, when the ***employee*** is subject to an ***employer layoff***. In no event will coverage continue for more than three (3) months after the ***employee's active service*** ends.

FAMILY AND MEDICAL LEAVE ACT (FMLA)

Eligible Leave

An ***employee*** who is eligible for unpaid leave and benefits under the terms of the Family and Medical Leave Act of 1993 (FMLA), as amended, has the right to continue coverage under this ***Plan*** for up to twelve (12) weeks (twenty-six (26) weeks in certain circumstances). ***Employees*** should contact the ***employer*** to determine whether they are eligible under FMLA.

Contributions

During this leave, the ***employer*** will continue to pay the same portion of the ***employee's*** contribution for the ***Plan***. The ***employee*** shall be responsible to continue payment for eligible ***dependent's*** coverage and any remaining ***employee*** contributions. If the covered ***employee*** fails to make the required contribution during a FMLA leave within thirty (30) days after the date the contribution was due, the coverage will terminate effective on the date the contribution was due.

Reinstatement

If coverage under the ***Plan*** was terminated during an approved FMLA leave, and the ***employee*** returns to active work immediately upon completion of that leave, ***Plan*** coverage will be reinstated on the date the ***employee*** returns to active work as if coverage had not terminated, provided the ***employee*** makes any necessary contributions and enrolls for coverage within thirty (30) days of his return to active work.

Repayment Requirement

The ***employer*** may require ***employees*** who fail to return from a leave under FMLA to repay any contributions paid by the ***employer*** on the ***employee's*** behalf during an unpaid leave. This repayment will be required only if the ***employee's*** failure to return from such leave is not related to a "serious health condition," as defined in FMLA, or events beyond the ***employee's*** control.

EMPLOYEE REINSTATEMENT

Employees and eligible ***dependents*** who lost coverage due to an approved ***leave of absence***, ***layoff***, or separation of service from the ***employer*** are eligible for reinstatement of coverage as follows:

1. Reinstatement of coverage is available to ***employees*** and ***dependents*** that were previously covered under the ***Plan***.

2. Rehire must occur within three (3) months of separation from service.

3. The ***employee*** must submit the completed application for enrollment to the ***employer*** within thirty-one (31) days of rehire.

4. Coverage shall be effective from the date of rehire. Prior benefits and limitations, such as deductible, ***maximum benefit***, ***pre-existing condition*** waiting period, shall be applied with no break in coverage.

If the provisions of (1) through (3) above are not met, the ***Plan's*** provisions for eligibility and application for enrollment shall apply.

An ***employee*** who returns to work after three (3) months of an approved ***leave of absence***, ***layoff***, or separation of service will be considered a new ***employee*** for purposes of eligibility and will be subject to all eligibility

requirements, including all requirements relating to the ***effective date*** of coverage and the ***pre-existing condition*** limitations.

An ***employee*** who elects to continue coverage and return to work before continuation coverage terminates will retain the same employment status as prior to the event that qualified him or her for continuation coverage and no new ***pre-existing*** condition limitation, or eligibility waiting period will again apply.

CERTIFICATES OF COVERAGE

The ***plan administrator*** shall provide each terminating ***covered person*** with a Certificate of Coverage, certifying the period of time the individual was covered under this ***Plan***. For ***employees*** with ***dependent*** coverage, the certificate provided may include information on all covered ***dependents***. This ***Plan*** intends to at all times comply with the provisions of the Health Insurance Portability and Accountability Act of 1996.

CONTINUATION OF COVERAGE

In order to voluntarily comply with federal regulations, this ***Plan*** includes a continuation of coverage option for certain individuals whose coverage would otherwise terminate. The following is intended to voluntarily comply with the Public Health Services Act. This continuation of coverage may be commonly referred to as "COBRA coverage" or "continuation coverage."

The coverage which may be continued under this provision consists of health coverage. It does not include life insurance benefits, accidental death and dismemberment benefits, or income replacement benefits. Health coverage includes medical, prescription drug, dental and vision benefits as provided under the ***Plan***.

QUALIFYING EVENTS

Qualifying events are any one of the following events that would cause a ***covered person*** to lose coverage under this ***Plan*** or cause an increase in required contributions, even if such loss of coverage or increase in required contributions does not take effect immediately, and allow such person to continue coverage beyond the date described in *Termination of Coverage*:

1. Death of the ***employee***.

2. The ***employee's*** termination of employment (other than termination for gross misconduct), or reduction in work hours to less than the minimum required for coverage under the ***Plan***. This event is referred to below as an "18-Month Qualifying Event."

3. Divorce or legal separation from the ***employee***.

4. The ***employee's*** entitlement to ***Medicare*** benefits under Title XVIII of the Social Security Act, if it results in the loss of coverage under this ***Plan***.

5. A ***dependent*** child no longer meets the eligibility requirements of the ***Plan***.

6. The last day of leave under the Family and Medical Leave Act of 1993, or an earlier date on which the ***employee*** informs the ***employer*** that he or she will not be returning to work.

7. The call-up of an ***employee*** reservist to active duty.

8. A covered ***retiree*** and their covered ***dependents*** whose benefits were substantially eliminated within one (1) year of the ***employer*** filing for Chapter 11 bankruptcy.

NOTIFICATION REQUIREMENTS

1. When eligibility for continuation of coverage results from a spouse being divorced or legally separated from a covered ***employee***, or a child's loss of ***dependent*** status, the ***employee*** or ***dependent*** must submit a completed Qualifying Event Notification form to the ***plan administrator*** (or its designee) within sixty (60) days of the latest of:

    a. The date of the event;
    b. The date on which coverage under this ***Plan*** is or would be lost as a result of that event; or
    c. The date on which the ***employee*** or ***dependent*** is furnished with a copy of this Plan Document.

A copy of the Qualifying Event Notification form is available from the ***plan administrator*** (or its designee). In addition, the ***employee*** or ***dependent*** may be required to promptly provide any supporting documentation as may be reasonably requested for purposes of verification. Failure to provide such notice and any requested supporting documentation will result in the person forfeiting their rights to continuation of coverage under this provision.

Within fourteen (14) days of the receipt of a properly completed Qualifying Event Notification, the ***plan administrator*** (or its designee) will notify the ***employee*** or ***dependent*** of his rights to continuation of coverage, and what process is required to elect continuation of coverage. This notice is referred to below as "Election Notice."

2. When eligibility for continuation of coverage results from any qualifying event under this ***Plan*** other than the ones described in Paragraph 1 above, the ***employer*** must notify the ***plan administrator*** (or its designee) not later than thirty (30) days after the date on which the ***employee*** or ***dependent*** loses coverage under the ***Plan*** due to the qualifying event. Within fourteen (14) days of the receipt of the notice of the qualifying event, the ***plan administrator*** (or its designee) will furnish the Election Notice to the ***employee*** or ***dependent***.

3. In the event it is determined that an individual seeking continuation of coverage (or extension of continuation coverage) is not entitled to such coverage, the ***plan administrator*** (or its designee) will provide to such individual an explanation as to why the individual is not entitled to continuation coverage. This notice is referred to here as the "Non-Eligibility Notice." The Non-Eligibility Notice will be furnished in accordance with the same time frame as applicable to the furnishing of the Election Notice.

4. In the event an Election Notice is furnished, the eligible ***employee*** or ***dependent*** has sixty (60) days to decide whether to elect continued coverage. Each person who is described in the Election Notice and was covered under the ***Plan*** on the day before the qualifying event has the right to elect continuation of coverage on an individual basis, regardless of family enrollment. If the ***employee*** or ***dependent*** chooses to have continuation coverage, he must advise the ***plan administrator*** (or its designee) of this choice by returning to the ***plan administrator*** (or its designee) a properly completed Election Notice not later than the last day of the sixty (60) day period. If the Election Notice is mailed to the ***plan administrator*** (or its designee), it must be postmarked on or before the last day of the sixty (60) day period. This sixty (60) day period begins on the later of the following:

   a. The date coverage under the ***Plan*** would otherwise end; or
   b. The date the person receives the Election Notice from the ***plan administrator*** (or its designee).

5. Within forty-five (45) days after the date the person notifies the ***plan administrator*** (or its designee) that he has chosen to continue coverage, the person must make the initial payment. The initial payment will be the amount needed to provide coverage from the date continued benefits begin, through the period in which the initial payment is made. Thereafter, payments for the continuation coverage are to be made monthly, and are due in advance, on the date specified by the ***plan administrator*** (or its designee).

COST OF COVERAGE

1. The ***Plan*** requires that ***covered persons*** pay the entire costs of their continuation coverage, plus a two percent (2%) administrative fee. Except for the initial payment (see above), payments must be remitted to the ***plan administrator*** (or its designee) by or before the first day of each period during the continuation period. The payment must be remitted on a timely basis in order to maintain the coverage in force.

2. For a person originally covered as an ***employee*** or as a spouse, the cost of coverage is the amount applicable to an ***employee*** if coverage is continued for himself alone. For a person originally covered as a

child and continuing coverage independent of the family unit, the cost of coverage is the amount applicable to an ***employee***.

WHEN CONTINUATION COVERAGE BEGINS

When continuation coverage is elected and the initial payment is made within the time period required, coverage is reinstated back to the date of the loss of coverage, so that no break in coverage occurs. Coverage for ***dependents*** acquired and properly enrolled during the continuation period begins in accordance with the enrollment provisions of the ***Plan***.

FAMILY MEMBERS ACQUIRED DURING CONTINUATION

A spouse or ***dependent*** child newly acquired during continuation coverage is eligible to be enrolled as a ***dependent***. The standard enrollment provision of the ***Plan*** applies to enrollees during continuation coverage. A ***dependent*** acquired and enrolled after the original qualifying event, other than a child born to or ***placed for adoption*** with a covered ***employee*** during a period of COBRA continuation coverage, is not eligible for a separate continuation if a subsequent event results in the person's loss of coverage.

EXTENSION OF CONTINUATION COVERAGE

1. In the event any of the following events occur during the period of continuation coverage resulting from an 18-Month Qualifying Event, it is possible for a ***dependent's*** continuation coverage to be extended:

   a. Death of the ***employee***.
   b. Divorce or legal separation from the ***employee***.
   c. The child's loss of ***dependent*** status.

   Written notice of such event must be provided by submitting a completed Additional Extension Event Notification form to the ***plan administrator*** (or its designee) within sixty (60) days of the latest of:

   (i.) The date of that event;
   (ii.) The date on which coverage under this ***Plan*** would be lost as a result of that event if the first qualifying event had not occurred; or
   (iii.) The date on which the ***employee*** or ***dependent*** is furnished with a copy of this Plan Document.

   A copy of the Additional Extension Event Notification form is available from the ***plan administrator*** (or its designee). In addition, the ***dependent*** may be required to promptly provide any supporting documentation as may be reasonably required for purposes of verification. Failure to properly provide the Additional Extension Event Notification and any requested supporting documentation will result in the person forfeiting their rights to extend continuation coverage under this provision. In no event will any extension of continuation coverage extend beyond thirty-six (36) months from the later of the date of the first qualifying event or the date as of which continuation coverage began.

   Only a person covered prior to the original qualifying event or a child born to or ***placed for adoption*** with a covered ***employee*** during a period of COBRA coverage may be eligible to continue coverage through an extension of continuation coverage as described above. Any other ***dependent*** acquired during continuation coverage is not eligible to extend continuation coverage as described above.

2. A person who loses coverage on account of an 18-Month Qualifying Event may extend the maximum period of continuation coverage from eighteen (18) months to up to twenty-nine (29) months in the event both of the following occur:

a. That person (or another person who is entitled to continuation coverage on account of the same 18-Month Qualifying Event) is determined by the Social Security Administration, under Title II or Title XVI of the Social Security Act, to have been disabled before the sixtieth (60^{th}) day of continuation coverage; and
b. The disability status, as determined by the Social Security Administration, lasts at least until the end of the initial eighteen (18) month period of continuation coverage.

The disabled person (or his representative) must submit written proof of the Social Security Administration's disability determination to the ***plan administrator*** (or its designee) within the initial eighteen (18) month period of continuation coverage and no later than sixty (60) days after the latest of:

(i.) The date of the disability determination by the Social Security Administration;
(ii.) The date of the 18-Month Qualifying Event;
(iii.) The date on which the person loses (or would lose) coverage under this ***Plan*** as a result of the 18-Month Qualifying Event; or
(iv.) The date on which the person is furnished with a copy of this Plan Document.

Should the disabled person fail to notify the ***plan administrator*** (or its designee) in writing within the time frame described above, the disabled person (and others entitled to disability extension on account of that person) will then be entitled to whatever period of continuation he or they would otherwise be entitled to, if any. The ***Plan*** may require that the individual pay one hundred and fifty percent (150%) of the cost of continuation coverage during the additional eleven (11) months of continuation coverage. In the event the Social Security Administration makes a final determination that the individual is no longer disabled, the individual must provide notice of that final determination no later than thirty (30) days after the later of:

(A.) The date of the final determination by the Social Security Administration; or
(B.) The date on which the individual is furnished with a copy of this Plan Document.

END OF CONTINUATION

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

1. Eighteen (18) months (or twenty-nine (29) months if continuation coverage is extended due to certain disability status as described above) from the date continuation began because of an 18-Month Qualifying Event or the last day of leave under the Family and Medical Leave Act of 1993.

2. Twenty-four (24) months from the date continuation began because of the call-up to military duty.

3. Thirty-six (36) months from the date continuation began for ***dependents*** whose coverage ended because of the death of the ***employee***, divorce or legal separation from the ***employee***, or the child's loss of ***dependent*** status.

4. The end of the period for which contributions are paid if the ***covered person*** fails to make a payment by the date specified by the ***plan administrator*** (or its designee). In the event continuation coverage is terminated for this reason, the individual will receive a notice describing the reason for the termination of coverage, the effective date of termination, and any rights the individual may have under this ***Plan*** or under applicable law to elect an alternative group or individual coverage, such as a conversion right. This notice is referred to below as an "Early Termination Notice."

5. The date coverage under this ***Plan*** ends and the ***employer*** offers no other group health benefit plan. In the event continuation coverage is terminated for this reason, the individual will receive an Early Termination Notice.

6. The date the ***covered person*** first becomes entitled, after the date of the ***covered person's*** original election of continuation coverage, to ***Medicare*** benefits under Title XVIII of the Social Security Act. In the event continuation coverage is terminated for this reason, the individual will receive an Early Termination Notice.

7. The date the ***covered person*** first becomes covered under any other employer's group health plan after the original date of the ***covered person's*** election of continuation coverage, but only if such group health plan does not have any exclusion or limitation that affects coverage of the ***covered person's pre-existing condition***. In the event continuation coverage is terminated for this reason, the individual will receive an Early Termination Notice.

8. For the spouse or ***dependent*** child of a covered ***employee*** who becomes entitled to ***Medicare*** prior to the spouse's or ***dependent's*** election for continuation coverage, thirty-six (36) months from the date the covered ***employee*** becomes entitled to ***Medicare***.

9. ***Retirees***, and widows or widowers of ***retirees*** who died before substantial elimination of coverage within one (1) year of the ***employer's*** bankruptcy, are entitled to lifetime continuation coverage. However, if a ***retiree*** dies after substantial elimination of coverage within one (1) year of the ***employer's*** bankruptcy, the surviving spouse and ***dependent*** children may only elect an additional thirty-six (36) months of continuation coverage after the death.

SPECIAL RULES REGARDING NOTICES

1. Any notice required in connection with continuation coverage under this ***Plan*** must, at minimum, contain sufficient information so that the ***plan administrator*** (or its designee) is able to determine from such notice the ***employee*** and ***dependent(s)*** (if any), the qualifying event or disability, and the date on which the qualifying event occurred.

2. In connection with continuation coverage under this ***Plan***, any notice required to be provided by any individual who is either the ***employee*** or a ***dependent*** with respect to the qualifying event may be provided by a representative acting on behalf of the ***employee*** or the ***dependent***, and the provision of the notice by one individual shall satisfy any responsibility to provide notice on behalf of all related eligible individuals with respect to the qualifying event.

3. As to an Election Notice, Non-Eligibility Notice or Early Termination Notice:

    a. A single notice addressed to both the ***employee*** and the spouse will be sufficient as to both individuals if, on the basis of the most recent information available to the ***Plan***, the spouse resides at the same location as the ***employee***; and
    b. A single notice addressed to the ***employee*** or the spouse will be sufficient as to each ***dependent*** child of the ***employee*** if, on the basis of the most recent information available to the ***Plan***, the ***dependent*** child resides at the same location as the individual to whom such notice is provided.

PRE-EXISTING CONDITIONS

In the event that a ***covered person*** becomes eligible for coverage under another employer-sponsored group health plan, and that group health plan has an applicable exclusion or limitation regarding coverage of the ***covered person's pre-existing condition***, the ***covered person's*** continuation coverage under the ***Plan*** will not be affected by enrollment under that other group health plan. This ***Plan*** shall be primary payer for the ***covered expenses*** that are excluded or limited under the other employer sponsored group health plan and secondary payer for all other expenses.

MILITARY MOBILIZATION

If an ***employee*** is called for active duty by the United States Armed Services (including the Coast Guard, the National Guard or the Public Health Service), the ***employee*** and the ***employee's dependent*** may continue their health coverages, pursuant to the Uniformed Services Employment and Reemployment Rights Act (USERRA).

When the leave is less than thirty-one (31) days, the ***employee*** and the ***employee's dependent*** may not be required to pay more than the ***employee's*** share, if any, applicable to that coverage. If the leave is thirty-one (31) days or longer, then the ***plan administrator*** (or its designee) may require the ***employee*** and the ***employee's dependent*** to pay no more than one hundred and two percent (102%) of the full contribution.

The maximum length of the continuation coverage required under the Uniformed Services Employment and Reemployment Rights Act (USERRA) is the lesser of:

1. Twenty-four (24) months beginning on the day that the leave commences, or

2. A period beginning on the day that the leave began and ending on the day after the ***employee*** fails to return to employment within the time allowed.

The period of continuation coverage under USERRA will be counted toward any continuation coverage period concurrently available under COBRA. Upon return from active duty, the ***employee*** and the ***employee's dependent*** will be reinstated without ***pre-existing conditions*** exclusions or a waiting period, regardless of their election of COBRA continuation coverage.

PLAN CONTACT INFORMATION

Questions concerning this ***Plan***, including any available continuation coverage, can be directed to the ***plan administrator*** (or its designee).

ADDRESS CHANGES

In order to help ensure the appropriate protection of rights and benefits under this ***Plan***, ***covered persons*** should keep the ***plan administrator*** (or its designee) informed of any changes to their current addresses.

MEDICAL/VISION CLAIM FILING PROCEDURE

A **"**Pre-service claim**"** is a claim for a ***Plan*** benefit that is subject to the prior certification rules, as described in the section below, Pre-service claim Procedure below. All other claims for ***Plan*** benefits are **"**Post-Service Claims" and are subject to the rules described in Post-Service Claim Procedure.

POST-SERVICE CLAIMS PROCEDURE

FILING A CLAIM

1. Claims should be submitted to the ***claims processor*** at the address noted below:

   CoreSource, Inc.
   Post Office Box 8215
   Little Rock, AR 72221-8215

   The date of receipt will be the date the claim is received by the c***laims processor.***

2. All claims submitted for benefits must contain all of the following:

   a. Name of patient
   b. Patient's date of birth.
   c. Name of ***employee.***
   d. Address of ***employee.***
   e. Name of ***employer*** and group number**.**
   f. Name, address and tax identification number of provider.
   g. ***Employee*** Social Security Number.
   h. Date of service.
   i. Diagnosis (applies to medical claims ONLY))
   j. Description of service and procedure number.
   k. Charge for service.
   l. The nature of the ***accident, injury*** or ***illness*** being treated.

3. Claims submitted for prescriptions must contain all of the following:

   a. Name of patient.
   b. Name of ***employee.***
   c. Name of ***employer*** and group number.
   d**.** ***Employee*** Social Security Number.
   e. Name and address of the pharmacy.
   f. Date of purchase.
   g. The cost.
   h. Prescription number and name of prescription drug.
   i. Prescription reference number.

   Cash register receipts, credit card copies, labels from containers and cancelled checks are not acceptable.

4. Properly completed claims not submitted by March 31st of the year following the date of service will not be a ***covered service*** and will be denied.

The ***covered person*** may ask the health care provider to submit the claim directly to the ***claims processor***, or the ***covered person*** may submit the bill with a claim form. However, it is ultimately the ***covered person's*** responsibility to make sure the claim for benefits has been filed.

NOTICE OF AUTHORIZED REPRESENTATIVE

The ***covered person*** may provide the ***plan administrator*** or their designee with a written authorization for an authorized representative to represent and act on behalf of a ***covered person*** and consent to the release of information related to the ***covered person*** to the authorized representative with respect to a claim for benefits or an appeal. Authorization forms may be obtained from the Human Resource Department.

NOTICE OF CLAIM

A claim for benefits should be submitted to the ***claims processor*** within ninety (90) calendar days after the occurrence or commencement of any services by the ***Plan***, or as soon thereafter as reasonably possible.

Failure to file a claim within the time provided shall not invalidate or reduce a claim for benefits if: (1) it was not reasonably possible to file a claim within that time; and (2) that such claim was furnished as soon as possible, but no later than one (1) year after the loss occurs or commences, unless the claimant is legally incapacitated.

Notice given by or on behalf of a ***covered person*** or his beneficiary, if any, to the ***plan administrator*** or to any authorized agent of the ***Plan***, with information sufficient to identify the ***covered person***, shall be deemed notice of claim.

TIMEFRAME FOR BENEFIT DETERMINATION

After a completed claim has been submitted to the ***claims processor,*** and no additional information is required, the ***claims processor*** will generally complete its determination of the claim within thirty (30) calendar days of receipt of the completed claim unless an extension is necessary due to circumstances beyond the ***Plan's*** control.

After a completed claim has been submitted to the ***claims processor,*** and if additional information is needed for determination of the claim, the ***claims processor*** will provide the ***covered person*** (or authorized representative) with a notice detailing information needed. The notice will be provided within thirty (30) calendar days of receipt of the completed claim and will state the date as of which the ***Plan*** expects to make a decision. The ***covered person*** will have forty-five (45) calendar days to provide the information requested, and the ***Plan*** will complete its determination of the claim within fifteen (15) calendar days of receipt by the ***claims processor*** of the requested information. Failure to respond in a timely and complete manner will result in the denial of benefit payment.

NOTICE OF BENEFIT DENIAL

If the claim for benefits is denied, the ***plan administrator*** or their designee shall provide the ***covered person*** or authorized representative with a written Notice of Benefit Denial within the timeframes described immediately above.

The Notice of Benefit Denial shall include an explanation of the denial, including:

1. The specific reasons for the denial.
2. Reference to the ***Plan*** provisions on which the denial is based.
3. A description of any additional material or information needed and an explanation of why such material or information is necessary.

4. A description of the ***Plan's*** claim appeal procedure and applicable time limits.
5. A statement that if the ***covered person's*** appeal (Refer to *Appealing a Denied Claim* below) is denied, the ***covered person*** has the right to bring a civil action under section 502 (a) of the Employee Retirement Income Security Act of 1974.
6. If an internal rule, guideline, protocol or other similar criterion was relied upon, the Notice of Benefit Denial will contain either:
   a. A copy of that criterion, or
   b. A statement that such criterion was relied upon and will be supplied free of charge, upon request.
7. If denial was based on ***medical necessity***, ***experimental/investigational*** treatment or similar exclusion or limit, the ***Plan*** will supply either:
   a. An explanation of the scientific or clinical judgment, applying the terms of the ***Plan*** to the ***covered person's*** medical circumstances, or
   b. A statement that such explanation will be supplied free of charge, upon request.

APPEALING A DENIED POST-SERVICE CLAIM

The "***named fiduciary***" for purposes of an appeal of a denied Post-Service claim, as described in U. S. Department of Labor Regulations 2560.503-1 (issued November 21, 2000), is the ***claims processor***.

A ***covered person***, or the ***covered person's*** authorized representative, may request a review of a denied claim by making written request to the ***named fiduciary*** within one hundred eighty (180) calendar days from receipt of notification of the denial and stating the reasons the ***covered person*** feels the claim should not have been denied.

The following describes the review process and rights of the ***covered person***:

1. The ***covered person*** has the right to submit documents, information and comments.
2. The ***covered person*** has the right to access, free of charge, ***relevant information*** to the claim for benefits.
3. The review takes into account all information submitted by the ***covered person***, even if it was not considered in the initial benefit determination.
4. The review by the ***named fiduciary*** will not afford deference to the original denial.
5. The ***named fiduciary*** will not be:
   a. The individual who originally denied the claim, nor
   b. Subordinate to the individual who originally denied the claim.
6. If original denial was, in whole or in part, based on medical judgment:
   a. The ***named fiduciary*** will consult with a ***professional provider*** who has appropriate training and experience in the field involving the medical judgment; and
   b. The ***professional provider*** utilized by the ***named fiduciary*** will be neither:
      (i.) An individual who was consulted in connection with the original denial of the claim, nor
      (ii.) A subordinate of any other ***professional provider*** who was consulted in connection with the original denial.
7. If requested, the ***named fiduciary*** will identify the medical or vocational expert(s) who gave advice in connection with the original denial, whether or not the advice was relied upon.

NOTICE OF BENEFIT DETERMINATION ON APPEAL

The ***plan administrator*** or their designee shall provide the ***covered person*** (or authorized representative) with a written notice of the appeal decision within sixty (60) calendar days of receipt of a written request for the appeal.

If the appeal is denied, the Notice of Appeal Decision will contain an explanation of the Decision, including:

1. The specific reasons for the denial.
2. Reference to specific ***Plan*** provisions on which the denial is based.

3. A statement that the ***covered person*** has the right to access, free of charge, ***relevant information*** to the claim for benefits.
4. A statement that if the ***covered person's*** appeal is denied, the ***covered person*** has the right to bring a civil action under section 502 (a) of the Employee Retirement Income Security Act of 1974.
5. If an internal rule, guideline, protocol or other similar criterion was relied upon, the Notice of Appeal Decision will contain either:
   a. A copy of that criterion, or
   b. A statement that such criterion was relied upon and will be supplied free of charge, upon request.
6. If the denial was based on ***medical necessity***, ***experimental/investigational*** treatment or similar exclusion or limit, the ***Plan*** will supply either:
   a. An explanation of the scientific or clinical judgment, applying the terms of the ***Plan*** to the claimant's medical circumstances, or
   b. A statement that such explanation will be supplied free of charge, upon request.

FOREIGN CLAIMS

In the event a ***covered person*** incurs a ***covered expense*** in a foreign country, the ***covered person*** shall be responsible for providing the following information to the ***claims processor*** before payment of any benefits due are payable.

1. The claim form, provider invoice and any documentation required to process the claim must be submitted in the English language.

2. The charges for services must be converted into U.S. dollars.

3. A current published conversion chart, validating the conversion from the foreign country's currency into U.S. dollars, must be submitted with the claim.

PRE-SERVICE CLAIMS PROCEDURES

HEALTH CARE MANAGEMENT

Health Care Management is the process of evaluating whether proposed services, supplies or treatments are ***medically necessary*** and appropriate to help ensure quality, cost-effective care.

Certification of ***medical necessity*** and appropriateness by the ***Health Care Management Organization*** does not establish eligibility under the ***Plan*** nor guarantee benefits.

FILING A PRE-CERTIFICATION CLAIM

All ***inpatient*** admissions are to be certified by the ***Health Care Management Organization.*** For non-urgent care, the ***covered person*** or their authorized representative must call the ***Health Care Management Organization*** at least fifteen (15) calendar days prior to initiation of services. If the ***Health Care Management Organization*** is not called at least fifteen (15) calendar days prior to initiation of services for non-urgent care, benefits may be reduced. For ***urgent care,*** the ***covered person*** or their authorized representative must call the ***Health Care Management Organization*** within forty-eight (48) hours or the next business day after the initiation of services.

Covered persons **shall contact the** ***Health Care Management Organization*** **by calling:**

1-866-292-8108

When a ***covered person*** (or authorized representative) calls the ***Health Care Management Organization***, he or she should be prepared to provide all of the following information:

1. ***Employee's*** name, address, phone number and Social Security Number.
2. ***Employer's*** name.
3. If not the ***Employee***, the patient's name, address, phone number.
4. Admitting ***physician's*** name and phone number.
5. Name of ***facility.***
6. Date of admission or proposed date of admission.
7. Condition for which patient is being admitted.

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

However, ***hospital*** maternity stays in excess of forty-eight (48) or ninety-six (96) hours as specified above must be certified.

If the ***covered person*** (or authorized representative) fails to contact the ***Health Care Management Organization*** prior to the hospitalization and within the timelines detailed above, and/or the ***Health Care Management Organization*** declines to grant the full precertification requested, the amount of benefits that the ***Plan*** may pay for expenses ***incurred*** may be reduced by $200. (Refer to *Post-Service Claims Procedure* discussion above.)

NOTICE OF AUTHORIZED REPRESENTATIVE

The ***covered person*** may provide the ***plan administrator*** or their designee with a written authorization for an authorized representative to represent and act on behalf of a ***covered person*** and consent to release of information related to the ***covered person*** to the authorized representative with respect to a claim for benefits or an appeal. Authorization forms may be obtained from the Human Resource Department.

TIMEFRAME FOR PRE-SERVICE CLAIM DETERMINATION

A. In the event the ***Plan*** receives from the ***covered person*** (or authorized representative) a communication that fails to follow the pre-certification procedure as described above but communicates at least the name of the ***covered person***, a specific medical condition or symptom, and a specific treatment, service or product for which prior approval is requested, the ***covered person*** (or the authorized representative) will be orally notified (and in writing if requested), within five (5) calendar days of the failure of the proper procedure to be followed.

B. After a completed pre-certification request for non-urgent care has been submitted to the ***Plan,*** and if no additional information is required, the ***Plan*** will generally complete its determination of the claim within a reasonable period of time, but no later than fifteen (15) calendar days from receipt of the request.

C. After a pre-certification request for non-urgent care has been submitted to the ***Plan***, and if an extension of time to make a decision is necessary due to circumstances beyond the control of the ***Plan***, the ***Plan*** will, within fifteen (15) calendar days from receipt of the request, provide the ***covered person*** (or authorized representative) with a notice detailing the circumstances and the date by which the ***Plan*** expects to render a decision. If the circumstances include a failure to submit necessary information, the notice will specifically describe the needed information. The ***covered person*** will have forty-five (45) calendar days to provide the

information requested, and the ***Plan*** will complete its determination of the claim no later than fifteen (15) calendar days after receipt by the ***Plan*** of the requested information. Failure to respond in a timely and complete manner will result in a denial.

CONCURRENT CARE CLAIMS

If an extension beyond the original certification is required, the ***covered person*** (or authorized representative) shall call the ***Health Care Management Organization*** for continuation of certification.

A. If a ***covered person*** (or authorized representative) requests to extend benefits for a previously approved hospitalization or an ongoing course of treatment, and;
   1. The request involves non-urgent care, then the extension request must be processed within fifteen (15) calendar days after the request was received.
   2. The ***inpatient*** admission or ongoing course of treatment involves ***urgent care***, and
      a. The request is received at least twenty-four (24) hours before the scheduled end of a hospitalization or course of treatment, then the request must be ruled upon and the ***covered person*** (or authorized representative) notified as soon as possible but no later than twenty-four (24) hours after the request was received; or
      b. The request is received less than twenty-four (24) hours before the scheduled end of the hospitalization or course of treatment, then the request must be ruled upon and the ***covered person*** (or authorized representative) notified no later than seventy-two (72) hours after the request was received.

If the ***Health Care Management Organization*** determines that benefits for the ***hospital*** stay or course of treatment should be decreased or terminated before the end of the fixed number of days and/or treatments, or the fixed time period that was previously approved, then the ***Health Care Management Organization*** shall:

A. Notify the ***covered person*** of the proposed change, and
B. Allow the ***covered person*** to file an appeal and obtain a decision, before the end of the fixed number of days and/or treatments, or the fixed time period that was previously approved.

If, at the end of previously approved benefits for a hospitalization or course of treatment, the ***Health Care Management Organization*** determines that continued ***confinement*** is no longer ***medically necessary***, additional days will not be certified. (Refer to *Appealing a Denied Pre-Service Claim* discussion below.)

NOTICE OF PRE-SERVICE DENIAL

If a pre-certification request is denied in whole or in part, the ***plan administrator*** or their designee shall provide the ***covered person*** (or authorized representative) with a written Notice of Pre-Service Denial within the timeframes above.

The Notice of Pre-Service Denial shall include an explanation of the denial, including:

1. The specific reasons for the denial.
2. Reference to the ***Plan*** provisions on which the denial is based.
3. A description of any additional material or information needed and an explanation of why such material or information is necessary.
4. A description of the ***Plan's*** claim appeal procedure and applicable time limits.
5. A statement that if the ***covered person's*** appeal (Refer to *Appealing a Denied Pre-Service Claim* below) is denied, the ***covered person*** has the right to bring a civil action under section 502 (a) of the Employee Retirement Income Security Act of 1974.
6. If an internal rule, guideline, protocol or other similar criterion was relied upon, the Notice of Benefit Denial will contain either:

a. A copy of that criterion, or
b. A statement that such criterion was relied upon and will be supplied free of charge, upon request.

7. If denial was based on ***medical necessity***, ***experimental/investigational*** treatment or similar exclusion or limit, the ***Plan*** will supply either:
   a. An explanation of the scientific or clinical judgment, applying the terms of the ***Plan*** to the ***covered person's*** medical circumstances, or
   b. A statement that such explanation will be supplied free of charge, upon request.

APPEALING A DENIED PRE-SERVICE CLAIM

The ***named fiduciary*** for purposes of an appeal of a Pre-service claim, as described in U. S. Department of Labor Regulations 2560.503-1 (issued November 21, 2000), is the ***claims processor***.

A ***covered person*** (or authorized representative) may request a review of a denied claim by making a written request to the ***named fiduciary*** within one hundred eighty (180) calendar days from receipt of notification of the denial and stating the reasons the ***covered person*** feels the claim should not have been denied. If the ***covered person*** (or authorized representative) wishes to appeal the denial when the services in question have already been rendered, such an appeal will be considered as a separate Post-Service Claim. *(*Refer to *Post-Service Claims Procedure* discussion above*.)*

The following describes the review process and rights of the ***covered person***:

1. The ***covered person*** has a right to submit documents, information and comments.
2. The ***covered person*** has the right to access, free of charge, ***relevant information*** to the claim for benefits.
3. The review takes into account all information submitted by the ***covered person***, even if it was not considered in the initial benefit determination.
4. The review by the ***named fiduciary*** will not afford deference to the original denial.
5. The ***named fiduciary*** will not be:
   a. The individual who originally denied the claim, nor
   b. Subordinate to the individual who originally denied the claim.
6. If original denial was, in whole or in part, based on medical judgment,
   a. The ***named fiduciary*** will consult with a ***professional provider*** who has appropriate training and experience in the field involving the medical judgment.
   b. The ***professional provider*** utilized by the ***named fiduciary*** will be neither:
      i. An individual who was consulted in connection with the original denial of the claim, nor
      ii. A subordinate of any other ***Professional Provider*** who was consulted in connection with the original denial.
7. If requested, the ***named fiduciary*** will identify the medical or vocational expert(s) who gave advice in connection with the original denial, whether or not the advice was relied upon.

NOTICE OF PRE-SERVICE DETERMINATION ON APPEAL

The ***plan administrator*** or their designee shall provide the ***covered person*** (or authorized representative) with a written Notice of Appeal Decision as soon as possible, but not later than thirty (30) calendar days from receipt of the appeal.

If the appeal is denied, the Notice of Appeal Decision will contain an explanation of the decision, including:

1. The specific reasons for the denial.
2. Reference to specific ***Plan*** provisions on which the denial is based.
3. A statement that the ***covered person*** has the right to access, free of charge, ***relevant information*** to the claim for benefits.

4. A statement that if the ***covered person's*** appeal is denied, the ***covered person*** has the right to bring a civil action under section 502 (a) of the Employee Retirement Income Security Act of 1974.
5. A statement that the ***covered person*** has the right to access, free of charge, information about the voluntary appeal process.
6. If an internal rule, guideline, protocol or other similar criterion was relied upon, the Notice of Appeal Decision will contain either:
   a. A copy of that criterion, or
   b. A statement that such criterion was relied upon and will be supplied free of charge, upon request.
7. If the denial was based on ***medical necessity***, ***experimental/investigational*** treatment or similar exclusion or limit, the ***Plan*** will supply either:
   a. An explanation of the scientific or clinical judgment, applying the terms of the ***Plan*** to the claimant's medical circumstances, or
   b. A statement that such explanation will be supplied free of charge, upon request.

CASE MANAGEMENT

In cases where the ***covered person's*** condition is expected to be or is of a serious nature, the ***Health Care Management Organization*** may arrange for review and/or case management services from a professional qualified to perform such services. The ***plan administrator*** shall have the right to alter or waive the normal provisions of this ***Plan*** when it is reasonable to expect a cost-effective result without a sacrifice to the quality of care.

In addition, the ***Health Care Management Organization*** may recommend (or change) alternative:

1. methods of medical care or treatment;
2. equipment; or
3. supplies

that differ from the medical care or treatment, equipment or supplies that are considered ***covered expenses*** under the ***Plan***.

The recommended alternatives will be considered as ***covered expenses*** under the ***Plan*** provided the expenses can be shown to be viable, ***medically necessary***, and are included in a written case management report or treatment plan proposed by the ***Health Care Management Organization***.

Case management will be determined on the merits of each individual case, and any care or treatment provided will not be considered as setting any precedent or creating any future liability with respect to that ***covered person*** or any other ***covered person***.

SPECIAL DELIVERY PROGRAM

"Special Delivery" is a voluntary program for expectant mothers offering prenatal information, pre-screening for ***pregnancy*** related risks and information or preparation for childbirth. This program is designed to identify potential high-risk mothers, as well as help ensure a safer ***pregnancy*** for both mother and baby.

Expectant mothers who decide to participate in the "Special Delivery" Program will have access to a twenty-four (24) hour toll-free "babyline" which is staffed by obstetrical nurses and will also have a series of four (4) books called "Trimester."

An expectant mother may participate in this program by calling the number shown on her identification card and asking for a "Special Delivery" nurse. If possible, she should call during the first three (3) months of her ***pregnancy*** in order to receive the full benefits of this program.

DENTAL CLAIM FILING PROCEDURE

DENTAL CLAIMS

Dental Claims must be filed by ***Covered Person*** or ***Covered Person's*** authorized representative with ***DDAR*** within twelve (12) months after completion of dental treatment for which dental benefits are payable. Any Dental Claim filed after this period will be denied.

Claims should be submitted to the ***Claims Processor*** at the address noted below:

Delta Dental of Arkansas (**DDAR**)
c/o CoreSource, Inc.
P.O. Box 15965
North Little Rock, AR 72231

The date of receipt will be the date the claim is received by the ***Claims Processor.***

FILING CLAIMS/PARTICIPATING DENTISTS

Participating dentists will complete and submit the ***dental claim form*** for ***covered person*** at no charge. ***Participating dentists*** may ask ***covered person*** to fill out the patient section of the ***dental claim form***, which includes the covered ***employee's*** name, social security number (SSN), and address, the ***covered person's*** name, date of birth, and relationship to covered ***employee***; full-time student information, if ***dependent***; and coordination of benefits information, if applicable.

FILING CLAIMS/NON-PARTICIPATING DENTISTS

If the ***covered person*** visits a ***non-participating dentist***, the ***covered person*** may be required to complete the ***dental claim form*** or pay a service charge. The patient section of the ***dental claim form***, which includes the covered ***employee's*** name, social security number (SSN), and address, the ***covered person's*** name, date of birth, and relationship to covered ***employee***; full-time student information, if ***dependent***; and coordination of benefits information, if applicable.

Covered person will also be responsible for ensuring the ***non-participating dentist*** completes the ***dentist*** and the Diagnostic (TREATMENT) Sections of the ***dental claim form***. The ***dentist*** Section includes the ***dentist's*** name, address, SSN or TIN number, license number, and phone number. The ***dentist*** must also indicate whether x-rays are attached and answer questions regarding TREATMENT that is the result of an accident. The ***dentist*** must also indicate if dentures, bridges, and crowns are replacements, and if so, the date of prior placement and reason for replacement must be noted.

The Diagnostic Section (TREATMENT) includes services performed (name description and ADA procedure code), including date of service, fee for service, and if applicable, tooth number or letter and tooth surface. For any unusual services, the Remarks Section of the ***dental claim form*** must give a brief description. The ***dental claim form*** needs to be signed by the ***dentist*** who performed the services and by the ***covered person***.

PROCESSING THE CLAIM

If ***covered person*** visits a ***participating dentist***, the dental claim will be processed according to the ***Plan*** upon receipt. For ***covered persons*** who visit a ***participating dentist***, notification of the benefit determination will be sent to the ***covered person*** in the form of an Explanation of Benefits, which details by service rendered what the ***Plan*** allowed and the ***covered person's*** obligation, if any.

If ***covered person*** visits a ***non-participating dentist***, the ***covered person*** will receive a Dental Claim Payment Statement, which will detail by service rendered what the ***Plan*** allowed and the ***covered person's*** obligation, if any. The Dental Claim Payment Statement will include a benefit check made payable to the ***covered person.***

INITIAL CLAIM DETERMINATION

If the ***dental claims processor*** denies all or a portion of the dental claim, ***covered person*** will receive an Explanation of Benefits (for ***covered persons*** visiting a ***participating dentist***) or a Dental Claim Payment Statement (for ***covered persons*** visiting a ***non-participating dentist***) indicating the reason for the denial. The denial explanation will be printed at the bottom of the page.

The ***covered person*** will be notified within thirty (30) days of the receipt of the dental claim by ***dental claims processor*** of the benefit determination.

In the case of an ***urgent care claim***, the ***covered person*** will be notified within seventy-two (72) hours from the time the dental claim is received by the ***dental claims processor*** of the benefit determination.

APPEAL OF DENIED CLAIM

If the ***dental claims processor*** has denied a dental claim, ***covered person*** may appeal the denial. Both the ***covered person*** and ***dental claims processor*** must take the following steps to complete an appeal (decision review):

Procedures the claimant must follow:

1. Write to the ***Dental Claims Processor*** at the following address: Customer Service Support, Post Office Box 15965, North Little Rock, Arkansas, 72231 within one-hundred eighty (180) days of the date on the notice of ***covered person's*** dental claim denial.
2. State why the dental claim should not have been denied.
3. Include the denial notice and any other documents, data information, or comments that claimant believe may have an influence on the appeal of the dental claim.
4. If requested, ***covered person*** will receive, free of charge, reasonable access to and copies of all documents, records, and other information relevant to the denied dental claim.
5. For an expedited review of an ***urgent care claim***, the request may be submitted orally (by telephone) or in writing (by facsimile or another similarly expeditious method).

Procedures *Dental Claims Processor* must follow for a full and fair appeal:

1. Identify the medical or vocational experts whose advice was obtained and utilized on behalf of ***dental claims process*** in connection with the denial, without regard to whether the advice was relied upon in making the benefit determination.
2. Not consider the initial denial in the review.
3. Conduct a review that includes one or more of the members of the ***dental claims processor's*** Appeals Committee (to be determined at the sole discretion of ***dental claims processor***), but in no event will the individual who made the initial dental claim denial, nor the subordinate of that individual be part of the review.
4. Consult a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who was not consulted initially, nor who is the subordinate of such individual if your denial is based in whole or in part on a medical judgment, including determinations with regard to whether a particular TREATMENT, drug, or other item is experimental, investigational, or not medically necessary or appropriate.

Procedures *Dental Claims Processor* must follow to notify *covered person* of its decision (if adverse):

1. Provide ***covered person*** with a notice that includes the following information, to wit:
    a. The specific reason(s) for the adverse determination.
    b. Reference to the specific PLAN provision(s) on which the adverse determination is based.
    c. A statement that ***covered person*** is entitled to receive, free of charge, access to and copies of all information relevant to the dental claim.
    d. A statement describing any voluntary appeal procedures, if any, and a statement of ***covered person's*** right to bring an action under section 502 (a) of the Employee Retirement Income Security Act.
    e. The internal rule that was relied upon in making the adverse determination.
    f. If adverse determination is based on a ***medical necessity*** or ***experimental*** treatment, either an explanation of the scientific or clinical judgment for the determination, or a statement that such explanation will be provided free to charge upon request.
2. Provide ***covered person*** with the aforementioned notice within seventy-two (72) hours if the dental claim is an ***urgent care*** dental claim.
3. Provide ***covered person*** with the aforementioned notice within sixty (60) days if the dental claim is a post-service dental claim.

COORDINATION OF BENEFITS

The *Coordination of Benefits* provision is intended to prevent duplication of benefits. It applies when the ***covered person*** is also covered by any Other Plan(s). When more than one coverage exists, one plan normally pays its benefits in full, referred to as the primary plan. The Other Plan(s), referred to as secondary plan, pays a reduced benefit. When coordination of benefits occurs, the total benefit payable by all plans will not exceed 100% of "allowable expenses." Only the amount paid by this ***Plan*** will be charged against the ***maximum benefit***.

The *Coordination of Benefits* provision applies whether or not a claim is filed under the Other Plan(s). If another plan provides benefits in the form of services rather than cash, the reasonable value of the service rendered shall be deemed the benefit paid.

DEFINITIONS APPLICABLE TO THIS PROVISION

"Allowable Expenses" means any reasonable, necessary, and customary expenses ***incurred*** while covered under this ***Plan***, part or all of which would be covered under this ***Plan***. Allowable Expenses do not include expenses contained in the "Exclusions" sections of this ***Plan***.

When this ***Plan*** is secondary, "Allowable Expense" will include any ***deductible*** or ***coinsurance*** amounts not paid by the Other Plan(s). Additionally, if the primary plan is a closed panel plan and this ***Plan*** is not a closed panel plan, this ***Plan*** will pay as if it were the primary plan when a ***covered person*** uses a non-panel provider, except for emergency services that are paid or provided by the primary plan.

When this ***Plan*** is secondary, "Allowable Expense" shall <u>not</u> include any amount that is not payable under the primary plan as a result of a contract between the primary plan and a provider of service in which such provider agrees to accept a reduced payment and not to bill the ***covered person*** for the difference between the provider's contracted amount and the provider's regular billed charge.

"Other Plan" means any plan, policy or coverage providing benefits or services for, or by reason of medical, dental or vision care. Such Other Plan(s) do not include flexible spending accounts (FSA), health reimbursement accounts (HRA), health savings accounts (HSA), or individual medical, dental or vision insurance policies. “Other Plan” does not include Tricare, Medicare, Medicaid or a state child health insurance program (CHIP). Such Other Plan(s) may include, without limitation:

1. Group insurance or any other arrangement for coverage for ***covered persons*** in a group, whether on an insured or uninsured basis, including, but not limited to, hospital indemnity benefits and hospital reimbursement-type plans;

2. Hospital or medical service organization on a group basis, group practice, and other group prepayment plans or on an individual basis having a provision similar in effect to this provision;

3. A licensed Health Maintenance Organization (HMO);

4. Any coverage for students which is sponsored by, or provided through, a school or other educational institution;

5. Any coverage under a government program and any coverage required or provided by any statute;

6. Group automobile insurance;

7. Individual automobile insurance coverage;

8. Individual automobile insurance coverage based upon the principles of "No-fault" coverage;

9. Any plan or policies funded in whole or in part by an ***employer,*** or deductions made by an ***employer*** from a person's compensation or retirement benefits;

10. Labor/management trusteed, union welfare, employer organization, or employee benefit organization plans.

"This ***Plan***" shall mean that portion of the ***employer's Plan*** which provides benefits that are subject to this provision.

"Claim Determination Period" means a calendar year or that portion of a calendar year during which the ***covered person*** for whom a claim is made has been covered under this ***Plan***.

EFFECT ON BENEFITS

This provision shall apply in determining the benefits for a ***covered person*** for each claim determination period for the Allowable Expenses. If this ***Plan*** is secondary, the benefits paid under this ***Plan*** may be reduced so that the sum of benefits paid by all plans does not exceed 100% of total Allowable Expense.

If the rules set forth below would require this ***Plan*** to determine its benefits before such Other Plan, then the benefits of such Other Plan will be ignored for the purposes of determining the benefits under this ***Plan***.

ORDER OF BENEFIT DETERMINATION

Except as provided below in *Coordination with Medicare*, each plan will make its claim payment according to the first applicable provision in the following list of provisions which determine the order of benefit payment:

1. No Coordination of Benefits Provision
   If the Other Plan contains no provisions for coordination of benefits, then its benefits shall be paid before all Other Plan(s).

2. Member/Dependent
   The plan which covers the claimant as a member (or named insured) pays as though no Other Plan existed. Remaining ***covered expenses*** are paid under a plan which covers the claimant as a ***dependent***.

3. Dependent Children of Parents not Separated or Divorced
   The plan covering the parent whose birthday (month and day) occurs earlier in the year pays first. The plan covering the parent whose birthday falls later in the year pays second. If both parents have the same birthday, the plan that covered a parent longer pays first. A parent's year of birth is not relevant in applying this rule.

4. Dependent Children of Separated or Divorced Parents
   When parents are separated or divorced, the birthday rule does not apply, instead:

   a. If a court decree has given one parent financial responsibility for the child's health care, the plan of that parent pays first. The plan of the stepparent married to that parent, if any, pays second. The plan of the other natural parent pays third. The plan of the spouse of the other natural parent, if any, pays fourth.
   b. In the absence of such a court decree, the plan of the parent with custody pays first. The plan of the stepparent married to the parent with custody, if any, pays second. The plan of the parent without custody pays third. The plan of the spouse of the parent without custody, if any, pays fourth.

5. Active/Inactive
The plan covering a person as an active (not laid off or retired) ***employee*** or as that person's ***dependent*** pays first. The plan covering that person as a laid off or retired ***employee***, or as that person's ***dependent*** pays second.

6. Limited Continuation of Coverage
If a person is covered under another group health plan, but is also covered under this ***Plan*** for continuation of coverage due to the Other Plan's limitation for ***pre-existing conditions*** or exclusions, the Other Plan shall be primary.

7. Longer/Shorter Length of Coverage
If none of the above rules determine the order of benefits, the plan covering a person longer pays first. The plan covering that person for a shorter time pays second.

COORDINATION WITH MEDICARE

Individuals may be eligible for ***Medicare*** Part A at no cost if they: (i) are age 65 or older, (ii) have been determined by the Social Security Administration to be disabled, or (iii) have end stage renal disease. Participation in ***Medicare*** Part B and D is available to all individuals who make application and pay the full cost of the coverage.

1. When an ***employee*** becomes entitled to ***Medicare*** coverage (due to age or disability) and is still actively at work, the ***employee*** may continue health coverage under this ***Plan*** at the same level of benefits and contribution rate that applied before reaching ***Medicare*** entitlement.

2. When a ***dependent*** becomes entitled to ***Medicare*** coverage (due to age or disability) and the ***employee*** is still actively at work, the ***dependent*** may continue health coverage under this ***Plan*** at the same level of benefits and contribution rate that applied before reaching ***Medicare*** entitlement.

3. If the ***employee*** and/or ***dependent*** are also enrolled in ***Medicare*** (due to age or disability), this ***Plan*** shall pay as the primary plan. If, however, the ***Medicare*** enrollment is due to end stage renal disease, the ***Plan's*** primary payment obligation will end at the end of the thirty (30) month "coordination period" as provided in ***Medicare*** law and regulations. If the ***employee*** and/or ***dependent*** does not elect ***Medicare***, but is otherwise eligible due to end stage renal disease, benefits will be paid as if ***Medicare*** has been elected and this ***Plan*** will pay secondary benefits upon completion of the thirty (30) month "coordination period."

4. Notwithstanding Paragraphs 1 to 3 above, if the ***employer*** (including certain affiliated entities that are considered the same employer for this purpose) has fewer than one hundred (100) ***employees***, when a covered ***dependent*** becomes entitled to ***Medicare*** coverage due to ***total disability***, as determined by the Social Security Administration, and the ***employee*** is actively-at-work, ***Medicare*** will pay as the primary payer for claims of the ***dependent*** and this ***Plan*** will pay secondary.

5. If the ***employee*** and/or ***dependent*** elect to discontinue health coverage under this ***Plan*** and enroll under the ***Medicare*** program, no benefits will be paid under this ***Plan***. ***Medicare*** will be the only payor.

6. For a ***retiree*** eligible for ***Medicare*** due to age, ***Medicare*** shall be the primary payor and this ***Plan*** shall be secondary. If the ***retiree*** does not elect ***Medicare***, but is otherwise eligible due to age, benefits will be paid as if ***Medicare*** has been elected and this ***Plan*** will pay secondary benefits.

This section is subject to the terms of the ***Medicare*** laws and regulations. Any changes in these related laws and regulations will apply to the provisions of this section.

LIMITATIONS ON PAYMENTS

In no event shall the ***covered person*** recover under this ***Plan*** and all Other Plan(s) combined more than the total Allowable Expenses offered by this ***Plan*** and the Other Plan(s). Nothing contained in this section shall entitle the ***covered person*** to benefits in excess of the total ***maximum benefits*** of this ***Plan*** during the claim determination period. The ***covered person*** shall refund to the ***employer*** any excess it may have paid.

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION

For the purposes of determining the applicability of and implementing the terms of this *Coordination of Benefits* provision, the ***Plan*** may, without the consent of or notice to any person, release to or obtain from any insurance company or any other organization any information, regarding other insurance, with respect to any ***covered person***. Any person claiming benefits under this ***Plan*** shall furnish to the ***employer*** such information as may be necessary to implement the *Coordination of Benefits* provision.

FACILITY OF BENEFIT PAYMENT

Whenever payments which should have been made under this ***Plan*** in accordance with this provision have been made under any Other Plan, the ***employer*** shall have the right, exercisable alone and in its sole discretion, to pay over to any organization making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of this provision. Amounts so paid shall be deemed to be benefits paid under this ***Plan*** and, to the extent of such payments, the ***employer*** shall be fully discharged from liability.

AUTOMOBILE ACCIDENT BENEFITS

The ***Plan's*** liability for expenses arising out of an automobile accident shall always be secondary to any automobile insurance, irrespective of the type of automobile insurance law that is in effect in the ***covered person's*** state of residence. Currently, there are three (3) types of state automobile insurance laws.

1. No-fault automobile insurance laws

2. Financial responsibility laws

3. Other automobile liability insurance laws

No Fault Automobile Insurance Laws. In no event will the ***Plan*** pay any claim presented by or on behalf of an ***employee*** for lost wages or a ***covered person*** for medical benefits that would have been payable under an automobile insurance policy but for an election made by the principal named insured under the automobile policy that reduced covered levels and/or subsequent premium. This is intended to exclude, as a ***covered expense***, an ***employee's*** lost wages or a ***covered person's*** medical expenses arising from an automobile accident that are payable under an automobile insurance policy or that would have been payable under an automobile insurance policy but for such an election.

1. In the event an ***employee*** shall incur lost wages or a ***covered person*** incurs medical expenses as a result of ***injuries*** sustained in an automobile accident while "covered by an automobile insurance policy," as an operator of the vehicle, as a passenger, or as a pedestrian, benefits will be further limited to medical expenses, that would in no event be payable under the automobile insurance; provided however that benefits payable due to a required deductible under the automobile insurance policy will be paid by the ***Plan*** up to the amount equal to that deductible.

2. For the purposes of this section the following people are deemed "covered by an automobile insurance policy."

a. An owner or principal named insured individual under such policy.
b. A family member of an insured person for whom coverage is provided under the terms and conditions of the automobile insurance policy.
c. Any other person who, except for the existence of the ***Plan***, would be eligible for medical expense benefits under an automobile insurance policy.

Financial Responsibility Laws. The ***Plan*** will be secondary to any potentially applicable automobile insurance even if the state's "financial responsibility law" does not allow the ***Plan*** to be secondary.

Other Automobile Liability Insurance. If the state does not have a no-fault automobile insurance law or a "financial responsibility" law, the ***Plan*** is secondary to automobile insurance coverage or to any other person or entity who caused the ***accident*** or who may be liable for the ***employee's*** lost wages or ***covered person's*** medical expenses pursuant to the general rule for *Subrogation/Reimbursement*.

SUBROGATION/REIMBURSEMENT

The ***Plan*** is designed to only pay ***covered expenses*** for which payment is not available from anyone else, including any insurance company or another health plan. In order to help a ***covered person*** in a time of need, however, the ***Plan*** may pay ***covered expenses*** that may be or become the responsibility of another person, provided that the ***Plan*** later receives reimbursement for those payments (hereinafter called "Reimbursable Payments").

Therefore, by enrolling in the ***Plan***, as well as by applying for payment of ***covered expenses***, a ***covered person*** is subject to, and agrees to, the following terms and conditions with respect to the amount of ***covered expenses*** paid by the ***Plan***:

1. Assignment of Rights (Subrogation). The ***covered person*** automatically assigns to the ***Plan*** any rights the ***covered person*** may have to recover all or part of the same ***covered expenses*** from any party, including an insurer or another group health program (except flexible spending accounts, health reimbursement accounts and health savings accounts), but limited to the amount of Reimbursable Payments made by the ***Plan***. This assignment includes, without limitation, the assignment of a right to any funds paid by a third party to a ***covered person*** or paid to another for the benefit of the ***covered person***. This assignment applies on a first-dollar basis (*i.e.*, has priority over other rights), applies whether the funds paid to (or for the benefit of) the ***covered person*** constitute a full or a partial recovery, and even applies to funds actually or allegedly paid for non-medical or dental charges, attorney fees, or other costs and expenses. This assignment also allows the ***Plan*** to pursue any claim that the ***covered person*** may have, whether or not the ***covered person*** chooses to pursue that claim. By this assignment, the ***Plan's*** right to recover from insurers includes, without limitation, such recovery rights against no-fault auto insurance carriers in a situation where no third party may be liable, and from any uninsured or underinsured motorist coverage.

2. Equitable Lien and other Equitable Remedies. The ***Plan*** shall have an equitable lien against any rights the ***covered person*** may have to recover the same ***covered expenses*** from any party, including an insurer or another group health program, but limited to the amount of Reimbursable Payments made by the ***Plan***. The equitable lien also attaches to any right to payment from workers' compensation, whether by judgment or settlement, where the ***Plan*** has paid ***covered expenses*** prior to a determination that the ***covered expenses*** arose out of and in the course of employment. Payment by workers' compensation insurers or the employer will be deemed to mean that such a determination has been made.

   This equitable lien shall also attach to any money or property that is obtained by anybody (including, but not limited to, the ***covered person***, the ***covered person's*** attorney, and/or a trust) as a result of an exercise of the ***covered person's*** rights of recovery (sometimes referred to as "proceeds"). The ***Plan*** shall also be entitled to seek any other equitable remedy against any party possessing or controlling such proceeds. At the discretion of the ***plan administrator***, the ***Plan*** may reduce any future ***covered expenses*** otherwise available to the ***covered person*** under the ***Plan*** by an amount up to the total amount of Reimbursable Payments made by the ***Plan*** that is subject to the equitable lien.

   This and any other provisions of the ***Plan*** concerning equitable liens and other equitable remedies are intended to meet the standards for enforcement under the United States Supreme Court's decision entitled, Great-West Life & Annuity Insurance Co. v. Knudson, 534 US 204 (2002). The provisions of the ***Plan*** concerning subrogation, equitable liens and other equitable remedies are also intended to supercede the applicability of the federal common law doctrines commonly referred to as the "make whole" rule and the "common fund" rule.

3. Assisting in ***Plan's*** Reimbursement Activities. The ***covered person*** has an obligation to assist the ***Plan*** to obtain reimbursement of the Reimbursable Payments that it has made on behalf of the ***covered person***, and to provide the ***Plan*** with any information concerning the ***covered person's*** other insurance coverage (whether through automobile insurance, other group health program, or otherwise) and any other person or

entity (including their insurer(s)) that may be obligated to provide payments or benefits to or for the benefit of the ***covered person***. The ***covered person*** is required to (a) cooperate fully in the ***Plan's*** (or any ***Plan*** fiduciary's) enforcement of the terms of the ***Plan***, including the exercise of the ***Plan's*** right to subrogation and reimbursement, whether against the ***covered person*** or any third party, (b) not do anything to prejudice those enforcement efforts or rights (such as settling a claim against another party without including the ***Plan*** as a co-payee for the amount of the Reimbursable Payments and notifying the ***Plan***), (c) sign any document deemed by the ***plan administrator*** to be relevant to protecting the ***Plan's*** subrogation, reimbursement or other rights, and (d) provide relevant information when requested. The term "information" includes any documents, insurance policies, police reports, or any reasonable request by the ***plan administrator*** or ***claims processor*** to enforce the ***Plan***'s rights.

The ***plan administrator*** has delegated to the ***claims processor*** for medical/dental/vision claims the right to perform ministerial functions required to assert the ***Plan's*** rights with regard to such claims and benefits; however, the ***plan administrator*** shall retain discretionary authority with regard to asserting the ***Plan's*** recovery rights.

GENERAL PROVISIONS

ADMINISTRATION OF THE PLAN

The ***Plan*** is administered through the Human Resources Department of the ***employer***. The ***employer*** is the ***plan administrator***. The ***plan administrator*** shall have full charge of the operation and management of the ***Plan***. The ***employer*** has retained the services of an independent ***claims processor*** experienced in claims review.

The ***employer*** is the ***named fiduciary*** of the ***Plan*** except as noted herein. The ***claims processor*** is the ***named fiduciary*** of the ***Plan*** for pre-service and post service claim (this may be different if an outside vendor is involved) appeals. As the ***named fiduciary*** for appeals, the ***claims processor*** maintains discretionary authority to review all denied claims under appeal for benefits under the ***Plan***. The ***employer*** maintains discretionary authority to interpret the terms of the ***Plan***, including but not limited to, determination of eligibility for and entitlement to ***Plan*** benefits in accordance with the terms of the ***Plan***; any interpretation or determination made pursuant to such discretionary authority shall be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

APPLICABLE LAW

Except to the extent preempted by other federal law, all provisions of the ***Plan*** shall be construed and administered in a manner consistent with the requirements under the laws of the State of Arkansas.

ASSIGNMENT

The ***Plan*** will pay benefits under this ***Plan*** to the ***employee*** unless payment has been assigned to a ***hospital***, ***physician,*** or other provider of service furnishing the services for which benefits are provided herein. No assignment of benefits shall be binding on the ***Plan*** unless the ***claims processor*** is notified in writing of such assignment prior to payment hereunder.

Preferred providers normally bill the ***Plan*** directly. If services, supplies or treatment has been received from such a provider, benefits are automatically paid to that provider. The ***covered person's*** portion of the ***negotiated rate***, after the ***Plan's*** payment, will then be billed to the ***covered person*** by the ***preferred provider***.

This ***Plan*** will pay benefits to the responsible party of an ***alternate recipient*** as designated in a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN).

BENEFITS NOT TRANSFERABLE

Except as otherwise stated herein, no person other than an eligible ***covered person*** is entitled to receive benefits under this ***Plan***. Such right to benefits is not transferable.

CLERICAL ERROR

No clerical error on the part of the ***employer*** or ***claims processor*** shall operate to defeat any of the rights, privileges, services, or benefits of any ***employee*** or any ***dependent(s)*** hereunder, nor create or continue coverage which would not otherwise validly become effective or continue in force hereunder. An equitable adjustment of contributions and/or benefits will be made when the error or delay is discovered. However, if more than six (6) months has elapsed prior to discovery of any error, any adjustment of contributions shall be waived. No party shall be liable for the failure of any other party to perform.

CONFORMITY WITH STATUTE(S)

Any provision of the ***Plan*** that is in conflict with statutes that are applicable to this Plan is hereby amended to conform to the minimum requirements of said statute(s).

EFFECTIVE DATE OF THE PLAN

The original ***effective date*** of this ***Plan*** was August 1, 1995. The ***effective date*** of the modifications contained herein is January 1, 2013.

NOTE: The claim benefit plan year is calendar year, January 1st through December 31st.

FRAUD OR INTENTIONAL MISREPRESENTATION

If the ***covered person*** or anyone acting on behalf of a ***covered person*** makes a false statement on the application for enrollment, or withholds information with intent to deceive or affect the acceptance of the enrollment application or the risks assumed by the ***Plan***, or otherwise misleads the ***Plan***, the ***Plan*** shall be entitled to recover its damages, including legal fees, from the ***covered person***, or from any other person responsible for misleading the ***Plan***, and from the person for whom the benefits were provided. Any fraud or intentional misrepresentation of a material fact on the part of the ***covered person*** or an individual seeking coverage on behalf of the individual in making application for coverage, or any application for reclassification thereof, or for service thereunder is prohibited and shall render the coverage under the ***Plan*** null and void.

FREE CHOICE OF HOSPITAL AND PHYSICIAN

Nothing contained in this ***Plan*** shall in any way or manner restrict or interfere with the right of any person entitled to benefits hereunder to select a ***hospital*** or to make a free choice of the attending ***physician*** or ***professional provider***. However, benefits will be paid in accordance with the provisions of this ***Plan***, and the ***covered person*** will have higher out-of-pocket expenses if the ***covered person*** uses the services of a ***nonpreferred provider***.

FREE CHOICE OF DENTIST

Neither the ***Plan Administrator*** nor the ***Dental Claims Processor*** furnishes covered dental services directly. The ***Dental Claims Processor*** pays for licensed ***dentists*** to provide these services. A ***covered person*** may choose any ***dentist***. ***Covered persons*** should determine the qualifications of the ***dentist*** they select. Participation in the ***DDAR*** network is open to all ***dentists*** who meet ***DDAR***'s standards and who are licensed in Arkansas unless they have previously had their participation in ***DDAR*** terminated. ***DDAR*** only controls credentialing in Arkansas. However, there is currently in effect a policy by Delta Dental Association (National), which is applicable to DeltaUSA groups, that requires all Delta Plans to have credentialing. Other states's credentialing policies are available upon request. Whether a ***dentist*** is a ***Participating*** or ***Non-Participating Dentist*** should not be viewed as a statement about that ***dentist's*** abilities.

Visiting a ***DDAR participating dentist*** will result in savings. ***Participating dentists*** have agreed to accept ***DDAR's*** fee determination as payment in full. If ***DDAR's*** fee is lower than the ***dentist's*** charge, the ***dentist*** cannot bill for the difference for covered services. All ***dentists*** who participate in ***DDAR's*** networks agree to fill out and file claims for their patients with ***DDAR*** coverage; this means less paperwork for ***covered persons***.

INCAPACITY

If, in the opinion of the ***employer***, a ***covered person*** for whom a claim has been made is incapable of furnishing a valid receipt of payment due him and in the absence of written evidence to the ***Plan*** of the qualification of a guardian or personal representative for his estate, the ***employer*** may on behalf of the ***Plan***, at his discretion, make any and all such payments to the provider of services or other person providing for the care and support of such person. Any payment so made will constitute a complete discharge of the ***Plan's*** obligation to the extent of such payment.

INCONTESTABILITY

All statements made by the ***employer*** or by the ***employee*** covered under this ***Plan*** shall be deemed representations and not warranties. Such statements shall not void or reduce the benefits under this ***Plan*** or be used in defense to a claim unless they are contained in writing and signed by the ***employer*** or by the ***covered person***, as the case may be. A statement made shall not be used in any legal contest unless a copy of the instrument containing the statement is or has been furnished to the other party to such a contest.

LEGAL ACTIONS

No action at law or in equity shall be brought to recover on the benefits from the ***Plan*** prior to the expiration of sixty (60) days after all information on a claim for benefits has been filed and the appeal process has been completed in accordance with the requirements of the ***Plan***. No such action shall be brought after the expiration of two (2) years from the date the expense was ***incurred***, or one (1) year from the date a completed claim was filed, whichever occurs first.

LIMITS ON LIABILITY

Liability hereunder is limited to the services and benefits specified, and the ***employer*** shall not be liable for any obligation of the ***covered person incurred*** in excess thereof. The liability of the ***Plan*** shall be limited to the reasonable cost of ***covered expenses*** and shall not include any liability for suffering or general damages.

LOST DISTRIBUTEES

Any benefit payable hereunder shall be deemed forfeited if the ***plan administrator*** is unable to locate the ***covered person*** to whom payment is due, provided, however, that such benefits shall be reinstated if a claim is made by the ***covered person*** for the forfeited benefits within the time prescribed in *Claim Filing Procedure*.

MEDICAID ELIGIBILITY AND ASSIGNMENT OF RIGHTS

The ***Plan*** will not take into account whether an individual is eligible for, or is currently receiving, medical assistance under a State plan for medical assistance as provided under Title XIX of the Social Security Act ("State Medicaid Plan") either in enrolling that individual as a ***covered person*** or in determining or making any payment of benefits to that individual. The ***Plan*** will pay benefits with respect to such individual in accordance with any assignment of rights made by or on behalf of such individual as required under a State Medicaid plan pursuant to § 1912(a)(1)(A) of the Social Security Act. To the extent payment has been made to such individual under a State Medicaid Plan and this ***Plan*** has a legal liability to make payments for the same services, supplies or treatment, payment under the ***Plan*** will be made in accordance with any State law which provides that the State has acquired the rights with respect to such individual to payment for such services, supplies or treatment under the ***Plan***.

PHYSICAL EXAMINATIONS REQUIRED BY THE PLAN

The ***Plan***, at its own expense, shall have the right to require an examination of a person covered under this ***Plan*** when and as often as it may reasonably require during the pendency of a claim.

DENTAL CLINICAL EXAMINATION

Before approving a claim, the ***dental claims processor*** may obtain from any ***dentist*** or hospital such information and records they may require to administer the ***dental claim***. The ***Plan***, at its own expense, may require that a ***covered person*** be examined by a dental consultant, retained by the ***Plan***, in or near the ***covered person's*** place of residence.

PLAN IS NOT A CONTRACT

The ***Plan*** shall not be deemed to constitute a contract between the ***employer*** and any ***employee*** or to be a consideration for, or an inducement or condition of, the employment of any ***employee***. Nothing in the ***Plan*** shall be deemed to give any ***employee*** the right to be retained in the service of the ***employer*** or to interfere with the right of the ***employer*** to terminate the employment of any ***employee*** at any time.

PLAN MODIFICATION AND AMENDMENT

The ***employer*** may modify or amend the ***Plan*** from time to time at its sole discretion, and such amendments or modifications which affect ***covered persons*** will be communicated to the ***covered persons***. Any such amendments shall be in writing, setting forth the modified provisions of the ***Plan***, the ***effective date*** of the modifications, and shall be signed by the ***employer's*** designee.

Such modification or amendment shall be duly incorporated in writing into the master copy of the ***Plan*** on file with the ***employer***, or a written copy thereof shall be deposited with such master copy of the ***Plan***. Appropriate filing and reporting of any such modification or amendment with governmental authorities and to ***covered persons*** shall be timely made by the ***employer***.

PLAN TERMINATION

The ***employer*** reserves the right to terminate the ***Plan*** at any time. Upon termination, the rights of the ***covered persons*** to benefits are limited to claims ***incurred*** up to the date of termination. Any termination of the ***Plan*** will be communicated to the ***covered persons***.

Upon termination of this ***Plan***, all claims ***incurred*** prior to termination, but not submitted to either the ***employer*** or ***claims processor*** within three (3) months of the ***effective date*** of termination of this ***Plan***, will be excluded from any benefit consideration.

PRONOUNS

All personal pronouns used in this ***Plan*** shall include either gender unless the context clearly indicates to the contrary.

RECOVERY FOR OVERPAYMENT

Whenever payments have been made from the ***Plan*** in excess of the maximum amount of payment necessary, the ***Plan*** will have the right to recover these excess payments. If the company makes any payment that, according to the terms of the ***Plan***, should not have been made, the ***Plan*** may recover that incorrect payment, whether or not it was

made due to the Company's own error, from the person or entity to whom it was made or from any other appropriate party.

STATUS CHANGE

If an ***employee*** or ***dependent*** has a status change while covered under this ***Plan*** (i.e. ***dependent*** to ***employee***, COBRA to active) and no interruption in coverage has occurred, the ***Plan*** will provide continuous coverage with respect to any ***pre-existing condition*** limitation, deductible(s), ***coinsurance*** and ***maximum benefit***.

TIME EFFECTIVE

The effective time with respect to any dates used in the ***Plan*** shall be 12:00 a.m. (midnight) as may be legally in effect at the address of the ***plan administrator***.

WORKERS' COMPENSATION NOT AFFECTED

This ***Plan*** is not in lieu of, and does not affect any requirement for, coverage by Workers' Compensation Insurance.

HIPAA PRIVACY

The following provisions are intended to comply with applicable ***Plan*** amendment requirements under Federal regulation implementing Section 264 of the Health Insurance Portability and Accountability Act of 1996 (***HIPAA***).

DISCLOSURE BY PLAN TO PLAN SPONSOR

The ***Plan*** may take the following actions only upon receipt of a ***Plan*** amendment certification:

1. Disclose protected health information to the ***plan sponsor***.
2. Provide for or permit the disclosure of protected health information to the ***plan sponsor*** by a health insurance issuer or HMO with respect to the ***Plan***.

USE AND DISCLOSURE BY PLAN SPONSOR

The ***plan sponsor*** may use or disclose protected health information received from the ***Plan*** to the extent not inconsistent with the provisions of this *HIPAA PRIVACY* Section or the ***privacy rule***.

OBLIGATIONS OF PLAN SPONSOR

The ***plan sponsor*** shall have the following obligations:

1. Ensure that:
   a. Any agents (including a subcontractor) to whom it provides protected health information received from the ***Plan*** agree to the same restrictions and conditions that apply to the ***plan sponsor*** with respect to such information; and

   b. Adequate separation between the ***Plan*** and the ***plan sponsor*** is established in compliance with the requirement in 45 C.F.R. 164.504(f)(2)(iii).

2. Not use or further disclose protected health information received from the ***Plan***, other than as permitted or required by the ***Plan*** documents or as ***required by law***.

3. Not use or disclose protected health information received from the ***Plan***:
   a. For employment-related actions and decisions; or

   b. In connection with any other benefit or employee benefit plan of the ***plan sponsor***.

4. Report to the ***Plan*** any use or disclosure of the protected health information received from the ***Plan*** that is inconsistent with the use or disclosure provided for of which it becomes aware.

5. Make available protected health information received from the ***Plan***, as and to the extent required by the ***privacy rule***:
   a. For access to the individual;

   b. For amendment and incorporate any amendments to protected health information received from the ***Plan***; and

   c. To provide an accounting of disclosures.

6. Make its internal practices, books, and records relating to the use and disclosure of protected health information received from the ***Plan*** available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining compliance by the ***Plan*** with the ***privacy rule***.

7. Return or destroy all protected health information received from the ***Plan*** that the ***plan sponsor*** still maintains in any form and retain no copies when no longer needed for the purpose for which the disclosure by the ***Plan*** was made, but if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

8. Provide protected health information only to those individuals, under the control of the ***plan sponsor*** who perform administrative functions for the ***Plan***; (i.e. eligibility, enrollment, payroll deduction, benefit determination, claim reconciliation assistance), and to make clear to such individuals that they are not to use protected health information for any reason other than for ***Plan*** administrative functions nor to release protected health information to an unauthorized individual.

9. Provide protected health information only to those entities required to receive the information in order to maintain the ***Plan*** (i.e. claim administrator, case management vendor, pharmacy benefit manager, claim subrogation, vendor, claim auditor, network manager, stop-loss insurance carrier, insurance broker/consultant, and any other entity subcontracted to assist in administering the ***Plan***).

10. Provide an effective mechanism for resolving issues of noncompliance with regard to the items mentioned in this provision.

11. Reasonably and appropriately safeguard electronic protected health information created, received, maintained, or transmitted to or by the ***plan sponsor*** on behalf of the ***Plan***. Specifically, such safeguarding entails an obligation to:
    a. Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information that the ***plan sponsor*** creates, receives, maintains, or transmits on behalf of the ***Plan***;
    b. Ensure that the adequate separation as required by 45 C.F.R. 164.504(f)(2)(iii) is supported by reasonable and appropriate security measures;
    c. Ensure that any agent, including a subcontractor, to whom it provides this information agrees to implement reasonable and appropriate security measures to protect the information; and
    d. Report to the ***Plan*** any security incident of which it becomes aware.

EXCEPTIONS

Notwithstanding any other provision of this *HIPAA PRIVACY* Section, the ***Plan*** (or a health insurance issuer or HMO with respect to the ***Plan***) may:

1. Disclose summary health information to the ***plan sponsor***:
    a. If the ***plan sponsor*** requests it for the purpose of:
        i. Obtaining premium bids from health plans for providing health insurance coverage under the ***Plan***; or
        ii. Modifying, amending, or terminating the ***Plan***;

2. Disclose to the ***plan sponsor*** information on whether the individual is participating in the ***Plan***, or is enrolled in or has disenrolled from a health insurance issuer or HMO offered by the ***Plan***;

3. Use or disclose protected health information:
    a. With (and consistent with) a valid authorization obtained in accordance with the ***privacy rule***;
    b. To carry out treatment, payment, or health care operations in accordance with the ***privacy rule***; or
    c. As otherwise permitted or required by the ***privacy rule***.

DEFINITIONS

Certain words and terms used herein shall be defined as follows and are shown in ***bold and italics*** throughout the document:

Accident

An unforeseen event resulting in ***injury***.

Alternate Recipient

Any child of an ***employee*** or their spouse who is recognized in a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN) which has been issued by any court judgment, decree, or order as being entitled to enrollment for coverage under this ***Plan***.

Ambulatory Surgical Facility

A ***facility*** provider with an organized staff of ***physicians*** which has been approved by the Joint Commission on the Accreditation of Healthcare Organizations, or by the Accreditation Association for Ambulatory Health, Inc.**,** which:

1. Has permanent facilities and equipment for the purpose of performing surgical procedures on an ***outpatient*** basis;

2. Provides treatment by or under the supervision of ***physicians*** and nursing services whenever the ***covered person*** is in the ***ambulatory surgical facility***;

3. Does not provide ***inpatient*** accommodations; and

4. Is not, other than incidentally, a ***facility*** used as an office or clinic for the private practice of a ***physician***.

Birthing Center

A ***facility*** that meets professionally recognized standards and complies with all licensing and other legal requirements that apply.

Chemical Dependency

A physiological or psychological dependency, or both, on a controlled substance and/or alcoholic beverages. It is characterized by a frequent or intense pattern of pathological use to the extent the user exhibits a loss of self-control over the amount and circumstances of use; develops symptoms of tolerance or physiological and/or psychological withdrawal if the use of the controlled substance or alcoholic beverage is reduced or discontinued; and the user's health is substantially impaired or endangered or his social or economic function is substantially disrupted. Diagnosis of these conditions will be determined based on standard DSM-III-R (diagnostic and statistical manual of mental disorders) criteria.

Chiropractic Care

Services as provided by a licensed Chiropractor, M.D., or D.O. for manipulation or manual modalities in the treatment of the spinal column, neck, extremities or other joints, other than for a fracture or surgery.

Claims Processor

Refer to the *Summary Plan Description* (SPD) section of this document.

Close Relative

The ***employee's*** spouse, children, brothers, sisters, or parents; or the children, brothers, sisters or parents of the ***employee's*** spouse.

Coinsurance

The benefit percentage of ***covered expenses*** payable by the ***Plan*** for benefits that are provided under the ***Plan***. The ***coinsurance*** is applied to ***covered expenses*** after the deductible(s) have been met, if applicable.

Complications of Pregnancy

A disease, disorder or condition that is diagnosed as distinct from ***pregnancy***, but is adversely affected by or caused by ***pregnancy***. Some examples are:

1. Intra-abdominal surgery (but not elective Cesarean Section).

2. Ectopic ***pregnancy***.

3. Toxemia with convulsions (Eclampsia).

4. Pernicious vomiting (hyperemesis gravidarum).

5. Nephrosis.

6. Cardiac Decompensation.

7. Missed Abortion.

8. Miscarriage.

These conditions are not included: false labor; occasional spotting; rest during ***pregnancy*** even if prescribed by a ***physician;*** morning sickness; or like conditions that are not medically termed as ***complications of pregnancy***.

Concurrent Care

A request by a ***covered person*** or their authorized representative to the ***Health Care Management Organization*** prior to the expiration of a ***covered person's*** current course of treatment to extend such treatment OR a determination by the ***Health Care Management Organization*** to reduce or terminate an ongoing course of treatment.

Confinement

A continuous stay in a ***hospital, treatment center, extended care facility***, ***hospice***, or ***birthing center*** due to an ***illness*** or ***injury*** diagnosed by a ***physician***.

Copay

A cost sharing arrangement whereby a ***covered person*** pays a set amount to a provider for a specific service at the time the service is provided.

Cosmetic Surgery

Surgery for the restoration, repair, or reconstruction of body structures directed toward altering appearance.

Covered Expenses

Medically necessary services, supplies or treatments that are recommended or provided by a ***physician***, ***professional provider*** or covered ***facility*** for the treatment of an ***illness*** or ***injury*** and that are not specifically excluded from coverage herein. ***Covered expenses*** shall include specified preventive care services.

Covered Person

A person who is eligible for coverage under this ***Plan,*** or becomes eligible at a later date, and for whom the coverage provided by this ***Plan*** is in effect.

Custodial Care

Care provided primarily for maintenance of the ***covered person*** or which is designed essentially to assist the ***covered person*** in meeting his activities of daily living and which is not primarily provided for its therapeutic value in the treatment of an ***illness*** or ***injury***. ***Custodial care*** includes, but is not limited to: help in walking, bathing, dressing, feeding, preparation of special diets and supervision over self-administration of medications. Such services shall be considered ***custodial care*** without regard to the provider by whom or by which they are prescribed, recommended or performed.

Room and board and skilled nursing services are not, however, considered ***custodial care*** (1) if provided during ***confinement*** in an institution for which coverage is available under this ***Plan,*** and (2) if combined with other ***medically necessary*** therapeutic services, under accepted medical standards, which can reasonably be expected to substantially improve the ***covered person's*** medical condition.

Customary and Reasonable Amount

The fee assessed by a provider of service for services, supplies or treatment which shall not exceed the general level of charges made by others rendering or furnishing such services, supplies or treatment within the area where the charge is ***incurred*** and is comparable in severity and nature to the ***illness*** or ***injury***. Due consideration shall be given to any medical complications or unusual circumstances which require additional time, skill or experience. The ***customary and reasonable amount*** is determined from a statistical review and analysis of the charges for a given procedure in a given area. The term "area" as it would apply to any particular service, supply or treatment means a county or such greater area as is necessary to obtain a representative cross-section of the level of charges. The percentage applicable to this ***Plan*** is 90% and is applied to CPT codes or HIAA Code Analysis using MDR or HIAA tables.

Dentist

A Doctor of Dental Medicine (D.M.D.), a Doctor of Dental Surgery (D.D.S.), a Doctor of Medicine (M.D.), or a Doctor of Osteopathy (D.O.), other than a ***close relative*** of the ***covered person***, who is practicing within the scope of his license.

Dependent

A ***dependent*** is:

1. The term "spouse" means the spouse of the ***employee*** under a legally valid existing marriage between person's of the opposite sex, unless court ordered separation exists. This also includes a valid marriage entered into in another state between persons of the opposite sex, unless court ordered separation exists.

2. The term "child" means the ***employee's*** natural child, stepchild, legally adopted child, child ***placed for adoption***, foster child, and a child for whom the ***employee*** or covered spouse has been appointed legal guardian, provided the child is less than twenty-six (26) years of age and is not eligible to enroll in any other employer sponsored group health plan, other than through a parent.

3. An eligible child shall also include any other child of an ***employee*** or their spouse who is recognized in a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN) which has been issued by any court judgment, decree, or order as being entitled to enrollment for coverage under this ***Plan***. Such child shall be referred to as an ***alternate recipient***. ***Alternate recipients*** are eligible for coverage regardless of whether the ***employee*** elects coverage for himself. An application for enrollment must be submitted to the ***employer*** for coverage under this ***Plan***. The ***employer/plan administrator*** shall establish written procedures for determining whether a medical child support order is a QMCSO or NMSN and for administering the provision of benefits under the ***Plan*** pursuant to a valid QMCSO or NMSN. Within a reasonable period after receipt of a medical child support order, the ***employer/plan administrator*** shall determine whether such order is a QMCSO, as defined in Section 609 of ERISA, or a NMSN, as defined in Section 401 of the Child Support Performance and Incentive Act of 1998.

   The ***employer/plan administrator*** reserves the right, waivable at its discretion, to seek clarification with respect to the order from the court or administrative agency which issued the order, up to and including the right to seek a hearing before the court or agency.

4. A ***dependent*** child who was covered under the ***Plan*** prior to reaching the maximum age limit of twenty-six (26) years and who lives with the ***employee***, is unmarried, incapable of self-sustaining employment and dependent upon the ***employee*** for support due to a mental and/or physical disability, will remain eligible for coverage under this ***Plan*** beyond the date coverage would otherwise terminate.

   Proof of incapacitation must be provided within thirty-one (31) days of the child's loss of eligibility and thereafter as requested by the ***employer*** or ***claims processor***, but not more than once every two (2) years. Eligibility may not be continued beyond the earliest of the following:

   a. Cessation of the mental and/or physical disability;
   b. Failure to furnish any required proof of mental and/or physical disability or to submit to any required examination.

Every eligible ***employee*** may enroll eligible ***dependents***. However, if both the husband and wife are ***employees***, they may choose to have one covered as the ***employee***, and the spouse covered as the ***dependent*** of the ***employee***, or they may choose to have both covered as ***employees***. Eligible children may be enrolled as ***dependents*** of one spouse, but not both.

For further information regarding eligibility for ***dependents,*** refer to *Eligibility, Dependent Eligibility*.

Durable Medical Equipment

Medical equipment which:

1. Can withstand repeated use;

2. Is primarily and customarily used to serve a medical purpose;

3. Is generally not used in the absence of an ***illness*** or ***injury***;

4. Is appropriate for use in the home.

All provisions of this definition must be met before an item can be considered ***durable medical equipment***. ***Durable medical equipment*** includes, but is not limited to: crutches, wheel chairs, ***hospital*** beds, etc.

Effective Date

The date of this ***Plan*** or the date on which the ***covered person's*** coverage commences, whichever occurs later.

Emergency

An accidental ***injury***, or the sudden onset of an ***illness*** where the symptoms are of such severity that the absence of immediate medical attention could reasonably result in:

1. Placing the ***covered person's*** life in jeopardy, or

2. Causing other serious medical consequences, or

3. Causing serious impairment to bodily functions, or

4. Causing serious dysfunction of any bodily organ or part.

Employee

An ***Employee*** is defined as a Bishop, ministerial member, full-time lay pastor or layperson employed by The United Methodist Church or an Annual Conference, local Church, or an agency or institution of such Church.

You are eligible if you are a:

1. Full-Time Active ***Employee*** of participating Annual Conferences, local churches, agencies, or institutions of The United Methodist Church. (Non-Clergy ***employees*** who perform active work thirty (30) or more hours per week are considered full-time ***Employees***.)

2. Retired ***Employee*** of the above participating groups.

3. Surviving Spouse of a deceased ***employee*** who was an active ***employee*** at time of death.

4. Disabled Clergy Employee not currently assigned to a church and will remain eligible under this Plan Until they are reassigned to a church or becomes classified as a retired employee.

A Retired ***Employee*** is defined as a former ***Employee*** retired by a participating group who is receiving a pension financed by the ***Employer*** and covered under the ***Plan*** prior to retirement.

Surviving Spouse of a deceased ***employee*** of the above participating groups.

A Surviving Spouse is defined as the wife or husband of a deceased ***Employee*** of a participating group included under this Plan and covered under the ***Plan*** prior to the ***employee's*** death and/or retirement.

Employer

The ***employer*** is Arkansas United Methodist Conferences.

Enrollment Date

A ***covered person's enrollment date*** is the first day of any applicable service waiting period or the date of hire.

Essential Health Benefits

Those benefits identified by the U.S. Secretary of Health and Human Services, including benefits for ***covered expenses*** incurred for the following services:

1. Ambulatory patient services;
2. Emergency Services;
3. Hospitalization;
4. Maternity and newborn care;
5. Mental health and substance use disorder services, including behavioral health treatment ***(mental and nervous disorder*** and ***chemical dependency)***;
6. Prescription drugs;
7. Rehabilitative and habilitative services and devices;
8. Laboratory services;
9. Preventive and wellness services and chronic disease management;
10. Pediatric services, including oral and vision care.

Experimental/Investigational/Investigative

Services, supplies, drugs and treatment which do not constitute accepted medical practice properly within the range of appropriate medical practice under the standards of the case and by the standards of a reasonably substantial, qualified, responsible, relevant segment of the medical community or government oversight agencies at the time services were rendered.

The ***claims processor***, ***named fiduciary for post-service claim appeals***, ***named fiduciary for pre-service claim appeals***, ***employer/plan administrator***, or their designee must make an independent evaluation of the ***experimental***/non-experimental standings of specific technologies. The ***claims processor***, ***named fiduciary for post-service claim appeals***, ***named fiduciary for pre-service claim appeals***, ***employer/plan administrator*** or their designee shall be guided by a reasonable interpretation of ***Plan*** provisions and information provided by qualified independent vendors who have also reviewed the information provided. The decisions shall be made in good faith and rendered following a factual background investigation of the claim and the proposed treatment. The ***claims processor***, ***named fiduciary for post-service claim appeals***, ***named fiduciary for pre-service claim appeals***, ***employer/plan administrator*** or their designee will be guided by the following examples of ***experimental*** services and supplies:

1. If the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or

2. If the drug, device, medical treatment or procedure, was not reviewed and approved by the treating facility's institutional review board or other body serving a similar function, or if federal law requires such review or approval; or

3. If "reliable evidence" shows that the drug, device, medical treatment or procedure is the subject of on-going Phase I or Phase II clinical trials, is in the research, ***experimental***, study or ***investigational*** arm of on-going Phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, or its efficacy as compared with a standard means of treatment or diagnosis; or

4. If "reliable evidence" shows that prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum

tolerated dose, its toxicity, its safety, or its efficacy as compared with standard means of treatment or diagnosis.

"Reliable evidence" shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure.

Extended Care Facility

An institution, or distinct part thereof, operated pursuant to law and one which meets all of the following conditions:

1. It is licensed to provide, and is engaged in providing, on an ***inpatient*** basis, for persons convalescing from ***illness*** or ***injury***, professional nursing services, and physical restoration services to assist ***covered persons*** to reach a degree of body functioning to permit self-care in essential daily living activities. Such services must be rendered by a Registered Nurse or by a Licensed Practical Nurse under the direction of a registered nurse.

2. Its services are provided for compensation from its ***covered persons*** and under the full-time supervision of a ***physician*** or Registered Nurse.

3. It provides twenty-four (24) hour-a-day nursing services.

4. It maintains a complete medical record on each ***covered person***.

5. It is not, other than incidentally, a place for rest, a place for the aged, a place for drug addicts, a place for alcoholics, a place for custodial or educational care, or a place for the care of ***mental and nervous disorders***.

6. It is approved and licensed by ***Medicare***.

This term shall also apply to expenses ***incurred*** in an institution referring to itself as a skilled nursing facility, convalescent nursing facility, or any such other similar designation.

Facility

A healthcare institution which meets all applicable state or local licensure requirements.

Full-time

Employees who are regularly scheduled to work not less than thirty (30) hours per work week.

Generic Drug

A prescription drug that is generally equivalent to a higher-priced brand name drug with the same use and metabolic disintegration. The drug must meet all Federal Drug Administration (FDA) bioavailability standards and be dispensed according to the professional standards of a licensed pharmacist or ***physician*** and must be clearly designated by the pharmacist or ***physician*** as generic.

Health Care Management

A process of evaluating if services, supplies or treatment are ***medically necessary*** and appropriate to help ensure cost-effective care.

Health Care Management Organization

The individual or organization designated by the ***employer*** for the process of evaluating whether the service, supply, or treatment is ***medically necessary***. The ***Health Care Management Organization*** is CoreSource, Inc.

Home Health Aide Services

Services which may be provided by a person, other than a Registered Nurse, which are ***medically necessary*** for the proper care and treatment of a person.

Home Health Care

Includes the following services: private duty nursing, skilled nursing visits, and ***hospice***.

Home Health Care Agency

An agency or organization which meets fully every one of the following requirements:

1. It is primarily engaged in and duly licensed, if licensing is required, by the appropriate licensing authority, to provide skilled nursing and other therapeutic services.

2. It has a policy established by a professional group associated with the agency or organization to govern the services provided. This professional group must include at least one ***physician*** and at least one Registered Nurse. It must provide for full-time supervision of such services by a ***physician*** or Registered Nurse.

3. It maintains a complete medical record on each ***covered person***.

4. It has a full-time administrator.

5. It qualifies as a reimbursable service under ***Medicare***.

Hospice

An agency that provides counseling and medical services and may provide ***room and board*** to a terminally ill ***covered person*** and which meets all of the following tests:

1. It has obtained any required state or governmental Certificate of Need approval.

2. It provides service twenty-four (24) hours-per-day, seven (7) days a week.

3. It is under the direct supervision of a ***physician***.

4. It has a Nurse coordinator who is a Registered Nurse.

5. It has a social service coordinator who is licensed.

6. It is an agency that has as its primary purpose the provision of ***hospice*** services.

7. It has a full-time administrator.

8. It maintains written records of services provided to the ***covered person***.

9. It is licensed, if licensing is required.

Hospital

An institution which meets the following conditions:

1. It is licensed and operated in accordance with the laws of the jurisdiction in which it is located which pertain to ***hospitals***.

2. It is engaged primarily in providing medical care and treatment to ***ill*** and ***injured*** persons on an ***inpatient*** basis at the ***covered person's*** expense.

3. It maintains on its premises all the facilities necessary to provide for the diagnosis and medical and surgical treatment of an ***illness*** or ***injury;*** and such treatment is provided by or under the supervision of a ***physician*** with continuous twenty-four (24) hour nursing services by or under the supervision of Registered Nurses.

4. It qualifies as a ***hospital*** and is accredited by the Joint Commission on the Accreditation of Healthcare Organizations.

5. It must be approved by ***Medicare***.

Under no circumstances will a ***hospital*** be, other than incidentally, a place for rest, a place for the aged, or a nursing home.

Hospital shall include a facility designed exclusively for physical rehabilitative services where the ***covered person*** received treatment as a result of an ***illness*** or ***injury***.

The term ***hospital,*** when used in conjunction with ***inpatient confinement*** for mental and nervous conditions or ***chemical dependency***, will be deemed to include an institution which is licensed as a mental ***hospital*** or ***chemical dependency*** rehabilitation and/or detoxification ***facility*** by the regulatory authority having responsibility for such licensing under the laws of the jurisdiction in which it is located.

Illness

A bodily disorder, disease, physical sickness, or ***pregnancy*** of a ***covered person***.

Immediate Care Center

A ***facility*** which is engaged primarily in providing minor emergency and episodic medical care and which has:

1. a board-certified ***physician***, a Registered Nurse (RN) and a registered x-ray technician in attendance at all times;

2. has x-ray and laboratory equipment and life support systems.

An ***immediate care center*** may include a clinic located at, operated in conjunction with, or which is part of a regular ***hospital***.

Incurred or Incurred Date

With respect to a ***covered expense***, the date the services, supplies or treatment are provided.

Injury

A physical harm or disability that is the result of a specific incident caused by external means. The physical harm or disability must have occurred at an identifiable time and place. ***Injury*** does not include ***illness*** or infection of a cut or wound.

Inpatient

A ***confinement*** of a ***covered person*** in a ***hospital***, ***hospice***, or ***extended care facility*** as a registered bed patient, for twenty-three (23) or more consecutive hours and for whom charges are made for ***room and board***.

Intensive Care

A service that is reserved for critically and seriously ill ***covered persons*** requiring constant audio-visual surveillance which is prescribed by the attending ***physician***.

Intensive Care Unit

A separate, clearly designated service area which is maintained within a ***hospital*** solely for the provision of ***intensive care***. It must meet the following conditions:

1. Facilities for special nursing care not available in regular rooms and wards of the ***hospital***;

2. Special life saving equipment which is immediately available at all times;

3. At least two beds for the accommodation of the critically ill; and

4. At least one Registered Nurse in continuous and constant attendance twenty-four (24) hours-per-day.

This term does not include care in a surgical recovery room, but does include cardiac care unit or any such other similar designation.

Late Enrollee

A ***covered person*** who did not enroll in the ***Plan*** when first eligible or as the result of a special enrollment period.

Layoff

A period of time during which the ***employee***, at the ***employer's*** request, does not work for the ***employer***, but which is of a stated or limited duration and after which time the ***employee*** is expected to return to ***full-time***, ***active work***. Layoffs will otherwise be in accordance with the ***employer's*** standard personnel practices and policies.

Leave of Absence

A period of time during which the ***employee*** does not work, but which is of stated duration after which time the ***employee*** is expected to return to active work.

Maximum Benefit

Any one of the following, or any combination of the following:

1. The maximum amount paid by this ***Plan*** for any one ***covered person*** during the entire time he is covered by this ***Plan***.

2. The maximum amount paid by this ***Plan*** for any one ***covered person*** for a particular ***covered expense***. The maximum amount can be for:

   a. The entire time the ***covered person*** is covered under this ***Plan***, or
   b. A specified period of time, such as a calendar year.

3. The maximum number as outlined in the ***Plan*** as a ***covered expense***. The maximum number relates to the number of:

   a. Treatments during a specified period of time, or
   b. Days of ***confinement***, or
   c. Visits by a ***home health care agency***.

The ***maximum benefit*** for ***Essential Health Benefits*** and non-***Essential Health Benefits*** is tracked separately.

Maximum Plan Allowance or MPA

The maximum dental payment allowed under the ***Plan*** for the applicable covered dental service(s) provided by the ***Dentist***. The ***Dental Claims Processor*** shall have the discretionary authority to determine the ***MPA***.

Medically Necessary (or Medical Necessity)

Service, supply or treatment which is determined by the ***claims processor, named fiduciary for post-service claims, named fiduciary for*** pre-service claim***s, employer/plan administrator*** or their designee to be:

1. Appropriate and consistent with the symptoms and provided for the diagnosis or treatment of the ***covered person's illness*** or ***injury*** and which could not have been omitted without adversely affecting the ***covered person's*** condition or the quality of the care rendered; and

2. Supplied or performed in accordance with current standards of medical practice within the United States; and

3. Not primarily for the convenience of the ***covered person*** or the ***covered person's*** family or ***professional provider***; and

4. Is an appropriate supply or level of service that safely can be provided; and

5. Is recommended or approved by the attending ***professional provider***.

The fact that a ***professional provider*** may prescribe, order, recommend, perform or approve a service, supply or treatment does not, in and of itself, make the service, supply or treatment ***medically necessary*** and the ***claims processor, named fiduciary for post-service claims, named fiduciary for*** pre-service claim***s, employer/plan administrator*** or its designee, may request and rely upon the opinion of a ***physician*** or ***physicians***. The determination of the ***claims processor, named fiduciary for post-service claims, named fiduciary for*** pre-service claim***s, employer/plan administrator*** or its designee shall be final and binding.

Medicare

The programs established by Title XVIII known as the Health Insurance for the Aged Act, which includes: Part A, Hospital Benefits For The Aged; Part B, Supplementary Medical Insurance Benefits For The Aged; Part C, Miscellaneous provisions regarding both programs; and Part D, Medicare Prescription Drug Benefit, including any subsequent changes or additions to those programs.

Mental and Nervous Disorder

An emotional or mental condition characterized by abnormal functioning of the mind or emotions. Diagnosis and classifications of these conditions will be determined based on standard DSM-III-R (diagnostic and statistical manual of mental disorders) or the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services.

Named Fiduciary for Post-Service Claim Appeals

Medical Claims—CoreSource, Inc.
Dental Claims—Delta Dental of Arkansas
Prescription Drug Claims—CareMark

Named Fiduciary for Pre-Service Claim Appeals

Medical Claims—CoreSource, Inc.
Dental Claims—Delta Dental of Arkansas
Prescription Drug Claims—CareMark

Negotiated Rate

The rate the ***preferred providers*** have contracted to accept as payment in full for ***covered expenses*** of the ***Plan***.

Network Provider

An organization who selects and contracts with certain ***hospitals***, ***physicians***, and other health care providers to provide ***covered persons*** services, supplies and treatment at a ***negotiated rate***.

Nonparticipating Dentist

Any ***Dentist*** other than a ***Participating Dentist***.

Nonparticipating Pharmacy

Any pharmacy, including a ***hospital*** pharmacy, ***physician*** or other organization, licensed to dispense prescription drugs which does not fall within the definition of a ***participating pharmacy***.

Nonpreferred Provider

A ***physician, hospital,*** or other health care provider that does not have an agreement in effect with the Preferred Provider Organization at the time services are rendered.

Nurse

A licensed person holding the degree Registered Nurse (R.N.), Licensed Practical Nurse (L.P.N.) or Licensed Vocational Nurse (L.V.N.) who is practicing within the scope of the license.

Outpatient

A ***covered person*** shall be considered to be an ***outpatient*** if he is treated at:

1. A ***hospital*** as other than an ***inpatient***;

2. A ***physician's*** office, laboratory or x-ray ***facility***; or

3. An ***ambulatory surgical facility***; and

The stay is less than twenty-three (23) consecutive hours.

Participating Dentist or Network Provider

A licensed ***dentist*** who has contracted with and agreed to abide by the rules and regulations of ***DDAR*** or any other organization that is a member of Delta Dental Plans Association, DeltaUSA or its affiliates. A list of current ***Participating Dentists*** or ***Network Providers*** is available from ***DDAR*** or a ***covered person*** may access the website at www.deltadentalar.com.

Participating Pharmacy

Any pharmacy licensed to dispense prescription drugs which is contracted within the pharmacy organization.

Pharmacy Organization

The ***pharmacy organization*** is CareMark.

Physician

A Doctor of Medicine (M.D.) or a Doctor of Osteopathy (D.O.), other than a ***close relative*** of the ***covered person*** who is practicing within the scope of his license.

Placed For Adoption

The date the ***employee*** assumes legal obligation for the total or partial financial support of a child during the adoption process.

Plan

"***Plan***" refers to the benefits and provisions for payment of same as described herein. The ***Plan*** is the Arkansas United Methodist Conferences Employee Benefit Plan.

Plan Administrator

The ***plan administrator*** is responsible for the day-to-day functions and management of the ***Plan***. The ***plan administrator*** is the ***employer***.

Plan Sponsor

The ***Plan sponsor*** is Arkansas United Methodist Conferences.

Plan Year End

The plan year end is July 31st.

Pre-Determination

This is an opinion from the ***Dental Claims Processor*** as to payments that would be made by the ***Plan*** as reasonably necessary for anticipated ***Dental Treatment*** of a ***covered person***. The opinion is based upon information forwarded to the ***Dental Claims Processor***. It does not guarantee such payment in that actual payment would also depend on applicable coverage being in effect at the time any such services were rendered. The payment is subject to ***Plan***

Dental Deductibles, co-insurance and Dental Maximums. A ***covered person*** is not required to seek a ***pre-determination*** for any ***Dental Treatment*** under the ***Plan***.

Pre-existing Conditions

An ***illness*** or ***injury*** which existed within six (6) months before the ***covered person's*** enrollment date for coverage under this ***Plan***. An ***illness*** or ***injury*** is considered to have existed when the ***covered person***:

1. Sought or received professional advice for that ***illness*** or ***injury***, or

2. Received medical care or treatment for that ***illness*** or ***injury***, or

3. Received medical supplies, drugs, or medicines for that ***illness*** or ***injury***.

Preferred Provider

A ***physician***, ***hospital*** or other health care ***facility*** who has an agreement in effect with the ***Preferred Provider Organization*** at the time services are rendered.

Preferred Provider Organization

An organization who selects and contracts with certain ***hospitals***, ***physicians***, and other health care providers to provide services, supplies and treatment to ***covered persons*** at a ***negotiated rate***.

Pregnancy

The physical state which results in childbirth or miscarriage.

Primary Care Physician (PCP)

A licensed Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) who is a general or family practitioner, pediatrician, OB/GYN or general internist and has contracted with the network to render services, supplies and treatment to ***covered persons*** and to assist in managing the care of ***covered persons***.

Privacy Rule

Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its implementing regulation concerning privacy of individually identifiable health information, as published in 65 Fed. Reg. 82461 (Dec. 28, 2000) and as modified and published in 67 Fed. Reg. 53181 (Aug. 14, 2002).

Professional Provider

A person or other entity licensed where required and performing services within the scope of such license. The covered ***professional providers*** include, but are not limited to:

Certified Addictions Counselor

Certified Registered Nurse Practitioner

Chiropractor

Clinical Laboratory

Dental Hygienist

Dentist

Dietitian

Licensed Counselors

Licensed Social Workers

Nurse (R.N., L.P.N., L.V.N.)

Nurse Practitioner

Occupational Therapist

Ophthalmologist

Optician

Optometrist

Physical Therapist

Physician

Physician's Assistant

Podiatrist

Psychologist

Respiratory Therapist

Speech Therapist

Qualified Prescriber

A physician, dentist or other health care practitioner who may, in the legal scope of the license, prescribe drugs or medicines.

Required By Law

The same meaning as the term "required by law" as defined in 45 CFR 164.501, to the extent not preempted by other Federal law.

Retiree

A former ***employee*** who retired from service of the ***employer*** and has met the ***Plan's*** eligibility requirements to continue coverage under the ***Plan*** as a ***retiree***. As used in this document, the term ***employee*** shall include ***retirees*** covered under the ***Plan***.

Relevant Information

Relevant information, when used in connection with a claim for benefits or a claim appeal, means any document, record or other information:

1. Relied on in making the benefit determination; or
2. That was submitted, considered or generated in the course of making a benefit determination, whether or not relied upon; or
3. That demonstrates compliance with the duties to make benefit decisions in accordance with plan documents and to make consistent decisions; or
4. That constitutes a statement of policy or guidance for the Plan concerning the denied treatment or benefit for the covered person's diagnosis, even if not relied upon.

Retrospective Review

A review by the ***Health Care Management Organization*** after the ***covered person's*** discharge from ***hospital confinement*** to determine if, and to what extent, ***inpatient*** care was a covered service.

Room and Board

Room and linen service, dietary service, including meals, special diets and nourishments, and general nursing service. ***Room and board*** does not include personal items.

Routine Examination

A comprehensive history and physical examination which would include services as defined in *Medical Expense Benefit, Routine Preventive Care/Wellness Benefit.*

Semiprivate

The daily ***room and board*** charge which a ***facility*** applies to the greatest number of beds in it's ***semiprivate*** rooms containing two (2) or more beds.

Treatment Center

1. An institution which does not qualify as a ***hospital***, but which does provide a program of effective medical and therapeutic treatment for ***chemical dependency***, and

2. Where coverage of such treatment is mandated by law, has been licensed and approved by the regulatory authority having responsibility for such licensing and approval under the law, or

3. Where coverage of such treatment is not mandated by law, meets all of the following requirements:

    a. It is established and operated in accordance with the applicable laws of the jurisdiction in which it is located.
    b. It provides a program of treatment approved by the ***physician***.
    c. It has or maintains a written, specific, and detailed regimen requiring full-time residence and full-time participation by the ***covered person***.
    d. It provides at least the following basic services:
        (1) ***Room and board***
        (2) Evaluation and diagnosis
        (3) Counseling
        (4) Referral and orientation to specialized community resources.

Urgent Care

An ***emergency*** or an onset of severe pain that cannot be managed without immediate treatment.

Claims Processor

CoreSource, Inc.
PO Box 8215
Little Rock, AR 72221-8215

For Claims Administration:

Local: (501) 221-9905
Toll Free: 1-888-604-9397
FAX: (501) 221-9302

For Pre-Certification Information:

CORESOURCE, INC.
Toll Free: 1-866-292-8108