

PLAN DOCUMENT
FOR

ARKANSAS STATE AND PUBLIC SCHOOL EMPLOYEES AND RETIREES

Benefits effective January 1, 2021

TABLE OF CONTENTS

INTRODUCTION 1
DEFINED TERMS 2
HOW COVERAGE UNDER ARBENEFITS WORKS 14
PRIMARY COVERAGE CRITERIA 17
ELIGIBILITY, FUNDING, EFFECTIVE DATE AND TERMINATION PROVISIONS 21
OPEN ENROLLMENT 24
DESCRIPTION OF BENEFIT PLAN OPTIONS 34
SCHEDULE OF BENEFITS, ASE/PSE Premium Plan 36
SCHEDULE OF BENEFITS, ASE/PSE Classic Plan 41
SCHEDULE OF BENEFITS, ASE Basic Plan 47
SCHEDULE OF BENEFITS, PSE Basic Plan 52
SCHEDULE OF BENEFITS, ASE/PSE Premium Plan (Medicare Primary Plan) 57
CORONAVIRUS PANDEMIC, TEMPORARY BENEFITS 59
MEDICAL BENEFITS 60
BARIATRIC SURGERY PILOT PROGRAM 78
COST MANAGEMENT SERVICES 80
PLAN EXCLUSIONS 83
HOW TO SUBMIT A CLAIM 97
COORDINATION OF BENEFITS 110
THIRD PARTY RECOVERY PROVISION 113
COVERAGE CONTINUATION DURING RETIREMENT 115
CONTINUATION COVERAGE RIGHTS UNDER COBRA 119
RESPONSIBILITIES FOR PLAN ADMINISTRATION 127
FUNDING THE PLAN AND PAYMENT OF BENEFITS 132
GENERAL PLAN INFORMATION 133
APPENDIX 1 – PHARMACY BENEFIT MANAGER 135

INTRODUCTION

This Plan Document explains the benefits available to Members of the Arkansas State and Public School Employee Health Insurance Plan (known as the Plan or ARBenefits throughout the rest of this document). The Plan provides coverage for participating Employees, Retirees, and eligible Dependents. The Employee Benefits Division of the State of Arkansas Department of Transformation and Shared Services (TSS EBD) reserves the right to interpret the elements of this Plan Document as necessary for the continued administration of the Plan. No oral interpretations can change this Plan.

To obtain additional information, free of charge, about Plan coverage of a specific benefit, particular drug, treatment, test, or any other aspect of Plan benefits or requirements, individuals can call EBD Member Services at (501) 682-9656 or toll free at (877) 815-1017, press one, then press two.

To the extent that an item or service is a covered benefit under the Plan, the terms of the Plan shall be applied in a manner that does not discriminate against a health care Provider who is acting within the scope of the Provider's license or other required credentials under applicable State law. This provision does not preclude the Plan from setting limits on benefits, including cost sharing provisions, frequency limits, or restrictions on the methods or settings in which treatments are provided and does not require the Plan to accept all types of Providers as a Network Provider.

Failure to follow the eligibility or enrollment requirements of this Plan may result in delay of coverage or no coverage at all. Reimbursement from the Plan can be reduced or denied because of certain provisions in the Plan, such as coordination of benefits, subrogation, exclusions, timeliness of COBRA elections, utilization review or other cost management requirements, lack of Medical Necessity, lack of timely filing of claims, or lack of coverage. These provisions are explained in summary fashion in this document; additional information is available from the Plan Administrator at no extra cost.

The Plan will pay benefits only for the expenses incurred while this coverage is in force. No benefits are payable for expenses incurred before coverage began or after coverage terminated. An expense for a service or supply is incurred on the date the service or supply is furnished.

No action at law or in equity shall be brought to recover under any section of this Plan until the appeal rights provided have been exercised and the Plan benefits requested in such appeals have been denied in whole or in part.

Changes in the Plan may occur in any or all parts of the Plan including benefit coverage, Deductibles, maximums, Copayments, exclusions, limitations, definitions, eligibility, and the like.

DEFINED TERMS

The following terms have special meanings and when used in this Plan will be capitalized.

Accidental Injury is defined as bodily injury (other than intentionally self-inflicted injury) sustained by a Member while the coverage is in force, and which is the direct cause of the loss, independent of disease or bodily infirmity. Injury to a tooth or teeth while eating is not considered an Accidental Injury.

Active Employee is an Employee who is on the regular payroll of the Employer and who has begun to perform the duties of his or her job with the Employer on a full-time basis.

Advanced Diagnostic Imaging means Computed tomography scanning ("CT SCAN"), Magnetic Resonance Angiography or Imaging ("MRA/MRI"), Nuclear Cardiology, and positron emission tomography scans ("PET SCAN").

Allowance or Allowable Charge, when used in connection with Covered Services or supplies delivered in Arkansas, will be the amount deemed by the Claims Administrator, to be reasonable. The customary allowance is the basic Allowance or Allowable Charge. However, the Allowance or Allowable Charge may vary, given the facts of the case and the opinion of Claims Administrator's medical director.

Allowances or Allowable Charges for services or supplies received out of Arkansas may be determined by the local Blue Cross and Blue Shield Plan. **Please note that all benefits under this Plan are subject to and shall be paid only by reference to the Allowance or Allowable Charge as determined at the discretion of the Claims Administrator. This means that regardless of how much a health care Provider may bill for a given service, the benefits under this Plan will be limited by the established Allowance or Allowable Charge. Participating Providers are obligated to accept the Claims Administrator's established rate as payment in full, and should only bill the Covered Person for Deductible, Coinsurance, and any non-Covered Services; however, if a Covered Person uses a non-participating Provider, they will be responsible for all amounts billed in excess of the Allowance or Allowable Charge.**

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

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

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

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

Ambulance Service means ground or air transportation in a regularly equipped ambulance licensed by an appropriate agency and where the use of any other means of transportation is not medically indicated. All

services provided by the ambulance personnel, including but not limited to, the administration of oxygen, medications, life support, etc. are included in the specific Plan limitation applied to ambulance benefits.

Ambulatory Surgery Center means a distinct entity that operates exclusively for the purpose of providing surgical services to patients not requiring hospitalization.

Approved Clinical Trial means a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other Life-Threatening Disease or Condition and is described in any of the following subparagraphs:

Federally Funded Trials- The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:

(1) The National Institutes of Health;

(2) The Centers for Disease Control and Prevention;

(3) The Agency for Health Care Research and Quality;

(4) The Centers for Medicare & Medicaid Services;

(5) Cooperative group or center of any of the entities described in clauses a. through b. or the Department of Defense or the Department of Veterans Affairs; or,

(6) A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.

(a) The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration.

(b) The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

ASE Employer is the State of Arkansas.

Balance billing is an Out-of-Network Provider practice of charging a Covered Person for the difference between the Plan Allowance and the full, billed charges. Benefits under the Plan will always be limited to the Plan Allowance. The In-Network Provider contract protects the Covered Person from additional billing beyond the Plan Allowance. However, Out-of-Network Providers may choose to bill the Covered Person for the balance.

Birthing Center means any freestanding health facility, place, professional office, or institution which is not a Hospital or in a Hospital, where births occur in a home-like atmosphere. This facility must be licensed and operated in accordance with the laws pertaining to Birthing Centers in the jurisdiction where the facility is located.

The Birthing Center must provide facilities for obstetrical delivery and short-term recovery after delivery; provide care under the full-time supervision of a Physician and either a registered nurse (R.N.) or a licensed nurse-midwife; and have a written agreement with a Hospital in the same locality for immediate acceptance of patients who develop complications or require pre- or post-delivery confinement.

Calendar Year means January 1st through December 31st of the same year.

Case Management is a program in which a registered nurse employed by the Claims Administrator, known as a Case Manager, assists a Member through a collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates options and health care benefits available to a Member. Case Management is instituted at the discretion of the Claims Administrator when mutually agreed to by the Member and the Member's Physician.

Chemotherapy means therapy for the treatment of a malignant neoplastic disease by chemical agents. High dose Chemotherapy is Chemotherapy several times higher than the standard dose for malignant disease (as determined in recognized medical compendia) and which would automatically require the addition of drugs and procedures (e.g., Granulocyte Colony-Stimulating Factor, Granulocyte- Macrophage Colony-Stimulating Factor, re-infusion of stem cells, re-infusion of autologous bone marrow transplantation, or allogeneic bone marrow transplantation) in any patient who received this high dose Chemotherapy, to prevent life-threatening complications of the Chemotherapy on the patient's own progenitor blood cells.

COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Coinsurance means the obligation of a Member to pay a portion of an Allowance or Allowable Charge. Coinsurance is expressed as a percentage in the Schedule of Benefits. The Schedule of Benefits sets forth the Coinsurance for services or supplies received from an In-Network Provider and the Coinsurance for services and supplies from Out-of-Network Providers. **NOTE**: Because the contract between Health Advantage and an In-Network Provider may include risk sharing arrangements that may involve a portion of the In-Network Provider's compensation or fees being withheld at the time the claim is paid the actual Coinsurance percentage for which a Member is responsible on any given claim may be higher than the percentages stated in the Schedule of Benefits. The actual Coinsurance percentage is dependent upon the year-end settlement or periodic adjustments between the In-Network Provider and the Claims Examiner.

Copayment means the amount required to be paid to an In-Network Provider by or on behalf of a Member in connection with Covered Services. Copayments are listed in the Schedule of Benefits.

Cosmetic Service means any treatment or corrective surgical procedure performed to reshape structures of the body in order to alter the individual's appearance or to alter the manifestation of the aging process. Breast augmentation, mastoplexy, breast reduction for cosmetic reasons, otoplasty, rhinoplasty, collagen injection, and scar reversals are examples of Cosmetic Services. Cosmetic Services also includes any procedure required to correct complications caused by or arising from prior Cosmetic Services. Cosmetic Services do not include the following services in connection with a mastectomy resulting from cancer: (a) reconstruction of the breast on which the cancer-related surgery has been performed, and (b) surgery to reconstruct the other breast to produce a symmetrical appearance. The following procedures are not considered Cosmetic Services: correction of a cleft palate or cleft lip, removal of a port-wine stain, or hemangioma on the head, neck, or face.

Coverage Policy means a statement developed by the Claims Administrator that sets forth the medical criteria for coverage. Some limitations of benefits related to coverage, of a drug, treatment, service equipment, or supply are also outlined in the Coverage Policy. A copy of a Coverage Policy is available from the Claims Administrator at no cost, upon request, or a Coverage Policy can be reviewed on Health Advantage's website at www.healthadvantage-hmo.com.

Covered Charge(s) means those Medically Necessary services or supplies that are covered under this Plan.

Covered Person is an Employee or Dependent who is covered under this Plan.

Covered Services means services for which a Member is entitled to benefits under the terms of this Plan.

Deductible means the amount of out of pocket expense a Member must incur for Covered Services each Calendar Year before any expenses are paid by the Plan. This amount is calculated from Allowance or Allowable Charges, not the billed charges. Once the Deductible has been met, subject to all other terms, conditions, limitations, and exclusions in the Plan, payment for Covered Services begins. The Deductible is waived for some services, such as Preventive Care, as identified in the Schedule of Benefits.

Dental Care means the treatment or repair of the teeth, bones, and tissues of the mouth and defects of the human jaws and associated structures and shall include surgical procedures involving the mandible and maxilla where such is done for the purpose of correcting malocclusion of the teeth or for the purpose, at least in part, of preparing such bony structure for dentures or the attachment of teeth, artificial or natural.

Dependent means any member of an Employee's or Retiree's family who meets the Plan's eligibility requirements.

Diabetes Self-Management Training means instruction, including medical nutrition therapy relating to diet, caloric intake, and diabetes management (excluding programs the primary purpose of which is weight reduction) which enables diabetic patients to understand the diabetic management process and daily management of diabetic therapy as a means of avoiding frequent hospitalizations and complications when the instruction is provided in accordance with a program in compliance with the National Standards for Diabetes Self-Management Education Program as developed by the American Diabetes Association.

Durable Medical Equipment (DME) means equipment which (1) can withstand repeated use; and (2) is primarily and customarily used to serve a medical purpose; and (3) generally is not useful to a person in the absence of an Illness or Accidental Injury; and (4) is appropriate for use in the home.

Emergency Care means health care services required to evaluate and treat medical conditions of a recent onset and severity, including, but not limited to, severe pain that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that a condition, Sickness, or Accidental Injury is of such a nature that failure to get immediate medical care could result in (i) placing the patient's health in serious jeopardy; (ii) serious impairment to bodily functions; or (iii) serious dysfunction of any bodily organ or part. In order to qualify as Emergency Care, health care services must be sought 48 hours of the onset of the Illness or Accidental Injury.

Employee means a person who is classified by his Employer as an Active, common law employee.

Family Unit is the covered Employee and the family members who are covered as Dependents under the Plan.

Freestanding Facility means an entity that furnishes health care services and that is neither integrated with, nor a department of, a Hospital. Physically separate facilities on the campus of a Hospital are considered freestanding unless they are integrated with, or a department of, the Hospital. Examples of Freestanding Facilities include, but are not limited to, and Free-Standing Residential Treatment Centers. Ambulatory Surgery Centers performing Covered Services are not considered Freestanding Facilities. Laboratories are not considered Freestanding Facilities.

Health Insurance Representatives are individuals appointed by a state agency or school district who provide Plan Participants with enrollment information and assist them with questions regarding the Plan. These individuals often work in the payroll or personnel sections and have a variety of other duties to perform.

Health Intervention or **Intervention** means an item, Medication, or service delivered or undertaken primarily to diagnose, detect, treat, palliate, or alleviate a medical condition or to maintain or restore

functional ability of the mind or body.

Home Health Agency means an organization, licensed by the appropriate regulatory authority, which has entered into an agreement with the Plan to render home health services to Members.

Homeopathic means healing the underlying cause of disease not simply eliminating the symptoms caused by the disease. Some forms of homeopathic treatment may include, but are not limited to diet therapy, environment services, minimum doses of natural medications. Homeopathic treatments are not covered.

Hospice Care means an autonomous, centrally administered, medically directed, coordinated program providing a continuum of home, outpatient, and home-like inpatient care for the terminally ill patient and family. Hospice Care provides palliative and supportive care to meet the special needs arising out of the physical, emotional, spiritual, social, and economic stresses which are experienced during the final stages of Illness and during dying and bereavement.

Hospital means an acute general care Hospital, a Psychiatric Hospital, and a Rehabilitation Hospital licensed as such by the appropriate state agency. It does not include any of the following, unless required by applicable law or approved by the Board of Directors of Health Advantage: Hospitals owned or operated by state or federal agencies, convalescent homes, or Hospitals, homes for the aged, sanitariums, long term care facilities, infirmaries, or any institution operated mainly for treatment of long- term chronic diseases.

Illness means a bodily disorder, disease, physical sickness, or Mental Disorder. Illness includes Pregnancy, childbirth, miscarriage, or complications of Pregnancy.

In-Network Provider means a health care provider who has entered into a network participation contract with either the Claims Administrator or, outside the state of Arkansas, with the Blue Cross and Blue Shield plan in the state where services were provided ("Host Plan").

Infertility means the inability to conceive.

Initial Enrollee an employee or spouse who requests enrollment to the ARBenefits plan at the first opportunity; i.e. new hire election, or newly eligible (moving from part time to full time).

Laboratory means an entity furnishing biological, microbiological, serological, chemical, immunohematological, hematological, biophysical, cytological, pathological, or other examination of materials derived from the human body for the purpose of providing information for the diagnosis, prevention, or treatment of any disease or impairment of, or the assessment of the health of, human beings. These examinations also include procedures to determine, measure or otherwise describe the presence or absence of various substances or organisms in the body. Entities only collecting or preparing specimens (or both) or only serving as a mailing service and not performing testing are not considered laboratories.

Life-Threatening Disease or Condition means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

Long Term Acute Care means the medical and nursing care treatment of medically stable but fragile patients over an extended period of time, anticipated to be at least 25 days. Long Term Acute Care includes, but is not limited to, treatment of chronic cardiac disorders, ventilator dependent respiratory disorder, post-operative complications, and total parenteral nutrition (TPN) issues.

Low Protein Modified Food Products means a food product that is specifically formulated to have less than one gram of protein per serving and intended to be used under the direction of a Physician for the dietary treatment of a Medical Disorder Requiring Specialized Nutrients or Formulas.

Medical Care Facility means a Hospital, a facility that treats one or more specific ailments, or any type of Skilled Nursing Facility.

Medical Disorder Requiring Specialized Nutrients or Formulas means the following inherited metabolic disorders involving a failure to properly metabolize certain nutrients: nitrogen metabolism disorder; phenylketonuria; maple syrup urine disease; homocystinuria; citrullinemia; argininosuccinic academia; tyrosinemia, type 1; very-long-chain acyl-CoA dehydrogenase deficiency long-chain 3 hydroxyacyl-CoA dehydrogenase deficiency; trifunctional protein deficiency; glutaric academia, type 1; methylcrotonyl CoA carboxylase deficiency, propionic academia; methylmalonic academia due to mutase deficiency; methlmalonic academia due to cobalamin A,B defect; isovaleric academia; ornithine transcarbamyalse deficiency; non-ketotic hyperglycinemia; glycogen storage diseases; disorders of creatine metabolism; malonic aciduria; carnitine palmitoyl transferase deficiency type II; glutaric aciduria type II; and sulfite oxidase deficiency.

Medical Emergency means a medical condition of a recent onset and severity, including, but not limited to, severe pain that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that a condition, Sickness, or Accidental Injury is of such a nature that failure to get immediate medical care could result in (i) placing the patient's health in serious jeopardy; (ii) serious impairment to bodily functions; or (iii) serious dysfunction of any bodily organ or part.

Medical Food means a food that is intended for dietary treatment of a Medical Disorder Requiring Specialized Nutrients or Formulas for which nutritional requirements are established by recognized scientific principles and formulated to be consumed or administered enterally under the direction of a Physician.

Medical Supply or Supplies means an item which (1) is consumed or diminished with use so that it cannot withstand repeated use; and (2) is primarily or customarily used to serve a medical purpose; and generally is not useful to a person in the absence of an Illness or Accidental Injury.

Medically Necessary care and treatment is recommended or approved by a Physician; is consistent with the patient's condition or accepted standards of good medical practice; is medically proven to be effective treatment of the condition; is not performed mainly for the convenience of the patient or provider of medical services; is not conducted for research purposes; and is the most appropriate level of services which can be safely provided to the patient.

All of these criteria must be met; merely because a Physician recommends or approves certain care does not mean that it is Medically Necessary.

Medicare is a federal system of health insurance for people over 65 years of age and for certain younger people with disabilities. It is comprised of three sections:

(1) **Medicare Part A**-Medicare Part A hospital insurance covers inpatient hospital care, skilled nursing facility, hospice, lab tests, surgery, and home health care.

(2) **Medicare Part B** -Medicare Part B (medical insurance) is part of Original Medicare and covers medical services and supplies that are medically necessary to treat your health condition. This can include outpatient care, preventive services, ambulance services, and durable medical equipment.

(3) **Medicare Part D**-Medicare Part D is a federal program administered through private insurance companies. These companies offer retail prescription drug coverage to Medicare beneficiaries.

(4) **Medicare Part C**- also known as Medicare replacement plans. Medicare Advantage health plans pay for managed health care based on a monthly fee per enrollee, rather than on the basis of billing a fee for each medical service provided, which is the way Original Medicare Parts A and B work.

Member means an Employee or Retiree or Dependent who is covered under the Plan.

Mental Illness means and includes (whether organic or non-organic, whether of biological, non-biological, chemical or non-chemical origin, and irrespective of cause, basis or inducement) mental disorders, mental illness, psychiatric illness, mental conditions, and psychiatric conditions. This includes, but is not limited to schizophrenic spectrum and other psychotic disorders, bipolar and related disorders, depressive disorders, anxiety disorders, obsessive-compulsive and related disorders, trauma and stressor-related disorders, dissociative disorders, somatic symptom and related disorders, feeding and eating disorders, elimination disorders, sleep-wake disorders, sexual dysfunctions, gender dysphoria, disruptive, impulse-control and conduct disorders, substance-related and addictive disorders, neurocognitive disorders, personality disorders, paraphilic disorders, and psychological or behavioral abnormalities associated with transient or permanent dysfunction of the brain or related neurohormonal systems. (This is intended to include only illnesses classified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association, Washington, D.C.)

Neurologic Rehabilitation Facility means an institution licensed as such by the appropriate state agency. A Neurological Rehabilitation Facility must:

(1) be operated pursuant to law;

(2) be accredited by the Joint Commission on Accreditation of Healthcare Organizations and the Commission on Accreditation of Rehabilitation Facilities;

(3) be primarily engaged in providing, in addition to room and board accommodations, rehabilitation services for Severe Traumatic Brain Injury under the supervision of a duly licensed Physician (M.D. or D.O.); and,

(4) maintain a daily progress record for each patient.

No-Fault Auto Insurance is the basic reparations provision of a law providing for payments without determining fault in connection with automobile accidents.

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

Nurse Hotline means a 24/7 hotline available for Members who wish to seek the advice of a nurse. If referred to the emergency room by the hotline nurse, the emergency room Copayment will be waived for Members on the Premium plan.

Orthotic Device means a support, brace, or splint used to support, align, prevent, or correct the function of movable parts of the body.

Out-of-Network Provider means a health care provider who does not have a network participation contract with either the Claims Administrator or, outside the state of Arkansas, with the Blue Cross and Blue Shield plan in the state where services were provided ("Host Plan").

Outpatient Care means all care received including services, supplies, and Medications in a Physician's

office, Outpatient Surgery Center, x-ray or Laboratory, the Member's home, or at a Hospital where the Member receives services but is not admitted to the Hospital.

Outpatient Hospital means a portion of a Hospital which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services by, or under the supervision of, a Physician to patients admitted for a variety of medical conditions.

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

Partial Hospitalization means continuous treatment for a Member who requires care or support, or both, in a Hospital but who does not require 24-hour supervision. A Physician must prescribe services for at least four hours, but not more than 16 hours in any 24-hour period.

Pharmacy means a licensed establishment where covered Prescription Drugs are filled and dispensed by a pharmacist licensed under the laws of the state where he or she practices.

Physician means a Doctor of Medicine (M.D.) or a Doctor of Osteopathy (D.O.) duly licensed and qualified to practice medicine and perform surgery at the time and place a claimed Intervention is rendered. Physician also means a Doctor of Podiatry (D.P.M.), a Chiropractor (D.C.), a Psychologist (Ph.D.), an Oral Surgeon (D.D.S.), or an Optometrist (O.D.) duly licensed and qualified to perform the claimed Health Intervention at the time and place such Intervention is rendered.

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

Plan means ARBenefits, which is a benefits plan for Arkansas State and Public School Employees, Retirees, and their eligible Dependents, and is described in this document.

Plan Administrator means Employee Benefits Division for the appropriate department of the State of Arkansas.

Plan Allowance means the maximum amount the Plan will cover or pay for any health care services, drugs, medical devices, equipment, supplies, or benefits covered by the Plan. This overall limit on the amount of Plan benefits available under the Plan may also be referred to as the "Allowable Charge or "Allowance" under the Plan.

Plan Participant is any Employee or Dependent who is covered under this Plan.

Plan Year is the 12-month period beginning on January 1 and ending on the following December 31.

Pregnancy is childbirth and conditions associated with Pregnancy, including complications.

Prescription means an order for Medications by a Physician or health care Provider authorized by applicable law to issue a Prescription, to a Pharmacy for the benefit of and use by a Member.

Prescription Medication or **Medication** means any pharmaceutical that has been approved by the FDA and can be obtained only through a Prescription. The Claims Administrator has classified selected Prescription Medications, primarily Medications intended for self-administration as "A Medications." The Claims Administrator has classified Intra-muscular injections, Intravenous injections, and other pharmaceuticals that are primarily intended for professional administration as "B Medications."

Primary Care Physician means an In-Network M.D. or D.O. Physician who provides primary medical care in one of these medical specialties: General Practice, Pediatrics, Family Practice, Obstetrics/Gynecology, or Internal Medicine. This also includes advanced practice nurses or physician assistants who provide primary medical care in these medical specialties and are performed in the Primary Care Physician's office.

Prior Approval means the process by which the Claims Administrator, acting on the Plan's behalf, determines in advance of the Member obtaining a requested medical service, Medication, supply, test, or equipment that such medical service, Medication, supply, test, or equipment meets Primary Coverage Criteria. **NOTE: Prior Approval does not mean that the service, supply or treatment will be covered regardless of other terms, conditions, or limitations outlined in this document, but means only that the information furnished to the Claims Administrator in the pre-service claim indicates that the requested medical service, Medication, supply, test, or equipment meet the Primary Coverage Criteria requirements and the Applications of the Primary Coverage Criteria and is not subject to a specific Plan Exclusion. All Health Interventions receiving Prior Approval must still meet all other coverage terms, conditions, and limitations, and coverage for these services may still be limited or denied if, when the post-service claim for the services is received by the Claims Administrator, investigation shows that a benefit exclusion or limitation applies because of a difference in the Health Intervention described in the pre-service claim and the actual Health Intervention, that the Member ceased to be eligible for benefits on the date the services were provided, that coverage lapsed for non-payment of premium, that Out-of-Network limitations apply, or any other basis specified in this document.**

Professional Services means those Covered Services rendered by Physician and other health care provided in accordance with this Plan. Except for Emergency Care, all services must be performed, prescribed, directed, or authorized in advance by the Member's Primary Care Physician.

Prosthetic Device means an artificial device that replaces a missing body part, which may be lost through trauma, disease, surgery, or congenital conditions.

Provider means an advance practice nurse; an athletic trainer; an audiologist; a certified orthotist; a chiropractor; a community mental health center or clinic; a dentist, a Hospital; a licensed ambulatory surgery center; a licensed certified social worker; a licensed dietician; a licensed durable medical equipment provider; a licensed professional counselor; a licensed psychological examiner; a long-term care facility; a non-Hospital based medical facility providing clinical diagnostic services for sleep disorders; a non-Hospital based medical facility providing magnetic resonance imagining, computed axial tomography, or other imaging diagnostic testing; an occupational therapist; an optometrist; a pharmacist; a physical therapist; a physician or surgeon (M.D. and D.O.); a podiatrist; a prosthetist; a psychologist; a respiratory therapist; a rural health clinic; a speech pathologist and any other type of health care Provider which Health Advantage, in its sole discretion, approves for reimbursement for services rendered.

PSE Employer is the employee's respective school district.

Relevant to the Claim means a document, record or other information that:

(1) was relied upon in making the benefit determination;

(2) was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination;

(3) demonstrates compliance with the administrative processes and safeguards required by 7.2.5.b.; and,

(4) constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for the Member's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

Routine Patient Costs in connection with an Approved Clinical Trial mean the costs for health interventions covered by the Plan except:

(1) the investigational item, device, or service, itself;

(2) items and services that are provided solely to satisfy data collection and analysis needs and that are not used in direct clinical management of the individual undergoing the clinical trial; or,

(3) a service that is clearly inconsistent with widely accepted and established standards of care for the particular diagnosis.

Severe Traumatic Brain Injury means a sudden trauma causing damage to the brain as a result of the head suddenly and violently hitting an object or an object piercing the skull and entering brain tissue with an extended period of unconsciousness or amnesia after the injury or a Glasgow Coma Scale below 9 within the first 48 hours of Accidental Injury.

Service Area is the state of Arkansas.

Sickness is Illness, disease, or Pregnancy.

Skilled Nursing Facility means an institution licensed as such by the appropriate state agency. A Skilled Nursing Facility must:

(1) be operated pursuant to law;

(2) be approved for payment of Medicare benefits or be qualified to receive such approval, if so requested;

(3) be primarily engaged in providing, in addition to room and board accommodations, skilled nursing care under the supervision of a duly licensed Physician (M.D. or D.O.);

(4) provide continuous 24 hours a day nursing service by or under the supervision of a registered graduate professional nurse (R.N.) for at least eight hours per day and a registered graduate professional nurse (R.N.) or licensed practical nurse (L.P.N.) for the remaining 16 hours; and,

(5) maintain a daily medical record of each patient. However, a Skilled Nursing Facility does not include:

(a) any home, facility, or part thereof used primarily for rest;

(b) a home or facility for the aged or for the care of drug addicts or alcoholics; or

(c) a home or facility primarily used for the care and treatment of mental diseases, or disorders, or Custodial Care or educational care.

Specialty Care Provider means a Physician or other health care provider other than a Primary Care Physician.

Substance Use Disorder means a maladaptive pattern of substance use manifested by recurrent and significant adverse consequences related to the repeated use of substances.

Substance Use Disorder Residential Treatment Center means a facility that provides treatment for substance (alcohol and drug) use disorder to live-in residents who do not require acute medical care. Services include individual and group therapy and counseling, family counseling, Laboratory tests, drug and supplies, psychological testing, and room and board.

Telemedicine means the use of information and communication technology to deliver healthcare services, including without limitation to the assessment, diagnosis, consultation, treatment, education, care management, and self-management. Telemedicine includes store-and-forward technology and remote patient monitoring but does not include audio-only communication, including without limitation interactive audio, a facsimile machine, text messaging, or electronic mail systems.

Temporomandibular Joint (TMJ) syndrome is the treatment of jaw joint disorders including conditions of structures linking the jaw bone and skull and the complex of muscles, nerves, and other tissues related to the temporomandibular joint.

Total Disability (Totally Disabled) means, in the case of a Dependent, the complete inability as a result of Accidental Injury or Sickness to perform the normal activities of a person of like age and sex in good health.

Transplant Global Period means a period of time that begins on or prior to the day of the transplant procedure and extends for a number of days after the transplant procedure. The length of the Transplant Global Period varies, depending upon the type of transplant involved.

Urgent Care services means care and treatment for an Illness, Accidental Injury, or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room services.

HOW COVERAGE UNDER THE PLAN WORKS

The Employer has established and maintains this Plan for Employees, Retirees, and their eligible Dependents. The health benefit Plan provides a range of coverage for medical services. This is a very valuable benefit, but Members should understand that the Plan does NOT cover all medical services, drugs, supplies, tests, or equipment ("Health Interventions" or "Interventions"). A Plan covering all Health Interventions would be prohibitively expensive. For that reason, this Plan is more limited. This document is a guide to what is and is not eligible for benefits under the Plan. **Accordingly, Members should read this entire document carefully both now and BEFORE obtaining medical or preventive health services to be sure they understand what is covered and the limitations on coverage.**

The Employer wants Members to have coverage for the vast majority of medical needs they may face, including most Hospital and Physician Services, Emergency Care, preventive and wellness services, medications, supplies, and equipment. However, in order to keep costs of the Plan within reasonable limits, the Plan has deliberately excluded coverage of a number of specific Health Interventions, placed coverage limits on some other Interventions, and established an overall standard called the "Primary Coverage Criteria" that each and every claim for benefits must meet in order to be covered under the Plan.

For any Health Intervention, there are several general coverage criteria that must be met in order for that Intervention to qualify for coverage under the Plan.

(1) The Primary Coverage Criteria must be met;

(2) At the time of the Intervention, the Member must meet the Plan's eligibility standards;

(3) The Health Intervention must conform to specific limitations stated in the Plan;

(4) The Health Intervention must not be specifically excluded under the terms of the Plan;

(5) Members must comply with the Plan's Provider network and cost sharing arrangements; and,

(6) The Plan's procedures for filing claims must be followed.

Following is a brief description of each of these qualifications.

The Primary Coverage Criteria. The Primary Coverage Criteria apply to ALL benefits a Member may claim under the Plan. It does not matter what types of Health Intervention may be involved or when or where the Intervention is obtained. The Primary Coverage Criteria are designed to allow Plan benefits for only those Health Interventions that are proven as safe and effective treatment. The Primary Coverage Criteria also provide benefits only for the least invasive or risky Intervention when such Intervention would safely and effectively treat the medical condition; or they provide benefits for treatment in an outpatient, doctor's office or home care setting when such treatment would be a safe and effective alternative to hospitalization. Examples of the types of Health Interventions that the Primary Coverage Criteria exclude from coverage include such things as the cost of hospitalization for a minor cold or some other condition that could be treated outside the Hospital, or the cost of an investigational drug or treatment such as herbal therapy, or some forms of Chemotherapy not shown to have any beneficial or curative effect on a particular cancerous condition. Finally, the Primary Coverage Criteria require that if there are two or more effective alternative Health Interventions, the Plan should limit its payment to the Allowance or Allowable Charge for the most cost effective Intervention. The specific coverage standards that must be met under the Primary Coverage Criteria are outlined in the Primary Coverage Criteria Section found later in this document.

Eligibility Standards. Members must be eligible for benefits under the Plan at the time they receive a Health Intervention. Eligibility standards are set forth in the Eligibility, Funding, Effective Date, and Termination Section of this document. In order to be an eligible Member of the Plan, Members must meet the Plan's eligibility standards, which often include limited enrollment periods. It is important for Members to understand the provisions that outline the circumstances under which coverage may terminate under the Plan.

Special situations provided by state and federal law that allow continued coverage under the Plan for a limited time after an individual is no longer an Employee, Retiree, or Dependent, are described later in the document in the Section entitled Continuation Coverage Rights Under COBRA.

Specific Limitations. Because of the high cost of some Health Interventions, as well as the difficulty in some cases of determining whether an Intervention is really needed, the Plan includes coverage for such Health Interventions but place limits on the extent of coverage by limiting the number of Provider visits or treatments received during a Calendar Year or other specified time period. Examples of such limitations include a limit on the number of covered visits for chiropractic services. Other types of limitations include requirements that an Intervention be provided in a particular location or by a Provider holding a particular type of license, or in accordance with a written treatment plan or other documentation. Common benefits and limitations are outlined in detail in the Schedules of Benefits and the Medical Benefits Sections of this document. Members will note that this document refers to Coverage Policies the Claims Administrator has developed that may address limitations of coverage for a particular service, treatment, or drug. Members may request a copy of Coverage Policy with respect to a particular service, treatment, or drug, or may review established Coverage Policies on the Claims Administrator's website at www.healthadvantage-hmo.com.

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

Other exclusions are based on the Plan's judgment that the need for such Health Intervention is questionable in many cases, or that the services are of unknown or unproven beneficial effect. Examples of these types of exclusions include biofeedback and cranial electrotherapy stimulation devices, as well as some forms of high dose Chemotherapy and bone marrow transplantation. **Before undergoing treatment or tests, Members should review the specific exclusions listed in the Plan Exclusions Section of this document. If they have any questions about whether a specific exclusion applies, they should discuss it with their doctor(s). Assistance is also available from the Claims Administrator or EBD.** Members may request a copy of Coverage Policy with respect to a particular service, treatment, or drug, or may review established Coverage Policies on the Claims Administrator's website at www.healthadvantage-hmo.com.

Provider Network and Cost Sharing Procedures. The Plan does not provide coverage for 100% of the costs associated with covered Health Interventions. Members are expected to pay Copayments, Deductible, and Coinsurance. Members are encouraged to select, and to maintain a patient-physician relationship with, their Primary Care Physician. Coverage includes a special limitation in the form of provider network requirements. These provisions are designed to try to hold down the costs of coverage by limiting the coverage to those Physicians, Hospitals, or other health care Providers who participate in the Plan's provider networks, and by having the Primary Care Physician consult with the Member in advance on whether the

sometimes more expensive services of a specialist are really needed, or whether the Primary Care Physician can adequately address the problem. Members and their Physician are always free to make any decision they believe is best for the Member concerning whether to receive any particular service or treatment, or whether to see any Provider (in or out of the network). However, if a Member does decide to go "out-of-network" for services or treatment, coverage will be reduced or limited to the Out-of-Network rate. Member cost-sharing responsibilities are identified in the Schedule of Benefits Section.

Prior Approval. In some cases, the Member also may be required to meet certain prior approval of coverage procedures as outlined in this document. A complete list of services subject to prior approval is provided in the Cost Management Section. There are exceptions to the network for emergencies or, in rare cases upon approval by the Plan, where services or treatment covered under the Plan are not available for some reason from an In-Network Provider. In- Network Providers are identified in a published provider directory, or Members may call the Claims Administrator to ask about a specific Provider, or visit the claims administrator's website at www.healthadvantage-hmo.com.

Claim Filing Procedures. The Plan provides procedures that the Covered Person, their Provider or Authorized Representative must follow in filing claims. Failure to follow these procedures could result in significant delays in the processing of a claim, as well as potential denial of benefits. For example, not informing a Provider of the timely filing provision which causes the claim to not meet timely filing requirements will make a Member fully responsible for charges for services from that Provider. These procedures are set out in the How to Submit a Claim Section. In addition, the Section explains how a Member can appeal a benefit determination in the event he or she believes that such benefit determination does not comply with the terms of the Plan.

PRIMARY COVERAGE CRITERIA

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

Elements of the Primary Coverage Criteria. In order to be covered, medical services, drugs, treatments, procedures, tests, equipment, or supplies ("Interventions") must be recommended by the treating Physician and meet all of the following requirements:

(1) The Intervention must be an item or service delivered or undertaken primarily to prevent, diagnose, detect, treat, palliate, or alleviate a medical condition or to maintain or restore functional ability of the mind or body. A "medical condition" means a disease, Illness, Accidental Injury, Pregnancy, or a biological or psychological condition that, if untreated, impairs or threatens to impair ability of the body or mind to function in a normal, healthy manner.

(2) The Intervention must be proven to be effective (as defined below) in preventing, treating, diagnosing, detecting, or palliating a medical condition.

(3) The Intervention must be the most appropriate supply or level of service, considering potential benefits and harm to the patient. The following examples illustrate application of this standard (but are not intended to limit the scope of the standard): (i) An Intervention is not appropriate, for purposes of the Primary Coverage Criteria, if it would expose the patient to more invasive procedures or greater risks when less invasive procedures or less risky Interventions would be safe and effective to diagnose, detect, treat, or palliate a medical condition. (ii) An Intervention is not appropriate, under the Primary Coverage Criteria, if it involves hospitalization or other intensive treatment settings when the Intervention could be administered safely and effectively in an outpatient or other less intensive setting, such as the home.

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

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

necessarily mean the lowest price.

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

(1) Effective defined:

(a) **An existing Intervention** (one that is commonly recognized as accepted or standard treatment or which has gained widespread, substantially unchallenged use and acceptance throughout the United States) will be deemed "effective" for purposes of the Primary Coverage Criteria if the Intervention is found to achieve its intended purpose and to prevent, cure, alleviate, or enable diagnosis or detection of a medical condition without exposing the patient to risks that outweigh the potential benefits. This determination will be based on consideration of the following factors, in descending order of priority and weight:

(i) Scientific evidence, as defined below (where available);

(ii) If scientific evidence is not available, expert opinion(s) (whether published or furnished by private letter or report) of an Independent Medical Reviewer(s) with education, training, and experience in the relevant medical field or subject area; or,

(iii) If scientific evidence is not available, and if expert opinion is either unavailable for some reason or is substantially equally divided, professional standards, as defined and qualified below, may be consulted.

(iv) If neither scientific evidence, expert opinion nor professional standards show that an existing Intervention will achieve its intended purpose to prevent, cure, alleviate, or enable diagnosis or detection of a medical condition, then the Plan in its discretion may find that such existing Intervention is not effective and on that basis fails to meet the Primary Coverage Criteria.

(b) **A New Intervention** (one that is not commonly recognized as accepted or standard treatment or which has not gained widespread, substantially unchallenged use and acceptance throughout the United States) will be deemed "effective" for purposes of the Primary Coverage Criteria if there is scientific evidence (as defined below) showing that the Intervention will achieve its intended purpose and will cure, alleviate, or enable diagnosis or detection of a medical condition without exposing the patient to risks that outweigh the potential benefits. Scientific evidence is deemed to exist to show that a new Intervention is **not** effective if the procedure is the subject of an ongoing phase I, II, or III trial or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis. If there is a lack of scientific evidence regarding a new Intervention, or if the available scientific evidence is in conflict or the subject of continuing debate, the new Intervention shall be deemed "not effective," and therefore not covered in accordance with the Primary Coverage Criteria, with one exception – if there is a new Intervention for which clinical trials have not been conducted because the disease at issue is rare or new or affects only a remote population, then the Intervention may be deemed "effective" if, but only if, it meets the definition of "effective" as defined for existing Interventions above.

(2) **Scientific Evidence defined.** "Scientific Evidence," for purposes of the Primary Coverage Criteria, shall mean only one or more of the following listed sources of relevant clinical information and evaluation:

(a) Results of randomized controlled clinical trials, as published in the authoritative medical and scientific literature that directly demonstrate a statistically significant positive effect of an Intervention on a medical condition. For purposes of this Subsection a., "authoritative medical and scientific literature" shall be such publications as are recognized by the Plan, listed in the Claims Administrator's Coverage Policy or otherwise listed as authoritative medical and scientific literature on the Claims Administrator's website at www.healthadvantage-hmo.com; or,

(b) Published reports of independent technology or pharmaceutical assessment organizations recognized as authoritative by the Plan. For purposes of this Subsection b. an independent technology or pharmaceutical assessment organization shall be considered "authoritative" if it is recognized as such by the Plan, listed in the Claims Administrator's Coverage Policy or otherwise listed as authoritative on the Claims Administrator's website at www.healthadvantage-hmo.com.

(3) **Professional Standards defined.** "Professional standards," for purposes of applying the "effectiveness" standard of the Primary Coverage Criteria to an existing Intervention, shall mean only the published clinical standards, published guidelines or published assessments of professional accreditation or certification organizations or of such accredited national professional associations as are recognized by the Claims Administrator's Medical Director as speaking authoritatively on behalf of the licensed medical professionals participating in or represented by the associations. The Claims Administrator, acting on the Plan's behalf, shall have full discretion whether to accept or reject the statements of any professional association or professional accreditation or certification organization as "professional standards" for purposes of this Primary Coverage Criteria. No such statements shall be regarded as eligible to be classified as "professional standards" under the Primary Coverage Criteria unless such statements specifically address effectiveness of the Intervention, and conclude with substantial supporting evidence that the Intervention is safe, that its benefits outweigh potential risks to the patient, and that it is more likely than not to achieve its intended purpose and to prevent, cure, alleviate, or enable diagnosis or detection of a medical condition.

Application and Appeal of Primary Coverage Criteria.
The following rules apply to any application of the Primary Coverage Criteria. The Claims Administrator, acting on the Plan's behalf, shall have full discretion in applying the Primary Coverage Criteria, and in interpreting any of its terms or phrases, or the manner in which it shall apply to a given Intervention. No Intervention shall be deemed to meet the Primary Coverage Criteria unless the Intervention qualifies under ALL of the following rules:

(1) **Illegality.** An Intervention does not meet the Primary Coverage Criteria if it is illegal to administer or receive it under federal laws or regulations or the law or regulations of the state where administered.

(2) **FDA Position.** An Intervention does not meet the Primary Coverage Criteria if it involves any device or drug that requires approval of the U.S. Food and Drug Administration ("FDA"), and FDA approval for marketing of the drug or device for a particular medical condition has not been issued prior to the date of service. In addition, an Intervention does not meet the Primary Coverage Criteria if the FDA or the U.S. Department of Health and Human Services or any agency or division thereof, through published reports or statements, or through official

announcements or press releases issued by authorized spokespersons, have concluded that the Intervention or a means or method of administering it is unsafe, unethical, or contrary to federal laws or regulations. Neither FDA Pre-Market Approval nor FDA finding of substantial equivalency under 510(k) automatically guarantees coverage of a drug or device.

(3) **Proper License.** An Intervention does not meet the Primary Coverage Criteria if the health care professional or facility administering it does not hold the proper license, permit, accreditation, or other regulatory approval required under applicable laws or regulations in order to administer the Intervention.

(4) **Plan Exclusions, Limitations, or Eligibility Standards**. Even if an Intervention otherwise meets the Primary Coverage Criteria, it is not covered under this Plan if the Intervention is subject to a Plan exclusion or limitation, or if the Member fails to meet Plan eligibility requirements.

(5) **Position Statements of Professional Organizations.** Regardless of whether an Intervention meets some of the other requirements of the Primary Coverage Criteria, the Intervention shall not be covered under the Plan if any national professional association, any accrediting or certification organization, any widely-used medical compendium, or published guidelines of any national or international workgroup of scientific or medical experts have classified such Intervention or its means or method of administration as "experimental" or "investigational" or as questionable or of unknown benefit. However, an Intervention that fails to meet other requirements of the Primary Coverage Criteria shall not be covered under the Plan, even if any of the foregoing organizations or groups classify the Intervention as not "experimental" or not "investigational," or conclude that it is beneficial or no longer subject to question. For purposes of this Subsection 5, "national professional association" or "accrediting or certifying organization," or "national or international workgroup of scientific or medical experts" shall be such organizations or groups recognized by the Plan, listed in the Claims Administrator's Coverage Policy or otherwise listed as authoritative on the Claims Administrator's website at www.healthadvantage-hmo.com.

(6) **Coverage Policy.** With respect to certain drugs, treatments, services, tests, equipment, or supplies, the Claims Administrator has developed specific Coverage Policies, which have been put into writing, and are published on the Claims Administrator's website at www.healthadvantage-hmo.com. If the Claims Administrator has developed a specific Coverage Policy that applies to the drug, treatment, service, test, equipment, or supply that a Member received or seeks to have covered under the Plan, the Coverage Policy shall be deemed to be determinative in evaluating whether such drug, treatment, service, test, equipment, or supply meets the Primary Coverage Criteria; however, the absence of a specific Coverage Policy with respect to any particular drug, treatment, service, test, equipment, or supply shall not be construed to mean that such drug, treatment, service, test, equipment, or supply meets the Primary Coverage Criteria.

Members may appeal a determination that an Intervention does not meet the Primary Coverage Criteria to the Appeals Coordinator. Use the procedures for appeals outlined in the How to Submit a Claim Section.

Any appeal available with respect to a Primary Coverage Criteria determination shall be subject to the terms, conditions and definitions set forth in the Primary Coverage Criteria. An appeal shall also be subject to the terms, conditions and definitions set forth elsewhere in this Plan. The Appeals Coordinator or an External Review organization shall render its independent evaluation so as to comply with and achieve the intended purpose of the Primary Coverage Criteria and other provisions of this Plan.

FUNDING, ELIGIBILITY, EFFECTIVE DATE, AND TERMINATION PROVISIONS

FUNDING

The Plan is considered a self-insured plan, which means that all expenses incurred by the Plan are paid by contributions from the Employer and the Member. The Plan is responsible for the payment of all eligible claims and does not rely on protection from outside carriers to assume the risk. The Plan maintains a cash balance held in reserve to cover catastrophic claims if they are incurred. This claims reserve and other monies collected are held in trust and are used to administer the Plan.

Benefits are paid directly from the Plan through the Claims Administrator.

On an annual basis, claims information of the Plan, national inflationary factors, and other information is examined by an outside actuary/consulting team and rates are presented to the Board for review and approval. The rate that each Member pays is derived from the base monthly premium for the benefit option elected by the Member, less any Employer contributions and/or additional subsidies.

Rates are not published in this document but are available on the central website for the Plan (https://www.arbenefits.org).

ELIGIBILITY

All Active Employees and Retired Employees, who qualify under one of the classes below, are eligible for enrollment in the Plan.

Eligible Classes of State Employees. All State Employees who qualify under one of the classes below:

(1) Regular Full-Time Employees of a participating agency, institution, commission, or constitutional office who are: in a budgeted position or a position recognized by the General Assembly; and not seasonal or temporary; and working 1,000 or more hours each year.

(2) A member of the General Assembly.

(3) An elected Constitutional Officer.

(4) An Appointed or elected member of a Board or Commission on a full-time, salaried basis.

(5) An extra help employee who:

- **(a)** Was assured of coverage under the Plan by their agency;
- **(b)** Whose agency has agreed to pay the State match for their coverage;
- **(c)** Is a non-eligible state employee as defined under the law; and,
- **(d)** Is willing to be responsible for all costs for participating in the Plan (unless the agency has chosen to pay all or part of the cost).

Eligible Class of Public School Employees. All Public School Employees who qualify as a full-time Employee in a position that requires on average at least 30 hours per week of actual performance of duty during the annual school year.

As of **July 23, 2019**, Act 563 allows "full-time school bus drivers" to elect coverage through ARBenefits.

A bus driver employed by a public-school district to drive regular routes during the school year will be considered a "full-time school bus driver" if one of the following is true:

(1) The bus driver contracts with the school district to operate a school bus for a minimum of 720 hours during the school year; or

(2) The bus driver's primary source of income is obtained by operating a school bus within the school district; or,

(3) The bus driver is under contract with the public-school district to operate a school bus and is designated by the superintendent as a "full-time school bus driver". The superintendent's designation must be provided in writing by the superintendent to the Director of EBD.

Eligible Retired Employees. An Employee who terminates active employment and is enrolled for health coverage on their last day of employment may continue coverage as a Retiree if all of the following conditions are met.

(1) The Retired Employee is an active Member of one of the following retirement plans and drawing their retirement annuity:

(a) Arkansas Public Employees' Retirement System (APERS), including members of the legislative division and the contract personnel of the Arkansas National Guard; or,

(b) Arkansas Teacher Retirement System (ATRS); or,

(c) Arkansas State Highway Employees' Retirement System; or,

(d) Arkansas Judicial Retirement System; or,

(e) Alternative Retirement Plan.

(2) Elects to continue insurance coverage within 30 days of the qualifying event

(3) The Retiree makes the appropriate contribution required to continue the coverage from the date that employment ends or the date enrolled in the Plan.

The Plan Administrator may require documentation that the Retired Employee is drawing on the annuity.

Members of the General Assembly and state elected constitutional officers must have 10 years vested service in one of the listed retirement systems, and drawing an annuity, to be eligible to enroll in the retiree health insurance Plan.

For more information regarding eligibility rules and requirements for Retired Employees, see the section entitled "Coverage Continuation – Retirement."

Are your Dependents eligible for this insurance?

(**1**) If your dependent is your spouse, he or she may join the Plan as long as they are your current legal spouse. Former spouses with court orders requiring coverage are NOT ELIGIBLE to join the Plan. Spouses eligible for coverage through his or her employer are not eligible for coverage.

(**2**) If your dependent is a child, they may join the Plan as long as they can answer yes to the following questions:

(a) Is he or she your child, adopted child, stepchild, or do you have legal guardianship for him or her?

(b) Is he or she under age 26?

(c) Is he or she a Qualified Medical Child Support Order (QMCSO) dependent under age 26 and do you have a judgement, decree, or order issued under state law?

(d) Is he or she a qualified disabled dependent and have they been medically certified as Totally Disabled due to mental or physical incapacity?

Totally Disabled Dependent
Newly hired employees can add unmarried disabled dependents at or over age 26. Currently covered employees cannot add disabled dependents to their coverage if the dependent was not covered on the ARBenefits plan when the medical certification for the disability was determined.

Contact EBD to obtain an application for continuation of insurance due to incapacity. This document must be completed by the member and the dependent's physician.

Disabled dependents cannot leave the ARBenefits plan and be re-enrolled at a later date.

These persons are excluded as Dependents: Other individuals living in the covered Employee's home, but who are not eligible as defined; grandchildren (unless the Employee is their Legal Guardian); the legally separated or divorced former Spouse of the Employee (regardless of a court order requiring coverage); any person who is on active duty in any military service of any country; or any person who is covered under the Plan as an Employee.

Notice of Dual Enrollment. Employees and/or their Dependents cannot have dual coverage under ARBenefits. For example, a state Employee married to a school Employee cannot be covered as the primary insured Member on his contract and as a Dependent on his Spouse's contract.

Additionally, if two Employees are married, their eligible Dependent children will be covered as the Dependent of one parent or the other, but not of both.

IMPORTANT NOTE

Certain documents (or certified copies) such as marriage certificates, birth certificates, Medicare enrollment documentation, divorce decrees, etc. may be requested for enrollment in this Plan or as Employees make changes to their coverages. Failure to promptly provide requested information within the designated time periods may result in a loss of certain rights under the Plan.

At any time, the Plan may require proof that a Spouse or a Child qualifies or continues to qualify as a Dependent as defined by this Plan.

Only eligible Employees, Retirees, and Dependents can participate in the Plan. Falsification of eligibility is a serious offense and may permanently disqualify an individual from participation in the Plan. Financial penalties may be imposed as well.

ENROLLMENT

Enrollment Requirements. An Employee must enroll for coverage by completing an election form and submitting it to their Health Insurance Representative or the Plan Administrator. The covered Employee is required to complete an election form to enroll each individual Dependent for coverage, also.

Enrollment Requirements for Newborn Children and Adopted Children. A newborn child of a covered Employee who has Dependent coverage is not automatically enrolled in this Plan. If the Member fails to submit an election form within 60 days of birth, the newborn child will not be eligible to enroll until the next open enrollment period or the Dependent experiences another qualifying event. There will be no payment from the Plan and the parents will be responsible for all costs. For an adopted child, the Member must submit an election form within 60 days of the adoption being finalized.

INITIAL ENROLLMENT

The enrollment will be considered initial if the election form is submitted to EBD no later than 60 days after the employee's initial eligibility for the plan, i.e. new hire. Coverage will become effective on the first day of the month following the date of hire and the date on the election form submitted to EBD.

OPEN ENROLLMENT

Every fall, during the annual open enrollment period, eligible Employees, and their eligible Dependents will be able to enroll in the Plan.

Benefit choices made during the open enrollment period will become effective January 1 and remain in effect until the next January 1 unless there is a Qualifying Event or a change in family status during the year (birth, death, marriage, divorce, adoption) or loss of coverage due to loss of a Spouse's employment.

Non-Medicare Retiree Members can make changes to their choice of Plan level only (Premium, Classic, or Basic).

Plan Participants will receive detailed information regarding open enrollment from their Employer.

QUALIFYING EVENT RIGHTS

Federal law provides Qualifying Event provisions under some circumstances. If an Employee is declining enrollment for himself or herself or his or her Dependents (including his or her Spouse) because of other health insurance or group health plan coverage, there may be a right to enroll in this Plan if there is a loss of eligibility for that other coverage (or if the employer stops contributing towards the other coverage). However, a request for enrollment must be made within 60 days after the coverage ends (or after the employer stops contributing towards the other coverage).

In addition, in the case of a birth, marriage, adoption, or placement for adoption, there may be a right to enroll in this Plan. An Active Employee has a period of 60 days from the date of the Qualifying Event to enroll his-or herself or his or her Dependents into the Plan. Retirees and COBRA participants have a period of 30 days from the Qualifying Event to enroll.

The Qualifying Event rules are described in more detail below. To request enrollment or obtain more detailed information of these portability provisions, contact the Employee Benefits Division.

QUALIFYING EVENTS

The events described below may create a right to enroll in the Plan under a Qualifying Event.

(1) **Losing other coverage may create a Qualifying Event.** An Employee or Dependent who is eligible, but not enrolled in this Plan, may enroll if the individual loses eligibility for other coverage and loss of eligibility for coverage meets all of the following conditions:

(a) The Employee or Dependent was covered under a group health plan or had health insurance coverage at the time coverage under this Plan was previously offered to the individual.

(b) The Employee stated in writing at the time that coverage was offered that the other health coverage was the reason for declining enrollment.

(c) Either (i) the other coverage was COBRA coverage and the COBRA coverage was exhausted, or (ii) the other coverage was not COBRA coverage, and the coverage was terminated as a result of loss of eligibility for the coverage or because employer contributions towards the coverage were terminated. Coverage will begin no later than the first day of the first calendar month following the date the completed enrollment form is received.

(d) The Employee or Dependent requests enrollment in this Plan not later than 60 days after the date of exhaustion of COBRA coverage or the termination of non-COBRA coverage due to loss of eligibility or termination of employer contributions, described above. Coverage will begin no later than the first day of the first calendar month following the date the completed enrollment form is received.

(2) **For purposes of these rules, a loss of eligibility occurs if one of the following occurs:**

(a) The Employee or Dependent has a loss of eligibility due to the plan no longer offering any benefits to a class of similarly situated individuals (for example: part-time Employees).

(b) The Employee or Dependent has a loss of eligibility as a result of legal separation, divorce, cessation of Dependent status (such as attaining the maximum age to be eligible as a Dependent child under the plan), death, termination of employment, or reduction in the number of hours of employment or contributions towards the coverage were terminated.

(c) The Employee or Dependent has a loss of eligibility when coverage is offered through an HMO, or other arrangement, in the individual market that does not provide benefits to individuals who no longer reside, live, or work in a service area, (whether or not within the choice of the individual).

(d) The Employee or Dependent has a loss of eligibility when coverage is offered through an HMO, or other arrangement, in the group market that does not provide benefits to individuals who no longer reside, live, or work in a service area, (whether or not within the choice of the individual), and no other benefit package is available to the individual.

NOTE: Medicare Part D Prescription Drug Coverage does not constitute group health coverage as described above when Medicare Part A and/or Part B are already in effect.

If the Employee or Dependent lost the other coverage as a result of the individual's failure to pay premiums or required contributions or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan), that individual has not met the criteria for a Qualifying Event.

(3) Acquiring a newly eligible Dependent may create a Qualifying Event. If:

(a) The Employee is a participant under this Plan (or is eligible to be enrolled under this Plan but for a failure to enroll during a previous enrollment period);

(b) A person becomes a Dependent of the Employee through marriage, birth, adoption, or placement for adoption; and,

then the Dependent may be enrolled under this Plan. If the Employee is not enrolled at the time of the event, the Employee must enroll under a Qualifying Event in order for his eligible Dependents to enroll. Any additional family members who are not enrolled at the time of the event must wait until the annual Open Enrollment period to join the Plan.

A Qualifying Event for newly eligible Dependents begins after the date of the marriage, birth, adoption, or placement for adoption. To be eligible for a Qualifying Event, the Dependent and/or Employee must request enrollment within 60 days of the event (or within 30 days of the event for Retiree and COBRA participants).

The coverage of the Dependent and/or Employee enrolled in a Qualifying Event will be effective on the first of the month following the date of application. However, in the case of birth, coverage for a Member’s newborn child shall become effective as of the first of the month the child is born, if the Member submits an election form to EBD within the appropriate timeframe. In the case of an adoption or placement for adoption, coverage will be effective as of the first of the following month, after the adoption is final. If the Member fails to submit the election form within the 60-day time period, the Member’s newborn or adopted child will not be eligible to enroll until the next open enrollment period or the Dependent experiences another qualifying event.

Changes to the Member's coverage and/or the coverage of any Dependent are based on a qualifying event as defined under HIPAA (Health Insurance Portability and Accountability Act) and is Dependent upon the participation or lack of participation in the Employer's Cafeteria Plan.

(4) Eligibility changes in Medicaid or State Child Health Insurance Programs may create a Qualifying Event right.

An Employee or Dependent who is eligible, but not enrolled in this Plan, may enroll if:

(a) The Employee or Dependent is covered under a Medicaid plan under Title XIX of the Social Security Act or a State child health plan (CHIP) under Title XXI of such Act, and coverage of the Employee or Dependent is terminated due to loss of eligibility for such coverage, and the Employee or Dependent requests enrollment in this Plan within 60 days after such Medicaid or CHIP coverage is terminated.

(b) The Employee or Dependent becomes eligible for assistance with payment of Employee contributions to this Plan through a Medicaid or CHIP plan (including any waiver or demonstration project conducted with respect to such plan), and the Employee or Dependent requests enrollment in this Plan within 60 days after the date the Employee or Dependent is determined to be eligible for such assistance.

If a Dependent becomes eligible to enroll under this provision and the Employee is not then enrolled, the Employee must enroll in order for the Dependent to enroll.

Coverage will become effective as of the first day of the first calendar month following the date the completed enrollment form is received unless an earlier date is established by the Employer or by regulation.

IMPORTANT NOTE

ASE (State) Only: No changes in coverage are allowed at the time of transfer from one state agency to another. Steps should be taken to eliminate a lapse of coverage due to a simple transfer.

PSE (School) Only: No transfers are permitted on the PSE side unless approved through summertime portability process.

ASE& PSE Retirees: Retirees have 30 days to submit changes to EBD for qualified changes in coverage.

SUPPORTING DOCUMENTATION

Supporting documentation is required when the Member elects changes to their coverage elections due to a qualifying event. Following is a table of required documentation that must be submitted to EBD for elected changes to be reviewed for approval. Employees have 60 days to elect qualifying event changes, Retirees have 30 days.

To add/drop coverage as a qualifying event, the Member must provide documented proof that there has been a gain or loss of other group coverage. Proof must include the date that coverage started or ended, and list those affected. Examples of proof can be a Certificate of Credible Coverage from the other

health care issuer, a signed letter from an employer that states when coverage started or ended, military discharge paper work, letters from government entities such as Medicaid, etc.

NOTE: Any information received by the Plan from Federal sources will be considered documentary evidence for enrollment changes.

Qualifying Event Action	Required Documentation
Adding a Spouse: **Due to Marriage**	• ARBenefits Change Form • Marriage license • ARBenefits Spousal Affidavit
Due to Loss of Other Group Coverage	• Same as above as well as proof of loss of other group coverage. Proof must contain the dates of coverage, and the affected parties.
Adding a Newborn	• ARBenefits Change Form • Copy of birth certificate o If birth certificate is unavailable, a hospital announcement is acceptable if the newborn is under six months of age.
Adding a Dependent Child	• ARBenefits Change Form • Copy of birth certificate or a receipt from appropriate state Vital Records department • Marriage license if adding a stepchild • Adoption/Legal Guardianship paperwork signed by judge, if applicable If adding Dependent due to loss of other group coverage: • Same as above as well as proof of loss of group coverage. Proof must contain the dates of coverage, and the affected parties.
Removing Dependent/Spouse	• ARBenefits Change Form • Proof of gain of group coverage. Proof must contain the dates of coverage, and the affected parties.
Removing Spouse Due to Spouse Gaining Employer Group Coverage	• Updated ARBenefits Spousal Affidavit • ARBenefits Change Form
Gain of Other Group Coverage	• ARBenefits Change Form • Proof of gain of group coverage. Proof must contain the dates of coverage, and the affected parties.
Employee Loss of Other Group Coverage	• ARBenefits Enrollment Form • Proof of loss of group coverage. Proof must contain the dates of coverage, and the affected parties.
Divorce: Removing a Spouse	• ARBenefits Change Form • Judge-signed divorce decree

EFFECTIVE DATE

Active Employee Requirement. An Employee must be an Active Employee (as defined by this Plan) for this coverage to take effect.

Effective Date of Dependent Coverage. A Dependent's coverage will take effect on the day that the Eligibility Requirements are met; the Employee is covered under the Plan; and all Enrollment Requirements are met.

TRANSFERS BETWEEN STATE AGENCIES OR SCHOOL DISTRICTS

Employees/members who transfer between state agencies/school districts with no break in coverage will keep the same plan and all accumulated out of pocket costs will transfer with the member. No plan changes can be made.

Employees/members who transfer between state agencies/school districts that experience a break in coverage may choose a new plan (due to the qualifying event (loss of coverage/new hire)). Accumulated out of pocket costs will not transfer.

SUMMER PORTABILITY POLICY FOR PUBLIC SCHOOL EMPLOYEES

School districts have the option to participate in a portability policy during the summer. The policy allows Employees who are moving between school districts during the summer to continue their health insurance coverage without the need to enroll in COBRA.

Not every school district participates in the policy. For an Employee to be considered a transfer, both the former and the new district must participate. If one or neither district participates, the Employee will be treated like a brand new hire with their new district. This means the Employee may need to establish COBRA for the summer months to keep their coverage active prior to starting with the new district.

Employees have the option to move as a transfer, or as a new hire, even when moving between participating districts. Employees must contact their district HIR for more information.

How the Portability Policy Works

(1) For Employees Moving as a Transfer Between Two Districts That Participate:

(a) Former district covers the Employee until 8/31, and the new district will begin covering the Employee 9/1.

(b) The Employee must notify their outgoing district that they want to be considered a transfer by the deadline that district establishes. The Employee can work with their district concerning how to submit their premiums during the summer.

(c) Transfer Employees should not submit an Enrollment Form to EBD. Your new district will provide a separate form to EBD letting us know you have moved to their district as a transfer.

(d) Transfer Employees are not allowed to make changes to their health plan. Their current coverages will continue with their new district. However, employees who are not already enrolled in health plan who transfer will be allowed to enroll in a new health plan with their new district.

(2) For Employees Moving Between Districts Where at Least One Does Not Participate:

(a) Your outgoing district will term your coverage according to your contract. You can contact your school district Health Insurance Representative to get the date your coverage will end.

(b) You will be eligible for coverage with your new district the first of the month following your date of hire. To bridge any gap in coverage, you can elect to take COBRA coverage.

(c) The Employee must fill out an ARBenefits Enrollment Form with their new district to enroll in health coverage. Coverage is effective the first of the month following the date on the election form. New hire Employees are allowed to make changes to their plan. Deductibles will reset if you elect changes, or if there is a gap in coverage.

TERMINATION OF COVERAGE

The Employer or Plan has the right to rescind any coverage of the Employee and/or Dependents for cause, making a fraudulent claim or an intentional material misrepresentation in applying for or obtaining coverage, or obtaining benefits under the Plan. The Employer or Plan may either void coverage for the Employee and/or covered Dependents for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage. If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the Plan will provide at least 30 days' advance written notice of such action. The Employer will refund all contributions paid for any coverage rescinded; however, claims paid will be offset from this amount. The Employer reserves the right to collect additional monies if claims are paid in excess of the Employee's and/or Dependent's paid contributions.

When Employee Coverage Terminates. Employee coverage will terminate on the earliest of these dates (except in certain circumstances, a covered Employee may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, see the section entitled Continuation Coverage Rights under COBRA):

(1) The date the Plan is terminated.

(2) The date the covered Employee's Eligible Class is eliminated.

(3) The last day of the calendar month in which the covered Employee ceases to be in one of the Eligible Classes. This includes death or termination of Active Employment of the covered Employee. (See the section entitled Continuation Coverage Rights under COBRA.)

(4) The last day of the calendar month preceding the covered Employee’s enrollment in Medicare.

(5) The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due. This includes non-payment of premiums while in a Leave Without Pay (LWOP) status or late COBRA payments. If coverage under LWOP is terminated due to non-payment of premiums, no COBRA coverage will be offered.

(6) Failure to submit a LWOP Election form to continue coverage while on LWOP may result in coverage being terminated. Should this occur, the Employee will be eligible for re-enrollment in the Plan. For non-military LWOP, the Employee must enroll within 30 days following return to active employment and payment in full of any outstanding debt. The Employee will be reinstated in the Plan effective the first day of the month following the application date. For reinstatement of

Military LWOP, the Employee will be eligible to re-enroll within 120 days following return to active employment. The Employee must complete the application within that 120-day period and the new coverage will be effective the first day of the month following the application date. The Employee will still be responsible for any outstanding premium debt.

(7) If an Employee commits fraud, makes an intentional misrepresentation of material fact in applying for or obtaining coverage, or obtaining benefits under the Plan, or fails to notify their Health Insurance Representative or the Plan Administrator that he or she has become ineligible for coverage, then the Employer or Plan may either void coverage for the Employee and covered Dependents for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage. If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the Plan will provide at least 30 days' advance written notice of such action.

Continuation During Periods of Leave Without Pay, Family Medical Leave, or Worker Compensation. A person may remain eligible for a limited time if Active, full-time work ceases due to LWOP, Family Medical Leave, or Worker Compensation.

(1) **School Employees.** School districts administer leave without pay policies for their Employees. Employees should contact their school district for information regarding their options and instructions.

(2) **State (NON-AASIS) Employees.** Non-AASIS agencies administer leave without pay policies for their Employees. Employees should contact their HR department for information regarding their options and instructions.

(3) **State (AASIS) Employees.** Once entering leave without pay status, EBD will send the Employee a LWOP packet. The LWOP packet will provide the Employee with all the essential information needed to maintain coverage. Inside the packet, there will be a Leave Without Pay Notification, LWOP Election Form, and a Table of Important Dates Schedule for LWOP. To continue coverage, the Employee must sign and return the LWOP Election Form by the election due date to continue coverage while on Leave Without Pay. Employees are required to remit premium payments directly to EBD according to the Table of Important Dates schedule for LWOP.

If the Employee chooses to discontinue coverage, they will be eligible to re-enroll within 30 days following return to active employment. The application must be completed within that 30-day period and the new coverage will be effective the first day of the month following the application date. Employees should be aware that if there is a break in coverage and then they re-enroll, they will have to start over to meet any Deductible and out of pocket maximum.

Rehiring a Terminated Employee. A terminated Employee who is rehired will be treated as a new hire and be required to satisfy all Eligibility and Enrollment requirements to the extent permitted by the terms of the Plan and applicable law.

Employees on Military Leave. Employees going into or returning from military service may elect to continue Plan coverage as mandated by the Uniformed Services Employment and Reemployment Rights Act (USERRA) under the following circumstances. These rights apply only to Employees and their Dependents covered under the Plan immediately before leaving for military service. Only the Employee has election rights. Dependents do not have any independent right to elect USERRA health plan continuation.

Employees may choose to continue or discontinue their coverage. Whichever option chosen, the Employee must submit a copy of their military/deployment orders to their Health Insurance Representative:

(1) Choosing to continue coverage.

(a) School Employees. Once entering leave without pay status, the District should provide the Employee with all the essential information needed to maintain coverage. Premium payments should be remitted according to payroll dates provided by the district, in accordance with the District's pay cycle. The District will collect premiums and include it with their monthly billing. EBD will not accept Member checks or money orders.

(b) State (NON-AASIS) Employees. Once entering leave without pay status, the agency should provide the Employee with all the essential information needed to maintain coverage. Premium payments should be remitted according to payroll dates provided by the agency, in accordance with the agency's pay cycle. The agency will collect premiums and include it with their monthly billing. EBD will not accept Member checks or money orders.

(c) State (AASIS) Employees. Once entering leave without pay status, EBD will send the Employee a LWOP packet. The LWOP packet will provide the Employee with all the essential information needed to maintain coverage. Inside the packet, there will be a Leave Without Pay Notification, LWOP Election Form, and a Table of Important Dates Schedule for LWOP. The Employee must sign and return the LWOP Election Form by the election due date to continue coverage while on Leave Without Pay. Employees are required to remit premium payments directly to EBD according to the Table of Important Dates schedule for LWOP.

(2) Choosing to discontinue coverage. If the Employee chooses this option, they must fill out a change form to cancel coverage. The Employee will be eligible to re-enroll within 120 days following return to active employment. The application must be completed within that 120-day period and the new coverage will be effective the first day of the month following the application date. Employees should be aware that if there is a break in coverage, and then they re-enroll, they will have to start over to meet any Deductible and out of pocket maximum.

When Dependent Coverage Terminates. A Dependent's coverage will terminate on the earliest of these dates (except in certain circumstances, a covered Dependent may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, see the section entitled Continuation Coverage Rights under COBRA):

(1) The date the Plan or Dependent coverage under the Plan is terminated.

(2) The date that the Employee's coverage under the Plan terminates for any reason including death.

(3) The date a covered Spouse loses coverage due to loss of eligibility status.

(4) Coverage will end on the last day of the month in which the Child ceases to meet the applicable eligibility requirements.

(5) The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due.

(6) If a Dependent commits fraud or makes an intentional misrepresentation of material fact in applying for or obtaining coverage, or obtaining benefits under the Plan, or fails to notify their Health Insurance Representative or the Plan Administrator that he or she has become ineligible for coverage, then the Employer or Plan may either void coverage for the Dependent for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the

Plan's discretion, or may immediately terminate coverage. If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the Plan will provide at least 30 days' advance written notice of such action.

Surviving Dependent coverage, following Employee's death while an Active Employee.
Health coverage is available for Spouses and Dependent child(ren) covered on the Plan at the date of the Employee's death per the following guidelines:

(1) Spouse with and without Dependents

(a) If the Spouse is eligible to receive a survivor retirement annuity, the Spouse and covered Dependents, are eligible to continue on the health Plan. If the survivor annuity benefit is available upon death of the Member (first of the month following death), the surviving Spouse has 30 days from the end of the month in which the active coverage ended to enroll in the retirement health plan.

(b) If the survivor retirement annuity is not immediately available to the Spouse, but available at a later date, either the month following the date the Employee would have been eligible to receive benefits had the Employee survived or the date that an application for a surviving Spouse's benefit is filed with the appropriate retirement system, the Spouse has 30 days from the time he or she becomes eligible to draw the survivor annuity to enroll in the retirement health plan.

(c) If the Spouse is not eligible to receive a survivor annuity, the Spouse and/or Dependents have the option to enroll on the COBRA health plan for a period of 36 months. A COBRA packet will automatically be sent to the surviving Spouse with a 60-day enrollment period.

(2) Dependents without Spouse on the Plan

(a) If a Dependent child is eligible to draw a survivor retirement annuity, and the check is paid directly to the child, the child is eligible to enroll in the retirement health insurance until the retirement annuity ends, which will be until his or her death or his or her marriage or his or her attainment of age 18.

(b) Coverage will be extended past age 18 as long as the child continues uninterrupted as a full-time student at an accredited secondary school or college or university, but in no event beyond his or her attainment of age 23. The Dependent child has 30 days to enroll in the retirement health plan once the annuity becomes available.

(c) If a Dependent child was covered on the Active Employee's health plan, without spousal coverage, and there is no survivor annuity paid to the Dependent, the Dependent child has the option to enroll on the COBRA health plan for a period of 36 months. A COBRA packet will automatically be sent to surviving Dependents. There is a 60-day enrollment period for the COBRA health plan.

(d) If there are multiple Dependents (other than the Spouse) on the Employee's health plan at the time of death, and COBRA is the only option available, each Dependent must enroll under their own health plan.

NOTE: If the Spouse and/or Dependents do not enroll in the retirement health plan or COBRA within their respective enrollment periods, all privileges under the plan are terminated.

DESCRIPTION OF BENEFIT PLAN OPTIONS

The Plan offers multiple options for active members and Retirees - the ARBenefits Premium, Classic and Basic Plans, and the ARBenefits Retiree Plan. The options are different in how medical services are covered and how much the Member will pay for monthly premiums. Members should review each plan carefully to find the best fit for them and their family.

ARBenefits Premium. The Premium Plan is a POS (Point of Service) plan and is considered the "richest" of the plan options, as it contains the maximum amount of benefits with copays and coinsurance. It also has the highest monthly premium cost to the member. This plan has a deductible ($500 individual /$1,000 family deductible for ASE, and $750 individual/$1,500 family for PSE) that must be met before the plan begins to pay for some services. The plan consists of a $3,000 individual and $6,000 family medical In-Network out-of-pocket maximum for ASE, and $3,250 individual/$6,500 family medical In-Network out-of-pocket maximum for PSE. There is not an out-of-pocket maximum for Out-of-Network services for ASE or PSE. The copays are $25 for a primary physician and $50 for a specialist. The emergency room copay is $250. The Premium plan includes a prescription drug plan, which offers $15, $40, $80 and $100 copays depending on tier. The prescription drug plan also includes a $3,100 individual/ $6,200 family pharmacy out-of-pocket maximum.

ARBenefits Classic. The Classic Plan is a High-Deductible PPO Plan. This plan has a deductible ($2,500 individual/$5,000 family for ASE, and $1,750 individual/$2,850 family for PSE). The family deductible for both ASE and PSE includes an embedded individual deductible of $2,800. When an individual on a Classic family plan meets the $2,800 amount, the plan will begin applying coinsurance for that member. The plan consists of a $6,450 individual/ $12,900 family medical out-of-pocket maximum for ASE, and $6,450 individual/ $9,675 family medical out-of-pocket maximum for PSE. Eligible active employees are advised to have a Health Savings Account (HSA) with this plan. There are no copays with the Classic Plan (with the exception of hearing and vision services). Prescriptions, medical services, and any copays apply to the deductible limit, and can be paid with HSA funds.

ARBenefits Basic – ASE. The Basic Plan is a High-Deductible PPO Plan. It features the lowest monthly premium of any plan. The plan has a deductible ($6,450 individual/$12,900 family) for ASE. There is no coinsurance for the Basic Plan on the ASE plan. Once the deductible is met, the plan pays at 100% for allowable services. Eligible active employees are advised to have a Health Savings Account (HSA) with this plan. There are no copays (with the exception of hearing and vision services) with the Basic Plan. Prescriptions, medical services, and any copays apply to the deductible limit, and can be paid with HSA funds.

ARBenefits Basic – PSE. The Basic Plan is a High-Deductible PPO Plan. It features the lowest monthly premium of any plan. The plan has a deductible ($4,000 individual/$8,000 family). The PSE Basic Plan does have coinsurance. Once the deductible is met, the plan pays at 80% for allowable services. The plan consists of a $6,450 individual / $12,900 family medical out-of-pocket maximum. Eligible active employees are recommended to have a Health Savings Account (HSA) with this plan. There are no copays (with the exception of hearing and vision services) with the Basic Plan. Prescriptions, medical services, and any copays apply to the deductible limit, and can be paid with HSA funds.

ARBenefits Retiree. A Retiree that is not eligible for Medicare may choose from the ARBenefits Premium, Classic or Basic Plan until the Retiree or Spouse reaches the age of 65, or becomes eligible for Medicare. There is only one plan option for Medicare-eligible members: the ARBenefits ASE/PSE Premium Plan (Medicare Primary Plan). Once the member becomes eligible for Medicare coverage, the member and Dependents will automatically be moved to the ARBenefits ASE/PSE Premium Plan (Medicare Primary Plan) if they are currently enrolled in the Classic or Basic Plan. Medicare primary members will not have to use the Health Advantage network of Providers. However, anyone on the Medicare Primary plan who is not eligible for Medicare, will be required to use the Health Advantage network to receive In-Network benefits.

Members have the option to terminate coverage on their Spouses when he or she becomes Medicare eligible to avoid being moved to the Medicare Primary Plan and remain on the Classic or Basic Plan. Members must submit an Election Form to EBD, requesting termination of the Spouse 60 days prior to the eligibility date of Medicare for the Spouse so that the plan change will not automatically occur. Members who wait until after the plan change has been made cannot change back to the original plan until Open Enrollment for the next January effective date.

Medicare-Primary Retirees and/or Dependents will have the Medicare Primary Plan for insurance coverage through Health Advantage, with the flexibility to visit any physician or hospital as long as they accept Medicare assignment. The Medicare Primary Plan will coordinate your benefit coverage with Medicare Parts A & B and the Plan will pay secondary to Medicare. Coverage for all other non-Medicare members on the policy will be on the Health Advantage network at the Premium level.

The Public-School Medicare-Primary Retirees do not have prescription drug coverage and are encouraged to consider Medicare Part D for additional coverage.

NOTE: The ARBenefits Medicare Premium Plan for Retirees will coordinate as if Medicare Part A and Part B are both in force at the time of service. If the member does not have Part B, the Plan will pay as though the member does have Medicare Part B and the member will have full financial responsibility for incurred claims.

SCHEDULE OF BENEFITS
ARBenefits ASE/PSE Premium Plan

This Schedule of Benefits applies to all Active Employees and Retired Employees under the age of 65 and their covered Dependents.

All benefits described in this Schedule are subject to the Primary Coverage Criteria, the Allowable Charge, and the benefit limits and exclusions described more fully herein.

This Plan has entered into an agreement with certain Hospitals, Physicians, and other health care Providers, which are called In-Network Providers. Because these In-Network Providers have agreed to charge reduced fees to persons covered under the Plan, the Plan can afford to reimburse a higher percentage of their fees.

Therefore, when a Covered Person uses an In-Network Provider, that Covered Person will receive a higher payment from the Plan than when an Out-of-Network Provider is used. It is the Covered Person's choice as to which Provider to use.

A listing of In-Network Providers is available on the Claims Administrator's website at www.healthadvantage-hmo.com.

MEDICAL BENEFITS

Calendar Year Deductibles	**In-Network Deductible**		**Out-of-Network Deductible**	
	Per Person	**Per Family Unit**	**Per Person**	**Per Family Unit**
Arkansas State Employees	$500	$1,000	$2,000	$4,000
Public School Employees	$750	$1,500	$2,000	$4,000

Deductible Accumulation. The In-Network and Out-of-Network Deductibles are totally separate and do not contribute toward or offset each other.

This Plan has an embedded individual deductible, meaning that an individual enrolled in family coverage will never have to pay more than the individual deductible amount before the Plan begins to pay coinsurance for the individual.

Annual Out-Of-Pocket Limits	**In-Network Out-of-Pocket Limit**		**Out-of-Network Out-of-Pocket Limit**	
	Per Person	**Per Family Unit**	**Per Person**	**Per Family Unit**
Arkansas State Employees	$3,000	$6,000	Unlimited	Unlimited
Public School Employees	$3,250	$6,500	Unlimited	Unlimited

Out-of-Pocket Accumulation.
The In-Network and Out-of-Network Out-of-Pocket amounts are totally separate and do not contribute toward or offset each other.

This Plan has an embedded individual out-of-pocket limit, meaning that an individual enrolled in family coverage will never have to pay more than the individual out-of-pocket limit before the Plan begins to pay Covered Charges at 100% for the individual.

MEDICAL BENEFITS, continued		
Coinsurance Payable By Plan	**In-Network Coinsurance**	**Out-of-Network Coinsurance**
The charges for the following do not apply to the annual Out-of-Pocket Limit: • Out-of-Network services • Penalties for failure to obtain prior approval • Amounts in excess of the Allowable Charge • Non-Covered Services		
Unless stated otherwise in this document, the Plan will pay the coinsurance percentage shown until the annual Out-of-Pocket Limit is satisfied, at which time the Plan will pay 100% of the remainder of In-Network Covered Charges for the rest of the Calendar Year.	80%	60%

HOSPITAL BENEFITS		
Charges billed by a facility	**In-Network**	**Out-of-Network**
Inpatient Services	80%, after Deductible	60%, after Deductible
• **Prior Approval.** Prior Approval is required for all inpatient admissions as well as specific outpatient medical services and procedures and some Durable Medical Equipment. See the Cost Management Section for a detailed list of services which require prior approval. • **Room and Board Allowances.** Covered Charges for room and board during an inpatient admission shall be limited to the lesser of the billed charge or the Allowable Charge established by the Plan.		
Outpatient Services	80%, after Deductible	60%, after Deductible
Emergency Room Services		
Medical Emergency • Premium Plan members can have the Copayment for an emergency room admission waived if the patient is referred to the ER by the Nurse Hotline.	$250 Copay 100%, Deductible waived	$250 Copay 100%, Deductible waived
non-Medical Emergency	80%, after Deductible	60%, after Deductible

PHYSICIAN BENEFITS		
Charges billed by a Physician	**In-Network**	**Out-of-Network**
Office visit	$25 PCP Copay or $50 Specialist Copay (per office visit charge)	60%, after Deductible
Additional services in an office setting	80%, after Deductible	
Inpatient Services	80%, after Deductible	60%, after Deductible
Outpatient Services	80%, after Deductible	60%, after Deductible
Emergency Room Services		
Medical Emergency	100%, Deductible waived	100%, Deductible waived
non-Medical Emergency	80%, after Deductible	60%, after Deductible

PHYSICIAN BENEFITS, continued		
Charges billed by a Physician	**In-Network**	**Out-of-Network**
Urgent Care Services	$100 copay (per encounter) 100%, Deductible waived	$100 copay (per encounter) 100%, Deductible waived

SPECIFIC BENEFIT LIMITS AND MAXIMUMS		
Covered service	**In-Network**	**Out-of-Network**
Advanced Diagnostic Imaging – *Prior Approval is required.*	80%, after Deductible	60%, after Deductible
Allergy services Injections Serum Testing	 100%, deductible waived 80%, after deductible 80%, after deductible	 60%, after Deductible 60%, after Deductible 60%, after Deductible
Ambulance services Air ambulance Ground ambulance • *Limited to $2,000 per trip.* Water ambulance	 90%, Deductible waived $50 copay per trip 100%, Deductible waived not covered	 90%, Deductible waived $50 copay per trip 100%, Deductible waived not covered
Autism treatment, including Applied Behavioral Analysis (ABA) Therapy • *Limited to $50,000 per Calendar Year.*	80%, after Deductible	60%, after Deductible
Diabetes Management Program *Coverage includes Accu-Chek Guide Me meter, and Accu-Chek Guide test strips. Pen needles and syringes are provided by TRUEplus. Other brands not covered.*	100%, Deductible waived	Not covered
Eyeglasses or contact lenses following cataract surgery • *Limited to initial pair of glasses or contact lenses.*	80%, after Deductible	60%, after Deductible
Hearing Exams Routine screening, *limited to one screening every 3 years.* • Primary Care Physician • Specialist	 $25 copay, deductible waived $50 copay, deductible waived	 $25 copay, deductible waived $50 copay, deductible waived
Hearing aids • *Limited to $1,400 per ear every three years.*	100%, Deductible waived	100%, Deductible waived
Medications provided in a facility or office *Includes injectable, oral & intravenous medications. Some require Prior Approval.*	80%, after Deductible	60%, after Deductible

SPECIFIC BENEFIT LIMITS AND MAXIMUMS, continued		
Covered service	**In-Network**	**Out-of-Network**
Mental Illness and Substance Use Disorder Treatment		
Psychotherapy or ABA Therapy in an office or outpatient setting	$25 copay per visit 100%, Deductible waived	60%, after Deductible
Psychological Testing in an office or outpatient setting	$35 copay per visit 100%, Deductible waived	60%, after Deductible
Partial Hospitalization, Day Treatment or Intensive Outpatient Therapy – ***Prior Approval is required.***	80%, after Deductible	60%, after Deductible
Prosthetic and Orthotic Devices		
Prosthetic Device • *Limited to one device per lifetime.*	80%, after Deductible	60%, after Deductible
Orthotic Devices used for correction or prevention of skeletal deformities • *Limited to two devices per lifetime.*	80%, after Deductible	60%, after Deductible
Bras following mastectomy • *Limited to six bras per Calendar Year.*	80%, after Deductible	60%, after Deductible
Routine Obstetrical Ultrasound • *Limited to one ultrasound per Pregnancy.*	80%, after Deductible	60%, after Deductible
Standard Preventive Care	100%, Deductible waived	not covered
TMJ Disorder Treatment • *Limited to $1,000 per Calendar Year.*	80%, after Deductible	60%, after Deductible
Therapy Benefits		
Occupational, Physical and Speech Therapies in an office or outpatient setting • *Prior Approval is required for outpatient therapy.*	$25 Copay 100%, Deductible waived	60%, after Deductible
Chiropractic services in an office or outpatient setting • *Limited to 15 visits per Calendar Year.*	$25 Copay 100%, Deductible waived	60%, after Deductible
Transplant Services – *Prior Approval is required.*		
Transplant surgery • *Limited to two transplants of the same organ per lifetime.*	$250 Copay 80%, Deductible waived	60%, after Deductible
Travel and lodging • *Limited to $10,000 per lifetime.*	100%, Deductible waived	60%, after deductible

SPECIFIC BENEFIT LIMITS AND MAXIMUMS, continued		
Covered service	**In-Network**	**Out-of-Network**
Vision Exams Routine screening • Limited to one screening every two years	$50 copay, deductible waived	$50 copay, deductible waived

PHARMACY BENEFITS	
Prescription Tiers	**Copay**
Tier I – Generic	$15
Tier II – Preferred	$40
Tier III – Non-Preferred	$80
Tier IV – Specialty	$100
RX Out-of-Pocket Max *Excluded drugs, reference price drugs, and brand drugs where generic is available does not apply towards the RX Out-of-Pocket Max.*	
Individual	$3,100
Family	$6,200

SPECIAL IN-NETWORK PROVISIONS
• Certain types of suppliers and specialists are not offered provider participation contracts and will be reimbursed at the In-Network level of benefits if a network exception from the Claims Administrator is provided in advance of services. • If services are not available from an In-Network provider, Covered Charges will be reimbursed at the In-Network level of benefits if a network exception from the Claims Administrator is provided in advance of services. • If services from an In-Network Provider are not accessible, Covered Charges will be reimbursed at the In-Network level of benefits if a network exception from the Claims Administrator is provided in advance of services. • Covered Charges for Medical Emergency and accident services will be reimbursed at the In-Network level of benefits. • Covered Charges for inpatient or outpatient services rendered by an Out-of-Network anesthesiologist, pathologist or radiologist in connection with an In-Network facility will be paid at the In-Network level of benefits.

SCHEDULE OF BENEFITS
ARBenefits ASE/PSE Classic Plan

This Schedule of Benefits applies to all Active Employees and Retired Employees under the age of 65 and their covered Dependents.

All benefits described in this Schedule are subject to the Primary Coverage Criteria, the Allowable Charge, and the benefit limits and exclusions described more fully herein.

High Deductible Health Plan
A qualified High Deductible Health Plan (HDHP) with a Health Savings Account provides comprehensive coverage for high cost medical events and a tax-advantaged way to help build savings for future medical expenses. The Plan gives a Covered Person greater control over how health care benefits are used. A HDHP satisfies certain statutory requirements with respect to minimum Deductibles and out-of-pocket expenses for both single and family coverages. These minimum Deductibles and limits for out-of-pocket expenses' limit are set forth by the U.S. Department of Treasury and will be indexed for inflation in the future.

This Plan has entered into an agreement with certain Hospitals, Physicians, and other health care Providers, which are called In-Network Providers. Because these In-Network Providers have agreed to charge reduced fees to persons covered under the Plan, the Plan can afford to reimburse a higher percentage of their fees.

Therefore, when a Covered Person uses an In-Network Provider, that Covered Person will receive a higher payment from the Plan than when an Out-of-Network Provider is used. It is the Covered Person's choice as to which Provider to use.

A listing of In-Network Providers is available on the Claims Administrator's website at www.healthadvantage-hmo.com.

MEDICAL BENEFITS

Calendar Year Deductibles	**Individual Plan Deductibles**		**Family Plan Deductibles**	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
Arkansas State Employees	$2,500 per individual	$4,000 per individual	$2,800 per individual $5,000 per family	$8,000 per family
Public School Employees	$1,750 per individual	$3,000 per individual	$2,800 per individual $2,850 per family	$6,000 per family

Deductible Accumulation. The In-Network and Out-of-Network Deductibles are totally separate and do not contribute toward or offset each other.

This Plan has an embedded individual deductible, meaning that an individual enrolled in family coverage will never have to pay more than the individual deductible amount before the Plan begins to pay coinsurance for the individual.

The Calendar Year Deductible is waived for the following Covered Charges:
- In-Network Preventive Care Benefits

MEDICAL BENEFITS, continued				
Annual Out-Of-Pocket Limits	**Individual Plan Out-of-Pocket Limits**		**Family Plan Out-of-Pocket Limit**	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
Arkansas State Employees	$6,450 per individual	unlimited	$6,450 per individual $12,900 per family	unlimited
Public School Employees	$6,450 per individual	unlimited	$6,450 per individual $9,675 per family	unlimited

Out-of-Pocket Accumulation.
The In-Network and Out-of-Network Out-of-Pocket amounts are totally separate and do not contribute toward or offset each other.

This Plan has an embedded individual out-of-pocket limit, meaning that an individual enrolled in family coverage will never have to pay more than the individual out-of-pocket limit before the Plan begins to pay Covered Charges at 100% for the individual.

The charges for the following do not apply to the annual Out-of-Pocket Limit:

- Out-of-Network services
- Penalties for failure to obtain prior approval
- Amounts in excess of the Allowable Charge
- Non-Covered Services

Coinsurance Payable By Plan	**In-Network Coinsurance**	**Out-of-Network Coinsurance**
Unless stated otherwise in this document, the Plan will pay 80% of In-Network Covered Charges until the annual Out-of-Pocket Limit is satisfied, at which time the Plan will pay 100% of the remainder of In-Network Covered Charges for the rest of the Calendar Year. The Plan will never pay more than 60% of Out-of-Network Covered Charges.	80%	60%

HOSPITAL BENEFITS		
Charges billed by a facility	**In-Network**	**Out-of-Network**
Inpatient Services	80%, after Deductible	60%, after Deductible

- **Prior Approval.** Prior Approval is required for all inpatient admissions as well as specific outpatient medical services and procedures and some Durable Medical Equipment. See the Cost Management Section for a detailed list of services which require prior approval.
- **Room and Board Allowances.** Covered Charges for room and board during an inpatient admission shall be limited to the lesser of the billed charge or the Allowable Charge established by the Plan.

Outpatient Services	80%, after Deductible	60%, after Deductible

HOSPITAL BENEFITS, continued		
Charges billed by a Physician	**In-Network**	**Out-of-Network**
Emergency Room Services		
Medical Emergency	80%, after Deductible	80%, after Deductible
non-Medical Emergency	80%, after Deductible	60%, after Deductible

PHYSICIAN BENEFITS		
Charges billed by a Physician	**In-Network**	**Out-of-Network**
Office Services	80%, after Deductible	60%, after Deductible
Inpatient Services	80%, after Deductible	60%, after Deductible
Outpatient Services	80%, after Deductible	60%, after Deductible
Emergency Room Services		
Medical Emergency	80%, after Deductible	80%, after Deductible
non-Medical Emergency	80%, after Deductible	60%, after Deductible
Urgent Care Services	80%, after Deductible	60%, after Deductible

SERVICES WITH BENEFIT LIMITS AND MAXIMUMS		
Covered service	**In-Network**	**Out-of-Network**
Advanced Diagnostic Imaging – *Prior Approval is required.*	80%, after Deductible	60%, after Deductible
Allergy services		
Injections	100%, after Deductible	60%, after Deductible
Serum	80%, after Deductible	60%, after Deductible
Testing	80%, after Deductible	60%, after Deductible
Ambulance services		
Air ambulance	90%, after Deductible	90%, after Deductible
Ground ambulance • *Limited to $2,000 per trip.*	80%, after Deductible	80%, after Deductible
Water ambulance	not covered	not covered
Autism treatment, including Applied Behavioral Analysis (ABA) Therapy • *Limited to $50,000 per Calendar Year.*	80%, after Deductible	60%, after Deductible

SERVICES WITH BENEFIT LIMITS AND MAXIMUMS, continued		
Covered service	**In-Network**	**Out-of-Network**
Diabetes Management Program *Coverage includes Accu-Chek Guide Me meter, and Accu-Chek Guide test strips. Pen needles and syringes are provided by TRUEplus. Other brands not covered.*	100%, Deductible waived	Not covered
Eyeglasses or contact lenses following cataract surgery • *Limited to initial pair of glasses or contact lenses.*	80%, after Deductible	60%, after Deductible
Hearing Exams Routine screening, *limited to one screening every 3 years.* • Primary Care Physician • Specialist	 $25 copay, deductible waived $50 copay, deductible waived	 $25 copay, deductible waived $50 copay, deductible waived
Hearing aids • *Limited to $1,400 per ear every three years.*	100%, Deductible waived	100%, Deductible waived
Medications provided in a facility or office *Coverage includes injectable, oral, and intravenous medications. Some medications require Prior Approval.*	80%, after Deductible	60%, after Deductible
Mental Illness and Substance Use Disorder Treatment		
Psychotherapy or ABA Therapy in an office or outpatient setting	80%, after Deductible	60%, after Deductible
Psychological Testing in an office or outpatient setting	80%, after Deductible	60%, after Deductible
Partial Hospitalization, Day Treatment or Intensive Outpatient Therapy – ***Prior Approval is required.***	80%, after Deductible	60%, after Deductible
Prosthetic and Orthotic Devices		
Prosthetic Device • *Limited to one device per lifetime.*	80%, after Deductible	60%, after Deductible
Orthotic Devices used for correction or prevention of skeletal deformities • *Limited to two devices per lifetime.*	80%, after Deductible	60%, after Deductible
Bras following mastectomy • *Limited to six bras per Calendar Year.*	80%, after Deductible	60%, after Deductible
Routine Obstetrical Ultrasound • *Limited to one ultrasound per Pregnancy.*	80%, after Deductible	60%, after Deductible
Standard Preventive Care	100%, Deductible waived	not covered

SERVICES WITH BENEFIT LIMITS AND MAXIMUMS, continued		
Covered service	**In-Network**	**Out-of-Network**
TMJ Disorder Treatment • *Limited to $1,000 per Calendar Year.*	80%, after Deductible	60%, after Deductible
Therapy Benefits		
Occupational, Physical and Speech Therapies in an office or outpatient setting • *Prior Approval is required for outpatient therapy.*	80%, after Deductible	60%, after Deductible
Chiropractic services in an office or outpatient setting • *Limited to 15 visits per Calendar Year.*	80%, after Deductible	60%, after Deductible
Transplant Services – *Prior Approval is required.*		
Transplant surgery • *Limited to two transplants of the same organ per lifetime.*	80%, after Deductible	60%, after Deductible
Travel and lodging • *Limited to $10,000 per lifetime.*	100%, after Deductible	100%, after Deductible
Vision Exams		
Routine screening • Limited to one screening every two years	$50 copay, deductible waived	$50 copay, deductible waived

PHARMACY BENEFITS	
Prescription Tiers	**Coinsurance**
Tier I – Generic	20%
Tier II – Preferred	20%
Tier III – Non-Preferred	20%
Tier IV – Specialty	20%
RX Out-of-Pocket Max *Excluded drugs, reference price drugs, and brand drugs where generic is available does not apply towards the RX Out-of-Pocket Max.*	

SPECIAL IN-NETWORK PROVISIONS
• Certain types of suppliers and specialists are not offered provider participation contracts and will be reimbursed at the In-Network level of benefits if a network exception from the Claims Administrator is provided in advance of services. • If services are not available from an In-Network provider, Covered Charges will be reimbursed at the In-Network level of benefits if a network exception from the Claims Administrator is provided in advance of services. • If services from an In-Network Provider are not accessible, Covered Charges will be reimbursed at the In-Network level of benefits if a network exception from the Claims Administrator is provided in advance of services. • Covered Charges for Medical Emergency and accident services will be reimbursed at the In-Network level of benefits. • Covered Charges for inpatient or outpatient services rendered by an Out-of-Network anesthesiologist, pathologist or radiologist in connection with an In-Network facility will be paid at the In-Network level of benefits.

SCHEDULE OF BENEFITS
ARBenefits ASE Basic Plan

This Schedule of Benefits applies to all Active Employees and Retired Employees under the age of 65 and their covered Dependents.

All benefits described in this Schedule are subject to the Primary Coverage Criteria, the Allowable Charge, and the benefit limits and exclusions described more fully herein.

High Deductible Health Plan
A qualified High Deductible Health Plan (HDHP) with a Health Savings Account provides comprehensive coverage for high cost medical events and a tax-advantaged way to help build savings for future medical expenses. The Plan gives a Covered Person greater control over how health care benefits are used. A HDHP satisfies certain statutory requirements with respect to minimum Deductibles and out-of-pocket expenses for both single and family coverage. These minimum Deductibles and limits for out-of-pocket expenses' limit are set forth by the U.S. Department of Treasury and will be indexed for inflation in the future.

This Plan has entered into an agreement with certain Hospitals, Physicians and other health care Providers, which are called In-Network Providers. Because these In-Network Providers have agreed to charge reduced fees to persons covered under the Plan, the Plan can afford to reimburse a higher percentage of their fees.

Therefore, when a Covered Person uses an In-Network Provider, that Covered Person will receive a higher payment from the Plan than when an Out-of-Network Provider is used. It is the Covered Person's choice as to which Provider to use.

A listing of In-Network Providers is available on the Claims Administrator's website at www.healthadvantage-hmo.com.

NOTE: The ASE Basic Plan does not provide coverage for Out-of-Network services with the exception of emergency care.

MEDICAL BENEFITS				
Calendar Year Deductibles	**Individual Plan Deductibles**		**Family Plan Deductibles**	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
Arkansas State Employees	$6,450 per individual	not covered	$6,450 per individual $12,900 per family	not covered

Deductible Accumulation. This Plan has an embedded individual deductible, meaning that an individual enrolled in family coverage will never have to pay more than the individual deductible amount before the Plan begins to pay coinsurance for the individual.

The Calendar Year Deductible is waived for the following Covered Charges:
- In-Network Preventive Care Benefits

MEDICAL BENEFITS, continued				
Annual Out-Of-Pocket Limits	**Individual Plan Out-of-Pocket Limits**		**Family Plan Out-of-Pocket Limit**	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
Arkansas State Employees	$6,450 per individual	not covered	$6,450 per individual $12,900 per family	not covered
Out-of-Pocket Accumulation. This Plan has an embedded individual out-of-pocket limit, meaning that an individual enrolled in family coverage will never have to pay more than the individual out-of-pocket limit before the Plan begins to pay Covered Charges at 100% for the individual.				
The charges for the following do not apply to the annual Out-of-Pocket Limit: • Penalties for failure to obtain prior approval • Amounts in excess of the Allowable Charge • Non-Covered Services				

Coinsurance Payable By Plan	**In-Network Coinsurance**	**Out-of-Network Coinsurance**
Because the In-Network Deductibles are equal to the In-Network Out-of-Pocket Limits, once the Deductible has been satisfied, the Plan will pay 100% of In-Network Covered Charges for the remainder of the Calendar Year.	100%	not covered

HOSPITAL BENEFITS		
Charges billed by a facility	**In-Network**	**Out-of-Network**
Inpatient Services	100%, after Deductible	not covered
• **Prior Approval.** Prior Approval is required for all inpatient admissions as well as specific outpatient medical services and procedures and some Durable Medical Equipment. See the Cost Management Section for a detailed list of services which require prior approval. • **Room and Board Allowances.** Covered Charges for room and board during an inpatient admission shall be limited to the lesser of the billed charge or the Allowable Charge established by the Plan.		
Outpatient Services	100%, after Deductible	not covered
Emergency Room Services		
Medical Emergency	100%, after Deductible	100%, after Deductible
non-Medical Emergency	100%, after Deductible	not covered

PHYSICIAN BENEFITS		
Charges billed by a Physician	**In-Network**	**Out-of-Network**
Office Services	100%, after Deductible	not covered
Inpatient Services	100%, after Deductible	not covered
Outpatient Services	100%, after Deductible	not covered
Emergency Room Services		
Medical Emergency	100%, after Deductible	100%, after Deductible
non-Medical Emergency	100%, after Deductible	not covered
Urgent Care Services	100%, after Deductible	not covered

SERVICES WITH BENEFIT LIMITS AND MAXIMUMS		
Covered service	**In-Network**	**Out-of-Network**
Advanced Diagnostic Imaging – *Prior Approval is required.*	100%, after Deductible	not covered
Allergy services		
Injections	100%, after Deductible	60%, after Deductible
Serum	80%, after Deductible	60%, after Deductible
Testing	80%, after Deductible	60%, after Deductible
Ambulance services		
Air ambulance	90%, after Deductible	90%, after Deductible
Ground ambulance • *Limited to $2,000 per trip.*	80%, after Deductible	80%, after Deductible
Water ambulance	not covered	not covered
Autism treatment, including Applied Behavioral Analysis (ABA) Therapy • *Limited to $50,000 per Calendar Year.*	100%, after Deductible	not covered
Diabetes Management Program *Coverage includes Accu-Chek Guide Me meter, and Accu-Chek Guide test strips. Pen needles and syringes are provided by TRUEplus. Other brands not covered.*	100%, Deductible waived	not covered
Eyeglasses or contact lenses following cataract surgery • *Limited to initial pair of glasses or contact lenses.*	100%, after Deductible	not covered

SERVICES WITH BENEFIT LIMITS AND MAXIMUMS, continued		
Covered service	**In-Network**	**Out-of-Network**
Hearing Exams Routine screening, *limited to one screening every 3 years.* • Primary Care Physician • Specialist	 $25 copay, deductible waived $50 copay, deductible waived	 not covered not covered
Hearing aids • *Limited to $1,400 per ear every three years.*	100%, Deductible waived	100%, Deductible waived
Medications provided in a facility or office *Coverage includes injectable, oral, and intravenous medications. Some medications require Prior Approval.*	100%, after Deductible	not covered
Mental Illness and Substance Use Disorder Treatment Psychotherapy or ABA Therapy in an office or outpatient setting Psychological Testing in an office or outpatient setting Partial Hospitalization, Day Treatment or Intensive Outpatient Therapy– ***Prior Approval is required.***	 100%, after Deductible 100%, after Deductible 100%, after Deductible	 not covered not covered not covered
Prosthetic and Orthotic Devices Prosthetic Device *Limited to one device per lifetime.* Orthotic Devices used for correction or prevention of skeletal deformities • *Limited to two devices per lifetime.* Bras following mastectomy • *Limited to six bras per Calendar Year.*	 100%, after Deductible 100%, after Deductible 100%, after Deductible	 not covered not covered not covered
Routine Obstetrical Ultrasound • *Limited to one ultrasound per Pregnancy.*	100%, after Deductible	not covered
• **Standard Preventive Care**	100%, Deductible waived	not covered
TMJ Disorder Treatment *Limited to $1,000 per Calendar Year.*	100%, after Deductible	not covered
• **Therapy Benefits** Occupational, Physical and Speech Therapies in an office or outpatient setting *Prior Approval is required for outpatient therapy.* Chiropractic services in an office or outpatient setting • *Limited to 15 visits per Calendar Year.*	 100%, after Deductible 100%, after Deductible	 not covered not covered

SERVICES WITH BENEFIT LIMITS AND MAXIMUMS, continued		
Covered service	**In-Network**	**Out-of-Network**
Transplant Services – *Prior Approval is required.*		
Transplant surgery • *Limited to two transplants of the same organ per lifetime.*	100%, after Deductible	not covered
Travel and lodging • *Limited to $10,000 per lifetime.*	100%, after Deductible	not covered
Vision Exams		
Routine screening • Limited to one screening every two years	$50 copay, deductible waived	not covered

PHARMACY BENEFITS	
Prescription Tiers	**Coinsurance**
Tier I – Generic	0%
Tier II – Preferred	0%
Tier III – Non-Preferred	0%
Tier IV – Specialty	0%
RX Out-of-Pocket Max *Excluded drugs, reference price drugs, and brand drugs where generic is available does not apply towards the RX Out-of-Pocket Max.*	

SPECIAL IN-NETWORK PROVISIONS
• Certain types of suppliers and specialists are not offered provider participation contracts and will be reimbursed at the In-Network level of benefits if a network exception from the Claims Administrator is provided in advance of services. • If services are not available from an In-Network provider, Covered Charges will be reimbursed at the In-Network level of benefits if a network exception from the Claims Administrator is provided in advance of services. • If services from an In-Network Provider are not accessible, Covered Charges will be reimbursed at the In-Network level of benefits if a network exception from the Claims Administrator is provided in advance of services. • Covered Charges for Medical Emergency and accident services will be reimbursed at the In-Network level of benefits. • Covered Charges for inpatient or outpatient services rendered by an Out-of-Network anesthesiologist, pathologist or radiologist in connection with an In-Network facility will be paid at the In-Network level of benefits.

SCHEDULE OF BENEFITS
ARBenefits PSE Basic Plan

This Schedule of Benefits applies to all Active Employees and Retired Employees under the age of 65 and their covered Dependents.

All benefits described in this Schedule are subject to the Primary Coverage Criteria, the Allowable Charge, and the benefit limits and exclusions described more fully herein.

High Deductible Health Plan
A qualified High Deductible Health Plan (HDHP) with a Health Savings Account provides comprehensive coverage for high cost medical events and a tax-advantaged way to help build savings for future medical expenses. The Plan gives a Covered Person greater control over how health care benefits are used. A HDHP satisfies certain statutory requirements with respect to minimum Deductibles and out-of-pocket expenses for both single and family coverages. These minimum Deductibles and limits for out-of-pocket expenses' limit are set forth by the U.S. Department of Treasury and will be indexed for inflation in the future.

This Plan has entered into an agreement with certain Hospitals, Physicians, and other health care Providers, which are called In-Network Providers. Because these In-Network Providers have agreed to charge reduced fees to persons covered under the Plan, the Plan can afford to reimburse a higher percentage of their fees.

Therefore, when a Covered Person uses an In-Network Provider, that Covered Person will receive a higher payment from the Plan than when an Out-of-Network Provider is used. It is the Covered Person's choice as to which Provider to use.

A listing of In-Network Providers is available on the Claims Administrator's website at www.healthadvantage-hmo.com.

NOTE: The PSE Basic Plan does not provide coverage for Out-of-Network services with the exception of emergency care.

MEDICAL BENEFITS				
Calendar Year Deductibles	**Individual Plan Deductibles**		**Family Plan Deductibles**	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
Public School Employees	$4,000 per individual	not covered	$4,000 per individual $8,000 per family	not covered

Deductible Accumulation. This Plan has an embedded individual deductible, meaning that an individual enrolled in family coverage will never have to pay more than the individual deductible amount before the Plan begins to pay coinsurance for the individual.

The Calendar Year Deductible is waived for the following Covered Charges:
- In-Network Preventive Care Benefits

MEDICAL BENEFITS, continued				
Annual Out-Of-Pocket Limits	**Individual Plan Out-of-Pocket Limits**		**Family Plan Out-of-Pocket Limit**	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
Public School Employees	$6,450 per individual	not covered	$6,450 per individual $12,900 per family	not covered

Out-of-Pocket Accumulation. This Plan has an embedded individual out-of-pocket limit, meaning that an individual enrolled in family coverage will never have to pay more than the individual out-of-pocket limit before the Plan begins to pay Covered Charges at 100% for the individual.

The charges for the following do not apply to the annual Out-of-Pocket Limit:

- Penalties for failure to obtain prior approval
- Amounts in excess of the Allowable Charge
- Non-Covered Services

Coinsurance Payable By Plan	**In-Network Coinsurance**	**Out-of-Network Coinsurance**
Unless stated otherwise in this document, the Plan will pay 80% of In-Network Covered Charges until the annual Out-of-Pocket Limit is satisfied, at which time the Plan will pay 100% of the remainder of In-Network Covered Charges for the rest of the Calendar Year. Out-of-Network charges are not covered.	80%	not covered

HOSPITAL BENEFITS		
Charges billed by a facility	**In-Network**	**Out-of-Network**
Inpatient Services	80%, after Deductible	not covered
• **Prior Approval.** Prior Approval is required for all inpatient admissions as well as specific outpatient medical services and procedures and some Durable Medical Equipment. See the Cost Management Section for a detailed list of services which require prior approval. • **Room and Board Allowances.** Covered Charges for room and board during an inpatient admission shall be limited to the lesser of the billed charge or the Allowable Charge established by the Plan.		
Outpatient Services	80%, after Deductible	not covered
Emergency Room Services		
Medical Emergency	80%, after Deductible	80%, after Deductible
non-Medical Emergency	80%, after Deductible	not covered

PHYSICIAN BENEFITS		
Charges billed by a Physician	**In-Network**	**Out-of-Network**
Office Services	80%, after Deductible	not covered
Inpatient Services	80%, after Deductible	not covered
Outpatient Services	80%, after Deductible	not covered
Emergency Room Services		
Medical Emergency	80%, after Deductible	80%, after Deductible
non-Medical Emergency	80%, after Deductible	not covered
Urgent Care Services	80%, after Deductible	not covered

SERVICES WITH BENEFIT LIMITS AND MAXIMUMS		
Covered service	**In-Network**	**Out-of-Network**
Advanced Diagnostic Imaging – *Prior Approval is required.*	80%, after Deductible	not covered
Allergy services		
Injections	100%, after Deductible	60%, after Deductible
Serum	80%, after Deductible	60%, after Deductible
Testing	80%, after Deductible	60%, after Deductible
Ambulance services		
Air ambulance	90%, after Deductible	90%, after Deductible
Ground ambulance • *Limited to $2,000 per trip.*	80%, after Deductible	80%, after Deductible
Water ambulance	not covered	not covered
Autism treatment, including Applied Behavioral Analysis (ABA) Therapy • *Limited to $50,000 per Calendar Year.*	80%, after Deductible	not covered
Diabetes Management Program *Coverage includes Accu-Chek Guide Me meter, and Accu-Chek Guide test strips. Pen needles and syringes are provided by TRUEplus. Other brands not covered.*	100%, Deductible waived	not covered
Eyeglasses or contact lenses following cataract surgery • *Limited to initial pair of glasses or contact lenses.*	80%, after Deductible	not covered

SERVICES WITH BENEFIT LIMITS AND MAXIMUMS, continued		
Covered service	**In-Network**	**Out-of-Network**
Hearing Exams Routine screening, *limited to one screening every 3 years.* • Primary Care Physician • Specialist	 $25 copay, deductible waived $50 copay, deductible waived	 not covered not covered
Hearing aids • *Limited to $1,400 per ear every three years.*	100%, Deductible waived	100%, Deductible waived
Psychotherapy or ABA Therapy in an office or outpatient setting	80%, after Deductible	not covered
Psychological Testing in an office or outpatient setting	80%, after Deductible	not covered
Partial Hospitalization, Day Treatment or Intensive Outpatient Therapy– ***Prior Approval is required.***	80%, after Deductible	not covered
Prosthetic and Orthotic Devices		
Prosthetic Device • *Limited to one device per lifetime.*	80%, after Deductible	not covered
Orthotic Devices used for correction or prevention of skeletal deformities • *Limited to two devices per lifetime.*	80%, after Deductible	not covered
Bras following mastectomy • *Limited to six bras per Calendar Year.*	80%, after Deductible	not covered
Routine Obstetrical Ultrasound • *Limited to one ultrasound per Pregnancy.*	80%, after Deductible	not covered
Standard Preventive Care	100%, Deductible waived	not covered
TMJ Disorder Treatment • *Limited to $1,000 per Calendar Year.*	80%, after Deductible	not covered
Therapy Benefits		
Occupational, Physical, and Speech Therapies in an office or outpatient setting • *Prior Approval is required for outpatient therapy.*	80%, after Deductible	not covered
Chiropractic services in an office or outpatient setting • *Limited to 15 visits per Calendar Year.*	80%, after Deductible	not covered

SERVICES WITH BENEFIT LIMITS AND MAXIMUMS, continued		
Covered service	**In-Network**	**Out-of-Network**
Transplant Services – *Prior Approval is required.*		
Transplant surgery • *Limited to two transplants of the same organ per lifetime.*	80%, after Deductible	not covered
Travel and lodging • *Limited to $10,000 per lifetime.*	100%, after Deductible	not covered
Vision Exams		
Routine screening • Limited to one screening every two years	$50 copay, deductible waived	not covered

PHARMACY BENEFITS	
Prescription Tiers	**Coinsurance**
Generic – Tier I	20%
Preferred – Tier II	20%
Non-Preferred – Tier III	20%
Specialty – Tier IV	20%
RX Out-of-Pocket Max *Excluded drugs, reference price drugs, and brand drugs where generic is available does not apply towards the RX Out-of-Pocket Max.*	

SPECIAL IN-NETWORK PROVISIONS
• Certain types of suppliers and specialists are not offered provider participation contracts and will be reimbursed at the In-Network level of benefits if a network exception from the Claims Administrator is provided in advance of services. • If services are not available from an In-Network provider, Covered Charges will be reimbursed at the In-Network level of benefits if a network exception from the Claims Administrator is provided in advance of services. • If services from an In-Network Provider are not accessible, Covered Charges will be reimbursed at the In-Network level of benefits if a network exception from the Claims Administrator is provided in advance of services. • Covered Charges for Medical Emergency and accident services will be reimbursed at the In-Network level of benefits. • Covered Charges for inpatient or outpatient services rendered by an Out-of-Network anesthesiologist, pathologist or radiologist in connection with an In-Network facility will be paid at the In-Network level of benefits.

SCHEDULE OF BENEFITS
ASE/PSE Premium Plan (Medicare Primary Plan)

This Schedule of Benefits describes benefits available to members enrolled in the ASE/PSE Premium (Medicare Primary Plan) who are eligible for Medicare coverage. Once a member becomes eligible for Medicare coverage, the member's entire family will automatically be moved to the ARBenefits ASE/PSE Premium Plan if they are currently enrolled in the Classic Plan or Basic Plan**.**

The **ARBenefits ASE/PSE Premium Plan (Medicare Primary Plan)** is an employer sponsored health benefit plan that supplements most benefits provided by Medicare.

In order for a particular Health Intervention to qualify for coverage under the Plan, the following criteria must be met:

(1) The health intervention must conform to specific limitations stated in the Plan.

(2) The health intervention must not be specifically excluded under the terms of the Plan.

(3) At the time of the intervention, the Covered Person must meet the Plan's eligibility standards.

(4) You must follow the Plan's procedures for filing claims.

MEDICAL BENEFITS AND SPECIFIC LIMITATIONS

This health benefit plan provides coverage that supplements most benefits provided by Medicare. This Section describes medical services, drugs, supplies, tests, and equipment for which coverage is provided under the Plan, provided all terms, conditions, exclusions, and limitations of the Plan, including the four coverage criteria, are satisfied.

What does ARBenefits cover for Medicare Primary Retirees?

Medicare Does Not Pay	ARBenefits Retiree Plan Covers
Part A Hospital Services	
Inpatient hospital deductible each benefit period	ARBenefits pays the deductible
Copayment per day for days 61-90 in a hospital	ARBenefits pays the copayment per day
Copayment per day for days 91-150 (Lifetime Reserve)	ARBenefits pays the copayment per day
100% of Medicare - Allowable expenses for additional 365 days after Medicare hospital benefits stop completely	ARBenefits pays
Medicare Does Not Pay	**ARBenefits Retiree Plan Covers**

Part A Hospital Services, continued	
Calendar year blood deductible (First 3 Pints of Blood) If deductible is not met by the replacement of blood	ARBenefits pays
Copayment per day for days 21-100 in a Skilled Nursing Facility	ARBenefits pays the copayment per day
Part B Physician and Medical Services	
Part B deductible	ARBenefits pays the deductible.
Normally 20% of Medicare-approved amount (Part B Coinsurance) and 20% of Medicare-approved charges for Durable Medical Equipment (After Part B Deductible Is Met)	ARBenefits pays 20% of the Medicare-approved amount, unless the benefit excluded.
Medicare Part B excess charges 100% (*This benefit would apply when you receive services from a physician that does not accept Medicare assignment.*)	Coverage will be determined based on the level of coverage outlined in the SPD for active and non-Medicare members. Services paid at 100% will be no charge. Plan will pay 80% for Medicare Part B excess charges not paid by Medicare, but will be paid according to the deductible, copay, and coinsurance when applicable.

CORONAVIRUS PANDEMIC, TEMPORARY BENEFITS

During the coronavirus (COVID-19) pandemic, the Plan will provide temporary benefits as specified below. These benefit enhancements apply solely and exclusively during the temporary period specified herein and will not be available at the conclusion of the public health emergency. All other terms, conditions, exclusions or limitations in the Plan Document continue to apply and must be satisfied in order for any benefits to be paid.

Families First Coronavirus Response Act (FFCRA) and Coronavirus Aid, Relief, and Economic Security (CARES) Act

Effective March 18, 2020, in accordance with the FFCRA and CARES Act, the Plan shall provide coverage, and shall not impose any cost sharing (including deductibles, copayments, and coinsurance) requirements or prior authorization or other medical management requirements, for the following items and services furnished during the federally-declared public health emergency period. Benefits are available for services rendered by an In-Network or Out-of-Network Provider.

(1) FDA-approved diagnostic testing products for the detection of SARS-CoV-2 or the diagnosis of the virus that causes COVID-19 and the administration of such diagnostic tests.

(2) Items and services furnished to an individual during health care provider office visits (including in-person visits and telehealth visits), urgent care center visits, and emergency room visits that result in an order for or administration of a diagnostic test, or an evaluation to determine if a diagnostic test is necessary.

In the event that any new federal laws or regulations are enacted, the Plan will comply with the applicable law or regulation.

Additional benefits

In addition to the services mandated by the FFCRA and CARES Act, the Plan will also provide the following additional benefits in an effort to help mitigate the spread of the coronavirus. Coverage will begin on the date cited and will continue for the duration of the public health emergency unless otherwise indicated.

(1) Effective March 12, 2020, (prior to the FFCRA), FDA-approved diagnostic testing products for the detection of SARS-CoV-2 or the diagnosis of the virus that causes COVID-19 and the administration of such diagnostic tests, available at zero cost-sharing.

(2) Effective March 20, 2020, telehealth services, for treatment of eligible diagnoses, including phone-based consultations and audio-visual telemedicine visits rendered by an In-Network Provider, available at zero cost-sharing. This includes Psychological or Neuropsychological testing services.

(3) Effective April 1, 2020, telemedicine services provided by In-Network health care professionals licensed to perform Physical Therapy, Occupational Therapy, Speech and Language Therapy, Chiropractic medicine, Podiatric medicine, Registered Dietician services, or Board Certified Behavioral Analyst services, via a telemedicine link. Eligible charges will be reimbursed according to standard Plan reimbursement rates.

(4) Effective April 1, 2020, telehealth services, for wellness and preventive services, including phone-based consultations and audio-visual telemedicine visits rendered by an In-Network Provider, available at zero cost-sharing.

MEDICAL BENEFITS

Medical Benefits apply when Covered Charges are incurred by a Covered Person for care of an Accidental Injury or Sickness and while the person is covered for these benefits under the Plan.

DEDUCTIBLE

Deductible means the amount of out of pocket expense a Member must incur for Covered Services each Calendar Year before any expenses are paid by the Plan. This amount is calculated from Allowance or Allowable Charges, not the billed charges. Once the Deductible has been met, subject to all other terms, conditions, limitations, and exclusions in the Plan, payment for Covered Services begins. The Deductible is waived for some services, such as Preventive Care, as identified in the Schedule of Benefits.

Only In-Network Deductibles will accrue toward the Annual Out-of-Pocket Limit.

PLAN COINSURANCE

Each Calendar Year, benefits will be paid for the Covered Charges of a Covered Person that are in excess of the Deductible and any Copayments. Payment will be made at the rate shown under reimbursement rate in the Schedule of Benefits. No benefits will be paid in excess of any listed limit of the Plan.

OUT-OF-POCKET LIMIT

Covered Charges are payable at the percentages shown each Calendar Year until the out-of-pocket limit shown in the Schedule of Benefits is reached. Then, Covered Charges incurred by a Covered Person will be payable at 100% (except for any charges excluded as shown in the Schedule of Benefits) for the rest of the Calendar Year.

When a Family Unit reaches the out-of-pocket limit, Covered Charges for that Family Unit will be payable at 100% (except for any charges excluded, as shown on the Schedule of Benefits) for the rest of the Calendar Year.

PLAN ALLOWANCE

The Plan has defined an outer limit on Plan benefits that applies whether a Covered Person chooses to receive services from an In-Network Provider or an Out-of-Network Provider. This overall limit on the amount of Plan benefits available under the Plan is defined in this Plan Document description as the “Allowable Charge” or “Allowance,” and may also be referred to from time to time as the “Plan Allowance” under the Plan. Benefits under the Plan will always be limited by the Plan Allowance that the Plan has adopted, as further defined in this section. This means that regardless of how much a health care Provider may bill for any service, drug, medical device, equipment, or supplies, the benefits under the Plan will be limited to the Plan Allowance, as established in the Defined Terms section.

Patient’s Share of the Plan Allowance and Billed Charges of the Provider
The Plan calculates and pays Plan benefits on the basis of the Plan Allowance, an amount that may vary substantially from the amount a Provider chooses to bill. Once the Plan Allowance is determined with respect to any Provider’s billed charges, the Covered Person may be responsible for a percentage or portion of the Plan Allowance, depending on the terms of the Plan with respect to Copayments, Coinsurance, and Deductible. For example, if services are provided by an In-Network Provider, the Plan may pay 80% of the Plan Allowance, in which case the Covered Person would be responsible for the remaining 20% of the Plan Allowance, but not for the difference between the Plan Allowance and the Provider’s billed charges. In this situation, the In-Network Provider contract protects the Covered Person from additional billing beyond the Plan Allowance. For an Out-

of-Network Provider, the circumstances are substantially different. For example, if services are provided by an Out-of-Network Provider, the Plan may pay only 50% of the Plan Allowance, in which case the Covered Person would be responsible for the remaining 50% of the Plan Allowance. However, the Covered Person might also be held responsible by the Out-of-Network Provider for paying the difference between the Plan Allowance and the Provider's full, billed charges.

COVERED CHARGES

ARBenefits is a comprehensive major medical health plan, with Covered Services including preventive care, Physician Services, Hospital admissions, and Outpatient Care, prescription drug coverage, behavioral/mental health services, rehabilitation, Emergency Care, and much more. It is important to remember that not every medical service is covered by the Plan. Certain exclusions and limitations do exist and it is the members' responsibility to understand the Covered Services under this Plan.

Some services require prior approval before the Plan will consider the expense as a Covered Service. This process is referred to as Utilization Management and can be a very effective plan management tool. See the Cost Management Section for more information regarding Utilization Management.

Because of the high cost of some services or treatments, as well as the difficulty in some cases of determining whether services are really needed, the Plan includes coverage for such services or treatments but place limits on the extent of coverage by limiting the number of Provider visits or treatments received during a Calendar Year or other specified period of time. This section describes medical services, drugs, supplies, tests, and equipment for which coverage is provided under the Plan, provided all terms, conditions, exclusions, and limitations of the Plan, including the six coverage criteria, are satisfied. Specific limitations applicable to each covered medical service, drug, supply, test, or equipment are identified in the Schedules of Benefits and in this section.

Coverage is subject to all terms, conditions, exclusions, and limitations of the Plan set forth in this document, the Claims Administrator's established Coverage Policy, and any applicable Deductible, Coinsurance, and Copayment obligations described in the Schedules of Benefits. For a description of the amount of these obligations and how they may vary depending upon whether the Member selects an In-Network or Out-of-Network Provider, Members can refer to the definition of Allowance or Allowable Charge as set out in the Defined Terms Section and the Schedules of Benefits.

(1) **Professional Services.** Coverage is provided for the following Professional Services when performed by a Physician.

(a) **Primary Care Physician Office Visits.** Coverage is provided for the diagnosis and treatment of Illness or Accidental Injury when provided in the medical office of a Primary Care Physician (PCP). Members are encouraged to select and maintain a patient-Physician relationship with a PCP. A PCP can be helpful in managing an individual's health care. The PCP selected must be an In-Network Physician listed in the Preferred Provider Directory as a PCP and must be accepting Members. Members may contact Customer Service to select a PCP or change their PCP.

(b) **Specialty Care Provider Office Visits.** Coverage is provided for the diagnosis and treatment of Illness or Accidental Injury when provided in the medical office of the Specialty Care Provider.

(c) **Physician Hospital Visits.** Coverage is provided for services of Physicians for diagnosis, treatment and consultation while the Member is admitted as an inpatient in a Hospital for Covered Services.

(d) **Surgical Services.** Coverage is provided for services of Physicians for surgery, either as an inpatient or outpatient. If coverage is provided for two or more surgical operations performed during the same surgical encounter or for bilateral procedures, payment for the secondary or subsequent procedure will be made at a reduced rate. In general, overall payment for one or more procedures during the same operative setting will be no more than if the procedures had been done by one Physician. Further, the Plan's payment for an assistant surgeon shall be limited to one Physician qualified to act as an assistant for the surgical procedure.

(e) **Assistant Surgeon Services.** Not all surgeries merit coverage for an assistant surgeon. Further, the Plan's payment for a covered assistant surgeon shall be limited to one Physician qualified to act as an assistant for the surgical procedure.

(f) **Standby Physicians.** Services of standby Physicians are only covered in the event such Physician is required to assist with certain high-risk services specified by the Plan, and only for such time as such Physician is in immediate proximity to the patient.

(2) **Preventive Health Services.** The Plan will pay 100% of the Allowance or Allowable Charges for the routine preventive health services listed below when provided by a Primary Care Physician or an advanced practice nurse or physician assistant who provides primary medical care in the areas of general practice, pediatrics, family practice, internal medicine, or obstetrics/gynecology, which are performed in the Primary Care Physician's office. Coverage is also provided for certain preventive health services listed below when performed in an Outpatient Hospital or Ambulatory Surgery Center setting when the service cannot be performed in an office by a Primary Care Physician.

(a) Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force but not for the related treatment of disease;

(b) Routine immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved;

(c) With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration;

(d) With respect to women, such additional preventive care and screenings not described above, as provided for in comprehensive guidelines supported by the Health Resources and Services Administration for purposes of this subsection; and,

(e) The current recommendations of the United States Preventive Service Task Force regarding breast cancer screening, mammography, and prevention shall be considered the most current other than those issued in or around November 2009, unless state law provides a greater benefit.

(3) **Hospital Services.** Coverage is provided for the following Hospital services. All Hospital Services must be performed or prescribed by a Physician and provided by a Hospital.

Inpatient Hospital Services. This benefit is subject to the following specific limitations:

(a) Payment for Hospital charges for inpatient admissions shall be limited to the lesser of the billed charge or the Allowance or Allowable Charge.

(b) If a Covered Person has a condition requiring that they be isolated from other patients, the Plan will pay for an isolation unit equipped and staffed as such.

(c) In the event services are rendered for a covered benefit during an inpatient admission to a Hospital where the admitting diagnosis was for a non-covered benefit, the Plan will pay that portion of the Hospital Charge which is attributable to services rendered for the covered benefit.

(d) The services of social workers shall be included in the basic daily room and board Allowance.

(e) Hospital admissions and admissions to a Long Term Acute Care Hospital or to a Long Term Acute Care division of a Hospital require prior approval.

(f) Services rendered in a Hospital in a country outside of the United States of America shall not be paid except at the sole discretion of the Plan Administrator.

Outpatient Hospital Services. Coverage is provided for services of an Outpatient Hospital, Outpatient Surgery Center or Outpatient Radiation Therapy Center.

Hospital Services in Connection with Dental Treatment. The Plan generally does not cover dental services. Subject to Prior Approval from the Claims Administrator, acting on the Plan's behalf, coverage is provided for Hospital services, including anesthesia, services in connection with treatment for a complex dental condition provided to: (i) a Member under seven years of age who is determined by two dentists to require the dental treatment without delay; (ii) a Member with a diagnosis of serious mental or physical condition; or (iii) a Member, certified by his or her Primary Care Physician to have a significant behavioral problem.

(4) **Ambulatory Surgery Center.** Coverage is provided for specific surgical services received at an Ambulatory Surgery Center that are performed or prescribed by a Physician. Covered services include diagnostic imaging and Laboratory services required to augment a surgical service and performed on the same day as such surgical service. A list of services covered in an Ambulatory Surgery Center is available on the Claims Administrator's website www.healthadvantage-hmo.com.

(5) **Outpatient Diagnostic Services.** Coverage is provided for diagnostic services and materials, including but not limited to, diagnostic imaging (e.g. x-rays, fluoroscopy, ultrasounds, radionuclide studies) electrocardiograms, electroencephalograms, and Laboratory tests when performed or prescribed by a Physician.

(6) **Advanced Diagnostic Imaging Services.** Computed Tomography Scanning (CT Scan), Magnetic Resonance Angiography or Imaging (MRI/MRA), Nuclear Cardiology and Positron Emission Tomography scans (PET Scan) (collectively referred to as Advanced Diagnostic Imaging) require Prior Approval. Members may call the phone number printed on the front of

their health plan identification card to receive Prior Approval.

(7) **Maternity.** Coverage is provided for Maternity Care when performed or prescribed by a Physician.

(a) **Maternity and Obstetrical Care.** Coverage is provided for Maternity and Obstetrical Care, including Routine Prenatal Care and postnatal care; and use of Hospital or Birthing Center delivery rooms and related facilities; special procedures as may be necessary. Routine Prenatal Care includes the coverage of one routine ultrasound only.

(b) **Special Delivery.** The Expectant Mother is encouraged to enroll in the Special Delivery Program by the 20th week of Pregnancy. Special Delivery can be accessed by calling 1-800-225-1891, extension 20225. The Plan offers members a $250 incentive for enrolling and participating in this program. This program is designed to encourage the Covered Person to actively participate in obtaining comprehensive prenatal care. Services that are not normally offered, such as skilled nursing assessments or nursing assistant care in the home for conditions including Pregnancy-induced hypertension, diabetes mellitus, and preterm labor, are covered through the Special Delivery program. The Special Delivery nurse can assist in coordinating Home Health Care in lieu of hospitalization for those high risk patients who the Physician feels would benefit from this alternative care.

(c) **Midwives**. Services provided by any lay midwife are not covered. However, coverage is provided for services provided by a certified nurse midwife who has a collaborative agreement with a Physician who is within immediate proximity to the Hospital utilized by the certified nurse midwife, in case there is need for assistance during the delivery.

(d) **Newborn Care in the Hospital.** Routine well newborn nursery care is care while the newborn is Hospital-confined after birth and includes room, board, and other normal care for which a Hospital makes a charge.

This coverage is only provided if the newborn child is an eligible Dependent and a parent (1) is a Covered Person who was covered under the Plan at the time of the birth, or (2) enrolls himself or herself (as well as the newborn child if required) in accordance with the Qualifying Event provisions with coverage effective on the first day of the month that the newborn child is born.

The benefit is limited to Allowable Charges for nursery care after birth while the newborn child is Hospital confined as a result of the child's birth. Charges for covered routine nursery care will be applied toward the Plan of the newborn child.

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 48 hours following a vaginal delivery, or less than 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 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a Provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

(e) **Family Planning Services**. Coverage is provided for the following family planning services in accordance with established Coverage Policy when authorized and provided

by In-Network Physicians:

(i) Counseling and planning services for Infertility;

(ii) Infertility Testing. Coverage is provided for certain services to diagnose Infertility;

(iii) Pregnancy terminations when performed in an In-Network Hospital setting;

(iv) Oral Contraceptives are not covered under Medical Benefits, but may be covered under Pharmacy Benefits administered by the pharmacy benefits manager; and,

(v) Voluntary sterilizations (vasectomies and tubal ligations). Reversals not covered.

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

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

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

(8) **Therapy Services.** Coverage is provided for inpatient and outpatient therapy services when performed or prescribed by a Physician. Such therapy services include physical and occupational therapy. Such therapy services shall include services provided for developmental delay, developmental speech or language disorder, developmental coordination disorder, and mixed developmental disorder. Therapy services must be performed by an appropriate registered physical, occupational, or speech- language therapist licensed by the appropriate State Licensing Board and must be furnished in accordance with a written treatment Plan established and certified by the treating Physician.

(a) **Inpatient Therapy.** Coverage is provided for inpatient therapy services, including Professional Services, when performed or prescribed by a Physician and rendered in a Hospital. **Outpatient Therapy.** Coverage is provided for outpatient therapy services when performed or prescribed by a Physician. Coverage for chiropractic services is limited as shown in the Schedule of Benefits.

(b) **Cardiac and Pulmonary Rehabilitation Therapy.** Coverage for cardiac and pulmonary rehabilitation therapy is provided in accordance with Coverage Policy. However, coverage is not provided for cardiac or pulmonary rehabilitation therapy from Freestanding Facilities. Peripheral vascular disease rehabilitation therapy is not covered.

(c) **Cognitive Rehabilitation.** Cognitive Rehabilitation is generally not covered. However, coverage is provided for Neurologic Rehabilitation Facility Services for Members with Severe Traumatic Brain Injury.

(d) **Radio-Frequency Thermal Therapy.** The use of radio-frequency thermal therapy for treatment of orthopedic conditions is not covered. However, coverage for radio-frequency thermal therapy is provided and included in the payment for the primary procedure of the orthopedic condition.

(9) **Mental Illness and Substance Use Disorder.** Coverage is provided for Health Interventions to treat Mental Illness and Substance Use Disorder.

(a) **Inpatient, Partial Hospitalization Program, and Intensive Outpatient Program Health Interventions.** Coverage for Inpatient Hospitalization, Partial Hospitalization Programs, or Intensive Outpatient Programs for Mental Illness or Substance Use Disorder Health Interventions is subject to the following requirements.

(i) Inpatient Hospitalization requires a patient to receive Covered Services 24 hours a day as an inpatient in a Hospital.

(ii) Partial Hospitalization Programs generally require the patient to receive Covered Services six to eight hours a day, five to seven days per week in a Hospital outpatient setting.

(iii) Intensive Outpatient Programs generally require the patient to receive Covered Services lasting two to four hours a day, three to five days per week in a Hospital outpatient setting.

(iv) Inpatient Hospital admissions require prior approval. The Covered Person may call the MHSA phone number noted their health plan identification card to request prior approval.

(b) **Non-Hospital Health Interventions.**

(i) Coverage is provided for a Health Intervention provided during an office visit with a Psychiatrist, Psychologist, or other Provider licensed to provide treatment for Mental Illness or Substance Use Disorder.

(ii) Subject to Prior Approval from the Claims Administrator, acting on the Plan's behalf, coverage is provided for a Health Intervention at a Residential Treatment Facility for Mental Illness or Substance Use Disorder.

- The facility is licensed by the State of Arkansas or the appropriate agency in the state where the facility is located.
- The facility is accredited by The Joint Commission (TJC) or the Commission on Accreditation of Rehabilitation Facilities (CARF

International).

(iii) The services must be of a temporary nature and required to increase ability to function.

(iv) Custodial Care is not covered.

(v) Coverage for counseling or treatment of marriage, family, or child relationship dysfunction is only covered if the dysfunction is due to a condition defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

(vi) Hypnotherapy is not covered for any diagnosis or medical condition.

(vii) Repetitive Transcranial Magnetic Stimulation Treatment (rTMS). Coverage is provided for repetitive transcranial magnetic stimulation treatment (rTMS) subject to Prior Approval by the Claims Administrator acting on the Plan's behalf.

(10) Autism Spectrum Disorder Benefits. Coverage is provided for:

(a) Members with autism spectrum disorder.

(b) Applied behavioral analysis as specified in Coverage Policy and subject to Prior Approval from the Claims Administrator, acting on the Plan's behalf, when ordered by a medical doctor or a psychologist and provided under the direction of a Board Certified Behavioral Analyst (BCBA).

(c) Coverage is limited as shown in the Schedules of Benefits.

(11) Emergency Care Services. Coverage is provided for Emergency Care. When Emergency Care is needed the Member should seek care at the nearest facility within 48 hours. If the Member is admitted as an inpatient to the same Hospital where Emergency Care was rendered, the Emergency Care Copayment, if any, is waived and all services are subject to the inpatient Deductible, Copayment, and Coinsurance. Premium Plan members can also have their Copayment waived if the Nurse Hotline refers them to an Emergency Room facility.

(a) After-Hours Clinic or Urgent Care Center. Services provided in an after-hours or urgent care center.

(b) Observation Services. Observation services are covered when ordered by an In-Network Physician. Observation Services ordered in conjunction with an emergency room visit or outpatient visit.

(c) Transfer to In-Network Hospital. Continuing or follow-up treatment for Accidental Injury or Emergency Care is limited to care that meets Primary Coverage Criteria before a Member can be safely transferred, without medically harmful or injurious consequences, to an In-Network Hospital in the Service Area.

(d) **Emergency Hospital Admissions.** Members are responsible for notifying the Claims Administrator of an emergency admission to an In-Network Hospital in the Service Area or a Hospital outside the Service Area.

(12) **Durable Medical Equipment.** Coverage is provided for Durable Medical Equipment (DME) when prescribed by an In-Network Physician according to the guidelines specified below.

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

(b) DME delivery or set up charges are included in the Allowance or Allowable Charge for the DME.

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

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

(e) When it is more cost effective, the claims administrator in its discretion will purchase rather than lease equipment. In making such purchase, the Plan may deduct previous rental payments from its purchase Allowance.

(f) Services not covered by Medicare are not covered, unless the Plan specifically defines as a covered benefit.

(13) **Medical Supplies.** Medical Supplies, other than Medical Supplies that can be purchased without a Prescription, are covered when prescribed by a Physician.

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

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

(14) **Prosthetic and Orthotic Devices and Services.** Coverage is provided for Prosthetic and Orthotic Devices, including associated services, and its repair if such device is required for treatment of a condition arising from an Illness or Accidental Injury. Coverage is limited as shown in the Schedules of Benefits. The replacement of a Prosthetic or Orthotic Device is covered no more frequently than once per three-year period except when necessitated by normal growth or when the age of the Prosthetic or Orthotic Device exceeds the device's useful life. Maintenance and repair resulting from misuse or abuse of a Prosthetic or Orthotic Device are the

responsibility of the Member.

(a) General Orthotic Devices, splints, or bandages purchased "over the counter" for the support of strains and sprains, elastic stockings, garter belts are not covered.

(b) Orthopedic shoes and custom-molded foot orthotics are covered.

(c) Hearing aids, Prosthetic Devices to assist hearing, or talking devices are not generally covered. However, coverage is provided for:

(i) Hearing aids, limited as shown in the Schedules of Benefits;

(ii) Cochlear implant (an implantable hearing device inserted into the modiolus of the cochlea and into cranial bone) and its associated speech processor up to a lifetime maximum benefit of one cochlear implant per ear per Member;

(iii) One auditory brain stem implant per lifetime for an individual twelve years of age and older with a diagnosis of Neurofibromatosis Type II (NF2) who has undergone or is undergoing removal of bilateral acoustic tumors; and,

(iv) Surgically implantable osseointegrated hearing aid for patients with single-sided deafness and normal hearing in the other ear, subject to Prior Approval. Coverage is further limited to Members with:

- congenital or surgically induced malformations (e.g. atresia) of the external ear canal or middle ear;
- chronic external otitis or otitis media;
- tumors of the external canal and/or tympanic cavity; and
- sudden, permanent, unilateral hearing loss due to trauma, idiopathic sudden hearing loss, or auditory nerve tumor.

(15) **Diabetes Management Services.** The Plan will pay for Diabetes Self- Management Training. Such training program must be in compliance with the national standards for diabetes self-management education programs developed by the American Diabetes Association. This benefit is payable for training in or out of the Hospital that has been prescribed by a Physician.
The following services related to diabetes management are also covered by the Plan:

(a) Coverage is provided for diabetic testing supplies. Accu-Chek Guide Me ® glucometers, Accu-Chek Guide ® test strips, TRUEplus ® needles for insulin, and all lancets are reimbursed at 100% under the prescription drug benefit. No other brands are covered.

(b) Coverage is provided for insulin pumps and pump supplies, when purchased from a Durable Medical Equipment vendor.

(c) Coverage is provided for the Medtronic Guardian Connect continuous glucose meter from a Durable Medical Equipment vendor.

(d) The Plan will cover eye examinations to screen for diabetic retinopathy for Covered Persons who are diagnosed with diabetes.

(e) Coverage of routine foot care is provided when required for prevention of complications associated with diabetes mellitus.

(16) **Ambulance Services.** Coverage is provided for ground or air Ambulance Services to the nearest Hospital in the event Emergency Care is needed. The coverage for ground Ambulance Services is limited as shown in the Schedule of Benefits. Air ambulance service is not covered for international air evacuation.

(17) **Skilled Nursing Facility Services.** Coverage is provided for Skilled Nursing Facility services when authorized in advance by a Physician. See the definition of Skilled Nursing Facility. This Skilled Nursing Facility services benefit is subject to the following conditions:

(a) The admission must be within seven days of release from a Hospital.

(b) A request for Prior Approval must be submitted to the Claims Administrator prior to admission to the Skilled Nursing Facility.

(c) The Skilled Nursing Facility services are of a temporary nature and increase ability to function.

(d) Custodial Care is not covered.

(18) **Home Health Services.** Coverage is provided for Home Health Services when Coverage Policy supports the need for in-home service and such care is prescribed or ordered by a Physician. Covered Services must be provided through and billed by a licensed home health agency. Covered Services provided in the home include services of a Registered Professional Nurse (R.N.), a Licensed Practical Nurse (L.P.N.), or a Licensed Psychiatric Technical Nurse (L.P.T.N.), provided the nurse is not related to the Member by blood or marriage or does not ordinarily reside in the patient's home. Home Health visits require Prior Approval.

(19) **Hospice Care.** If the Member has been diagnosed and certified by the attending Physician as having a terminal Illness with a life expectancy of six months or less, and if arranged through a Health Advantage Case Manager, the Plan will pay the Allowance or Allowable Charge for Hospice Care. The services must be rendered by an entity licensed by the Arkansas Department of Health or other appropriate state licensing agency and accepted by the Plan as a Provider.

(20) **Oral Surgery.** The Plan will pay only for the following non-dental oral surgical procedures:

(a) Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof, and floor of the mouth when pathological examination is required.

(b) Surgical procedures required to treat an Accidental Injury to jaws, cheeks, lips, tongue, roof, and floor of the mouth. Injury to a tooth or teeth while eating is not considered an Accidental Injury; treatment of such injury will not be covered.

(c) Treatment or correction of a non-dental physiological condition caused by Sjogren's syndrome.

(d) Excision of exostoses of jaws and hard palate.

(e) External incision and drainage of abscess.

(f) Incision of accessory sinuses, salivary glands, or ducts.

(21) **Dental Care or Orthodontic Services.** Dental Care and orthodontic services are only covered when related to an Accidental Injury occurring on or after the Covered Person's effective date or as a result of Sjogren's syndrome. If a Member has an Accidental Injury, benefits will be provided, for Dental Care and x-rays necessary to correct damage to a Non-Diseased Tooth or surrounding tissue caused by the Accidental Injury. The Member must seek treatment within 72 hours of Accidental Injury for services to be covered. Coverage is subject to the following limitations:

(a) Only the natural, Non-Diseased Tooth or Teeth avulsed or extracted as a direct result of the Accidental Injury and the Non-Diseased Tooth or Teeth immediately adjacent will be considered for replacement.

(b) Orthodontic services are limited to the stabilization and re-alignment of the accident-involved teeth to their pre-accident position. Reimbursement for this service will be based on a per tooth Allowance.

(c) Injury to teeth while eating is not considered an Accidental Injury.

(d) Double abutments are not covered.

(e) Any Health Intervention related to dental caries or tooth decay is not covered.

(f) Removal of impacted or partially impacted wisdom teeth are covered.

(g) Benefits for dental services in connection with radiation treatment for cancer of the head or neck are covered.

(h) Benefits for anesthesia services in a Hospital or Ambulatory Surgery Center services and anesthesia services related to dental procedures, including services to children, are covered as described previously under Hospital Services.

(22) **Reconstructive Surgery.** Cosmetic Services are not covered. Coverage is provided for the following reconstructive surgery procedures when prescribed or ordered by a Physician:

(a) Treatment provided for the correction of defects incurred in an Accidental Injury sustained by the Covered Person.

(b) Surgery performed on a child for the correction of a cleft palate or cleft lip, removal of a port-wine stain or hemangioma (on the head, neck, or face). Dental Care to correct congenital defects is not a covered benefit.

(c) Subject to Prior Approval from the Plan, coverage for corrective surgery and related Health Interventions for a Covered Person who is diagnosed as having a craniofacial anomaly provided the Health Interventions meet Primary Coverage Criteria to improve a functional impairment that results from the craniofacial anomaly as determined by a nationally accredited cleft-craniofacial team approved by the American Cleft Palate-Craniofacial Association in Chapel Hill, North Carolina. A nationally accredited cleft-craniofacial team for cleft-craniofacial conditions shall evaluate Covered Persons with craniofacial anomalies and coordinate a treatment plan for each Covered Person. Coverage includes corrective surgery, dental care, vision care and the use of at least one (1) hearing aid.

(d) Treatment provided when it is incidental to disease or for reconstructive surgery following neoplastic (cancer) surgery.

(e) In connection with a mastectomy eligible for coverage under this Plan Document, services for (a) reconstruction of the breast on which the surgery was performed; (b) surgery to reconstruct the other breast to produce a symmetrical appearance; and (c) prostheses and services to correct physical complications for all stages of the mastectomy, including lymphedemas.

(f) In connection with a mastectomy eligible for coverage under this Benefit Certificate, services for (a) reconstruction of the breast on which the surgery was performed; (b) surgery to reconstruct the other breast to produce a symmetrical appearance; and (c) prostheses and services to correct physical complications for all stages of the mastectomy, including lymphedemas.

(g) Reduction mammoplasty, if such reduction mammoplasty meets Coverage Criteria and is Prior Approved by the Company is covered.

(23) Medications. Coverage is provided for Prescription Medication, depending upon the sites of service where the Medication is received by the Member.

(a) Sites of Service

(i) Hospital or Ambulatory Surgery Center. The benefit for Medications received from a Hospital or an Ambulatory Surgery Center is included in the Allowance or Allowable Charge for the Hospital Services.

(ii) Physician's Office. The benefit for Medications administered in a Physician's office is covered based upon the Allowance or Allowable Charge for the Medication. Conditions of coverage set forth below are applicable to this coverage.

(iii) Retail Pharmacy (Drug Store). There is no coverage under Medical Benefits for Prescription Medications that may be purchased from a retail Pharmacy (drug store), but coverage may be available under the prescription drug card program administered by the pharmacy benefits manager.

(iv) Home Infusion Therapy Pharmacy. The benefit for Medications received from a licensed retail Pharmacy designated by the Plan as a home infusion therapy Provider is covered based upon the Allowance or Allowable Charge for the Medication.

- **Covered Medications.** Medications are covered subject to the Deductible, Copayment, and Coinsurance listed in the Schedule of Benefits.

- **FDA approved medications.** FDA approved medications that exist as separate components and are intended for reconstitution prior to administration are covered. Examples include, but are not limited to, total parenteral, intravenous antibiotics, and hydration therapy.

- **Conditions of Coverage.** Conditions of coverage set forth below are applicable to this coverage.

- **Medical Supplies.** Medical Supplies used in connection with home infusion therapy are covered.

- **Administration Charges.** Charges to administer or inject Medication by a licensed medical professional operating under his or her scope of practice are covered according to the allowable fee schedule for skilled nursing under both home infusion therapy and Home Health.

(b) Conditions of Coverage

(i) Prior Approval. Selected Prescription Medications, as designated from time to time by the Plan, are subject to Prior Approval before coverage is allowed. A list of Medications for which Prior Approval is required is available from the Plan Administrator.

(ii) Specialty Medications. Selected Prescription Medications are designated by the Plan as "Specialty Medications" due to their route of administration, approved indication, unique nature, or inordinate cost. These medications usually require defined handling and home storage demands, crucial patient education, and careful monitoring. Such medications include, but are not limited to growth hormones, blood modifiers, immunoglobulins, and medications for the treatment of hemophilia, deep vein thrombosis, hepatitis C, Crohn's disease, cystic fibrosis, multiple sclerosis and rheumatoid arthritis. Specialty Medications may be A Medications or B Medications. Specialty Medications classified as A Medications are not covered under Medical Benefits but may be covered under the prescription drug card benefits administered by the pharmacy benefits manager. Specialty Medications classified as B Medications are covered. (See the definition "Prescription Medication" for a description of "A Medications" and "B Medications.") Coverage for Specialty Medications is subject to Prior Approval and may only be purchased through a specialty pharmacy vendor under contract with the Plan. A list of Specialty Medications is available from the Plan Administrator.

(24) Organ Transplant Services. Coverage is provided for human-to-human organ or tissue transplants in accordance with the following specific conditions:

(a) Not all transplants are covered. There must be a specific Coverage Policy which allows benefits for the transplant in question, and the Member must meet all of the required criteria necessary for coverage set forth in the Coverage Policy and in this document.

(b) Coverage for transplant services requires Prior Approval from the Claims Administrator, acting on the Plan's behalf. A request for approval must be submitted prior to receiving any transplant services, including transplant evaluation.

(c) The transplant benefit is subject to the Deductible and Coinsurance, and any additional limitations specified in the Schedules of Benefits.

(d) Transplants are only covered if provided in an In-Network facility or in a Blue Distinction Center for Transplants facility.

(e) Notwithstanding any other provisions of this document, the Allowance or Allowable

Charge for an organ transplant, including any charge for the procurement of the organ, Hospital services, Physician Services and associated costs, including costs of complications arising from the original procedure that occur within the Transplant Global Period, shall be limited to the lesser of (a) 90% of the billed charges or (b) the global payment determined as payment in full by a Blue Cross and Blue Shield Association Blue Distinction Centers for Transplant participating facility or a facility that has contracted with the Plan to provide the organ transplant. If the Member receives the transplant from a facility outside of Arkansas that is not in the Blue Distinction Centers for Transplant network, but is contracted with a local Blue Cross and/or Blue Shield Plan, the Allowable Charge shall be the price contracted by such Blue Cross and/or Blue Shield Plan. **Please note that payments for any transplant are limited to a global payment that applies to all covered transplant services. The Plan will not pay any amounts in excess of the global payment for services the facility or any Physician or other health care Provider or supplier may bill or attempt to bill separately, because the global payment is deemed to include payment for all related necessary services (other than non-Covered Services). If a Covered Person uses a facility participating in the Blue Distinction Centers for Transplant network, that facility has agreed to accept the global payment as payment in full, and should not bill the Covered Person for any excess amount above the global payment, except for applicable Deductible, Coinsurance, or non-Covered Services.**

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

(i) Allowance or Allowable Charges are only covered for the period beginning on the day before the transplant to the date of discharge or 39 days, whichever is less.

(ii) Donor testing is covered only if the tested donor is found compatible.

(g) When the Member is the donor, services, or supplies incidental to the organ or tissue transplant are not covered. Coverage is limited to services that use the Covered Person's cells and tissue.

(h) Solid organ transplants of any kind are not covered for individuals with a malignancy that is presently active or in partial remission. A solid organ transplant of any kind is not covered for a Member that has had a malignancy removed or treated in the three years prior to the proposed transplant. For purposes of this section, malignancy includes a malignancy of the brain or meninges, head or neck, bronchus or lung, thyroid, parathyroid, thymus, pleura, esophagus, heart or pericardium, liver, stomach, small or large bowel, rectum, kidney, bladder, prostate, testicle, ovary, uterus, other organs associated with the genito-urinary tract, bones, muscle, nerves, blood vessels, leukemia, lymphoma or melanoma, and breast. The only exception to this non-coverage is for solid organ transplant for hepatocellular carcinoma under certain circumstances, as outlined in the Coverage Policy for hepatocellular carcinoma.

(i) Coverage for high-dose or non-myeloablative Chemotherapy, allogeneic or autologous stem, or progenitor cell transplantation for the treatment of a medical condition is provided subject to the Claims Administrator's specific Coverage Policies relative to these specific conditions.

(j) Animal to human transplants are not covered.

(k) Artificial or mechanical devices designed to replace human organs are not covered.

(l) Small bowel transplantation is not covered.

(m) Pancreas transplant not done simultaneously with kidney transplant with diabetes and End Stage Renal Disease is not covered.

(n) Reasonable and necessary expenses for travel or transportation, food, and accommodations are covered only in connection with an approved organ transplant or stem cell treatment, provided the transplant recipient lives more than 100 miles from the place of treatment. Travel or transportation, lodging, and meals are covered only for the transplant recipient plus one companion. If the transplant recipient is a covered Dependent minor child, the transportation expenses of two companions will be covered. Coverage is further limited as shown in the Schedules of Benefits.

(25) **Medical Disorder Requiring Specialized Nutrients or Formulas.** Coverage is provided for Medical Foods and Low Protein Modified Food Products, amino-acid-based elemental formulas, extensively hydrolyzed protein formulas, formulas with modified vitamin or mineral content, and modified nutrient content formulas for the treatment of a Member diagnosed with a Medical Disorder Requiring Specialized Nutrients or Formulas if:

(a) The Medical Foods and Low Protein Modified Food Products shall only be administered under the direction of a clinical geneticist and a registered dietitian under the order of a licensed Physician; and,

(b) The Medical Foods and Low Protein Food Modified Products are prescribed in accordance with Coverage Policy for the therapeutic treatment of a Medical Disorder Requiring Specialized Nutrients or Formulas.

(26) **Prenatal Tests and Testing of Newborn Children.** Coverage is provided for prenatal tests and tests of newborn children that are supported by Coverage Policy. Examples of such tests that are covered include testing for Down's syndrome, hypothyroidism, sickle-cell anemia, phenylketonuria/ galactosemia, (PKU) and other disorders of metabolism.

(27) **Testing and Evaluation.** Coverage is provided for the following testing and evaluation, limited to 15 hours per year.

(a) Psychological testing, including but not limited to, assessment of personality, emotionality, and intellectual abilities;

(b) For Children under the age of six, childhood developmental testing, including but not limited to assessment of motor, language, social, adaptive, or cognitive function by standardized developmental instruments;

(c) Neurobehavioral status examination, including, but not limited to assessment of thinking, reasoning, and judgment; and,

(d) Neuropsychological testing, including, but not limited to Halstead-Reitan, Luria and WAIS-R.

(28) **Complications of Smallpox Vaccine.** Coverage is provided for complications resulting from a smallpox vaccination.

(29) **Neurologic Rehabilitation Facility Services.** Coverage is provided for Neurologic Rehabilitation Facility services. This Neurologic Rehabilitation Facility services benefit is subject to the following conditions:

(a) The Covered Person must be suffering from Severe Traumatic Brain Injury;

(b) The admission must be within seven days of release from a Hospital; and,

(c) A request for Prior Approval must be submitted to the Claims Administrator prior to the Member receiving Neurologic Rehabilitation Facility Services.

(i) The Neurologic Rehabilitation Facility services are of a temporary nature with a potential to increase ability to function;

(ii) Custodial Care is not covered.

(30) **Miscellaneous Health Interventions.** Coverage is provided for the following:

(a) **Allergy-related services.** Services include testing, extracts, and injections.

(b) **Anesthetic**. Administration of the following items is included: oxygen; blood and blood derivatives that are not donated or replaced; intravenous injections and solutions.

(c) **Contraceptive coverage.** Coverage is limited to charges billed by Physicians for contraceptive implants, diaphragms, and intrauterine devices (IUD's) and includes all services related to the administration, fitting, and insertion of such.

(d) **Dietary and Nutritional Counseling Services.** Coverage is available when services are provided in conjunction with Diabetic Self-Management Training, for services needed by Members in connection with cleft palate management and for nutritional assessment programs provided in and by a Hospital and approved by the Claims Administrator.

(e) **Eye exams.** Exams are covered when ordered by a Physician during treatment of a medical condition or Accidental Injury. Routine screenings are payable under Standard Preventive Care at zero cost-sharing to the member.

(f) **Gastric Pacemaker Coverage.** Coverage is provided, subject to Prior Approval from the Claims Administrator, acting on behalf of the Plan.

(g) **Hearing exams.** Exams are covered when ordered by a Physician during treatment of a medical condition or Accidental Injury. Routine screenings are payable under Standard Preventive Care at zero cost-sharing to the member.

(h) **High Frequency Chest Wall Oscillators.** Coverage is available to Members age two or older with cystic fibrosis, limited to one high frequency chest wall oscillator during such Member's lifetime.

(i) **Obesity.** Obesity treatment coverage, or any procedure performed for the purpose of

weight loss, is subject to Prior Approval from the Claims Administrator, acting on behalf of the Plan. Bariatric surgery is restricted to participants who are enrolled in the Bariatric Surgery Pilot Program. Weight loss medications are not a covered benefit.

(j) **Temporomandibular Joint (TMJ) Disorder**. Treatment is eligible for coverage in a manner consistent with established Coverage Policy and limited as shown in the Schedules of Benefits.

(k) **Trans-telephonic Home or ambulatory spirometry.** Coverage is available for patients who have had a lung transplant.

BARIATRIC SURGERY PILOT PROGRAM

ARBenefits will provide coverage for bariatric surgery for members who have completed all requirements in the Bariatric Surgery Pilot Program to include:

(1) Gastric bypass surgery;
(2) Adjustable gastric banding surgery;
(3) Sleeve gastrectomy surgery; and,
(4) Duodenal switch biliopancreatic diversion.

All program criteria must be met before Bariatric Surgery will be approved through the Pre-Certification process.

Eligibility Criteria

1. Primary insured only, no dependents.
2. Must have been the policy holder on our plan for at least 1 year.
3. BMI of 36 to 59 with an approved comorbidity, or a BMI of 40 to 59 without a comorbidity.
4. No previous bariatric surgery.
5. Active employee at enrollment and at time of surgery.
6. Financially able to cover all out of expenses including copays, and deductible.

NOTE: Approved comorbidities are: Sleep Apnea, Diabetes Mellitus Type II, Hypertension, and/or Osteoarthritis. The comorbidity must be verified by your surgeon or primary care provider.

Enrollment Steps

1) Go to https://my.arbenefits.org and log into your account.
2) Click on the Member tab, scroll down to External Links, then find Forms label and then Click on the application.
3) Fill out the form on the page and click submit.
4) Once you click on submit, the form is sent to the Case Mangers at Health Advantage to ensure you meet eligibility criteria.

Need assistance logging in to your ARBenefits account?

Contact Member Services at 1-877-815-1017 option 1 or send an e-mail to AskEBD@dfa.arkansas.gov. The ARBenefits Office is open Monday - Friday 8 a.m. - 4:30 p.m.

Participation Criteria

1. Meet all the eligibility criteria.
2. Must participate in a minimum of three (3) months of nurse coaching with a Health Advantage Case Manager and continue contact monthly until surgery. The length of the post-operative follow-up scheduled is determined by your Case Manager and based on their professional assessment. These intervals of contact will be set to meet your individual needs and will be a verbal contract between you and the Health Advantage Case Manager. **Maintaining contact with the Case Manager at the agreed upon interval is the member's responsibility both before and after surgery.**
3. Must have successfully completed at least a three-month health care provider-supervised nutrition and exercise program as detailed below.

4. Must have a working voicemail and email.
5. Must be able to speak with a nurse coach between the hours 8:00 am -4:00 pm Monday through Friday.

NOTE: No less than 20 days nor more than 40 days between contacts.

Nutrition and Exercise Program

1) A low-calorie diet or diet program recommended specifically for the member by his/her physician, mid-level practitioner, registered dietician, or surgeon.
2) Increased physical activity and behavior modification prescribed by medical provider.
3) Documentation of compliance monthly for a minimum of three (3) months and continuing until surgery is complete.

NOTE: A physician summary letter is NOT sufficient, and member's weight must be documented at each visit.

Other requirements

1) Surgery must be completed on or before December of the enrollment year.
2) Documentation required for prior approval must be submitted by a Health Advantage In-Network bariatric surgeon.
3) Letter from the surgeon or physician monitoring/supervising the weight loss prior to surgery is to include:
   I. Recommendation of member for bariatric surgery.
   II. Weight History – documentation of monthly compliance for a minimum of three (3) months and continuing surgery.
   III. Records of all studies/procedures such as, but not limited to, sleep study, cardiac studies, hernia repair and operations on the stomach or intestines.

NOTE: This pilot will only cover the first bariatric procedure per lifetime. (Employees who have had previous bariatric procedures are ineligible for this Pilot.) Any and all of the above requirements may be subject to change.

COST MANAGEMENT SERVICES

PRIOR APPROVAL OF MEDICAL SERVICES

The Plan has a program designed to help insure that all Covered Persons receive necessary and appropriate health care while avoiding unnecessary expenses.

Please refer to the health plan identification card for the prior approval Services phone number.

The program consists of:

(a) Prior Approval of the Medical Necessity for the following services before Medical and/or Surgical services are provided:

Inpatient Admissions
Emergency Inpatient Admissions (call must be made within 48 hours of admission)
Specific Outpatient Medical Services and Procedures (see list on next page)
Specific Durable Medical Equipment (see list on next page);

(b) Retrospective review of the Medical Necessity of the listed services provided;

(c) Concurrent review, in consideration of extended services; and,

(d) Discharge planning.

The purpose of the program is to determine what charges may be eligible for payment by the Plan. This program is not designed to be the practice of medicine or to be a substitute for the medical judgment of the attending Physician or other health care Provider.

If a particular course of treatment or medical service is not certified, it means that either the Plan will not pay for the charges or the Plan will not consider that course of treatment as appropriate for the maximum reimbursement under the Plan. The patient is urged to find out why there is a discrepancy between what was requested and what was certified before incurring charges.

Prior approval requirements are waived for a maternity length of stay that is 48 hours or less for a vaginal delivery or 96 hours or less for a cesarean delivery.

In order to maximize Plan reimbursements, please read the following provisions carefully.

Here's how the program works:

The responsible party must call the prior approval Services telephone number on the ID card.

Through the prior approval process, the number of days of Medical Care Facility confinement authorized for payment will be determined. **Failure to follow this procedure may reduce reimbursement received from the Plan.**

Concurrent review, discharge planning. Concurrent review of a course of treatment and discharge planning from a Medical Care Facility are parts of the prior approval program. The Covered Person's Medical Care Facility stay or use of other medical services will be monitored and either the scheduled release or an extension of the Medical Care Facility stay or extension or cessation of the use of other medical services will be coordinated with the attending Physician, Medical Care Facility, and Covered Person.

Responsibility for Obtaining Prior Approval
The following table identifies services which require prior approval. If the service or procedure is provided by an In-Network Provider, it is the Provider's responsibility to obtain prior approval. If the service or procedure is provided by an Out-of-Network Provider, it is the Covered Person's responsibility to obtain prior approval.

Some Out-of-Network Providers may have contracts with either the Claims Administrator or the Blue Cross and Blue Shield plan in the state where services were provided, which make them responsible for any penalty amounts incurred for failure to obtain prior approval. The Covered Person may contact Health Advantage at the customer service telephone number listed on the health plan identification card to determine if a specific Out-of-Network Provider has this type of contract.

Services requiring Prior Approval	
Inpatient admissions, including emergency admissions and concurrent care extension, at a Hospital and similar facilities, such as:	
Acute Care Facility	Skilled Nursing Facility
Inpatient Rehabilitation (Physical)	Long Term Acute Care (LTACH)
Residential Treatment Facility	
Specific Outpatient Medical Services	
Home Health Services	Physical Therapy
Occupational Therapy	Speech Therapy
Cognitive Rehabilitation	Enteral Formulae and Supplies
Intensity-Modulated Radiation Therapy (IMRT)	Applied Behavioral Analysis (ABA) Therapy
Specific Outpatient Medical Procedures	
Uvulopalatopharyngoplasty (UPPP)	Varicose Vein Treatment
Blepharoplasty and/or Brow Lift	Gynecomastia Reduction
Mammoplasty	Panniculectomy
Rhinoplasty	Scar Revision outside doctor's office
Gastric Pacemaker	
Bariatric Surgery (Including Revisions and, Reversals)	
Specific Durable Medical Equipment	
Spinal Cord Stimulators (implantation and device)	Defibrillator Vests Powers
Power Mobility Devices	Continuous Glucose Monitoring Devices (CGM)
Wound Vacuum Therapy / Device	*The Medtronic Guardian Connects is the only CGM Device covered as a Durable Medical Equipment. Please refer to the Preferred Drug List on page 141 for CGM benefits.

SECOND AND/OR THIRD OPINION PROGRAM

Certain surgical procedures are performed either inappropriately or unnecessarily. In some cases, surgery is only one of several treatment options. In other cases, surgery will not help the condition.

In order to prevent unnecessary or potentially harmful surgical treatments, the second and/or third opinion program fulfills the dual purpose of protecting the health of the Plan's Covered Persons and protecting the financial integrity of the Plan.

Benefits will be provided for a second (and third, if necessary) opinion consultation to determine the Medical Necessity of an elective surgical procedure. An elective surgical procedure is one that can be scheduled in advance; that is, it is not an emergency or of a life-threatening nature. Benefits for the second (and third, if necessary) opinion will be paid as any other Sickness.

PREADMISSION TESTING SERVICE

Diagnostic lab tests and x-ray exams will be reimbursed according to standard Plan benefit levels when:

(1) Performed on an outpatient basis within seven days before a Hospital confinement;

(2) Related to the condition which causes the confinement; and,

(3) Performed in place of tests while Hospital confined.

Covered Charges for this testing will be paid even if tests show the condition requires medical treatment prior to Hospital confinement or the Hospital confinement is not required.

CASE MANAGEMENT

Case Management is a program under which nurses communicate with Plan Participants' Physicians to facilitate access to benefits under the Plan Participants' Medical Benefits Plan, to identify benefit options for outpatient or home treatment settings, and, where appropriate in the Physician's independent professional judgment, to identify and offer Plan Participants a choice of cost-effective alternatives to hospitalization. Case Management nurses are licensed professionals who use their specialized skills to communicate effectively with Physicians; they do not, however, provide any medical services to Plan Participants. All treatment decisions remain exclusively with the Plan Participant and his or her Physicians.

Case Management services can provide the following value-added benefits for Plan Participants and the Plan:

(1) Maximize the benefits available under the Medical Benefits Plan;

(2) At the same time, identify cost-effective alternatives to high-cost treatment settings such as hospitalization;

(3) Educate Plan Participants and their Physicians on cost-effective alternatives from which they may choose;

(4) Provide health education to Plan Participants to empower them and their families to self-manage aspects of their care as deemed appropriate by their Physician; and,

(5) help Plan Participants better understand and deal with the complexities of the health care system and their Medical Benefits Plan.

PLAN EXCLUSIONS

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

Health Care Providers.

(1) **Custodial Care Facility.** Services or supplies furnished by an institution which is primarily a place of rest or a place for the aged are not covered. Youth homes, boarding schools, or any similar institution are not covered.

(2) **Freestanding Cardiac Care Facility.** Treatment received at a Freestanding Cardiac Care Facility is not covered.

(3) **Immediate Relatives.** Professional Services performed by a person who ordinarily resides in the covered Member's home, including self, or is related to the covered Member as a Spouse, parent, Child, brother or sister, grandparent and grandchild, whether the relationship is by blood or exists in law are not covered.

(4) **Midwives, Not Certified.** Services provided by a midwife who is not a licensed certified nurse midwife in the state where he or she renders services and who does not have a collaborative agreement with a Physician are not covered.

(5) **Physical Therapy Aide.** Services or supplies provided by a physical therapy aide are not covered.

(6) **Provider, Excluded.** Health Interventions received from any Provider who has been excluded from participation in any federally funded program, are not covered.

(7) **Private Duty Nurse.** Private duty nursing services and home care aides are not covered.

(8) **Recreational Therapist.** Services or supplies provided by a recreational therapist are not covered.

(9) **Residents, interns, students**, **or fellows.** Services performed or provided by a Hospital resident, intern, student, or fellow of any medical related discipline are not covered.

(10) **Surgical First Assistants.** Health Advantage does not recognize surgical first assistants as a covered Provider eligible for reimbursement for Covered Services. Any services performed by a surgical first assistant will be denied.

(11) **Unlicensed Providers or Provider Outside Scope of Practice.** Coverage is not provided for treatment, procedures or services received from any person or entity, including but not limited to Physicians, who is required to be licensed to perform the treatment, procedure, or service, but is not so licensed, or (2) has had his license suspended, revoked, or otherwise terminated for any reason, or (3) has a license that does not, in the opinion of Health Advantage's Medical Director, include within its scope the treatment, procedure, or service provided.

Health Interventions.

(1) **Abortion.** Abortion is not covered. However, Pregnancy terminations under the direction of a Physician are covered, but only when performed in an In-Network Hospital or In-Network Outpatient Hospital setting.

(2) **Abuse of Medications.** Medications, drugs, or substances used in an abusive, destructive, or injurious manner are not covered, except when caused by a mental or physical Illness.

(3) **Acupuncture.** Acupuncture and services related to acupuncture are not covered.

(4) **Adoptive Immunotherapy.** Adoptive immunotherapy, (lymphokine-activated killer (LAK) therapy, tumor-infiltrating lymphocyte (TIL) therapy, autolymphocyte therapy (ATL)) is not covered.

(5) **Allergy Testing by Serial Endpoint Titration (SET).** Allergy testing by serial endpoint titration (SET) is generally not covered. However, coverage may be provided for SET upon proof that the Member has airborne allergies with such severe reactions that standard allergy testing is considered too dangerous to attempt.

(6) **Antigen immunotherapy.** Antigen immunotherapy for repeat fetal loss is not covered.

(7) **Arthroereisis for Pes Planus (Flat Feet).** This treatment is sometimes used to treat flat feet and is not covered.

(8) **Balloon Sinuplasty.** A balloon sinuplasty device is sometimes used for treatment of sinusitis and is not covered.

(9) **Biofeedback.** Biofeedback and other forms of self-care or self-help training, and any related diagnostic testing are not covered for any diagnosis or medical condition.

(10) **Biochemical Markers for Alzheimer's Disease.** Measurement of cerebrospinal fluid and urinary biomarkers of Alzheimer's disease including but not limited to tau protein, amyloid beta peptides and neural thread proteins are not covered.

(11) **Blood Typing.** Blood Typing or DNA analysis for paternity testing is not covered.

(12) **Bone Growth Stimulation, electrical, as an adjunct to cervical fusion surgery.** Electrical Bone Growth Stimulation used as an adjunct to cervical fusion surgery is not covered.

(13) **Chelation therapy.** Services or supplies provided as, or in conjunction with, chelation therapy, are generally not covered. However, chelation therapy for control of ventricular arrhythmias or heart block associated with digitalis toxicity, emergency treatment of hypercalcemia, extreme conditions of metal toxicity, including thalassemia intermedia with hemosiderosis, Wilson's disease (hepatolenticular degeneration), lead poisoning, and hemochromatosis is covered.

(14) **Chemical Ecology.** Diagnostic studies and treatment of multiple chemical sensitivities, environmental Illness, environmental hypersensitivity disorder, total allergy syndrome, or chemical ecology is not covered.

(15) **Cognitive Rehabilitation.** Services or supplies provided as or in conjunction with, Cognitive Rehabilitation are not covered. However, coverage is provided for Neurologic Rehabilitation

Facility Services for Members with Severe Traumatic Brain Injury.

(16) **Cold Therapy.** Cold Therapy devices are used in place of ice packs. The use of active or passive, intermittent or continuous, with or without pneumatic compression, cold therapy is not covered. Examples of cold therapy devices include, but are not limited to, the Cryocuff device, the Polar Care Cub device, the Autochill device, and the Game Ready device.

(17) **Complications of non-covered treatments.** Care, services, or treatment required as a result of complications from a treatment or service not covered under this Plan are not covered. This is true even if coverage was provided through a previous carrier. This exclusion does not apply to complications of a bariatric surgery which was previously approved by the Plan.

(18) **Compression Garments.** All types of compression garments, support hose, or elastic supports are not covered even when purchased with a Prescription. However, coverage is provided for compression garments specifically designed to treat severe burns or compression sleeves and gloves used to treat lymphedemas following mastectomy.

(19) **Contraceptives.** Contraceptive implants, patches, cervical shields, or any other type of contraception that can be purchased from a Pharmacy or is available over the counter. Oral contraceptives are not covered under Medical Benefits, except as indicated by the PPACA mandate for Women's Contraceptive Services. Additional contraceptive coverage may be covered under the Prescription Drug Card program administered by the pharmacy benefits manager.

(20) **Convenience Items.** While not a complete list, personal convenience items such as: assistive talking devices, automobile / van conversion, or addition of patient lifts, hand controls, or wheel chair ramps, and home modifications such as overhead patient lifts and wheelchair ramps are not covered.

(21) **Cord Blood.** The collection and/or storage of cord or placental blood cells for an unspecified future use as an autologous stem-cell transplant in the original donor or for some other unspecified future use as an allogeneic stem-cell in a related or unrelated donor is not covered

(22) **Coverage Policy.** The Claims Administrator has developed and published on its website specific Coverage Policies in relation to certain Health Interventions. If a Coverage Policy exists for an Intervention, the Coverage Policy shall determine whether such Intervention meets the Primary Coverage Criteria. If a Coverage Policy determines that a Health Intervention does not meet the Primary Coverage Criteria, this Plan does not provide coverage for that Intervention. The absence of a specific Coverage Policy with respect to any particular Health Intervention should not be construed to mean that the Intervention meets the Primary Coverage Criteria.

(23) **Cranial electrotherapy or cranial electromagnetic stimulation devices.** Cranial electrotherapy or electromagnetic stimulation devices are not covered.

(24) **Cranial mandibular disharmony.** Charges related to the treatment of cranial mandibular disharmony are not covered.

(25) **Current Perception Threshold Testing.** This testing performed as a substitute for standard nerve conduction studies in diagnosing carpal tunnel or tarsal tunnel syndrome is not covered.

(26) **Dental Care or orthodontic services.** Dental Care and orthodontic services are not covered unless related to an Accidental Injury, or as a result of Sjogren's syndrome.

(27) **Dietary and Nutritional Services.** Any services or supplies provided for dietary and nutritional services, including but not limited to medical nutrition therapy, unless such dietary supplies are the sole source of nutrition for the Member, are not covered. Baby formula or thickening agents, whether prescribed by a Physician or acquired over the counter, is not a covered benefit. However, coverage is provided for Medical Foods and Low Protein Modified Food Products for the treatment of a Medical Disorder Requiring Specialized Nutrients or Formulas.

(28) **Digitization Computer Enhanced X-ray Analysis for Spinal Evaluation.** Spinal visualization using digitization of spinal x-rays and computerized analysis of the back or spine is not covered.

(29) **Dynamic Orthotic Cranioplasty.** Dynamic orthotic cranioplasty is not covered.

(30) **Dynamic spinal motion visualization techniques such as Digital Motion X-ray, Cineradiography**, **and Videoradiography.** The use of digital motion x-ray for the evaluation of musculoskeletal conditions is not covered.

(31) **EKG, Signal Averaged.** Signal averaged electrocardiography utilized to stratify risk for arrhythmias following myocardial infarction, in patients with cardiomyopathy, in patients with syncope, as an assessment of success after surgery for arrhythmia, in detection of acute rejection of heart transplants, as an assessment of efficiency of antiarrhythmic drug therapy and in the assessment of successful pharmacological, mechanical, or surgical interventions to restore coronary blood flow is not covered.

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

(33) **Enhanced External Counterpulsation.** Enhanced external counterpulsation (EECP) is generally not covered. However, coverage is provided for one course of enhanced external counterpulsation for the treatment of disabling angina in patients who are NYHA Class III or IV, or equivalent classification; who have experienced inadequate control of anginal symptoms with a medication regimen that consists of optimal dosages of platelet inhibitors, beta-blockers, calcium channel blockers, long-acting nitrates, lipid-lowering drugs, and antihypertensives when these drugs are appropriate and there is no contraindication to any of these drugs; and who are not amenable to surgical cardiac intervention such as angioplasty or coronary artery bypass grafting. Repeat courses of EECP are not covered.

(34) **Enteral Feedings.** Enteral feedings are generally not covered. However, enteral feedings are covered when such feedings have been approved and documented by an In-Network Physician as the Member's sole source of nutrition with Prior Approval by Case Management.

(35) **Environmental Intervention.** Services or supplies used in adjusting a Member's home, place of employment, or other environment so that it meets the Member's physical or psychological condition are not covered.

(36) **Epiduroscopy/spinal myeloscopy.** This service is used in the diagnosis and treatment of spinal

pain and is not covered.

(37) **Exercise programs.** Exercise programs for treatment of any condition are not covered.

(38) **Extracorporeal Shock Wave Therapy.** Extracorporeal shock wave therapy (ESWT) for any musculoskeletal condition, including but not limited to plantar fasciitis or tennis elbow, is not covered.

(39) **Family Planning.** The following family planning services are not covered:

(a) Reversal of sterilization;

(b) Preimplantation;

(c) Surrogate mothers;

(d) Treatment of Infertility; and,

(e) In-vitro fertilization

(40) **Foot care.** Non-custom shoe inserts are not covered. Services or supplies for the treatment of subluxations of the foot, arthroeresis for flat feet, care of corns, bunions, (except capsular or bone surgery), calluses, toe nails, fallen arches, weak feet, chronic foot strain, and symptomatic complaints of the feet are not covered. However, foot care is provided when required for prevention of complications associated with diabetes mellitus.

(41) **Fraud or Material Misrepresentation.** Health Interventions, including but not limited to Medications, obtained by unauthorized or fraudulent use of the health plan identification card or by material misrepresentation are not covered.

(42) **Free Health Interventions.** Health Interventions, including but not limited to Medications, provided or dispensed without charge to the Member or for which, normally (in professional practice), there is no charge, are not covered.

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

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

(44) **Hair loss or growth.** Wigs, hair transplants, or any Medication (e.g. Rogaine, minoxidil, etc.) that is taken for hair growth, whether or not prescribed by a Physician, are not covered regardless of the cause of hair loss. Treatment of male or female pattern baldness is not covered.

(45) **Health and Behavior Assessment/Intervention.** Evaluation of psychosocial factors potentially impacting physical health problems and treatments are not covered. This includes health and behavior assessment procedures used to identify psychological, behavioral, emotional, cognitive, and social factors affecting physical health problems. This does not include psychiatric services.

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

(47) **High dose Chemotherapy, Autologous Transplants, Allogeneic Transplants, or Nonmyeloablative Allogeneic Stem Cell Transplantation.** High dose Chemotherapy, Autologous Transplants, Allogeneic Transplants, or Nonmyeloablative Allogeneic Stem Cell Transplantation are not covered except in the limited circumstances.

(48) **Hippotherapy.** Hippotherapy is not covered.

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

(50) **Home Uterine Activity Monitor.** Home uterine activity monitors or their use is not covered.

(51) **Hypnotherapy.** Hypnotherapy is not covered for any diagnosis or medical condition.

(52) **Illegal Uses.** Medications, drugs, or substances that are illegal to dispense, possess, consume, or use under the laws of the United States or any state, or that are dispensed or used in an illegal manner, are not covered.

(53) **Inotropic Agents for Congestive Heart Failure.** Chronic, intermittent infusion of positive inotropic agents for patients with severe congestive heart failure is not covered. However, where the patient is on a cardiac transplant list at a Hospital where there is an ongoing cardiac transplantation program, the Plan will cover infusion of inotropic agents.

(54) **Interspinous Distraction Devices (Spacers).** These devices are inserted between the spinous processes, and they act as a spacer between the spinous processes. Their proposed use is to treat leg and/or back pain secondary to spinal stenosis and distract the spinous processes and restrict extension. Interspinous Distraction Devices (Spacers) are not covered. Examples include, but are not limited to, the X-STOP interspinous Process by Medtronics, the Wallis System by Abbott Spine, the Coflex implant by Paradigm Spine, the ExtendSure, and CoRoent devices by NuVasive, the NL-Prow by NonLinear Technologies, the Aperius by Medtronic Spine.

(55) **Intraoperative Neurophysiologic Monitoring, Remotely Performed.** Intraoperative neurophysiologic monitoring is used to monitor the integrity of neural pathways during high-risk neurosurgical, orthopedic, and vascular surgeries. It is not covered when performed from a remote location. The Physician performing this service must be a licensed Physician (other than the operating surgeon or the performing anesthesiologist) and be physically present in the operating suite. When intraoperative monitoring is remotely performed it is not covered.

(56) **In Vitro Chemoresistance and Chemosensitivity Assays.** In vitro chemoresistance and chemosensivity assays for neoplastic disease, including but not limited to extreme drug resistance assays, histoculture drug response assay, or a fluorescent cytoprint assay are not covered.

(57) **Laser Treatment of Spinal Intradiscal and Paravertebral Disc Disorders.** Laser treatment of spinal intradiscal and paravertebral disc disorders is not covered.

(58) **Learning Disabilities.** Services or supplies provided for learning disabilities, i.e. reading disorder, alexia, developmental dyslexia, dyscalculia, spelling difficulty, and other learning difficulties, are not covered.

(59) **Maintenance Therapy.** The plan does not provide benefits for maintenance therapy. Maintenance Therapy refers to therapy in which an individual actively participates, that is provided after no continued significant and measurable improvement is reasonably or medically anticipated.

(60) **Measurement of Exhaled Nitric Oxide.** Measurement of Exhaled Nitric Oxide used in the diagnosis and management of asthma and other respiratory disorders is not covered.

(61) **Measurement of Lipoprotein-Associated Phospholipase (Lp-PLA2).** Measurement of Lipoprotein-Associated Phospholipase (Lp-PLA2), also known as platelet-activating factor acetylhydrolase is not covered. The proposed use of this test is to assess cardiovascular risk.

(62) **Measurement of Novel Lipid Risk Factors in Risk Assessment and Management of Cardiovascular Disease.** Measurement of novel lipid risk factors including but not limited to apolipoprotein B, apolipoprotein A-1, HDL subclass, LDL subclass, apolipoprotein E, and Lipoprotein A are not covered.

(63) **Measurement of Serum Intermediate Density Lipoproteins (remnant-like particles).** These lipoproteins have a density that falls between low density lipoproteins and very low density lipoproteins. Measurements of these "remnant-like" particles are not covered.

(64) **Medical Supplies.** Medical Supplies that can be purchased without a Prescription or over the counter, whether or not a Prescription was obtained, are not covered; for example, medication coated dressings are not covered even with a Physician Prescription. However, Medical Supplies necessary for the management of diabetes mellitus or for home health services are covered. Expenses for Medical Supplies provided in a Physician's office are included in the reimbursement for the procedure or service for which the supplies are used.

(65) **Medication Therapy Management Services.** Medication therapy management services by a pharmacist, including but not limited to a review of a Member's history and medical profile, an evaluation of Prescription Medication, over-the-counter medications and herbal medications, are not covered.

(66) **Mobile Cardiac Outpatient Telemetry (MCOT).** Mobile Cardiac Outpatient Telemetry is sometimes used in patients who experience infrequent symptoms suggestive of cardiac arrhythmias. MCOT is not covered.

(67) **Naturopath/Homeopath Treatment.** Naturopathic or Homeopathic treatments of any condition are not covered.

(68) **Neural Therapy.** Neural therapy often involves the injection of a local anesthetic into scars, trigger points, acupuncture points, tendon insertions, ligament insertions, peripheral nerves, autonomic ganglia, the epidural space, and other tissues to treat chronic pain and Illness. Neural therapy is not covered.

(69) **Neurofeedback.** The proposed use of Neurofeedback has been to reinforce neurobehavior modification in patients with certain neurological and/or neurobehavioral disorders such as ADD, ADHD, Parkinson's Disease, epilepsy, insomnia, depression, mood disorders, post-traumatic stress disorder, alcoholism, drug addiction, menopausal symptoms, and migraine headaches. Neurofeedback is not covered.

(70) **Nicotine replacement products.** Charges for nicotine replacement products, including lozenges, nasal sprays, inhalers, nicotine gum, and transdermal nicotine patches purchased over the counter or with a Prescription, are not covered under Medical Benefits.

(71) **Non-Medicare Covered Durable Medical Equipment.** Medical equipment and supplies that are not covered by Medicare are specifically excluded and not covered by the Plan. Examples of excluded items include but are not limited to the purchase or rental of air conditioners, air purifiers, water beds, saunas, tanning beds, motorized transportation equipment except with Prior Approval, automobile/van conversion or addition of patient lifts, hand controls, or wheel chair ramps, home modifications such as overhead patient lifts and wheelchair ramps, exercise equipment, or similar items. Replacement or repair of Durable Medical Equipment and Prosthetic Devices is covered only when Medically Necessary due to normal wear and tear. Disposable items are not covered.

(72) **Orthognathic Surgery.** The surgical repositioning of segments of the mandible or maxilla containing one to several teeth, or the bodily repositioning of entire jaws, whether to reduce a dislocation of temporomandibular joint or for any other purpose, is not covered. However, coverage is provided for the repositioning of the mandible or maxilla after an Accidental Injury or the treatment of a tumor.

(73) **Orthoptic, Pleoptic**, **or Vision Therapy.** Orthoptic, pleoptic, or vision therapy services are generally not covered. However, coverage is provided for office-based orthoptic training in the treatment of convergence insufficiency when supported by the Coverage Policy on Orthoptic Training for the Treatment of Vision and Learning Disabilities.

(74) **Out-of-Network Infertility.** Testing, counseling, and planning services for Infertility are not covered when provided by Out-of-Network Providers.

(75) **Out-of-Network Mental Health and Substance Abuse Services.** Interventions to treat Mental Health or substance abuse are not covered when rendered by an Out-of-Network Provider.

(76) **Out-of-Network Services.** Services rendered Out-of-Network are not covered for Plan Participants enrolled in the Basic Plan.

(77) **Over the Counter Medications.** Over-the-counter Medications (except insulin) are not covered without a Prescription from a Physician.

(78) **Pain Pump, Disposable.** Disposable pain pumps following surgery are not covered.

(79) **Percutaneous diskectomy and Radio-frequency Thermocoagulation.** Any method of percutaneous diskectomy, including, but not limited to, automated or manual percutaneous diskectomy, laser diskectomy, radiofrequency nucleotomy or nucleolysis, and coblation therapy, is not covered. Radio-frequency Thermocoagulation or Intradiscal electrothermal therapy for discogenic or other forms of back pain are not covered.

(80) **Percutaneous Sacroplasty.** Percutaneous sacroplasty is not covered.

(81) **Peripheral Vascular Disease Rehabilitation Therapy.** Peripheral vascular disease rehabilitation therapy is not covered.

(82) **Prescription Medication Purchased at a Retail Pharmacy.** Prescription Medications purchased at a retail Pharmacy are not covered under Medical Benefits, but coverage may be available under the prescription drug card program administered by the pharmacy benefits manager.

(83) **Prolotherapy.** Prolotherapy or Sclerotherapy for the stimulation of tendon or ligament tissue or for pain relief in a localized area of musculoskeletal origin is not covered.

(84) **Radio-frequency Thermal Therapy for Treatment of Orthopedic Conditions.** The use of radio- frequency thermal therapy for treatment of orthopedic conditions is not covered.

(85) **Respite care**. Charges for services provided for the purpose of providing temporary relief to family members or friends from the duties of caring for the Covered Person are not covered.

(86) **Rest cures.** Services or supplies for rest cures are not covered.

(87) **School-Based Interventions.** With the exception of applied behavioral analysis (ABA) therapy for treatment of autism and seasonal flu vaccinations, Health Interventions provided in a school setting are not eligible for coverage under the Plan.

(88) **Seasonal Affective Disorder (SAD).** Use of photo therapy or light therapy to treat seasonal affective disorder or depression is not covered.

(89) **Sensory Stimulation for Coma Patients.** Sensory stimulation, whether visual, auditory, olfactory, gustatory, cutaneous, or kinesthetic, for coma patients is not covered.

(90) **Sex changes/sex therapy.** Care, services, or treatment for non-congenital transsexualism, gender dysphoria, or sexual reassignment or change are not covered. This exclusion includes medications, implants, hormone therapy, surgery, medical, or psychiatric treatment or other treatment of sexual dysfunction including Prescription Medications and sex therapy.

(91) **Sexual Enhancement Medications.** Medications used for the treatment of sexual dysfunction, including but not limited to medications for erectile dysfunction, are not covered regardless of the reason(s) for the sexual dysfunction.

(92) **Short stature syndrome.** Any services related to the treatment of short stature syndrome, except for Laboratory documented growth hormone deficiency, are not covered.

(93) **Sleep Apnea, Portable Studies.** Portable sleep apnea studies are not covered unless the following seven channel monitoring information is included: EEG, heart rate, Chin EMG, ECG, airflow, effort, and oxygen saturations, channels to identify awake versus asleep and apnea

events. Devices used are considered portable comprehensive polysomnography devices monitoring a minimum of seven channels.

(94) **Snoring.** Devices, procedures, or supplies to treat snoring are not covered.

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

(96) **Spinal Manipulation under general anesthesia.** This type of manipulation is sometimes used for treatment of arthrofibrosis of the knee or shoulder and is intended to overcome the patient's protective reflex mechanism. Spinal manipulation under anesthesia is not covered.

(97) **Spinal Uploading Devices for treatment of low back pain.** Spinal uploading devices including, but not limited to, gravity dependent and pneumatic devices are not covered. Examples include, but are not limited to, the Orthotrac Pneumatic Vest and other thoracic-lumbar-sacral orthotics which provide trunk support.

(98) **Substance Addiction.** Medications used to sustain or support an addiction or substance dependency are not covered. However, the use of designated agonist (e.g. methadone or buprenorphine) as part of a comprehensive substance abuse treatment plan are covered.

(99) **Tanning equipment or salon.** The purchase or rental of tanning equipment, supplies, or the services of a tanning salon are not covered.

(100) **Telephone and Other Electronic Consultation.** Telephone calls or other forms of electronic consultation (e.g. e-mail, internet, or video) between a Provider and a Covered Person, or between a Provider and another Provider, for medical management or coordinating care, are not covered. This includes reporting or obtaining tests or laboratory results. However, communications made by a Physician responsible for the direct care of a Covered Person in Case Management with involved Health Care Providers are covered.

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

(102) **Thoracoscopic Laser Ablation of Emphysematous Pulmonary Bullae.** Thoracoscopic laser ablation of emphysematous pulmonary bullae is not covered.

(103) **Total Facet Arthroscopy.** Facet arthroscopy refers to the implantation of a spinal prosthesis to restore posterior element structure and function as an adjunct to neural decompression surgery. Total Facet Arthroscopy is not covered. Examples of facet arthroplasty devices include, but are not limited to, the ACADIA facet replacement System, the Total Facet Arthroscopy System, and the Total Posterior-element System (TOPS).

(104) **Transesophageal Therapy for Gastroesophageal Reflux Disease.** Transesophageal Therapy for Gastroesophageal Reflux Disease (GERD), Endoscopic Suturing, Transoral Incisionless Fundoplication (TIF) including the following devices EndoCinch™ (CR Bard, Murray Hill, NJ) 2., Plicator™ (Ethicon Endo-Surgery, Chicago, IL) 3., and EsophyX™ (EndoGastric Solutions, Redmond, WA) are not covered. Magnetic Esophageal Ring for GERD including the The LINX™ Reflux Management System is not covered.

(105) Transplant procedures. The following transplant procedures and services are not covered:

(a) Solid organ transplants of any kind are not covered for a Member with a malignancy of any kind that is presently active, in partial remission or in complete remission less than two years. A solid organ transplant of any kind is not covered for a Member that has had a malignancy removed or treated in the three years prior to the proposed transplant. For purposes of this section, malignancy includes a malignancy of the brain or meninges, head or neck, bronchus or lung, thyroid, parathyroid, thymus, pleura, esophagus, heart or pericardium, liver, stomach, small or large bowel, rectum, kidney, bladder, prostate, testicle, ovary, uterus, other organs associated with the genito-urinary tract, bones, muscle, nerves, blood vessels, leukemia, lymphoma or melanoma, and breast. Exceptions to this non-coverage are (i) hepatocellular carcinoma under certain circumstances, as outlined in the Coverage Policy for hepatocellular carcinoma, and (ii) basal cell and squamous cell carcinomas of the skin, absent lymphatic or distant metastasis.

(b) Services are not covered unless provided by In-Network facilities or Blue Distinction Centers for Transplant facilities.

(c) Organ transplants not authorized by Coverage Policy are not covered.

(d) **Donor Services**. Services or supplies incidental to organ and tissue transplant, or other procedures when the covered Person acts as the donor are not covered except for services that use the Covered Person's cells and tissue. When the Covered Person is the potential transplant recipient, expenses for testing of a donor who is found to be incompatible are not covered.

(e) Charges for the following transplant procedures and services are not covered:

(i) Animal to human transplants;

(ii) Artificial or mechanical devices designed to replace human organs;

(iii) Services provided beyond the benefit maximums;

(iv) Small bowel transplantation;

(v) Pancreas transplant not done simultaneously with kidney transplant with diabetes and End Stage Renal Disease; and,

(vi) Solid organ transplantation in patients for carcinoma except for liver transplants for patient with hepatoma confined to the liver.

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

(107) Viscosupplementation for treatment of Osteoarthritis. Intra-articular hyaluronan such as Synvisc, Hyalgan, Supartz, Orthovisc, and Euflexxa are not covered when used to treat osteoarthritis of any joint other than the knee (e.g. the hip).

(108) Vision enhancement. Any procedure, treatment, service, equipment, or supply used to enhance vision by changing the refractive error of the eye is not covered. Examples of non-covered visual

enhancement services include, but are not limited to, the refraction for and the provision of eyeglasses and contact lenses, intraocular lenses, and Refractive Keratoplasty, with the exception of excessive, visually debilitating residual astigmatism following anterior segment surgery, i.e. corneal transplantation, cataract extraction, etc. Laser Assisted Insitu Keratomileusis (LASIK), and all other related refractive procedures are not covered. However, a procedure, treatment, service, equipment or supply to correct a refractive error of the eye is covered in two instances: (1) if such refractive error results from traumatic Accidental Injury or corneal disease, infectious or non-infectious, and (2) the single acquisition of eyeglasses or contact lenses within the first six months following cataract surgery. With respect to such eyeglasses or contact lenses, tinting or anti-reflective coating and progressive lenses are not covered. Eyeglass frames are subject to a $50 maximum Allowance or Allowable Charge.

(109) **Vitamins or Baby Formula.** Vitamins or food/nutrient supplements, except those that are Prescription Medications not available over the counter, are not covered. Baby formula and thickening agents, even if prescribed by a Physician, is not covered. However, coverage is provided for Medical Foods and Low Protein Modified Food Products for the treatment of Medical Disorder Requiring Specialized Nutrients or Formulas.

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

(111) **Weight Control.** Medications prescribed, dispensed, or used for the treatment of obesity, or for use in any program of, weight control, weight reduction, weight loss, or dietary control are not covered. Weight loss surgical procedures, including complications relating thereto and any concomitant surgical procedures, require Prior Approval from the Claims Administrator, acting on behalf of the Plan.

(112) **Whole body computed tomography.** Whole body computed tomography is not covered.

(113) **Wound Treatment.** Blood derived growth factors are not covered.

Miscellaneous Fees and Services.

(1) **Active Duty.** Charges for an Accidental Injury sustained or an Illness contracted while on active duty or military service, unless payment is legally required.

(2) **Administrative Fees.** Fees incurred for acquiring or copying medical records, sales tax, preparation of records for insurance carriers or insurance agencies, medical evaluation for life, disability, or any type of insurance coverage are not covered.

(3) **Appointments.** Charges resulting from the failure to keep a scheduled visit with a Physician or other Provider are not covered.

(4) **Clinical Trials.** Phase I, II, III, or IV clinical trials or any study to determine the maximum tolerated dose, toxicity, safety, efficacy, or efficacy as compared with a standard means of treatment or diagnosis of a drug, device, or medical treatment or procedure are not covered. However, Routine Patient Costs for items and services furnished in connection with participation in an Approved Clinical Trial are covered.

(5) **Comfort items.** Personal hygiene or comfort items including but not limited to, spray nozzle, heating pad, heating lamp, hot water bottle, ice cap, television, radio, telephone, guest meals,

whirlpool bath, adjustable bed, automobile/van conversion, or addition of patient lifts, hand control, or wheel chair ramp, and home modifications such as overhead patient lift and wheelchair ramps are not covered.

(6) **Cosmetic Services.** Cosmetic Services, including surgery, care, and treatment provided for cosmetic reasons. This exclusion will not apply if services are for reconstructive procedures following surgical treatment of an Illness or Accidental Injury, or correction of an abnormal congenital condition. Reconstructive mammoplasty will be covered after Medically Necessary surgery.

(7) **Court ordered or third party recommended treatment.** Services required or recommended by third parties, including physicals and/or vaccines/immunizations for employment, overseas travel, camp, marriage licensing, insurance, and services ordered by a court or arranged by law enforcement officials, unless otherwise covered by the Plan, are not covered.

(8) **Custodial Care.** Services or supplies for custodial, convalescent, domiciliary, or supportive care and non-medical services to assist a Member with activities of daily living are not covered.

(9) **Domestic Partners.** Domestic partners of the same or opposite sex are not eligible for coverage under this Plan.

(10) **Education Programs.** Education programs, including but not limited to physical education programs in a group setting, health club memberships, athletic training, back schools, Work Hardening and Work Integration (Community) training, are not covered. However, coverage is provided for Diabetes Self-Management Training.

(11) **Environmental change.** Charges for environmental change including Hospital or Physician charges connected with prescribing an environmental change.

(12) **Excess charges.** The part of an expense for care and treatment of an Illness or Accidental Injury that is in excess of the Allowance or Allowable Charge is not covered.

(13) **Foreign travel.** Care, treatment, or supplies out of the United States if travel is for the sole purpose of obtaining medical services. Services received outside of the United States must be Medically Necessary to be considered eligible for coverage.

(14) **Occupational.** Care and treatment of an Accidental Injury or Sickness that is occupational -- that is, arises from work for wage or profit including self-employment.

(15) **Postage or Delivery Charges.** Charges for shipping, packaging, handling or delivering Medications are not separately covered.

(16) **Prescription Medications used in connection with Health Interventions Not Covered by Plan.** Prescription Medications used or intended to be used in connection with or arising from a treatment, service, condition, Sickness, disease, Accidental Injury, or bodily malfunction that is not covered under this Plan, or for which this Plan's benefits have been exhausted, are not covered.

(17) **Services Received Outside the United States.** Services or supplies received outside of the United States of America shall not be covered except at the sole discretion of Health Advantage or the Plan Administrator.

(18) **Telephone and Other Electronic Consultation.** Subject to all other terms, conditions, exclusions, and limitations of this Plan set forth in this document:

(a) Coverage is provided for Telemedicine services performed by a Provider licensed, certified, or otherwise authorized by the laws of Arkansas to administer health care in the ordinary course of the practice of his or her profession at the same rate as if it had been performed in-person.

(b) However, electronic consultations such as, but not limited to, telephonic, interactive audio, fax, email, or for services that are, by their nature, hands-on (e.g. surgery, interventional radiology, coronary, angiography, anesthesia, and endoscopy) are not covered.

(c) Applied behavioral therapy is not covered when performed as a telemedicine service. The treating Provider must be present while carrying out the patient's daily treatment plan.

(d) Communications made by a Physician responsible for the direct care of a Participant in Case Management with involved health care Providers, however, are covered.

(19) **Travel or accommodations.** Travel or transportation and accommodations are covered only in connection with approved organ transplants. Travel as a treatment or to receive consultation or treatment, except Ambulance Services, are not covered. Accommodations, while receiving treatment or consultation or for any other purpose, are not covered.

(20) **War.** Services or supplies provided for treatment of disease or injuries sustained while serving in the military forces of any nation are not covered.

(21) **Workers' Compensation.** Treatment of any compensable injury, as defined by the Workers' Compensation Law is not covered, regardless of whether or not the Member filed a claim for workers' compensation benefits in a timely manner.

HOW TO SUBMIT A CLAIM

Benefits under this Plan shall be paid only if the Plan Administrator, in its discretion, interprets the Plan to provide such benefits to the Covered Person.

Following is a description of how the Plan processes claims for benefits and reviews the appeal of any claim that is denied. The terms used in this section are defined below.

A "Claim" is defined as any request for a Plan benefit, made by a claimant or by a representative of a claimant, which complies with the Plan's reasonable procedure for filing claims and making benefit claims determinations.

A "Claim" does not include a request for a determination of an individual's eligibility to participate in the Plan.

If a Claim is denied, in whole or in part, or if Plan coverage is rescinded retroactively for fraud or misrepresentation, the denial is known as an "Adverse Benefit Determination."

A claimant has the right to request a review of an Adverse Benefit Determination. This request is an "Appeal." If the Claim is denied at the end of the Appeal process, as described below, the Plan's final decision is known as a "Final Adverse Benefit Determination." If the claimant receives notice of a Final Adverse Benefit Determination, or if the Plan does not follow the Appeal procedures properly, the claimant then has the right to pursue legal action or, in certain categories of claims, may request an independent external review. The External Review procedures are described later in this section.

Both the Claims and the Appeal procedures are intended to provide a full and fair review. This means, among other things, that Claims and Appeals will be decided in a manner designed to ensure the independence and impartiality of the persons involved in making these decisions.

A claimant must follow and complete all Claims and Appeal procedures both internal and external, before he or she can file a lawsuit. If a lawsuit is brought, it must be filed within two years after the final determination of an Appeal.

Any of the authority and responsibilities of the Plan Administrator under the Claims and Appeal Procedures or the External Review Process, including the discretionary authority to interpret the terms of the Plan, may be delegated to a third party. If the Covered Person has any questions regarding these procedures, they should contact the Plan Administrator.

There are different kinds of Claims and each one has a specific timetable for each step in the review process. Upon receipt of the Claim, the Claims Administrator must decide whether to approve or deny the Claim. The Claims Administrator's notification to the claimant of its decision must be made as shown in the timetable. However, if the Claim has not been filed properly, or if it is incomplete, or if there are other matters beyond the control of the Claims Administrator, the claimant may be notified that the period for providing the notification will need to be extended. If the period is extended because the Claims Administrator needs more information from the claimant, the claimant must provide the requested information within the time shown on the timetable. Once the Claim is complete, the Claims Administrator must make its decision as shown in the timetable. If the Claim is denied, in whole or in part, the claimant has the right to file an Appeal. Then the Claims Administrator must decide the Appeal and, if the Appeal is denied, provide notice to the claimant within the time periods shown on the timetable. The time periods shown in the timetable begin at the time the Claim or Appeal is filed in accordance with the Plan's procedures. Decisions will be made within a reasonable period of time appropriate to the circumstances, but within the maximum time periods listed in the timetables. Unless otherwise noted, "days" means calendar days.

The definitions of the types of Claims are:

Urgent Care Claim

A Claim involving Urgent Care is any Claim for medical care or treatment where the Plan conditions receipt of benefits, in whole or in part, on approval in advance of obtaining the care or treatment, and using the timetable for a non-urgent care determination could seriously jeopardize the life or health of the claimant; or the ability of the claimant to regain maximum function; or in the opinion of the attending or consulting Physician, would subject the claimant to severe pain that could not be adequately managed without the care or treatment that is the subject of the Claim.

A Physician with knowledge of the claimant's medical condition may determine if a Claim is one involving Urgent Care. If there is no such Physician, an individual acting on behalf of the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine may make the determination.

In the case of a Claim involving Urgent Care, the following timetable applies:

Notification to claimant of Claim determination ..... 72 hours

Insufficient information on the Claim, or failure to follow the Plan's procedure for filing a Claim:

Notification to claimant, orally or in writing ..... 24 hours

Response by claimant, orally or in writing ..... 48 hours

Benefit determination, orally or in writing ..... 48 hours

Notification of Adverse Benefit Determination on Appeal ..... 72 hours

If there is an Adverse Benefit Determination on a Claim involving Urgent Care, a request for an expedited Appeal may be submitted orally or in writing by the claimant. All necessary information, including the Plan's benefit determination on review, may be transmitted between the Plan and the claimant by telephone, facsimile, or other similarly expeditious method. Alternatively, the claimant may request an expedited review under the External Review Process.

Concurrent Care Claims

A Concurrent Care Claim is a special type of Claim that arises if the Plan informs a claimant that benefits for a course of treatment that has been previously approved for a period of time or number of treatments is to be reduced or eliminated. In that case, the Plan must notify the claimant sufficiently in advance of the effective date of the reduction or elimination of treatment to allow the claimant to file an Appeal. This rule does not apply if benefits are reduced or eliminated due to Plan amendment or termination. A similar process applies for Claims based on a rescission of coverage for fraud or misrepresentation.

In the case of a Concurrent Care Claim, the following timetable applies:

Notification to claimant of benefit reduction ..... Sufficiently prior to scheduled termination of course of treatment to allow claimant to appeal

Notification to claimant of rescission	30 days
Notification of determination on Appeal of Urgent Care Claims	24 hours (provided claimant files Appeal more than 24 hours prior to scheduled termination of course of treatment)
Notification of Adverse Benefit Determination on Appeal for non-Urgent Claims	15 days
Notification of Adverse Benefit Determination on Appeal for Rescission Claims	30 days

Pre-Service Claim

A Pre-Service Claim means any Claim for a benefit under this Plan where the Plan conditions the receipt of the benefit, in whole or in part, on approval in advance of obtaining medical care. These are, for example, Claims subject to Predetermination of Benefits, prior approval, or mandatory second opinions. Please see the Cost Management section of this booklet for further information about Pre-Service Claims.

Post-Service Claim

A Post-Service Claim means any Claim for a Plan benefit that is not a Claim involving Urgent Care or a Pre-Service Claim; in other words, a Claim that is a request for payment under the Plan for medical services already received by the claimant.

In the case of a Post-Service Claim, the following timetable applies:

Notification to claimant of Adverse Benefit Determination	30 days
Extension due to matters beyond the control of the Plan	15 days
Extension due to insufficient information on the Claim	15 days
Response by claimant following notice of insufficient information	45 days
Notification of Adverse Benefit Determination on Appeal	60 days

PREFERRED PAYMENT PLAN AND HOSPITAL REIMBURSEMENT PROGRAM PARTICIPATING PROVIDERS

The Plan participates in the Preferred Payment Plan (PPP) and the Hospital Reimbursement Program (HRP) with Health Advantage. Participating Providers agree to accept the Allowances of Health Advantage and not charge the Covered Person more than that amount. No Assignment of Benefits by the Covered Person shall be valid until approved and accepted by the Claims Administrator. The Claims Administrator reserves the right to make payment of benefits, in its sole discretion, directly to the Provider of service or to the Covered Person.

A list of participating Providers is available on the Claims Administrator's website at www.healthadvantage-hmo.com.

The Claim Process

This Plan uses a direct claims administration system. Under this approach, the PPP or HRP Provider submits the claims directly to the Claims Administrator.

Any payment due for eligible services rendered by Preferred Providers will be made directly to the Provider unless the Provider requests payment be made directly to the Covered Person.

Any payment due for eligible services rendered by Non-Preferred Providers will typically be made directly to the Covered Person; however, the Plan reserves the right to make payment of benefits directly to the Provider of service or to the Covered Person.

PREFERRED PROVIDER ORGANIZATION (PPO)

The Plan participates in a Preferred Provider Organization (PPO). Participating Providers agree to accept the PPO Allowances and not charge the Covered Person more than that amount.

No Assignment of Benefits by the Covered Person shall be valid until approved and accepted by the Claims Administrator. The Claims Administrator reserves the right to make payment of benefits, in its sole discretion, directly to the Provider of service or to the Covered Person.

A list of participating Providers is available on the Claims Administrator's website at www.healthadvantage-hmo.com.

The Claims Process

The Plan uses a direct claims administration system. Under this approach, the PPO Provider submits the claims directly to the Claims Administrator.

Any payment due for eligible services rendered by PPO Providers will be made directly to the Provider unless the Provider requests payment be made directly to the Covered Person.

Any payment due for eligible services rendered by Non-PPO Providers will typically be made directly to the Covered Person; however, the Plan reserves the right to make payment of benefits directly to the Provider of service or to the Covered Person.

BLUECARD® PROGRAM

Out-of-Arkansas Services. The Health Plan participates in a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Programs." Whenever a Covered Person obtains health care services outside of the State of Arkansas ("the service area"), the claims for these services may be processed through one of these Inter-Plan Programs, which include the BlueCard Program and may include negotiated National Account arrangements available between the Health Plan and other Blue Cross and Blue Shield Licensees.

Typically, when accessing care outside the service area, a Covered Person will obtain care from health care Providers that have a contractual agreement (i.e., are "participating Providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, a Covered Person may obtain care from nonparticipating health care Providers. The Health Plan's practices for consideration of payment in both instances are described below.

(1) BlueCard® Program.

(a) Under the BlueCard® Program, when a Covered Person accesses covered health care services within the geographic area served by a Host Blue, the Health Plan will remain responsible for fulfilling its contractual obligations. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating health care Providers. Whenever a Covered Person accesses covered health care services outside the service area and the claim is processed through the BlueCard Program, the amount a Covered Person pays for covered health care services is calculated based on the lower of:

(i) The billed Covered Charges for the Covered Services; or

(ii) The negotiated price that the Host Blue makes available to the Health Plan.

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

(c) Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price used for a Covered Person's claim because the adjustments will not be applied retroactively to claims already paid.

(d) Laws in a small number of states may require the Host Blue to add a surcharge to the calculation. If any state laws mandate other liability calculation methods, including a surcharge, the Health Plan would then calculate the Covered Person's liability for any covered health care services according to applicable law.

(2) Non-Participating Health Care Providers Outside the Service Area

(a) When covered healthcare services are provided outside of the service area by non-participating health care Providers, the amount a Covered Person pays for such services will generally be based on either the Host Blue's nonparticipating health care Provider local payment or the pricing arrangements required by applicable state law. In these situations, a Covered Person may be liable for the difference between the amount that the non-participating health care Provider bills and any payment made for the covered services as set forth in this paragraph.

(b) In certain situations, the Health Plan may use other payment bases, such as billed Covered Charges, the payment the Health Plan would make if the health care services had been obtained within the service area, or a special negotiated payment, as permitted under Inter-Plan Programs Policies, to determine the amount the Health Plan will pay for services rendered by nonparticipating health care Providers. In these situations, a Covered Person may be liable for the difference between the amount that the non-participating health care Provider bills and the payment the Health Plan will make for the Covered Services as set forth in this paragraph.

BLUE CROSS BLUE SHIELD GLOBAL CORE

If the Covered Person is outside the United States (hereinafter "BlueCard service area"), they may be able to take advantage of Blue Cross Blue Shield Global Core when accessing Covered Services. Blue Cross Blue Shield Global Core is unlike the BlueCard Program available in the BlueCard service area in certain ways. For instance, although Blue Cross Blue Shield Global Core assists individuals with accessing a network of inpatient, outpatient, and professional Providers, the network is not served by a Host Blue. As such, when a Covered Person receives care from Providers outside the BlueCard service area, they will typically have to pay the Provider directly. If a Covered Person needs medical assistance services (including locating a doctor or Hospital) outside the BlueCard service area, they may contact customer service at the number on the back of their health plan identification card or additional information can be found at www.bcbsglobalcore.com.

(1) **Inpatient Services.** In most cases, if the Covered Person contacts Blue Cross Blue Shield Global Core for assistance, Hospitals will not require a Covered Person to pay for covered inpatient services, except for applicable cost-share amounts (Deductibles, coinsurance, etc.). In such cases, the Hospital will submit claims to the service center to begin claims processing. However, if the Covered Person paid in full at the time of service, they must submit a claim to receive a benefit determination. Contact the Claims Administrator to obtain Prior Approval for non-emergency inpatient services.

(2) **Outpatient Services.** Physicians, urgent care centers, and other outpatient Providers located outside the BlueCard service area will typically require the Covered Person to pay in full at the time of service. A claim must be submitted to receive a benefit determination.

(3) **Submitting a Blue Cross Blue Shield Global Core Claim.** When the Covered Person pays for services outside the BlueCard service area, a claim must be submitted to receive a benefit determination. For institutional and professional claims, a Blue Cross Blue Shield Global Core claim form should be completed and sent with the Provider's itemized bill(s) to the service center (the address is on the form) to initiate claims processing. Following the instructions on the claim form will help ensure timely processing of the claim. The claim form is available from the service center or online at www.bcbsglobalcore.com.

ALL OTHER PROVIDERS

When a Covered Person has a Claim to submit for payment that person must:

(1) Obtain a Claim form from their Health Insurance Representative or the Claims Administrator's website at www.healthadvantage-hmo.com.

(2) Complete the Employee portion of the form. ALL QUESTIONS MUST BE ANSWERED.

(3) Have the Physician complete the Provider's portion of the form. For Plan reimbursements, attach bills for services rendered. ALL BILLS MUST SHOW:

Name of Plan
Employee's name
Name of patient
Name, address, telephone number of the Provider of care
Diagnosis
Type of services rendered, with diagnosis and/or procedure codes
Date of services
Charges

Send the above to the Claims Administrator at this address:

HMO Partners, Inc. d/b/a Health Advantage
P.O. Office Box 8069
Little Rock, Arkansas 72203-8069

DEADLINE FOR FILING A PLAN BENEFITS CLAIM

The Plan has established and will enforce a 180-day timely filing deadline for all claims for benefits under the Plan, meaning that the Covered Person, the treating Provider, or an Authorized Representative acting on the Covered Person's behalf, must submit the claim to the Claims Administrator within 180 days from the date of service. However, In-Network Providers must submit claims within the time limits provided in their applicable Provider contract, if shorter than 180 days. Claims are not payable if they are not submitted to the Claims Administrator within the applicable time limit.

The Claims Administrator will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested from the claimant. The Plan reserves the right to have a Plan Participant seek a second medical opinion. Please note that in order to constitute a valid Plan claim, and start the clock with respect to the Plan's and Claims Administrator's adjudication deadlines, the claim must be submitted in writing, and must comply with the Plan and the Claims Administrator's standard claims submission and processing forms, policies, and procedures.

PERSONAL HEALTH STATEMENT (PHS)

A Plan Participant will be notified within 90 days of receipt of the claim as to the acceptance or denial of a claim. If a Plan Participant has not been notified within 90 days, the claim shall be considered denied. Upon making a determination of a claim, the Claims Administrator will deliver to the Covered Person a Personal Health Statement (PHS) containing the following information:

(1) the specific reason or reasons for the determination;

(2) specific reference to those Plan provisions on which the denial is based;

(3) a description of any additional information or material necessary to correct the claim and an explanation of why such material or information is necessary; and,

(4) appropriate information as to the steps to be taken if a Plan Participant wishes to submit the claim for review.

If special circumstances require an extension of time for processing the claim, the Claims Administrator shall send written notice of the extension to the Plan Participant. The extension notice will indicate the special circumstances requiring the extension of time and the date by which the Plan expects to render the final decision on the claim. In no event will the extension exceed a period of 90 days from the end of the initial 90-day period.

APPEALS PROCESS

The Plan Participant will receive an PHS explaining the claim determination, and if applicable, the reason or reasons for any denial or reduction of benefits. In cases where a claim for benefits payment is denied or reduced in whole or in part, the Plan Participant or the Authorized Representative may request an informal claim review.

In a situation where the determination, after informal review, remains adverse, the Plan Participant or the Authorized Representative may request an appeal of the denial.

NOTE:

- **Appeals initiated by a member, can be directed to EBD.**
- **Appeals initiated by a Provider, must be directed to Health Advantage, or in the case of pharmacy benefit decisions, to the pharmacy benefits manager, EBRX.**

This appeal provision will allow the Plan Participant to:

(1) Request a review of any partial or complete denial of any claim for Plan benefits. Such request must be submitted in writing by the Plan Participant/beneficiary or by a duly appointed Authorized Representative, and must include: the name of the Employee, his or her Social Security number, the name of the patient and the Group Identification Number, if any.

(2) The written appeal request should identify the specific services or benefits in dispute, including the date(s) of service and health care Provider(s) involved, as well as stating in clear and concise terms the reason or reasons for this disagreement with the handling of the claim.

NOTICE TO CLAIMANT OF ADVERSE BENEFIT DETERMINATIONS

If a Claim, or an Appeal of a Claim, is denied in whole or in part, the denial is considered to be an Adverse Benefit Determination. Except with Urgent Care Claims, when the notification may be oral followed by written or electronic notification within three days of the oral notification, the Claims Administrator or Plan Administrator shall provide written or electronic notification of the Adverse Benefit Determination, including in such notifications the content required under applicable U. S. Department of Labor claims regulations.

APPEALS SUBMITTED TO EBD BY MEMBERS

Members must file an appeal using the ARBenefits Appeal Request Form. If an Authorized Representative is

making an appeal on behalf of a member, an Authorization to Release Information form must be completed and on file with ARBenefits. Forms may be located at www.transform.ar.gov. Appeals will not be accepted if they are received without the required Appeal Request Form.

Appeals must be submitted separately for each individual and each issue.

(1) First Level Review:

First level reviews must be filed within 180 days of receipt of a Notice of Adverse Benefit Determination.

In preparing an appeal, the Member or their Authorized Representative will have the right to present documents and other information pertinent to the claim. A complete review of the claim will be performed by the Appeals Department. You will be notified of the appeal determination within 30 business days of EBD's receipt of the appeal.

(2) Second Level Review:

If a Member is not satisfied with the determination received on the first level review, he or she may request a second level review. The appeal must be received within 60 days of the notification of denial by the first level appeal. This request must also be made in writing following the established appeal process used when filing the first level appeal, and should contain any additional information not presented during the first level review.

All second level reviews are presented to the EBD Appeals Committee; a three-person panel. Designees may be named for any member on a case-by-case basis due to absence or recusals.

A member of the Appeals Department will present the information to the Appeals Committee along with all information presented by the Member and gathered from any outside resource such as medical professionals or other insurance carriers.

The Appeals Committee will review and make a determination of the appeal within 30 business days after the receipt of your second level appeal.

APPEALS SUBMITTED TO HEALTH ADVANTAGE BY PROVIDERS

The request for review must be submitted to the Claims Administrator not later than 180 days after the date of the notification of payment or denial of any disputed benefits. Failure to submit an appeal within the 180-day period allowed under the Plan waives any further challenge to the Plan's or Claims Administrator's benefits adjudication.

Upon timely submission of a properly-submitted appeal, the Claims Administrator will conduct its review and will provide the Plan Participant with a written response within 60 days. If not notified, the Plan Participant may deem the claim denied. If, because of extenuating circumstances, the Claims Administrator is unable to complete the review process within 60 days, the Claims Administrator shall notify the Plan Participant of the delay within the 60-day period and shall provide a final written response to the request for review within 120 days of the date the Claims Administrator received the Plan Participant's written request for review.

The Claims Administrator's written response to the Plan Participant shall cite the specific Plan provision(s) upon which the denial is based.

A Plan Participant must exhaust this Plan appeal procedure before filing a suit for benefits. If a lawsuit is brought, it must be filed within two years after the final determination of a timely appeal, or otherwise any such lawsuit is barred.

AUTHORIZED REPRESENTATIVE

One Authorized Representative. A Covered Person may have one representative, and only one representative at a time, to assist in submitting a claim or appealing an Adverse Benefit Determination.

Authority of Authorized Representative. An Authorized Representative shall have the authority to represent the Covered Person in all matters concerning the Covered Person's claim or appeal of a claim determination. If the Covered Person has an Authorized Representative, references to or "Covered Person" in the provision of this document entitled "How to Submit a Claim" refer to the Authorized Representative.

Designation of Authorized Representative. Except to the extent mandated by the U.S. Department of Labor claims rules in the case of a treating health care professionals and urgent care claims, the Plan does not permit appeals on a Covered Person's behalf by any person or entity not properly designated as an "authorized representative" in the manner specified in this section.

One of the following persons may act as a Covered Person's Authorized Representative:

(1) An individual designated by the Covered Person in writing in a form approved by the Claims Administrator. "Designation of Authorized Appeal Representative" and "Authorization for Release of Health Information" forms are available from the Claims Administrator or the Plan Administrator;

(2) The treating Provider, if the claim is a claim involving urgent care, or if the Covered Person has designated the Provider in writing in a form approved by the Claims Administrator. "Designation of Authorized Appeal Representative" and "Authorization for Release of Health Information" forms are available from the Claims Administrator or the Plan Administrator;

(3) A person holding the Covered Person's durable power of attorney;

(4) If the Covered Person is incapacitated due to Illness or Accidental Injury, a person appointed as guardian to have care and custody of the Covered Person by a court of competent jurisdiction; or,

(5) If the Covered Person is a minor, the Covered Person's parent or Legal Guardian, unless the Claims Administrator is notified that the Covered Person's claim involves health care services where the consent of the Covered Person's parent or Legal Guardian is or was not required by law and the Covered Person shall represent himself or herself with respect to the claim.

Term of the Authorized Representative. The authority of an Authorized Representative shall continue for the period specified in the Covered Person's appointment of the Authorized Representative or until the Covered Person is legally competent to represent him or herself and notifies the Claims Administrator in writing that the Authorized Representative is no longer required.

Communication with Authorized Representative.

(1) If the Authorized Representative represents the Covered Person because the Authorized Representative is the Covered Person's parent or Legal Guardian or attorney in fact under a durable power of attorney, the Claims Administrator shall send all correspondence, notices, and benefit determinations in connection with the Covered Person's claim to the Authorized Representative.

(2) If the Authorized Representative represents the Covered Person in connection with the submission of a pre-service claim, including a claim involving urgent care, or in connection with an appeal, the Claims Administrator shall send all correspondence, notices, and benefit determinations in connection with the Covered Person's claim to the Authorized Representative.

(3) If the Authorized Representative represents the Covered Person in connection with the submission of a post-service claim, the Claims Administrator will send all correspondence, notices, and benefit determinations in connection with the Covered Person's claim to the Covered Person, but the Claims Administrator will provide copies of such correspondence to the Authorized Representative upon request.

(4) The Covered Person understands that it will take the Claims Administrator at least 30 days to notify all its personnel about the termination of the Covered Person's Authorized Representative and it is possible that the Claims Administrator may communicate information about the Covered Person to the Authorized Representative during this 30-day period.

COORDINATION OF BENEFITS

Coordination of the benefit plans. Coordination of benefits sets out rules for the order of payment of Covered Charges when two or more plans -- including Medicare -- are paying. When a Covered Person is covered by this Plan and another plan, or the Covered Person's Spouse is covered by this Plan and by another plan or the couple's Covered Children are covered under two or more plans, the plans will coordinate benefits when a claim is received.

The plan that pays first according to the rules will pay as if there were no other plan involved. The secondary and subsequent plans will pay the balance due up to 100% of the total Allowable Charges.

Benefit plan. This provision will coordinate the medical benefits of a benefit plan. The term benefit plan means this Plan or any one of the following plans:

(1) Group or group-type plans, including franchise or blanket benefit plans.

(2) Blue Cross and Blue Shield group plans.

(3) Group practice and other group prepayment plans.

(4) Federal government plans or programs. This includes, but is not limited to, Medicare and Tricare.

(5) Other plans required or provided by law. This does not include any benefit plan that, by its terms, does not allow coordination.

(6) No Fault Auto Insurance, by whatever name it is called, when not prohibited by law.

Eligible Charge. For a charge to be eligible it must be an Allowable Charge and at least part of it must be covered under this Plan.

In the case of HMO (Health Maintenance Organization) or other in-network only plans: This Plan will not consider any charges in excess of what an HMO or network provider has agreed to accept as payment in full.

In the case of service type plans where services are provided as benefits, the reasonable cash value of each service will be the Allowable Charge.

Automobile limitations. When medical payments are available under vehicle insurance, the Plan shall always be considered the secondary carrier regardless of the individual's election under PIP (personal injury protection) coverage with the auto carrier.

Benefit plan payment order. When two or more plans provide benefits for the same Allowable Charge, benefit payment will follow these rules:

(1) Plans that do not have a coordination provision, or one like it, will pay first. Plans with such a provision will be considered after those without one.

(2) Plans with a coordination provision will pay their benefits up to the Allowable Charge:

(a) The benefits of the plan which covers the person directly (that is, as an employee, member or subscriber) ("Plan A") are determined before those of the plan which covers the person as a Dependent ("Plan B").

(b) The benefits of a benefit plan which covers a person as an Employee who is neither laid off nor retired are determined before those of a benefit plan which covers that person as a laid-off or Retired Employee. The benefits of a benefit plan which covers a person as a Dependent of an Employee who is neither laid off nor retired are determined before those of a benefit plan which covers a person as a Dependent of a laid off or Retired Employee. If the other benefit plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.

(c) The benefits of a benefit plan which covers a person as an Employee who is neither laid off nor retired or a Dependent of an Employee who is neither laid off nor retired are determined before those of a plan which covers the person as a COBRA beneficiary.

(d) When a Child is covered as a Dependent and the parents are not separated or divorced, these rules will apply:

(i) The benefits of the benefit plan of the parent whose birthday falls earlier in a year are determined before those of the benefit plan of the parent whose birthday falls later in that year; and,

(ii) If both parents have the same birthday, the benefits of the benefit plan which has covered the parent for the longer time are determined before those of the benefit plan which covers the other parent.

(e) When a Child's parents are divorced or legally separated, these rules will apply:

(i) This rule applies when the parent with custody of the Child has not remarried. The benefit plan of the parent with custody will be considered before the benefit plan of the parent without custody.

(ii) This rule applies when the parent with custody of the Child has remarried. The benefit plan of the parent with custody will be considered first. The benefit plan of the stepparent that covers the Child as a Dependent will be considered next. The benefit plan of the parent without custody will be considered last.

(iii) This rule will be in place of items (i) and (ii) above when it applies. A court decree may state which parent is financially responsible for medical and dental benefits of the Child. In this case, the benefit plan of that parent will be considered before other plans that cover the Child as a Dependent.

(iv) If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the Child, the plans covering the Child shall follow the order of benefit determination rules outlined above when a Child is covered as a Dependent and the parents are not separated or divorced.

(v) For parents who were never married to each other, the rules apply as set out above as long as paternity has been established.

(f) If there is still a conflict after these rules have been applied, the benefit plan which has covered the patient for the longer time will be considered first. This includes situations in which a person who is covered as a Dependent Child under one benefit plan is also covered as a Dependent Spouse under another benefit plan. When there is a conflict in

coordination of benefit rules, the Plan will never pay more than 50% of Allowable Charges when paying secondary.

(3) Medicare will pay primary, secondary, or last to the extent stated in federal law. When Medicare would be the primary payer if the person had enrolled in Medicare, this Plan will base its payment upon benefits that would have been paid by Medicare under Parts A and B regardless of whether or not the person was enrolled under any of these parts. ARBenefits is an entirely different benefit plan than that which is available through Medicare and is subject to different coverages and exclusions, as defined by EBD. ARBenefits is not a Medicare Supplement plan.

(4) If a Plan Participant is under a disability extension from a previous benefit plan, that benefit plan will pay first and this Plan will pay second.

(5) The Plan will pay primary to Tricare and a State child health plan to the extent required by federal law.

Claims determination period. Benefits will be coordinated on a Calendar Year basis. This is called the claims determination period.

Right to receive or release necessary information. To make this provision work, this Plan may give or obtain needed information from another insurer or any other organization or person. This information may be given or obtained without the consent of or notice to any other person. A Covered Person will give this Plan the information it asks for about other plans and their payment of Allowable Charges.

Facility of payment. This Plan may repay other plans for benefits paid that the Plan Administrator determines it should have paid. That repayment will count as a valid payment under this Plan.

Right of recovery. This Plan may pay benefits that should be paid by another benefit plan. In this case this Plan may recover the amount paid.

Further, this Plan may pay benefits that are later found to be greater than the Allowable Charge. In this case, this Plan may recover the amount of the overpayment from the source to which it was paid.

Exception to Medicaid. The Plan shall not take into consideration the fact that an individual is eligible for or is provided medical assistance through Medicaid when enrolling an individual in the Plan or making a determination about the payments for benefits received by a Covered Person under the Plan.

THIRD PARTY RECOVERY PROVISION

Reimbursement

This section applies when a Covered Person, or the legal representative, estate, or heirs of the Covered Person (sometimes collectively referred to as the "Covered Person") recovers damages, by settlement, verdict, or otherwise, for an Accidental Injury, Sickness, or other condition. If the Covered Person has made, or in the future may make, such a recovery, including a recovery from any insurance carrier, the Plan will not cover either the reasonable value of the services to treat such an Accidental Injury or Illness or the treatment of such an Accidental Injury or Illness. These benefits are specifically excluded.

However, if the Plan does advance moneys or provide care for such an Accidental Injury, Sickness, or other condition, the Covered Person shall promptly convey moneys or other property from any settlement, arbitration award, verdict or any insurance proceeds or monetary recovery from any party received by the Covered Person (or by the legal representative, estate or heirs of the Covered Person), to the Plan for the reasonable value of the medical benefits advanced or provided by the Plan to the Covered Person, regardless of whether or not [1] the Covered Person has been fully compensated, or "made-whole" for his or her loss; [2] liability for payment is admitted by the Covered Person or any other party; or [3] the recovery by the Covered Person is itemized or called anything other than a recovery for medical expenses incurred.

If a recovery is made, the Plan shall have first priority in payment over the Covered Person, or any other party, to receive reimbursement of the benefits advanced on the Covered Person's behalf. This reimbursement shall be from any recovery made by the Covered Person, and includes, but is not limited to, uninsured and underinsured motorist coverage, any No-Fault Auto Insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation settlement, compromises or awards, other group insurance (including student plans), and direct recoveries from liable parties.

In order to secure the rights of the Plan under this section, and because of the Plan's advancement of benefits, the Covered Person hereby [1] acknowledges that the Plan shall have first priority against proceeds of any such settlement, arbitration award, verdict, or any other amounts received by the Covered Person; and [2] assigns the Plan any benefits the Covered Person may have under any automobile policy or other coverage, to the extent of the Plan's claim for reimbursement. The Covered Person shall sign and deliver, at the request of the Plan or its agents, any documents needed to protect such priority or reimbursement right, or to effect such assignment of benefits. By accepting any benefits advanced by the Plan under this section, the Covered Person acknowledges that any proceeds of settlement of judgment, including a Covered Person's claim to such proceeds held by another person, held by the Covered Person or by another, are being held for the benefit of the Plan under these provisions.

The Covered Person shall cooperate with the Plan and its agents, and shall sign and deliver such documents as the Plan or its agents reasonably request to protect the Plan's right of reimbursement, provide any relevant information, and take such actions as the Plan or its agents reasonably request to assist the Plan making a full recovery of the reasonable value of the benefits provided. The Covered Person shall not take any action that prejudices the Plan' rights of reimbursement and consents to the right of the Plan, by and through its agent, to impress an equitable lien or constructive trust on the proceeds of any settlement to enforce the Plan's rights under this section, and/or to set off from any future benefits otherwise payable under the Plan the value of benefits advanced under this section to the extent not recovered by the Plan.

The Plan shall be responsible only for those legal fees and expenses to which it agrees in writing. No Covered Person hereunder shall incur any expenses on behalf of the Plan in pursuit of the Plan's rights hereunder. Specifically, no court costs or attorney's fees may be deducted from the Plan's recovery without the express written consent of the Plan. Any so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall not defeat this right.

The Plan shall recover the full amount of benefits advanced and paid hereunder, without regard to any claim or fault on the part of any beneficiary of Covered Person, whether under comparative negligence or otherwise.

Subrogation

This section applies when another party is, or may be considered, liable for a Covered Person's Accidental Injury, Sickness, or other condition (including insurance carriers who are financially liable) and the Plan has advanced benefits.

In consideration for the advancement of benefits, the Plan is subrogated to all of the rights of the Covered Person against any party liable for the Covered Person's Accidental Injury or Illness, or is or may be liable for the payment for the medical treatment of such Accidental Injury or occupational Illness (including any insurance carrier), to the extent of the value of the medical benefits advanced to the Covered Person under the Plan. The Plan may assert this right independently of the Covered Person. This right includes, but is not limited to, the Covered Person's rights under uninsured and underinsured motorist coverage, any No-Fault Auto Insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, or other insurance, as well as the Covered Person's rights under the Plan to bring an action to clarify his or her rights under the Plan. The Plan is not obligated in any way to pursue this right independently or on behalf of the Covered Person, but may choose to pursue its rights to reimbursement under the Plan, at its sole discretion.

The Covered Person is obligated to cooperate with the Plan and its agents in order to protect the Plan's subrogation rights. Cooperation means providing the Plan or its agents with any relevant information requested by them, signing and delivering such documents as the Plan or its agents reasonably request to secure the Plan's subrogation claim, and obtaining the consent of the Plan or its agents before releasing any party from liability for payment of medical expenses.

If the Covered Person enters into litigation or settlement negotiations regarding the obligations of other parties, the Covered Person must not prejudice, in any way, the subrogation rights of the Plan under this section. In the event that the Covered Person fails to cooperate with this provision, including executing any documents required herein, the Plan may, in addition to remedies provided elsewhere in the Plan and/or under the law, set off from any future benefits otherwise payable under the Plan the value of benefits advanced under this section to the extent not recovered by the Plan.

The costs of legal representation of the Plan in matters related to subrogation shall be borne solely by the Plan. The costs of legal representation of the Covered Person shall be borne solely by the Covered Person.

COVERAGE CONTINUATION DURING RETIREMENT

Retirees who meet the eligibility requirements for coverage as defined in the Eligibility Section of this document have the following enrollment options:

Retirement Health Enrollment Options

Option 1: If a Retiree meets the following eligibility requirements at the time of termination of active employment, they are eligible to enroll onto the Retirement Health Plan if they are:

- A fully vested member of one of the participating retirement systems
- Enrolled on the active health plan their last day of employment
- Eligible to begin drawing their retirement annuity

Option 2: If a Retiree meets the above eligibility requirements, except eligibility to draw their retirement annuity at termination of employment, they will have a qualifying event to enroll at a later date once they began drawing their retirement annuity. Often this applies to members who have the service but at the time of termination do not meet the age requirements.

The Retiree under Option 2, has 30 days from the time they begin drawing their annuity to enroll in the Retirement Health Plan. No documentation is required for the time between termination of employment and their qualifying to draw their annuity of other employer group health coverage.

Option 3: If a Retiree meets all the eligibility requirements listed in Option 1, but currently have employer group health coverage under their Spouse, or new employment, they can delay their enrollment onto the Retirement Health Plan. Once they experience a qualifying event of involuntary loss of employer group health coverage, they have 30 days to enroll onto the Retirement Health Plan. They will need to provide documentation of uninterrupted group health coverage from their last day of employment up to their qualifying event. The member may have a need during this time to enroll on COBRA for a short period to avoid any break in service.

Rehired Retirees

If a Medicare Retiree goes back to work as an Active Employee as a state or public school Employee, and is eligible for benefits, he or she MUST come off the retirement health insurance and enroll in one of the active plans. Once the Employee terminates employment again, the Employee has the option to re-enroll in the retirement health plan within 30 days of the loss of benefits. If an Employee chooses not to enroll in the retirement health plan at the second time of termination, and obtains health insurance outside of the State and Public School Health Plan, the Employee will not have a qualifying event to enroll a second time in the retirement health insurance.

A non-Medicare Retiree that goes back to work as an active state or public school Employee and is eligible for benefits MAY come off the retirement health insurance and enroll in one of the active plans. Once the Employee terminates employment again, the Employee has the option to re-enroll in the retirement health plan within 30 days of the loss of benefits. If an Employee chooses not to enroll in the retirement health plan at the second time of termination, and obtains health insurance outside of the State and Public School Health Plan, the Employee will not have a qualifying event to enroll a second time in the retirement health insurance. A Retiree who returns to work as an Arkansas State Employee or Public School Employee is not eligible to re-enroll in an active plan.

If a Retiree does not elect, decline, or meet the Arkansas Legislative Code eligibility requirements for retirement health insurance during their 30-day election period, it is not an option to return to active

employment as a rehired Retiree to re-establish eligibility. Eligibility is determined at the initial time the individual elects to become an active Retiree and begins drawing their retirement annuity.

Arkansas Legislative Code
ACA 21-5-411 (a)(2)(B)(C)(i):

> ***(C)(i) Except as provided in subdivision (a)(2)(C)(ii) of this section, an active Retiree's failure to make an election to participate in the program during the thirty-day election period or an active Retiree's election to decline participation in the program is final.***

RECIPROCITY SERVICE

Vesting Schedule:

Employment service prior to July 1, 1997 requires 10 years of fully vested service.
Employment service after July 1, 1997 requires five years of fully vested service.

(1) An Employee fully vested as a state Employee AND fully vested as a public school Employee (a participating member under both APERS and ATRS and drawing a retirement annuity from each) may choose to enroll in either the ASE or PSE retiree health plan. Verification by EBD is required.

(2) Effective July 1, 1997 – Vesting for retirement changed from a 10-year vesting to five years. Service prior to July 1, 1997 is still held to the 10-year vesting.

(3) A Member, who is not fully vested under either system, will enroll in the retiree health plan with the most vested years.

Enrollment Procedures

Members should notify EBD within 30 days of termination by submitting an Election Form and a Spousal Affidavit if they are continuing coverage for a Spouse from the active health plan coverage. Coverage will be effective the first of the month following the date on the Election Form. The Election Form can be accessed online at https://www.dfa.arkansas.gov/images/uploads/arBenefits/RetireeElection_ChangeForm.pdf.

Adding a Spouse or Dependents at the initial enrollment onto the retirement health plan

(1) At initial enrollment in retirement health insurance coverage, Retirees may only continue coverage on the Spouse/Dependents that are currently covered on the active plan at the time of enrollment in the retirement plan.

(2) Retirees may add newly acquired Dependents, i.e., newborn Children, adopted Children, or a new Spouse within 30 days of the event with supporting documentation.

2(a). If retiree health coverage is canceled on a dependent child, the decision is **final** and the dependent is no longer eligible for coverage under the plan.

(3) A Spouse cannot be on the retirement health plan as a Dependent if they are currently employed and have health insurance available through their employer. Retirees may bring them onto their plan if they experience a qualifying event of loss of employer group health coverage, but the Retiree must apply within 30 days of the event by completing an Election Form, Spousal Affidavit, and provide proof of continued group health coverage up until their qualifying event and submitting to EBD. A copy of the Marriage License is also required.

3(a). If retiree health coverage is canceled on a spouse other than leaving for continued employer coverage, the decision is **final** and the spouse is no longer eligible for coverage under the plan.

(4) Retirees DO NOT have an open enrollment to add Dependents to their plan, but

Non-Medicare Retirees have the option to change plans.

(5) If a Retiree has a Spouse on their plan that is also a retired member of a state or public school retirement system, they can make a one-time option and split off on separate plans, or they can move from separate plans to an Employee/Spouse plan. This is a one-time option and member cannot return to the former plan except for death of the policy holder. This one-time option is only available during Open Enrollment.

(6) At open enrollment, a Retiree who is fully vested under both the State & Public School retirement systems can make a one-time option and change to the other retirement system. The vesting requirement does not include reciprocity service.

MEDICARE ELIGIBLE MEMBERS/DEPENDENTS

Member and Dependents are required to send EBD a copy of their Medicare card.

If Medicare is due to End Stage Renal Disease (ESRD), ARBenefits is required to be primary for a period of 30 months. During this 30-month period, premiums will remain as a non-Medicare Retiree. When the 30-month period is ended, Medicare will become Primary and ARBenefits will be secondary. At that time premiums will reduce to the appropriate Medicare premium. It is the member's responsibility to notify EBD of an ESRD or disability status.

When a Retiree or Spouse reaches the age of 65, or becomes eligible for Medicare, the only plan option is the Medicare Primary Plan. When this occurs, the member and Dependents will automatically be moved to the Medicare Primary Plan at the Premium level if they are currently enrolled in the Classic or Basic Plan.

Employees have the option to terminate coverage on their Spouse when he or she becomes Medicare-eligible and not be moved to the Medicare Primary Plan, if the Employee wishes to remain on the Classic or Basic Plan. The Employee must submit an Election Form, to EBD, requesting termination of the Spouse 60 days prior to the eligibility date of the Medicare for the Spouse, so that the plan change will not automatically occur. After the plan change has been made, the Employee cannot change back to their original plan until Open Enrollment for the next January effective date.

Ninety days prior to a Spouse becoming age 65, EBD will send a letter informing the Employee of the automatic move to the Medicare Primary Plan, due to the Spouse's Medicare eligibility. If the Employee wishes to avoid this move and drop coverage on their Spouse, there will be included a form that the Employee will need to complete and send back to EBD 60 days prior to the Spouse becoming age 65.

Approximately 60 days prior to a Retiree and/or their Spouse becoming age 65, EBD will send a letter requesting Medicare information and a copy of any Medicare card(s). The Member must disclose if coverage is due to age, disability or End State Renal Disease.

EBD is able to identify members/Spouses who are age 65 but are unable to identify members who become Medicare eligible due to disability or End Stage Renal Disease (ESRD). The Member is asked to notify EBD so that claims are paid according to Medicare rules. EBD will need a copy of the Member's Medicare card.

> **NOTE: The ARBenefits Medicare Premium Plan for Retirees will coordinate as if Medicare Part A and Part B are both in force at the time of service. If the member does not have Part B, the Plan will pay as though the member does have Medicare Part B and the member will have full financial responsibility for incurred claims.**

Terminating Retirement Health Plan Coverage

Once you have exercised your one-time option to enroll in the retirement health insurance plan and request that the coverage be terminated, the decision is final and you will no longer be eligible to participate in the plan.

The only exception to this rule is if you cancel to go back as an Active Employee with a state or public school agency, and are eligible for active benefits. You can re-enroll in the plan once you terminate active employment again. This exception does not apply if you cancel retiree coverage to go back to active employment that is not affiliated with the state of public school agency.

Death of Retiree

(1) If a Retiree dies, and has covered Dependents on the ARBenefits Plan at the time of death, the Dependents have the right to continue coverage under the Plan. Dependent Children may be covered until they reach the maximum age limit for a Dependent Child. A surviving Spouse may continue coverage under the Plan provided payments are made timely. If a surviving Spouse or Dependent that was covered under the plan declines to enroll or cancels coverage after electing coverage, then the surviving Spouse/Dependent has no further privileges under the Plan. Surviving Dependents cannot add other Dependents to the Plan.

(2) A Surviving Spouse/Dependent Packet will be sent to the Dependent(s) once EBD has received notification of the death of the Retiree. EBD requires a copy of the Death Certificate. Surviving Dependents will have 30 days from the date of the letter to submit an Election Form to EBD for enrollment.

(3) If a Spouse/Dependent is not eligible to draw a survivor annuity from the Retiree, premiums must be setup to be bank-drafted monthly.

NOTE: If the Spouse and/or Dependents do not enroll in the retirement health plan or COBRA within their respective enrollment periods, all privileges under the plan are terminated.

CONTINUATION COVERAGE RIGHTS UNDER COBRA

Under federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), certain Employees and their families covered under ARBenefits (the Plan) will be entitled to the opportunity to elect a temporary extension of health coverage (called "COBRA continuation coverage") where coverage under the Plan would otherwise end. This notice is intended to inform Plan Participants and beneficiaries, in summary fashion, of their rights and obligations under the continuation coverage provisions of COBRA, as amended and reflected in final and proposed regulations published by the Department of the Treasury. This notice is intended to reflect the law and does not grant or take away any rights under the law.

COBRA continuation coverage under the Plan is administered by the COBRA Administrator. Complete instructions on COBRA, as well as election forms and other information, will be provided by the COBRA Administrator to Plan Participants who become Qualified Beneficiaries under COBRA.

There may be other options available when group health coverage is lost. For example, an individual may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, he or she may qualify for lower costs on their monthly premiums and lower out-of-pocket costs. Additionally, an individual may qualify for a 30-day special enrollment period for another group health plan for which he or she is eligible (such as a Spouse's plan), even if that plan generally doesn't accept late enrollees. More information about these options is available at www.healthcare.gov.

What is COBRA continuation coverage? COBRA continuation coverage is the temporary extension of group health plan coverage that must be offered to certain Plan Participants and their eligible family members (called "Qualified Beneficiaries") at group rates. The right to COBRA continuation coverage is triggered by the occurrence of a life event that results in the loss of coverage under the terms of the Plan (the "Qualifying Event"). The coverage must be identical to the Plan coverage that the Qualified Beneficiary had immediately before the Qualifying Event, or if the coverage has been changed, the coverage must be identical to the coverage provided to similarly situated active Employees who have not experienced a Qualifying Event (in other words, similarly situated non-COBRA beneficiaries).

Who can become a Qualified Beneficiary? In general, a Qualified Beneficiary can be:

(1) Any individual who, on the day before a Qualifying Event, is covered under a Plan by virtue of being on that day either a covered Employee, the Spouse of a covered Employee, or a Dependent Child of a covered Employee. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

(2) Any Child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, and any individual who is covered by the Plan as an alternate recipient under a qualified medical support order. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

The term "covered Employee" includes any individual who is provided coverage under the Plan due to his or her performance of services for the employer sponsoring the Plan (e.g., common-law Employees (full or part-time), self-employed individuals, independent contractor, or corporate director). However, this provision does

not establish eligibility of these individuals. Eligibility for Plan Coverage shall be determined in accordance with Plan Eligibility provisions.

An individual is not a Qualified Beneficiary if the individual's status as a covered Employee is attributable to a period in which the individual was a nonresident alien who received from the individual's Employer no earned income that constituted income from sources within the United States. If, on account of the preceding reason, an individual is not a Qualified Beneficiary, then a Spouse or Dependent Child of the individual will also not be considered a Qualified Beneficiary by virtue of the relationship to the individual.

Each Qualified Beneficiary (including a Child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage) must be offered the opportunity to make an independent election to receive COBRA continuation coverage.

What is a Qualifying Event? A Qualifying Event is any of the following if the Plan provided that the Plan participant would lose coverage (i.e.: cease to be covered under the same terms and conditions as in effect immediately before the Qualifying Event) in the absence of COBRA continuation coverage:

(1) The death of a covered Employee.

(2) The termination (other than by reason of the Employee's gross misconduct) or reduction of hours of a covered Employee's employment.

(3) The divorce or legal separation of a covered Employee from the Employee's Spouse. If the Employee reduces or eliminates the Employee's Spouse's Plan coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a Qualifying Event even though the Spouse's coverage was reduced or eliminated before the divorce or legal separation.

(4) A covered Employee's enrollment in any part of the Medicare program.

(5) A Dependent Child's ceasing to satisfy the Plan's requirements for a Dependent Child (for example, attainment of the maximum age for dependency under the Plan).

If the Qualifying Event causes the covered Employee, or the covered Spouse or a Dependent Child of the covered Employee, to cease to be covered under the Plan under the same terms and conditions as in effect immediately before the Qualifying Event, the persons losing such coverage become Qualified Beneficiaries under COBRA if all the other conditions of COBRA are also met. For example, any increase in contribution that must be paid by a covered Employee, or the Spouse, or a Dependent Child of the covered Employee, for coverage under the Plan that results from the occurrence of one of the events listed above is a loss of coverage.

The taking of leave under the Family and Medical Leave Act of 1993, as amended ("FMLA") does not constitute a Qualifying Event. A Qualifying Event will occur, however, if an Employee does not return to employment at the end of the FMLA leave and all other COBRA continuation coverage conditions are present. If a Qualifying Event occurs, it occurs on the last day of FMLA leave and the applicable maximum coverage period is measured from this date (unless coverage is lost at a later date and the Plan provides for the extension of the required periods, in which case the maximum coverage date is measured from the date when the coverage is lost.) Note that the covered Employee and family members will be entitled to COBRA continuation coverage even if they failed to pay the Employee portion of premiums for coverage under the Plan during the FMLA leave. For non-FMLA leaves of absence, the COBRA Qualifying Event date will be the day after the leave ends, if the Employee does not return to work in an Eligible Class.

What factors should be considered when determining to elect COBRA continuation coverage? When considering other options for health coverage, Qualified Beneficiaries should consider:

(1) **Premiums.** This plan can charge up to 102% of total plan premiums for COBRA coverage. Other options, like coverage on a Spouse's plan or through the Marketplace, may be less expensive. Qualified Beneficiaries have special enrollment rights under federal law (HIPAA). They have the right to request special enrollment in another group health plan for which they are otherwise eligible (such as a plan sponsored by a Spouse's employer) within 30 days after Plan coverage ends due to one of the Qualifying Events listed above.

(2) **Provider Networks.** If a Qualified Beneficiary is currently getting care or treatment for a condition, a change in health coverage may affect access to a particular health care Provider. An individual may want to check to see if their current health care Providers participate in a network in considering options for health coverage.

(3) **Drug Formularies.** For Qualified Beneficiaries taking medication, a change in health coverage may affect costs for medication - and in some cases, the medication may not be covered by another plan. Qualified beneficiaries should check to see if current medications are listed in drug formularies for other health coverage.

(4) **Severance payments.** If COBRA rights arise because the Employee has lost his job and there is a severance package available from the employer, the former employer may have offered to pay some or all of the Employee's COBRA payments for a period of time. This can affect the timing of coverage available in the Marketplace. In this scenario, the Employee may want to contact the Department of Labor at 1-866-444-3272 to discuss options.

(5) **Medicare Eligibility.** Individuals should be aware of how COBRA coverage coordinates with Medicare eligibility. If an individual is eligible for Medicare at the time of the Qualifying Event, or if he or she will become eligible soon after the Qualifying Event, he or she has eight months to enroll in Medicare after employment -related health coverage ends. Electing COBRA coverage does not extend this eight-month period. For more information, see https://www.Medicare.gov/sign-up-change-plans/.

(6) **Service Areas.** If benefits under the Plan are limited to specific service or coverage areas, benefits may not be available to a Qualified Beneficiary who moves out of the area.

(7) **Other Cost-Sharing.** In addition to premiums or contributions for health coverage, the Plan requires participants to pay Copayments, Deductibles, coinsurance, or other amounts as benefits are used. Qualified beneficiaries should check to see what the cost-sharing requirements are for other health coverage options. For example, one option may have much lower monthly premiums, but a much higher Deductible and higher Copayments.

What is the procedure for obtaining COBRA continuation coverage? The Plan has conditioned the availability of COBRA continuation coverage upon the timely election of such coverage. An election is timely if it is made during the election period.

What is the election period and how long must it last? The election period is the time period within which the Qualified Beneficiary must elect COBRA continuation coverage under the Plan. The election period must begin no later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event and ends 60 days after the later of the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event or the date notice is provided to the Qualified Beneficiary of his or her right to elect COBRA continuation coverage. If coverage is not elected within the 60-day period, all rights to elect COBRA continuation coverage are forfeited.

NOTE: If a covered Employee who has been terminated or experienced a reduction of hours qualifies for a trade readjustment allowance or alternative trade adjustment assistance under a federal law called the Trade Act of 2002, as extended by the Trade Preferences Extension Act of 2015, and the Employee and his or her covered Dependents have not elected COBRA coverage within the normal election period, a second opportunity to elect COBRA coverage will be made available for themselves and certain family members, but only within a limited period of 60 days or less and only during the six months immediately after their group health plan coverage ended. Any person who qualifies or thinks that he and/or his family members may qualify for assistance under this special provision should contact the Plan Administrator for further information about the special second election period. If continuation coverage is elected under this extension, it will not become effective prior to the beginning of this special second election period.

Is a covered Employee or Qualified Beneficiary responsible for informing the Plan Administrator of the occurrence of a Qualifying Event? The Plan will offer COBRA continuation coverage to Qualified Beneficiaries only after the Plan Administrator has been timely notified that a Qualifying Event has occurred. The employer (if the employer is not the Plan Administrator) will notify the Plan Administrator of the Qualifying Event within 30 days following the date coverage ends when the Qualifying Event is:

(1) The end of employment or reduction of hours of employment;

(2) Death of the Employee;

(3) Commencement of a proceeding in bankruptcy with respect to the employer; or,

(4) Entitlement of the employee to any part of Medicare.

IMPORTANT:

For the other Qualifying Events (divorce or legal separation of the Employee and Spouse or a Dependent Child's losing eligibility for coverage as a Dependent Child), the Covered Person or someone acting on their behalf must notify the Plan Administrator within 60 days after the Qualifying Event occurs, using the procedures specified below. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator or its designee during the 60-day notice period, any Spouse or Dependent Child who loses coverage will not be offered the option to elect continuation coverage.

NOTICE PROCEDURES:

Any notice must be ***in writing***. Oral notice, including notice by telephone, is not acceptable. The notice must be mailed, faxed or hand-delivered to the Plan Administrator.

If mailed, the notice must be postmarked no later than the last day of the required notice period. Any notice provided must state:

- the **name of the plan or plans** under which coverage has been lost or is being lost,
- the **name and address of the Employee** covered under the plan,
- the **name(s) and address(es) of the Qualified Beneficiary(ies)**, and
- the **Qualifying Event** and the **date** it happened.

If the Qualifying Event is a **divorce or legal separation**, the notice must include **a copy of the divorce decree or the legal separation agreement.**

There are other notice requirements in other contexts, for example, in order to qualify for a disability extension.

Once the Plan Administrator or its designee receives *timely notice* that a Qualifying Event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA continuation coverage. Covered Employees may elect COBRA continuation coverage for their Spouses, and parents may elect COBRA continuation coverage on behalf of their Children. For each Qualified Beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that plan coverage would otherwise have been lost. If an individual does not elect continuation coverage within the 60-day election period described above, the right to elect continuation coverage will be lost.

Is a waiver before the end of the election period effective to end a Qualified Beneficiary's election rights? If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of COBRA continuation coverage. However, if a waiver is later revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent to the COBRA Administrator.

Is COBRA coverage available if a Qualified Beneficiary has other group health plan coverage or Medicare? Qualified beneficiaries who are entitled to elect COBRA continuation coverage may do so even if they are covered under another group health plan or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, a Qualified Beneficiary's COBRA coverage will terminate automatically if, after electing COBRA, he or she becomes entitled to Medicare or becomes covered under other group health plan coverage.

When may a Qualified Beneficiary's COBRA continuation coverage be terminated? During the election period, a Qualified Beneficiary may waive COBRA continuation coverage. Except for an interruption of coverage in connection with a waiver, COBRA continuation coverage that has been elected for a Qualified Beneficiary must extend for at least the period beginning on the date of the Qualifying Event and ending not before the earliest of the following dates:

(1) The last day of the applicable maximum coverage period.

(2) The first day for which Timely Payment is not made to the Plan with respect to the Qualified Beneficiary.

(3) The date upon which the Employer ceases to provide any group health plan (including a successor plan) to any employee.

(4) The date, after the date of the election, that the Qualified Beneficiary first becomes entitled to Medicare (either part A or part B, whichever occurs earlier).

(5) In the case of a Qualified Beneficiary entitled to a disability extension, the later of:

(a) (i) 29 months after the date of the Qualifying Event, or (ii) the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier; or,

(b) the end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension.

The Plan can terminate the coverage of a Qualified Beneficiary for cause on the same basis that the Plan terminates the coverage of similarly situated non-COBRA beneficiaries; for example, for the submission of a fraudulent claim.

In the case of an individual who is not a Qualified Beneficiary and who is receiving coverage under the Plan solely because of the individual's relationship to a Qualified Beneficiary, if the Plan's obligation to make COBRA continuation coverage available to the Qualified Beneficiary ceases, the Plan is not obligated to make coverage available to the individual who is not a Qualified Beneficiary.

What are the maximum coverage periods for COBRA continuation coverage? The maximum coverage periods are based on the type of the Qualifying Event and the status of the Qualified Beneficiary, as shown below:

(1) In the case of a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period ends 18 months after the Qualifying Event if there is not a disability extension and 29 months after the Qualifying Event if there is a disability extension.

(2) In the case of a covered Employee's enrollment in the Medicare program before experiencing a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period for Qualified Beneficiaries ends on the later of:

(a) 36 months after the date the covered Employee becomes enrolled in the Medicare program. This extension does not apply to the covered Employee; or,

(b) 18 months (or 29 months, if there is a disability extension) after the date of the covered Employee's termination of employment or reduction of hours of employment.

(3) In the case of a Qualified Beneficiary who is a Child born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, the maximum coverage period is the maximum coverage period applicable to the Qualifying Event giving rise to the period of COBRA continuation coverage during which the Child was born or placed for adoption.

(4) In the case of any other Qualifying Event than that described above, the maximum coverage period ends 36 months after the Qualifying Event.

Under what circumstances can the maximum coverage period be expanded? If a Qualifying Event that gives rise to an 18-month or 29-month maximum coverage period is followed, within that 18- or 29-month period, by a second Qualifying Event that gives rise to a 36-months maximum coverage period, the original period is expanded to 36 months, but only for individuals who are Qualified Beneficiaries at the time of and with respect to both Qualifying Events. In no circumstance can the COBRA maximum coverage period be expanded to more than 36 months after the date of the first Qualifying Event. The Plan Administrator must be notified of the second Qualifying Event within 60 days of the second Qualifying Event. This notice must be sent to Plan Administrator in accordance with the procedures above.

How does a Qualified Beneficiary become entitled to a disability extension? A disability extension will be granted if an individual (whether or not the covered Employee) who is a Qualified Beneficiary in connection with the Qualifying Event that is a termination or reduction of hours of a covered Employee's employment, is determined under Title II or XVI of the Social Security Act to have been disabled at any time during the first 60 days of COBRA continuation coverage. To qualify for the disability extension, the Qualified Beneficiary must also provide the Plan Administrator with notice of the disability determination on a date that is both within 60 days after the date of the determination and before the end of the original 18-month maximum coverage. This notice should be sent to Plan Administrator in accordance with the procedures above.

Does the Plan require payment for COBRA continuation coverage? For any period of COBRA continuation coverage under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. Qualified beneficiaries will pay up to 102% of the applicable premium and up to 150% of the applicable premium for any expanded period of COBRA continuation coverage covering a disabled Qualified Beneficiary due to a disability extension. The Plan will terminate a Qualified Beneficiary's COBRA continuation coverage as of the first day of any period for which Timely Payment is not made.

Must the Plan allow payment for COBRA continuation coverage to be made in monthly installments? Yes. The Plan is also permitted to allow for payment at other intervals.

What is Timely Payment for payment for COBRA continuation coverage? Timely Payment means a payment made no later than 30 days after the first day of the coverage period. Payment that is made to the Plan by a later date is also considered Timely Payment if either under the terms of the Plan, covered employees or Qualified Beneficiaries are allowed until that later date to pay for their coverage for the period or under the terms of an arrangement between the Employer and the entity that provides Plan benefits on the Employer's behalf, the Employer is allowed until that later date to pay for coverage of similarly situated non-COBRA beneficiaries for the period.

Notwithstanding the above paragraph, the Plan does not require payment for any period of COBRA continuation coverage for a Qualified Beneficiary earlier than 45 days after the date on which the election of COBRA continuation coverage is made for that Qualified Beneficiary. Payment is considered made on the date on which it is postmarked to the Plan.

If Timely Payment is made to the Plan in an amount that is not significantly less than the amount the Plan requires to be paid for a period of coverage, then the amount paid will be deemed to satisfy the Plan's requirement for the amount to be paid, unless the Plan notifies the Qualified Beneficiary of the amount of the deficiency and grants a reasonable period of time for payment of the deficiency to be made. A "reasonable period of time" is 30 days after the notice is provided. A shortfall in a Timely Payment is not significant if it is no greater than the lesser of $50 or 10% of the required amount.

For More Information
If an individual has questions about COBRA continuation coverage, they should contact the Plan Sponsor. For more information about rights under COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

Keep The Plan Administrator Informed Of Address Changes
In order for an individual to protect his or her family's rights, they should keep the Plan Administrator informed of any changes in the addresses of family members. The individual should also keep a copy, for his or her records, of any notices sent to the Plan Administrator.

RESPONSIBILITIES FOR PLAN ADMINISTRATION

PLAN SPONSOR. The State and Public School Life and Health Insurance Board (the Board), as established by Annotated Code §21-5-402, is the Plan Sponsor. The Board is made up of the following members designated by law:

(1) A state Employee who is eligible to participate in the Plan appointed by the Governor;

(2) Two Public School Employees with at least one from a rural school district;

(3) The Insurance Commissioner or his or her designee;

(4) The Commissioner of Education or his or her designee;

(5) The Director of the Department of Finance and Administration or his or her designee;

(6) Three members who are engaged in employee benefits management or risk management at least one of whom is a licensed healthcare Provider appointed by the Governor;

(7) A retired Public School Employee appointed by the Governor;

(8) A retired state Employee appointed by the Governor;

(9) A public school administrator appointed by the Governor;

(10) The Executive Director of the Arkansas State Board of Pharmacy or his or her state employee pharmacist designee;

(11) The Director of Health Facility Services of the Department of Health or his or her designee; and,

(12) A licensed member of the Arkansas Medical, Dental and Pharmaceutical Association appointed by the Governor.

The Board establishes the benefit design, sets the rates, and sets policies for the Plan. The current list of Board members can be found on the official Employee Benefits Division's DFA website at http://www.arkansas.gov/dfa/ebd.

PLAN ADMINISTRATOR. The Employee Benefits Division (EBD) for the State of Arkansas Department of Transformation and Shared Services administers the Plan on behalf of the Board.

EBD has the administrative oversight of the day-to-day operations of the Plan with such functions as determining and maintaining eligibility, managing appeals, coordination of member communication and much more. EBD has contractual relationships with outside vendors, including Health Advantage, to perform such services as provider network management, claims payment, case management, and utilization review.

As the Administrator of the Plan, EBD has the full right to access all medical and claim information regarding the membership but will make every effort to protect any personal health information in accordance with applicable state and federal laws.

The Plan is not established under or subject to the Federal Employee Retirement Income Security Act of 1974 (commonly known as ERISA).

Service of legal process may be made upon the Plan Administrator.

DUTIES OF THE PLAN ADMINISTRATOR:

(1) To administer the Plan in accordance with its terms;

(2) To interpret the Plan, including the right to remedy possible ambiguities, inconsistencies, or omissions;

(3) To decide disputes which may arise relative to a Plan Participant's rights;

(4) To prescribe procedures for filing a claim for benefits and to review claim denials;

(5) To keep and maintain the Plan documents and all other records pertaining to the Plan;

(6) To appoint a Claims Administrator to pay claims;

(8) To establish and communicate procedures to determine whether a medical child support order is qualified; and,

(9) To delegate to any person or entity such powers, duties, and responsibilities as it deems appropriate.

PLAN ADMINISTRATION COMPENSATION. All expenses for plan administration, including compensation for hired services, will be paid by the Plan.

HEALTH INSURANCE REPRESENTATIVES. Each state agency and school district has appointed at least one person to work as their Health Insurance Representative (HIR). These individuals often work in the payroll or personnel sections and have a variety of other duties to perform. In regards to the Plan, they will provide members with enrollment information and assist with questions.

BENEFIT COORDINATORS. EBD contracts with various companies to work with the Plan to ensure that the members get the right coverage based on their election. Benefit Coordinators are contracted third-party administrators who perform many services, including but not limited to the list below:

(1) Provide a network of Physicians, Hospitals, labs, and other service Providers to ensure coverage under the Plan is appropriately managed;

(2) Pay claims on behalf of the Plan for medical claims submitted by health care Providers; and,

(3) Provide limited medical management services.

Benefit Coordinators have the authority and responsibility to make decisions on behalf of the Plan when there are questions about coverage. The decision of the Benefit Coordinator is final unless the member follows the steps outlined in the Appeals section of this document.

FIDUCIARY. A fiduciary exercises discretionary authority or control over management of the Plan or the disposition of its assets, renders investment advice to the Plan or has discretionary authority or responsibility in the administration of the Plan.

FIDUCIARY DUTIES. A fiduciary must carry out his or her duties and responsibilities for the purpose of providing benefits to the Employees and their Dependent(s), and defraying reasonable expenses of administering the Plan. These are duties which must be carried out:

(1) With care, skill, prudence, and diligence under the given circumstances that a prudent person, acting in a like capacity and familiar with such matters, would use in a similar situation;

(2) By diversifying the investments of the Plan so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so; and,

(3) In accordance with the Plan documents.

THE NAMED FIDUCIARY. A "named fiduciary" is the one named in the Plan. A named fiduciary can appoint others to carry out fiduciary responsibilities (other than as a trustee) under the Plan. These other persons become fiduciaries themselves and are responsible for their acts under the Plan.

COMPLIANCE WITH HIPAA PRIVACY STANDARDS. Certain members of the Employer's workforce perform services in connection with administration of the Plan. In order to perform these services, it is necessary for these Employees from time to time to have access to Protected Health Information (as defined below).

Under the Standards for Privacy of Individually Identifiable Health Information (45 CFR Part 164, the "Privacy Standards"), these Employees are permitted to have such access subject to the following:

(1) **General.** The Plan shall not disclose Protected Health Information to any member of the Employer's workforce unless each of the conditions set out in this HIPAA Privacy section is met. "Protected Health Information" shall have the same definition as set out in the Privacy Standards but generally shall mean individually identifiable health information about the past, present or future physical or mental health or condition of an individual, including genetic information and information about treatment or payment for treatment.

(2) **Permitted Uses and Disclosures.** Protected Health Information disclosed to members of the Employer's workforce shall be used or disclosed by them only for purposes of Plan administrative functions. The Plan's administrative functions shall include all Plan payment and health care operations. The terms "payment" and "health care operations" shall have the same definitions as set out in the Privacy Standards, but the term "payment" generally shall mean activities taken with respect to payment of premiums or contributions, or to determine or fulfill Plan responsibilities with respect to coverage, provision of benefits, or reimbursement for health care. "Health care operations" generally shall mean activities on behalf of the Plan that are related to quality assessment; evaluation, training, or accreditation of health care Providers; underwriting, premium rating, and other functions related to obtaining or renewing an insurance contract, including stop-loss insurance; medical review; legal services or auditing functions; or business planning, management and general administrative activities. However, Protected Health Information that consists of genetic information will not be used or disclosed for underwriting purposes.

(3) **Authorized Employees.** The Plan shall disclose Protected Health Information only to members of the Employer's workforce who are designated and are authorized to receive such Protected Health Information, and only to the extent and in the minimum amount necessary for these persons to perform duties with respect to the Plan. For purposes of this HIPAA Privacy section, "members of the Employer's workforce" shall refer to all Employees and other persons under the control of the Employer.

(a) **Updates Required.** The Employer shall amend the Plan promptly with respect to any changes in the members of its workforce who are authorized to receive Protected Health Information.

(b) **Use and Disclosure Restricted.** An authorized member of the Employer's workforce who receives Protected Health Information shall use or disclose the Protected Health Information only to the extent necessary to perform his or her duties with respect to the Plan.

(c) **Resolution of Issues of Noncompliance.** In the event that any member of the Employer's workforce uses or discloses Protected Health Information other than as permitted by the Privacy Standards, the incident shall be reported to the privacy official. The privacy official shall take appropriate action, including:

(i) Investigation of the incident to determine whether the breach occurred inadvertently, through negligence, or deliberately; whether there is a pattern of breaches; and the degree of harm caused by the breach;

(ii) Applying appropriate sanctions against the persons causing the breach, which, depending upon the nature of the breach, may include, oral or written reprimand, additional training, or termination of employment;

(iii) Mitigating any harm caused by the breach, to the extent practicable; and,

(iv) Documentation of the incident and all actions taken to resolve the issue and mitigate any damages.

(4) **Certification of Employer.** The Employer must provide certification to the Plan that it agrees to:

(a) Not use or further disclose the Protected Health Information other than as permitted or required by the Plan documents or as required by law;

(b) Ensure that any agent or subcontractor, to whom it provides Protected Health Information received from the Plan, agrees to the same restrictions and conditions that apply to the Employer with respect to such information;

(c) Not use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer;

(d) Report to the Plan any use or disclosure of the Protected Health Information of which it becomes aware that is inconsistent with the uses or disclosures hereunder or required by law;

(e) Make available Protected Health Information to individual Plan members in accordance with Section 164.524 of the Privacy Standards;

(f) Make available Protected Health Information for amendment by individual Plan members and incorporate any amendments to Protected Health Information in accordance with Section 164.526 of the Privacy Standards;

(g) Make available the Protected Health Information required to provide any accounting of disclosures to individual Plan members in accordance with Section 164.528 of the Privacy Standards;

(h) Make its internal practices, books and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Department of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Standards;

(i) If feasible, return or destroy all Protected Health Information received from the Plan that the Employer still maintains in any form, and retain no copies of such information when no longer needed for the purpose of which disclosure was made, except that, 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 unfeasible; and,

(j) Ensure the adequate separation between the Plan and member of the Employer's workforce, as required by Section 164.504(f)(2)(iii) of the Privacy Standards.

The following members of workforce are designated as authorized to receive Protected Health Information from ARBenefits ("the Plan") in order to perform their duties with respect to the Plan: Employee Benefits Division.

COMPLIANCE WITH HIPAA ELECTRONIC SECURITY STANDARDS. Under the Security Standards for the Protection of Electronic Protected Health Information (45 CFR Part 164.300 et. seq., the "Security Standards"), the Employer agrees to the following:

(1) The Employer agrees to implement reasonable and appropriate administrative, physical and technical safeguards to protect the confidentiality, integrity, and availability of Electronic Protected Health Information that the Employer creates, maintains or transmits on behalf of the Plan. "Electronic Protected Health Information" shall have the same definition as set out in the Security Standards, but generally shall mean Protected Health Information that is transmitted by or maintained in electronic media.

(2) The Employer shall ensure that any agent or subcontractor to whom it provides Electronic Protected Health Information shall agree, in writing, to implement reasonable and appropriate security measures to protect the Electronic Protected Health Information.

(3) The Employer shall ensure that reasonable and appropriate security measures are implemented to comply with the conditions and requirements set forth in Compliance With HIPAA Privacy Standards provisions (3) Authorized Employees and (4) Certification of Employers described above.

ASSIGNMENT OF BENEFITS

Any payment due for eligible services rendered by Preferred Providers will be made directly to the Provider unless the Provider requests payment be made directly to the Covered Person.

Any payment due for eligible services rendered by Non-Preferred Providers will typically be made directly to the Covered Person; however, the Plan reserves the right to make payment of benefits directly to the Provider of service or to the Covered Person.

Any payment due for eligible services rendered by PPO Providers will be made directly to the Provider unless the Provider requests payment be made directly to the Covered Person.

Any payment due for eligible services rendered by Non-PPO Providers will typically be made directly to the Covered Person; however, the Plan reserves the right to make payment of benefits directly to the Provider of service or to the Covered Person.

FUNDING THE PLAN AND PAYMENT OF BENEFITS

The Plan is considered a Self-Insured Plan, which means that all expenses incurred by the Plan are paid by contributions from the Employer and Members. The Plan is responsible for the payment of all eligible claims and does not rely on protection from outside carriers to assume the risk. The Plan maintains a cash balance held in reserve to cover catastrophic claims if they are incurred. This claims reserve and other monies collected are held in trust and are used to administer the Plan.

Benefits are paid directly from the Plan through the Claims Administrator.

On an annual basis, claims information of the Plan, national inflationary factors, and other information is examined by an outside actuary/consulting team and rates are presented to the Board for review and approval. The rate that each member pays is derived from the base monthly premium for the benefit option elected by the member, less any Employer contributions and/or additional subsidies.

Rates are not published in this document but are available on the central website for the Plan (https://www.arbenefits.org).

PLAN IS NOT AN EMPLOYMENT CONTRACT

The Plan is not to be construed as a contract for or of employment.

CLERICAL ERROR

Any clerical error by the Plan Administrator or an agent of the Plan Administrator in keeping pertinent records or a delay in making any changes will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered.

If, an overpayment occurs in a Plan reimbursement amount, the Plan retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money. In the case of a Plan Participant, the amount of overpayment may be deducted from future benefits payable.

AMENDING AND TERMINATING THE PLAN

If the Plan is terminated, the rights of the Plan Participants are limited to expenses incurred before termination.

The Employer reserves the right, at any time, to amend, suspend or terminate the Plan in whole or in part. This includes amending the benefits under the Plan or the Trust agreement (if any).

GENERAL PLAN INFORMATION

TYPE OF ADMINISTRATION

The Plan is a self-funded group health Plan and the claims administration is provided through a Third Party Claims Administrator. The funding for the benefits is derived from the funds of the Employer and contributions made by covered Employees. The Plan is not insured.

PLAN NAME: ARBenefits

PLAN NUMBER: 1-501-682-5500

TAX ID NUMBER: 81-4185138

PLAN EFFECTIVE DATE: January 1, 2020

PLAN YEAR ENDS: December 31

EMPLOYER INFORMATION

Employee Benefits Division
501 Woodlane Street
Little Rock, Arkansas 72201
1-877-815-1017 or 501-682-9656

PLAN ADMINISTRATOR

Employee Benefits Division
501 Woodlane Street
Little Rock, Arkansas 72201
1-877-815-1017 or 501-682-9656

NAMED FIDUCIARY

Employee Benefits Division
501 Woodlane Street
Little Rock, Arkansas 72201
1-877-815-1017 or 501-682-9656

AGENT FOR SERVICE OF LEGAL PROCESS

Fiscal Support Manager
501 Woodlane Street
Little Rock, Arkansas 72201
1-877-815-1017 or 501-682-9656

CLAIMS ADMINISTRATOR

HMO Partners, Inc. d/b/a Health Advantage
P.O. Office Box 8069
Little Rock, Arkansas 72203-8069

BY THIS AGREEMENT, the ARBenefits is hereby adopted as shown.

IN WITNESS WHEREOF, this instrument is executed for the Employee Benefits Division of the Arkansas State Department of Transformation and Shared Services on or as of the day and year first below written.

By _____

Date _____

Witness _____

Date _____

Prescription Drug Coverage

A Prescription Drug Program covers most members of the Plan with the exception being the Public School Medicare-Primary Retirees. Coverage under the Prescription Drug Program is not available without participation in the medical plan, meaning that a member cannot elect to have coverage for his or her prescription drugs as a stand-alone plan.

The Prescription Drug Program covers a wide selection of medications, but not all prescription drugs available in the United States are covered. The Plan uses an established Formulary of covered drugs and, in most cases, has the drugs classified into one of six tiers. Medications that are not on the formulary are not covered by the Plan and any cost associated with the drug would be the responsibility of the member.

- Tier I Generic
- Tier II Formulary Brand (Preferred)
- Tier III Non-Formulary Brand (Non-Preferred)
- Tier IV Specialty
- Reference Pricing
- Brand to Generic Incentive

Note: See section, "How much will my prescription cost?"

Who coordinates the prescription drug program?

EBD has a contract with an outside third-party company who serves as the PBM (Pharmacy Benefit Manager) for the Plan. The PBM has the responsibility to contract with pharmacies, negotiate discounts, and work with EBD to create a quality benefit program for the membership.

What types of prescription drugs and supplies are covered?

- Drugs prescribed by a physician that require a prescription under federal law, and are purchased in the United States at an in-network pharmacy, unless otherwise excluded from the plan
- Diabetic supplies such as lancets and test strips when prescribed by a physician.

Are there any limitations on the covered drugs?

Benefits for any one prescription may be limited to:

- Quantity limits established by the Plan
- Refills only up to the time specified by a physician
- Refills up to one year from the date of order by a physician
- Reference based pricing on certain medications instead of a flat co-pay (indicated as RP on the PDL)
- Prior authorization review on certain medications
- Step therapy guidelines established by the plan

How much will my prescription drugs cost?

The cost of a prescription at an in-network pharmacy will depend on a variety of issues, such as your plan option, the tier of the medication, and how much of your deductible has been met, if applicable.
If you are a member of the ARBenefits or ARBenefits Retiree plans (excluding the Public School Medicare-Primary Retirees), the cost of most covered prescription drugs will be tied to a co-payment based on the tier to which the drug has been assigned. The co-pay amounts are shown in the Schedule of Benefits. The co-pay is the maximum cost that a member will pay for a drug in a particular tier although the member will pay less if

the drug price is lower than the fixed co-pay. Some medications are not assigned to a co-payment tier, but are priced at a fixed rate per pill. Your cost for a prescription with this pricing method varies greatly depending on the prescription and pharmacy. Prescriptions that are priced at a fixed rate per pill are indicated on the Preferred Drug List (PDL) with an (RP) for reference pricing.

If you are a member of the ARBenefits HD Classic or Basic plans, you will be responsible for the total cost of the prescription (after any applicable network discount) until you have satisfied your deductible. After the deductible has been met, you will be responsible for a portion of the cost as a co-insurance up to the point when your maximum out-of-pocket annual co-insurance limit has been reached. When the annual co-insurance limit has been reached, the Plan will cover 100% of the cost of all covered medications. Medications listed as reference priced are considered non-covered on the Classic and Basic plans and will not apply to the deductible, annual coinsurance, or out of pocket limits. In addition, medications listed as reference priced will not apply to the annual out-of-pocket limits for members enrolled in the Premium or Primary plans. Please note: the ASE Basic plan does not have an annual coinsurance limit. The deductible is equal to the out-of-pocket amount. The plan will pay 100% once this amount has been reached.

What is the Brand Generic Program?

Currently, brand-name medications that are available in the generic form are covered with a brand copayment. Choosing to fill a brand-name drug that is available in an equivalent generic form will re- quire a tiered copayment **PLUS** the difference in the cost between the generic and equivalent brand-name drug. (Please note brand name drugs with equivalent generics available will be non-covered on the Classic and Basic plans, and will not apply to the annual out-of-pocket limits on the Premium and Primary plans.)

Example: Drug B is a brand drug and cost $150. Drug B has a generic drug available and it cost $30. For a one-month supply, the cost would be as follows.

Benefit example prior to 9/1/2012

Generic Drug Cost	$30	Non-Preferred Brand Drug Cost	$150
Member Copay	-$10	Member Copay	-$ 60
Plan Cost	$20	Plan Cost	$ 90

Benefit example prior to 9/1/2012

Generic Drug Cost	$30	Non-Preferred Brand Drug Cost	$150
Member Copay	-$10	Member Copay	-$ 20
Plan Cost	$20	Plan Cost	$130

If there is a clinically based reason your physician will not prescribe a generic medication for you, he or she can contact EBRx at (866) 564-8258 to inquire about an override.

How is a prescription filled at an Out-of-Network pharmacy?

If a prescription is filled at an out-of-network pharmacy, the member will be responsible for 100% of the cost of the drug when the medication is dispensed. The plan does not allow coverage for out-of-network pharmacies. Confirmation of participating pharmacies may be obtained by calling the number on your ARBenefits card and pressing 1 for assistance.

How are prescription drugs assigned to a Tier?

As new medications receive FDA approval and are released to the open market, they are excluded from coverage until the Arkansas State and Public School's Drug Utilization Evaluation Committee (DUEC) and the Prescription Benefit Consultant (University of Arkansas for Medical Sciences, College of Pharmacy) reviews them. Their recommendations are then taken to the State and Public School Life & Health Insurance Board (the Board) for a determination, which is in the best interest of our group as a whole.

When a covered, formulary preferred brand name drug becomes available in a generic alternative, the new generic will be placed at the same Tier as the brand and the brand will be subject to the brand/generic pricing incentive.

How do I find out, which drugs are in which Tier?

We publish a Preferred Drug List (PDL) that contains many of the more commonly prescribed medications and classifies the drugs into co-payment tiers. (See heading "Does the Plan have any special programs, limitations, or restrictions?" for additional information.) The PDL is available on the central web site of the Plan at www.ARBenefits.org, and is updated as needed.

If your medication is not listed on the PDL, you can obtain coverage information by calling thenumber on your ARBenefits card and pressing "1" for assistance. Alternatively, you may log in to the AR- Benefits member portal (www.ARBenefits.org), click on "Member Links", then "Personal Pharmacy Records" under the heading "Internal Links". The prescription drug benefit member portal will open. Coverage for medications can be found by clicking on "Drug Price Check" and then typing in the name of the drug.

What are my options for purchasing medication under the Plan?

The Prescription Drug Program offers two convenient and cost effective ways to purchase prescription medications. The combined medical/prescription drug card may be used to obtain prescription medications at a discounted cost from a participating retail pharmacy. The Mail Order Prescription Drug Program does not offer additional cost savings on medications; however, does provide a member with the convenience of receiving up to a 3-month supply of medications at their doorstep, paying one (1) co-pay for each month's supply. The Mail Order Program is limited to medications that are required on a long term or maintenance basis. Contact ARBenefits for information regarding prescriptions that can be filled through the Mail Order Program. Please note specialty medications are limited to a one month supply through all distribution services.

How do I use the Retail Prescription Drug Card Program?

Drugs that are prescribed for short-term use should be filled from a network pharmacy using your combined medical and pharmacy identification card. The network includes most pharmacies in Arkansas and pharmacies nationwide. Most chain stores participate in this network, as well as many independent pharmacies across the nation. Confirmation of participating pharmacies may be obtained by calling ARBenefits.

Most retail prescriptions are limited to a 31-day supply. Prescriptions are dispensed according to the instructions of the prescribing physician. If the medical condition is such that the prescription drug is to be taken over a prolonged period of time, (months or even years), you may be able to receive up to a 93-day supply. Contact ARBenefits to verify if your medication will be covered for a 93-day supply at a retail pharmacy or the mail order prescription drug program. (Examples of medications not covered for more than a 31-day supply include antidepressants, proton pump inhibitors, stimulants including those for ADHD, sleep aides, and non-steroidal anti-inflammatory agents.)

How do I use the Pharmacy Mail Order Program?

The mail order prescription program is designed to assist individuals who take the same medication for a long period of time for conditions such as diabetes, high blood pressure, heart, or thyroid conditions. You will need to obtain two (2) 31-day supplies of medication or two fills at a network retail pharmacy before the mail order program can be utilized. This helps to ensure that prescriptions are appropriate for the duration of therapy. If medication is still required after the two (2) 31-day supplies or two (2) fills, you may ask your physician for a prescription for up to a 93-day supply, if appropriate. The mail order program allows you to obtain a 93-day supply of certain medications at one time for three (3) months co-payments.

You may use the mail order option by calling the PBM's mail order provider at 1-855-873-8739.

Each mail order prescription is limited to a maximum quantity limit of a 93-day supply. Pharmacies are required by law to dispense the prescription in the exact quantity specified by the physician. Therefore, if the quantity prescribed is for less than 93 days per refill, the mail order pharmacy will fill the exact quantity written by the physician. **Please be aware that not all medications are available through the mail order program. Contact ARBenefits to verify that your prescription is covered through mail order.**

Why does the Plan encourage generic drugs?

A generic drug is identical in chemical composition to its brand name counterpart, has been approved by the Food and Drug Administration (FDA) to be therapeutically equivalent, and is as effective as the brand name product. The use of generics performs a vital role in controlling the cost of prescription drugs for both the participant and the Plan.

Who do I contact for drug information?

If your physician or pharmacist is unable to answer your drug information questions, you can call the Arkansas Drug Information Center, a service provided by the UAMS College of Pharmacy at 1-888-228-1233.

What about prescriptions for weight loss or smoking cessation?

If participating in the Tobacco Cessation Program, you can receive nicotine replacement patches, the medications bupropion (generic for Zyban), or Chantix at no cost if enrolled and approved by the smoking cessation program. Coverage for bupropion and Chantix is available to members who do not wish to participate in the program; however, standard tier co-payments will apply. To enroll in the program, you may call EBD Member Services at 1-877-815-1017. The PDL reflects which tier each medication falls under. Weight loss medications are not a covered benefit.

Does the Plan have any special programs, limitations, or restrictions?

The Pharmacy Benefits Manager for the Plan has several cost saving initiatives in place designed to assist our prescription drug program in delivering the best possible healthcare at the most reasonable cost. The programs described below are Prior Authorization, Quantity Limits, Daily Dose Edits, Step Therapy, Reference Pricing, and New Generics. Medications listed on the PDL are marked with the abbreviations PA, QL, ST, RP, or NG when applicable.

Prior Authorization (PA)

The Prior Authorization program helps to ensure the appropriate usage of certain medications by applying FDA approved indications and the manufacturer's guidelines to the utilization of certain medications. The DUEC, Pharmacy Benefits Manager, and pharmacy benefits consultant, (University of Arkansas for Medical Sciences College of Pharmacy), have identified the medications that have a high potential for serious side effects, high costs, or high abuse potential.

The following steps should be taken in order to obtain a Prior Authorization:

- Your **physician** may contact EBRx (Evidence Based Prescription drug call center at the UAMS College of Pharmacy) by calling 1-866-564-8258 to discuss prescription drugs that require prior authorization.
- A team of pharmacists is available to evaluate the information provided by yourphysician. Forms are not faxed to your physician's office, as all reviews are handled over thephone.

- Once the prior authorization clinical guidelines are met, your prior authorization will be approved and entered into the system.
- If the clinical guidelines are not met, your physician will be notified during the phone call.
- If the prior authorization is denied, you can still obtain your medication; however, you will be financially responsible for the full cost of the prescription.
- Your **physician** may appeal the denial by sending documentation to:

EBRx Medical Director
Attn: AR EBD APPEAL
4301 W. Markham, Slot 522-9
Little Rock, AR 72205

Quantity Limits (QL)

The QL program is intended to clarify the usual quantity that constitutes a 31-day supply for particular medications. The quantities allowed per each fill are based upon the dosing recommendations made by the manufacturer. To get access to this list of medications, you can call ARBenefits. In addition, these items are indicated on the Preferred Drug List with a (QL). (Note: Some medications, such as opioids for pain control, may have limits in place that allow for smaller quantities to be filled for a shorter time period than 31 days.)

Daily Dosing Edits

Daily Dose Edits are designed to notify members when they are taking lower strength medications multiple times a day when higher strengths are available.

Step Therapy (ST)

Step therapy is a program designed for people who take prescription drugs used to treat certain ongoing medical conditions. The step therapy program is designed with safety, cost, and most importantly, your health in mind. It allows you and your family to receive the affordable treatment you need and helps the Plan contain the rising cost of prescription drug coverage.

Prescription drugs that are placed under the step therapy program generally require you to have failed therapy with one drug before coverage for another drug will be given, unless your physician has a compelling reason you should not first try one of the other drugs.

To find out which medications are included in the Step Therapy program, contact ARBenefits. These products are also indicated on the Preferred Drug List with (ST).

Reference Pricing (RP)

The Reference Pricing program is used when evidence shows one product in a class of drugs is not any more effective than the other drugs within the same therapeutic class. The plan uses a lower cost medication as a "reference" to determine how much of the cost of a drug the plan will cover. If a member requires a higher priced product, the Plan pays the "referenced price" and the member is responsible for the remainder of the cost.

Refer to the Preferred Drug List (PDL) for the prescription drug therapeutic categories that are currently under the Reference Pricing program for the pharmacy benefit plan. These products are indicated on the Preferred Drug List with (RP).

Example: For calcium regulators, the medications Actonel, Atelvia, Boniva and ibandronate are referenced priced. The plan pays up to $0.10 per pill/unit. The member is responsible for the remaining cost.

New Generics (NG)

When a new generic drug is released, it will be placed at the same Tier as its Brand counterpart. For example, when a Tier 2 medication becomes available as a generic, the new generic preparation will also be place at Tier 2. The Branded product will no longer be Tier 2 and instead be subject to the "Brand/Generic" pricing incentive (See SPD page 46). **Please note that these new generics will not have the standard Tier 1 copayment that older generic products have**.

Timely Filing

In the event that a medication is not processed through the prescription drug program at the time of service, the member has 180 days from the date the prescription is filled to submit for member reimbursement. **Please note that paper claims submitted by a member are subject to the same coverage criteria as any other prescriptions. Paper claims are processed at the same discounted pharmacy rate that would apply had the pharmacy processed the claim. Member reimbursement will be applied after the plan discount and member copayment are determined. This may result in a member reimbursement less than what is expected. Submission of materials does not guarantee payment.**

Arkansas State and Public School Employees Preferred Drug List (PDL) - Effective March 2021

This PDL is a list of the most commonly prescribed drugs. It is not all-inclusive and is not a guarantee of coverage. Plan Benefit Design is the final determinate of coverage. For drugs not listed, please call the pharmacy program number listed on the back of your ARBenefits ID card for benefit coverage information.

PLEASE NOTE: Use of generic drugs can save both you and your health plan money. Generics that are new to the market will require a copyment equal to its branded product. These are indicated in the PDL with *(NG) and are shown in bold type. These new generics will not have the standard Tier 1 copayment that older generic products have. In addition, brand-name medications that are available in the generic form may still appear in a tiered copay box, however, they will require a generic drug copayment PLUS the difference in the plan's cost between the generic and equivalent brand-name drug. If the brand name product is a reference-priced medication*(RP), the equivalent new generic will also become reference-priced instead of applying the difference in brand/generic cost. *Brand drugs with an equivalent generic available are non-covered on the Classic and Basic plans.*

Specialty drugs *may require* prior authorization (PA) by EBRx (1-866-564-8258) to ensure appropriate usage. These medications are indicated in the PDL located under Tier 4.

Compounded medications require a Tier 3 copay for Premium plan members. Deductible and/or coinsurance will apply for Classic and Basic plan members. General benefit guidelines apply.

Medications listed as reference priced are considered non-covered on the Classic and Basic plans.

Key: Certain drugs (*) may be subject to Day Supply (DS), Quantity Limits (QL), Prior Authorization (PA), Step Therapy (ST), Contingent Therapy (CT), New Generics (NG) or Reference Pricing (RP) requirements according to Benefit Design. **Items indicated as *(RP) require special copayment pricing and do not apply to the standard tier copayments. This PDL is subject to change at any time.**

	Tier 1	Tier 2	Tier 3	Tier 4
ANTI-INFECTIVES				
Antibiotics-Cephalosporins	cefaclor, cefadroxil, cefpodoxime, cefprozil, cephalexin, cefdinir	Cedax, Spectracef, Suprax 400 mg capsule*(QL)		
Antibiotics-Macrolides	erythromycin, azithromycin*(QL), clarithromycin	Zmax Suspension		
Antibiotics-Fluoroquinolones	ciprofloxacin, levofloxacin			Baxdela*(PA)
Antibiotics-Penicillins	amoxicillin, amoxicillin/clavulanate, ampicillin, penicillin			
Antibiotics-Other	minocycline		Adoxa, linezolid*(PA) (**NG**)	Vabomere*(PA)
Antifungals	fluconazole, itraconazole*(PA), ketoconazole, nystatin, terbinafine			
Antiretrovirals	abacavir, didanosine, lamivudine, lamivudine/zidovudine, nevirapine, zidovudine	Isentress*(PA), Isentress Chewable*(PA), Prezista tablets, Reyataz, Sustiva, Viracept	Epivir, Evotaz, Reyataz powder, Vitekta	Aptivus, Biktarvy, Cimduo, Combivir, Crixivan, Delstrigo, Descovy, Dovata*(PA), **efavirenz/emtricitabine/ tenofovir*(NG),** Emtriva, Epzicom, Invirase, Isentress Powder*(PA), Juluca*(PA), Kaletra, Lexiva, Odefsey, Pifeltro, Prezcobix, Prezista soln*(PA), Rescriptor, Rukobia*(PA,QL), Selzentry*(PA), Stribild tablet*(QL)*(PA), Symfi Lo, Temixys, Tivicay, Trizivir, Truvada, Viread

	Tier 1	Tier 2	Tier 3	Tier 4
Antivirals-Flu	amantadine, rimantadine	oseltamivir*(**NG**), Xofluza*(QL)	Relenza	
Antivirals-Herpes	acyclovir, famciclovir, valacyclovir			
Antivirals-Other-Interferons/Interferon combinations	ribavirin*(PA)			Zepatier*(PA), Mavyret*(PA)
CARDIOVASCULAR				
Antihyperlipidemic-HMG (Statins) **(NOTE: See Wellness/Preventive section.)**	atorvastatin, lovastatin, pravastatin, rosuvastatin, simvastatin			
	***(RP) Reference Priced Antihyperlipidemic-HMG (Statins): Plan pays $0.30 per unit. Member is responsible for remaining cost. (Excluded for Classic & Basic plans.)**	Altoprev, Crestor 5mg, 10mg & 20mg, fluvastatin, Lescol XL, Lipitor, Mevacor, Pravachol, Zocor		
Other Antihyperlipidemic Agents	cholestyramine resin, colestipol, ezetimibe, gemfibrozil	Praluent*(PA), Welchol tablet		Repatha*(PA)
Antiplatelet Agents	clopidogrel, dipyridamole, dipyridamole/aspirin, anagrelide, cilostazol	Brilinta, prasugrel***(NG)**		
Anticoagulants	warfarin	Eliquis, Xarelto		
ACE Inhibitors and ACE Inhibitors combinations	amlodipine/benazepril, captopril, captopril hctz, enalapril, fosinopril, lisinopril, lisinopril hctz, moexipril/hctz, perindopril, quinapril/hctz, ramipril, trandolapril, trandolapril/verapamil			
Angiotensin II Rec Antagonist (ARB)/Direct Renin Inhibitor (DRI)	amlodipine/valsartan, irbesartan, irbesartan/HCTZ, losartan, losartan/HCTZ, olmesartan HCTZ, olmesartan medoxomil, telmisartan, valsartan, valsartan/HCTZ			
	***(RP) Reference Priced Angiotensin Receptor Blockers (ARB): Plan pays $0.81 per unit. Member is responsible for remaining cost. (Excluded for Classic & Basic plans.)**	**amlodipine/valsartan HCT*(NG)**, Atacand, **candesartan*(NG)**, Atacand HCT, candesartan cilexetil/HCTZ, Avalide, Avapro, Azor, Benicar, Benicar HCT, Cozaar, Diovan, Diovan HCT, Edarbi, Edarbyclor, Exforge, Exforge HCT, Hyzaar, Micardis, Micardis HCT, Tekturna, Tekturna HCT, Teveten, Teveten HCT, Twynsta, **telmisartan/amlodipine*(NG),** telmisartan HCTZ		

	Tier 1	Tier 2	Tier 3	Tier 4
Beta Blockers	acebutolol, atenolol, bisoprolol, labetalol, metoprolol, metoprolol hctz, metoprolol XL, propranolol, propranolol hctz			
Calcium Channel Blockers	amlodipine, diltiazem, felodipine, nicardipine, verapamil			nimodipine*(PA)
CENTRAL NERVOUS SYSTEM				
ADHD Medications	amphetamine salts IR*(QL), dexmethylphenidate tablets, dextroamphetamine*(QL), methylphenidate*(QL), methylphenidate ER*(QL), amphetamine salts XR*(QL)	Daytrana*(QL), Strattera*(QL), atomoxetine*(**NG**)(QL)	Adderall XR*(QL), dexmethylphenidate ER*(**NG**), dextroamphetamine ER, dextroamphetamine/amphetamine ER, Dexedrine*(QL), Metadate CD*(QL), ER*(QL), Ritalin LA*(QL), Vyvanse*(QL)	
	***(RP) Long Acting Amphetamines: Plan pays $2.50 per unit. Member is responsible for remaining cost. (Excluded for Classic & Basic plans.)**	Long Acting Amphetamines are ***reference priced*** for members 26 years of age or older; ****Quantity Limits*** will still apply to ***reference priced*** long acting amphetamines. Adderall XR*(QL), amphetamine salts extended release*(QL), Dexedrine*(QL), dextroamphetamine extended release*(QL), Vyvanse*(QL)		
Alzheimers	donepezil, galantamine, galantamine ER, memantine, rivastigmine	**rivastigmine patch*(NG)**		
Analgesics-Narcotic	codeine-apap*(QL), fentanyl patch, hydrocodone combinations*(QL), meperidine, morphine sulfate, oxycodone combinations*(QL), oxycodone controlled release 12HR		Fentora Tablet*(QL)*(PA), Oxycontin, Percocet*(QL), Percodan, Tylenol/w Codeine*(QL)	
Analgesics-NSAIDs (NOTE: Topical NSAIDs are not covered by the plan.)	Celecoxib 50mg, 100mg,& 200mg, Diclofenac tabs, Ibuprofen, Indomethacin, ketorolac*(QL), Meloxicam, Nabumetone, Naproxen, Sulindac			
	***(RP) Reference Priced NSAIDs: Plan pays $0.15 per unit. Member is responsible for the remaining cost. (Excluded for Classic & Basic plans.)**	Celecoxib 400mg, Diclofenac ER, Diclofenac/Misoprostol, Diclofenac Pottasium, Etodolac, Etodolac ER, Fenoprofen 400mg & 600mg, Flurbiprofen, Indomethacin ER, Ketoprofen ER, Meclofenamate, Mefenamic Acid, Naproxen CR 500mg, Oxaprozin, Piroxicam		
Anticonvulsants	carbamazepine, levetiracetam, phenytoin, valproic acid, gabapentin, lamotrigine, divalproex delayed release, divalproex SR, topiramate, oxcarbazepine, zonisamide	Nayzilam*(PA,QL)	Banzel*(PA), Fycompa, Potiga*(PA), Xcopri*(QL)	Diacomit*(PA), Fintepla*(PA), Sabril*(PA)

	Tier 1	Tier 2	Tier 3	Tier 4
	gabapentin, pregabalin*(NG)			
Fibromyalgia	***(RP) Reference Priced Anticonvulsants: Plan pays $0.35 per unit. Member is responsible for the remaining cost. (Excluded for Classic & Basic plans.)**	Lyrica CR		
Antidepressants-Other	amitriptyline, bupropion immediate release and SR, bupropion XL, desipramine, imipramine, mirtazapine, nortriptyline			
	duloxetine, venlafaxine, venlafaxine XR capsule			
Antidepressants (SNRIs)	***(RP) Serotonin norepinephrine reuptake inhibitors (SNRIs): Plan pays $0.75 per unit. Member is responsible for remaining cost. (Excluded for Classic & Basic plans.)**	Cymbalta, Effexor XR, venlafaxine extended release ***tablets***		
	citalopram, escitalopram, fluoxetine 10, 20 & 40mg, fluvoxamine, paroxetine, sertraline			
Antidepressants (SSRIs)	***(RP) Selective serotonin reuptake inhibitors (SSRIs): Plan pays $0.30 per unit. Member is responsible for remaining cost. (Excluded for Classic & Basic plans.)**	Lexapro, Luvox CR, fluvoxamine ER, Paxil, Paxil ER, paroxetine ER, Pexeva, Zoloft		
Anti-Parkinson	carbidopa/levadopa, entacapone, pramipexole, rasagiline, ropinirole, selegiline, tolcapone		Neupro*(PA), **pramipexole SR*(NG)**	Kynmobi*(QL), Nourianz*(PA)
Antipsychotic Agents	aripiprazole tablet, clozapine tablets, olanzapine/fluoxetine, olanzapine, olanzapine ODT, risperidone tablets, quetiapine, ziprasidone	Abilify Tablet*(PA), Seroquel XR*(QL)	Abilify Solution*(PA), Equetro, Latuda*(PA)	Invega Sustenna, Invega Trinz*(PA)
Migraine Products	eletriptan*(QL), rizatriptan*(QL), rizatriptan ODT*(QL), sumatriptan tablets*(QL)		sumatriptan injectables*(QL), Aimovig*(PA,QL), Emgality*(PA,QL), Nurtec ODT*(PA)	
	***RP Migraine Medications. Plan pays $0.50 per unit. Member is responsible for remaining cost. (Excluded for Classic & Basic plans.)**	almotriptan*(QL), Axert*(QL), Frova*(QL), Frovatriptan*(QL), Naratriptan*(QL), Relpax*(QL), Zolmitriptan*(QL), Zolmitriptan ODT*(QL)		
	***RP Migraine Medications. Plan pays $6.00 per prescription. Member is responsible for remaining cost. (Excluded for Classic & Basic plans.)**	Sumatriptan Nasal Sprays*(QL), Tosymra *(QL), Zomig nasal sprays*(QL)		

	Tier 1	Tier 2	Tier 3	Tier 4
Multiple Sclerosis Drugs				Aubagio tablet*(PA)*(QL), Avonex*(PA), Betaseron*(PA), **Dimethyl Fumarate*(NG)(PA)(QL)**, Extavia, Gilenya, **glatopa*(NG)**, Mavenclad*(PA), Rebif*(PA)
Sedative Hypnotics	temazepam 15mg, temezapam 30mg, triazolam, zaleplon, zolpidem			
	***(RP) Reference Priced Sedatives/Hypnotics: Plan pays $0.15 per unit. Member is responsible for remaining cost. (Excluded for Classic & Basic plans.)**	Ambiem, Ambien CR, zolpidem ER, eszopiclone*(NG), Lunesta, Rozerem, ramelteon, temazepam 7.5mg, temazepam 22.5mg		
Skeletal Muscle Relaxants	Baclofen, Carisoprodol 350mg, Chlorzoxazone 500mg, Cyclobenzaprine, Methocarbamol, Orphenadrine tablets, Tizanidine tabs			
	***(RP) Reference Priced Skeletal Muscle Relaxants: Plan pays $0.15 per unit. Member is responsible for remaining cost. (Excluded for Classic & Basic plans.)**	Carisoprodol 250mg, Carisoprodol/Aspirin, Chlorzoxazone 250mg, 375mg, & 750mg, Dantrolene, Metaxalone, Tizanidine caps		
ENDOCRINE				
Diabetes-Insulin	insulin lispro	Humulin R 100, Humulin N, Humulin 70/30, Humulin R U-500 Kwikpen, Humalog, Humalog JR Kwikpen, Lantus, Lyumjev, Toujeo, Toujeo Max Solostar		
Diabetes-Non-Insulin Injectable antihyperglycemic agents	no generics available at this time	Ozempic*(PA), Trulicity*(PA), Victoza*(PA)		
Diabetes-Insulin Sensitizing Agents	metformin, pioglitazone			
Diabetes-Insulin Secreting Agents	chlorpropamide, glimepiride, glipizide, glyburide, nateglinide, repaglinide, tolazamide			
Diabetes – SGLT2		Jardiance*(PA), Synjardy*(PA), Synjardy XR*(PA)		
Diabetes-Combinations	Glyburide - Metformin, piogiltazone HCL - glimepiride			

	Tier 1	Tier 2	Tier 3	Tier 4
Diabetes-Other Medications	acarbose	Glyset	Baqsimi, Gvoke Hypopen	
Diabetic Supplies	**The following diabetic testing supplies will be covered 100% by the plan when purchased through a network pharmacy with a prescription:** Accu-Chek® Guide Me glucometer, Accu-Chek® Guide test strips*(**QL**), TRUEplus® syringes/pen needles, and any brand of Lancets. (Note: No other glucometer, test strips or syringes/pen needles will be covered.)			
	Continuous Glucose Monitors (CGMs): The Dexcom G6 CGM is covered with an approved prior authorization. Physicians may call the EBRx PA line at (866) 564-8258 for review. If approved, Dexcom Sensors will have an $80 per month copay for all plans. Dexcom Transmitters and Receivers will be covered 100% by the plan. These must be purchased from a network pharmacy.			
Thyroid Agents	levothyroxine, Levoxyl			
GASTROINTESTINAL/URINARY				
Digestive Aids	pancrelipase	Creon, Viokace, Zenpep		
Gallstone Solubilizing Agents	ursodiol			
H-2 Antagonists	cimetidine, famotidine, nizatidine, ranitidine			
Proton Pump Inhibitors	lansoprazole OTC, omeprazole 10mg, omeprazole 20mg, omeprazole 40mg, omeprazole OTC, pantoprazole 20 & 40 mg, pantoprazole inj, Prevacid 24hr OTC, Prilosec OTC			
	***(RP) Reference Priced Proton Pump Inhibitors: Plan pays $0.30 per unit. Member is responsible for remaining cost. (Excluded for Classic & Basic plans.)**	Aciphex, **rabeprazole*(NG)**, Dexilant, esomeprazole, lansoprazole non-OTC, Nexium, Nexium OTC, Prevacid, Prilosec, Protonix		
Bowel Preparation Drugs	*See Wellness/Preventive under the Miscellaneous section for agents covered with no copay.	Colyte, Golytely, MoviPrep	Clenpiq	
Overactive Bladder Agents	oxybutynin immediate release			
	***(RP) Reference Priced Overactive Bladder Agents: Plan pays $0.51 per unit. Member is responsible for remaining cost. (Excluded for Classic & Basic plans.)**	Detrol, tolterodine, Detrol LA, tolterodine (extended release), Ditropan XL, Enablex, Gemtesa, Myrbetriq, trospium, trospium ER, Vesicare, **solifenacin*(NG)**, oxybutynin extended release		
Inflammatory Bowel	budesonide 3mg capsules, sulfasalazine	**mesalamine DR 400mg caps*(NG)**	**mesalamine ER 0.375gm caps*(NG,QL),** budesonide 9mg tablets*(PA), Canasa	mesalamine DR 1.2gm tabs, Pentasa

	Tier 1	Tier 2	Tier 3	Tier 4
Hyperparathyroid Agents	calcitriol	Hectorol, Zemplar	Rocaltrol	
MEN'S HEALTH				
Erectile Dysfunction		Muse*(QL)*(PA), Stendra*(QL)*(PA), **sildenafil*(NG)**(QL)	Cialis*(QL), Staxyn *(QL)*(PA), **vardenafil*(NG)(QL)(PA)**	
Hormone Replacement	Testostrone Injectable(s)*(PA)			
Prostate Health	doxazosin, dutasteride, tamsulosin, terazosin		**silodosin*(NG)**	
RESPIRATORY				
Nasal Products	azelastine, flunisolide, fluticasone			
	***(RP) Reference Priced Nasal Steroids: Plan pays up to $26.00 for a one month supply. Member is responsible for remaining cost. (Excluded for Classic & Basic plans.)**	Beconase AQ, Flonase, Nasonex, Rhinocort AQ, budesonide, QNasl		
Leukotriene Modulators	montelukast, zafirlukast			
**Steroid Inhalants	budesonide solution	Asmanex, QVAR RediHaler		
**Beta Agonists-Short Acting	albuterol sulfate HFA, metaproterenol	ProAir HFA, ProAir Respi Click		
**Beta Agonists-Long Acting	no generics available at this time	Foradil*(ST), Serevent Diskus*(ST)	Perforomist*(ST)	
**Inhaled Corticosteroids / Long Acting Beta Agonists	fluticasone/salmeterol	Dulera, **budesonide/formoterol fumarate*(NG)**, Symbicort		
**Long-Acting Muscarinic Agents + Long-Acting Beta Agonists		Stiolto Respimat		
**Long-Acting Anticholinergics		Spiriva, Spiriva Respimat		
**Respiratory-Other	albuterol/ipratropium, ipratropium, theophylline 200mg extended release	Breztri, Combivent		Nucala*(PA), Xolair*(PA)

NOTE - NO OTHER BRAND-NAME MEDICATIONS ARE COVERED IN THE RESPIRATORY DRUG CATEGORIES THAT ARE MARKED WITH **. ONLY THOSE LISTED IN THIS PDL ARE COVERED. ALL OTHER BRANDED PRODUCTS ARE EXCLUDED FROM COVERAGE.

	Tier 1	Tier 2	Tier 3	Tier 4
TOPICAL				
Ears	ofloxacin		**ciprofloxacin / dexamethason*(NG)**, Ciprodex	
Eye-Glaucoma	brimonidine, latanoprost, levobunolol, timolol, dorzolamide, dorzolamide/ timolol drops	Alphagan P 0.1% (if no generic available), Azopt, Betimol, Betoptic, Cosopt drops, Lumigan	Alphagan P 0.15%, Cosopt droperette, dorzolamide/timolol droperette, Timoptic, Trusopt, Xelpros, Xalatan	
Eye - Dry Eye Disease		Cequa		
Eye-Miscellaneous	cromolyn, ketorolac, levofloxacin 0.5%	Acuvail, Alrex, Lotemax (ointment & suspension *ONLY*)	Alocril, Alomide, Vigamox, Zirgan	
Skin-All	betamethasone, clotrimazole/betamethasone topical lotion, lidocaine >5%*(PA), mometasone	**Pimecrolimus*(NG)**	Diprolene AF, Ertaczo, Finacea Gel, Venelex Ointment	Dupixent*(PA)
Skin-Acne	benzoyl peroxide, benzoyl peroxide/erythromycin, clindamycin (foam is excluded), Amnesteem, Claravis, sulfacetamide sodium 10% topical solution, tretinoin*(PA age 26 & over)	Retin-A 0.05% topical solution*(PA age 26 & over), Retin-A micro*(PA age 26 & over)	**dapsone*(NG),** Retin-A (other strengths)*(PA age 26 & over)	
WOMEN'S HEALTH				
Combination HRT	Norethindrone Acetate/TE/Ethinyl Estradiol 1mg/5mcg	FemHRT 0.5mg/2.5mg, Prefest, Premphase, Prempro, Prempro Low Dose	Activella, Climara Pro, Combipatch	
Contraceptives	Plan will pay 100% for all *COVERED GENERIC contraceptives*. *COVERED BRANDS* with **no** generic available will be covered by the plan under ***Tier 3*** **(limited to *oral* forms).** *****Brand/Generic difference/penalty** pricing will apply if member chooses a *COVERED BRAND* where a generic is available.**** **Examples of COVERED GENERICS paid at 100%:** Amethia, Aviane, Azurette, Camrese, Camrese Lo, Cryselle, Daysee, Elinest, Emoquette, Enpresse, Gianvi, Gildess, Introvale, Jolessa, Junel 1/20, Junel 1.5/30, Junel FE 1/20, Junel FE 1.5/30, Kariva, Lessina, Levora, Loryna, Low-Ogestrel, Levonest, Lutera, Marlissa, Microgestin, Mono-Linyah, MonoNessa, Myzilra, Necon, Nortrel, Ocella, Ogestrel, Orsythia, Portia, Previfem, Quasense, Reclipsen, Sprintec, Sronyx, Syeda, Tilia, Trinessa, Trinessa Lo, Tri-Linyah, Tri-Lo- Estarylla, Tri-Sprintec, Tri-Lo-Sprintec, Trivora, Wymzya, Vestura, Viorele, Zarah, Zenchent **Examples of COVERED BRANDS paid at 100%:** Nuvaring and Ortho-Evra		LoLoestrin FE	

	Tier 1	Tier 2	Tier 3	Tier 4
Hormone Replacement Therapy (HRT)		Alora, Estrace Cream, Estrogel, Menest, Premarin, Prometrium, Vivelle-Dot, Yuvafem	Climara, Divigel, Enjuvia, Estrace Tablet, Estring, Femring	
Osteoporosis-Calcium Regulators	alendronate, calcitonin nasal spray	Miacalcin Injection		
	***(RP) Reference Priced Calcium Regulators: Plan pays up to $0.10 per pill/unit. Member is responsible for remaining cost. (Excluded for Classic & Basic plans.)**	Actonel, Atelvia, **risedronate sodium*(NG)**		
Osteoporosis-Hormone Receptor Modulators	raloxifene			Prolia*(PA)
Prenatal Vitamins	CompleteNate, CO-Natal FA, MACNATAL CN DHA, M-Vit, Mynatal Plus, Mynatal-Z, OB-Natal One, PNV-Select, Prenafirst, PrenataPlus, Prenatabs FA, Prenatal Low Iron, Se-Tan DHA, Taron EC Calcium, Taron-Prex, Trinatal RX 1, Ultimatecare One, Vinate IC	Concept DHA, Concept OB, Folcal DHA, Folcaps Omega 3, Folivane-PRx DHA NF, Gesticare DHA, Levomefolate DHA, Levomefolate PNV, L-Methylfolate PNV DHA, Tamdem DHA, Virt-PN, Zatean-PN	Complete-RF Prenatal, Folivane-OB, HemeNatal OB+DHA, NatalVit, Prenatal Vitamins Plus, Prenaissance Balance/Plus, O-Cal FA, O-Cal Prenatal, Venatal-FA, Venate, Vol-Nate, VP-CH-PNV, Zatean-CH	
Vaginal Products	clotrimazole, fluconazole, metronidazole vag gel, terconazole	Gynazole-1	Clindesse, Diflucan, Metrogel Vaginal, Terazol	
MISCELLANEOUS				
Antiemetics	granisetron*(QL), ondansetron*(QL)	Emend*(QL), Varubi	Anzemet*(QL)**,** Sancuso*(QL)(PA)	
Antipsoriatics	acitretin, tazarotene*(PA)		Zithranol Shampoo	
Botulinum Toxins				Xeomin® (PA)
Gout	allopurinol, colchicine		**febuxostat*(NG)(PA),** Zyloprim	
Growth Hormone	no generics available at this time	Norditropin*(PA)		Saizen*(PA), Serostim*(PA), Zorbitive*(PA)
Immunosuppressive Agents	azathioprine, cyclosporine, mycophenolate mofetil, tacrolimus capsule			Myfortic, Nulojix*(PA), Prograf injection, Rapamune, Simulect
Rheumatoid Arthritis	methotrexate, leflunomide	Trexall*(PA)		
Saliva Stimulants	cevimeline			
Targeted Immune Modulators (Step Therapy--Use Preferred Agents First) (NOTE: Samples of medication will not be recognized as a means of establishing prior drug use.)		Enbrel*(PA), Humira*(PA), Olumiant*(PA, QL), Renflexis*(PA), Rinvoq*(PA), Skyrizi*(PA), Taltz*(PA)		Actemra*(PA), Cimzia*(PA), Cosentyx*(PA), Entyvio*(PA), Inflectra*(PA), Kevzara*(PA), Kineret*(PA), Orencia*(PA), Otezla*(PA), Simponi*(PA), Stelara*(PA), Tysabri*(ST), Xeljanz*(PA), **Ruxience*(PA)(medical plan benefit)

	Tier 1	Tier 2	Tier 3	Tier 4
Wellness/Preventive	The following medications are covered 100% by the plan due to federal regulations. *Aspirin, Folic Acid, Iron Supplement (for children up to 1 year of age), Vitamin D (for adults age 65 and older) *Chantix, bupropion & nicotine patches when enrolled in the ARBenefits Smoking Cessation Program *All preventive vaccines recommended by the CDC advisory Committee on Immunization Practices *Generic bowel prep products (Gavilyte-C/G/H/N, Peg 3350/Electrolytes, Peg-Prep, Peg-3350/KCL Sol /Sodium, Trilyte *Some statin medications may be covered with a $0 copay for eligibile members. Preventive care restrictions apply.			

Specialty Drug List--March 2021

*This Specialty Drug List includes medications that are classified as **Tier 4** drugs (by plan coverage) and **most** will require pre-authorization by EBRx (1-866-564-8258) when obtained from the pharmacy or administered in the physician's office.*

***NOTE:** Samples of medication will not be recognized as a means of establishing prior drug use during the step therapy/prior authorization criteria review for Targeted Immune Modulators (ex; Humira, Enbrel, etc).*

ACROMEGALY

Sandostatin
Sandostatin LAR
Somatuline Depot
Somavert

BOTULINUM TOXINS

Dysport
Xeomin

CRYOPYRIN-ASSOCIATED PERIODIC SYNDROMES

Arcalyst

CYSTIC FIBROSIS

Cayston
Kalydeco
Orkambi
Pulmozyme
Symdeko
Trikafta

ENZYME DEFICIENCY OR LYSOSOMAL STORAGE

Aldurazyme
Cerdelga
Cerezyme
Cystadane
Cystaran
Elaprase
Fabrazyme
Lumizyme
Myozyme
Naglazyme
Nityr
Sucraid
Zavesca

GROWTH HORMONE & RELATED DISORDERS

Saizen
Serostim
Somavert
Zorbtive

HEMATOPOIETICS

Aranesp
Epogen
Fulphila
Mozobil
Procrit
Zarxio

HORMONAL THERAPIES

Eligard
Firmagon
Supprelin LA
Synarel
Vantas

IGF-1 Deficiency

Increlex

IMMUNE DEFICIENCY & RELATED DISORDERS

Bivigam
Flebogamma
Gamastan S/D
Octagam
Xembify

IMMUNE THROMBOCYTO-PENIC PURPURA

Cablivi
Promacta

IRON OVERLOAD

Exjade
Ferriprox

MACULAR DEGENERATION

Eylea
Macugen
Visudyne

MULTIPLE SCLEROSIS

Aubagio
Avonex
Betaseron
Extavia
Gilenya
Glatopa
Mavenclad
Rebif
Tecfidera
Tysabri
Vumerity
Zeposia

HEMATOPOIETICS (CONTINUED)

Leukine

HEMOPHILIA & RELATED BLEEDING DISORDERS

Advate
Adynovate
Alphanate
Alphanine SD
Alprolix
Bebulin
Bebulin VH
Benefix
Feiba NF
Feiba VH
Helixate FS
Hemlibra
Hemofil M
Humate-P
Idelvion
Jivi
Koate-DVI
Kogenate FS
Monoclate-P
Mononine
NovoEight
NovoSeven RT
Nuwiq
Obizur
Profilnine SD
Rebinyn
Recombinate
Stimate
Wilate
Xyntha

HEPATITIS B

Baraclude
Epivir HBV
Hepsera
Lamivudine
Tyzeka
Vemlidy

HEPATITIS C

Mavyret
Zepatier

HEREDITARY ANDIOEDEMA

Haegarda

HIV

Aptivus
Atripla
Biktarvy
Cimduo
Combivir
Complera
Crixivan
Delstrigo
Descovy
Dovato
Edurant
Egrifta
Emtriva
Odefsey
Pifeltro
Prezcobix
Prezista
Rescriptor
Retrovir
Reyataz
Selzentry
Stavudine
Stribild
Sustiva
Symtuza
Temixys

ONCOLOGY – ORAL

Alecensa
Braftovi
Daurismo
Erleada
Gleevec
Hycamtin
Ibrance
Imbruvica
Inlyta
Jakafi
Kisqali
Lynparza
Matulane
Mekinist
Mektovi
Myleran
Nexavar
Ninlaro
Nubeqa
Onureg
Pomalyst
Revlimid
Rydapt
Sprycel
Sutent
Stivarga
Tafinlar
Tagrisso
Talzenna
Tarceva
Targretin
Tasigna
Temodar
Thalomid
Tibsovo
Tykerb
Venclexta
Verzenio
Vitrakvi
Vizimpro
Votrient
Xeloda
Xospata
Xtandi
Zelboraf
Zolinza
Zydelig

ONCOLOGY - SUPPORTIVE CARE

Zometa

OSTEOPOROSIS

Prolia
Reclast

PULMONARY ARTERIAL HYPERTENSION

Adcirca
Adempas
Flolan
Letairis
Opsumit
Remodulin
sildenafil 20mg
Tracleer
Tyvaso
Uptravi
Veletri
Ventavis

RESPIRATORY SYNCYTIAL VIRUS

Synagis

TRANSPLANT

Cellcept
Prograf

HIV (CONTINUED)

Epzicom
Fuzeon
Genvoya
Intelence
Invirase
Isentress
Juluca
Kaletra
Lexiva
Norvir
Symfi Lo
Triumeq
Trizivir
Truvada
Tybost
Videx
Viracept
Viramune
Viread
Zerit
Ziagen

TRANSPLANT (CONTINUED)

Gengraf
Myfortic
Neoral
Nulojix
Rapamune
Sandimmune
Zortress

OTHER THERAPIES

Aranesp
Cystadrops
Dupixent
Esbriet
Invega Sustenna
Invega Trinz
Nucala
Siklos
Soliris
Vivitrol
Xenazine
Xolair