



**PLAN DOCUMENT AND
SUMMARY PLAN DESCRIPTION
FOR**

HENDRIX COLLEGE HEALTH BENEFIT PLAN

Benefits effective January 1, 2024

- PPO Plan
- High Deductible Health Plan

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INTRODUCTION

This document is a description of Hendrix College Health Benefit Plan (the Plan). No oral interpretations can change this Plan. The Plan described is designed to protect Plan Participants against certain catastrophic health expenses. The High Deductible Health Plan option is designed to be used with Health Savings Accounts (HSA).

Para obtener asistencia en Espanol, llame al 1-800-370-5852.

The Employer fully intends to maintain this Plan indefinitely. However, it reserves the right to terminate, suspend, discontinue or amend the Plan at any time and for any reason.

At all times this Plan will comply with all applicable laws and regulations.

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

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.

If the Plan is terminated, amended, or benefits are eliminated, the rights of Covered Persons are limited to Covered Charges incurred before termination, amendment or elimination.

This document summarizes the Plan rights and benefits for covered Employees and their Dependents and is divided into the following parts:

Eligibility, Funding, Effective Date and Termination. Explains eligibility for coverage under the Plan, funding of the Plan and when the coverage takes effect and terminates.

Schedule of Benefits. Provides an outline of the Plan reimbursement formulas as well as payment limits on certain services.

Benefit Descriptions. Explains when the benefit applies and the types of charges covered.

Cost Management Services. Explains the methods used to curb unnecessary and excessive charges.

This part should be read carefully since each Participant is required to take action to assure that the maximum payment levels under the Plan are paid.

Defined Terms. Defines those Plan terms that have a specific meaning.

Plan Exclusions. Shows what charges are **not** covered.

Claim Provisions. Explains the rules for filing claims and the claim appeal process.

Coordination of Benefits. Shows the Plan payment order when a person is covered under more than one plan.

Third Party Recovery Provision. Explains the Plan's rights to recover payment of charges when a Covered Person has a claim against another person because of injuries sustained.

Continuation Coverage Rights Under COBRA. Explains when a person's coverage under the Plan ceases and the continuation options which are available.

ERISA Information. Explains the Plan's structure and the Participants' rights under the Plan.

ELIGIBILITY, FUNDING, EFFECTIVE DATE AND TERMINATION PROVISIONS

A Plan Participant should contact the Plan Administrator 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.

ELIGIBILITY

Eligible Classes of Employees. All Active Employees, who qualify under one of the classes below, and Retired Employees.

New Hires:

- **Regular Full-Time Employees:** Employees are considered Full-Time Employees if the Employee, on his or her date of hire, is reasonably expected to work an average of at least 30 hours per week as determined by the Employer and is on the regular payroll of the Employer for that work.. Coverage for Full-Time Employees becomes effective on the date of hire, subject to completion of enrollment requirements. A new hire Employee must enroll within 30 days of date of hire otherwise he or she is considered a Late Enrollee.
- **Retired Employees** who meet the following qualifications:
 - (1) An Active Employee who have been continuously covered, and any eligible Dependent covered, by this Plan prior to August 2, 2012; and
 - (2) Has reached age:
 - (i) 55 with at least 20 full-time continuous years of service at the time of retirement; or
 - (ii) 60 with at least 18 full-time continuous years of service at the time of retirement; or
 - (iii) 62 with at least 15 full-time continuous years of service at the time of retirement; and
 - (3) He or she is not eligible for Medicare; and
 - (4) Enrolls and elect to contribute to the Plan the contribution that is required from a Retired Employee.

Impact of Breaks in Service:

If an Employee has a Break in Service and then returns to work, he or she will be treated as a New Hire, and eligibility for coverage under the Plan upon return will be determined in accordance with the New Hire rules above. However, if the Employee is not actively at work for a period and returns to work or is otherwise credited with Hours of Service before incurring a Break in Service, he or she will be treated as a continuous employee and will be eligible for coverage under the Plan upon return if he or she was enrolled in coverage prior to the start of the period during which there were no Hours of Service. The Employee's coverage will be effective on the first day of the month that coincides with or follows the date he or she resumed Hours of Service, subject to completion of enrollment requirements.

Eligible Classes of Dependents. A Dependent is any one of the following persons:

(1) A covered Employee's Spouse.

The term "Spouse" shall mean the person with whom covered Employee has established a valid marriage under applicable State law and shall include common law marriages. The term "Spouse" shall include an individual of the same sex as the covered employee, if they were legally married under the laws of a State or other foreign or domestic jurisdiction. The Plan Administrator may require documentation proving a legal marital relationship.

The term "Spouse" shall also mean the person who is currently registered with the Employer as the Domestic Partner of the Employee, this includes opposite sex and same sex couples. An individual is a Domestic Partner of an Employee if that individual and the Employee meet each of the following requirements:

- (a)** The Employee and individual are 18 years of age or older and are mentally competent to enter into a legally binding contract.
- (b)** The Employee and the individual are not married to anyone.
- (c)** The Employee and the individual are not related by blood to a degree of closeness that would prohibit legal marriage between individuals of the opposite sex in the state in which they reside.
- (d)** The Employee and the individual share the same principal residence(s), the common necessities of life, the responsibility for each other's welfare, are financially interdependent with each other and have a long-term committed personal relationship in which each partner is the other's sole domestic partner. Each of the foregoing characteristics of the domestic partner relationship must have been in existence for a period of at least 12 consecutive months and be continuing during the period that the applicable benefit is provided. The Employee and the individual must have the intention that their relationship will be indefinite.
- (e)** The Employee and the individual have common or joint ownership of a residence (home, condominium, or mobile home), motor vehicle, checking account, credit account, mutual fund, joint obligation under a lease for their residence or similar type ownership.

To obtain more detailed information or to apply for this benefit, the Employee must contact the Plan Administrator, Hendrix College, 1600 Washington Ave, Conway, Arkansas, 72032, 501-450-1494.

In the event the domestic partnership is terminated, the Employee partner is required to inform Hendrix College of the termination of the partnership.

The Plan Administrator may require documentation proving a legal marital and/or Domestic Partner relationship.

(2) A covered Employee's Child(ren).

An Employee's "Child" includes his natural child, stepchild, adopted child, or a child placed with the Employee for adoption. An Employee's child will also include children, adopted children and children placed for adoption with the Employee's Domestic Partner. An Employee's Child will be an eligible Dependent until reaching the limiting age of 26, without regard to student status, marital status, financial dependency or residency status with the Employee or any other person. When the child reaches the applicable limiting age, coverage will end on the last day of the child's birthday month.

The phrase "placed for adoption" refers to a child whom a person intends to adopt, whether or not the adoption has become final, who has not attained the age of 18 as of the date of such placement for adoption. The term "placed" means the assumption and retention by such person of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child must be available for adoption and the legal process must have commenced.

(3) A covered Employee, Retired Employee, or Spouse's Qualified Dependents.

The term "Qualified Dependents" shall include individuals who do not qualify as a Child as defined above, but who are children for whom the Employee, Retired Employee, or the Employee or Retiree's spouse is a Legal Guardian, stepchildren of the Employee's Domestic Partner, foster children of the Employee's Domestic Partner and children for whom the Employee's Domestic Partner is a Legal Guardian.

To be eligible for Dependent coverage under the Plan, a Qualified Dependent must be under the limiting age of 26 years and primarily dependent upon the covered Employee for support and maintenance. Coverage will end on the last day of the month in which the Qualified Dependent ceases to meet the applicable eligibility requirements.

Any child of a Plan Participant who is an alternate recipient under a qualified medical child support order shall be considered as having a right to Dependent coverage under this Plan.

A participant of this Plan may obtain, without charge, a copy of the procedures governing qualified medical child support order (QMCSO) determinations from the Plan Administrator.

The Plan Administrator may require documentation proving eligibility for Dependent coverage, including birth certificates, tax records or initiation of legal proceedings severing parental rights.

(4) A covered Dependent Child or Qualified Dependent who reaches the limiting age and is Totally Disabled, incapable of self-sustaining employment by reason of mental or physical handicap, primarily dependent upon the covered Employee for support and maintenance and unmarried. The Plan Administrator may require, at reasonable intervals, continuing proof of the Total Disability and dependency.

The Plan Administrator reserves the right to have such Dependent examined by a Physician of the Plan Administrator's choice, at the Plan's expense, to determine the existence of such incapacity.

These persons are excluded as Dependents: other individuals living in the covered Employee's or Retiree's home, but who are not eligible as defined; the legally separated or divorced former Spouse of the Employee or Retiree; any person who is on active duty in any military service of any country; any former Domestic Partner of the Employee; or any person who is covered under the Plan as an Employee or Retiree.

If a person covered under this Plan changes status from Employee to Dependent or Dependent to Employee, and the person is covered continuously under this Plan before, during and after the change in status, credit will be given for deductibles and all amounts applied to maximums.

If both parents are Employees, their eligible Dependent will be covered as the Dependent of one or the other, but not of both.

Eligibility Requirements for Dependent Coverage. A family member of an Employee will become eligible for Dependent coverage on the first day that the Employee is eligible for Employee coverage and the family member satisfies the requirements for Dependent coverage.

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

FUNDING

Cost of the Plan. Hendrix College shares the cost of Employee and Dependent coverage under this Plan with the covered Employees. The enrollment application for coverage will include a payroll deduction authorization. This authorization must be completed in a manner set forth by the Plan Administrator.

The level of any Employee or Retired Employee contributions is set by the Plan Administrator. The Plan Administrator reserves the right to change the level of Employee contributions.

The Claims Administrator provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

Payment of Benefits. Nothing in this Plan is intended to require the establishment of a trust and the Employer will pay Benefits under this Plan, if any, out of the general assets of the Employer at the time such Benefits are to be paid.

ENROLLMENT

Enrollment Requirements. An Employee must enroll for coverage by completing the electronic enrollment process. A new Full Time Employee who fails to enroll for coverage when first eligible shall not be eligible to enroll and be covered under the Plan until the next Annual Open Enrollment Period or pursuant to a Special Enrollment Period, if eligible. ~~An~~ If an eligible Employee or Retiree Employee wishes to add Dependents to their coverage, the covered Employee or covered Retired Employee is required to enroll each Dependent.

Enrollment Requirements for Newborn Children. A newborn child of a covered Employee is not automatically enrolled in this Plan and must be enrolled by the Covered Employee. The enrollment application must be received by the Plan administrator within 90 days of the date of birth. If the enrollment application is not received within 30 days of birth, coverage for the newborn child will not be available until the next Open Enrollment Period unless a Special Enrollment Right applies.

Parents are Both Employees. If two Employees who are covered under the Plan are the parents of children who are covered under the Plan, and the Employee who is covering the Dependent children terminates coverage, the Dependent coverage may be continued by the other covered Employee as long as coverage has been continuous.

SPECIAL ENROLLMENT RIGHTS

Federal law provides Special Enrollment 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 30 days after the coverage ends (or after the employer stops contributing towards the other coverage). This Special Enrollment provision does not apply to Retired Employees.

In addition, in the case of a birth, marriage, adoption or placement for adoption, there may be a right to enroll in this Plan. However, a request for enrollment must be made within 30 days of the date of birth, marriage, Legal Guardianship, adoption or placement for adoption.

The Special Enrollment rules are described in more detail below. To request Special Enrollment or obtain more detailed information of these portability provisions, contact the Plan Administrator, Hendrix College, 1600 Washington Ave, Conway, Arkansas, 72032, 1-501-329-6811.

SPECIAL ENROLLMENT PERIODS

The events described below may create a right to enroll in the Plan under a Special Enrollment Period.

- (1) Losing other coverage may create a Special Enrollment right.** 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. This provision does not apply to Retired Employees.
 - (b)** If required by the Plan Administrator, 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 30 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.

If the Employee, Retired 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 does not have a Special Enrollment right.

(3) Acquiring a newly eligible Dependent may create a Special Enrollment right. 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), and
- (b)** A person becomes a Dependent of the Employee through marriage, registration of domestic partnership, birth, Legal Guardianship, adoption or placement for adoption,

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 this Special Enrollment Period in order for his eligible Dependents to enroll. In the case of the birth or adoption of a child, the Spouse or Domestic Partner of the covered Employee may be enrolled as a Dependent of the covered Employee if the Spouse or Domestic Partner is otherwise eligible for coverage. The Special Enrollment rights based on the acquisition of a new eligible dependent are only applicable with the respect to the Retired Employee who is covered under the Plan at this time of the acquisition of a new eligible Dependent.

The Special Enrollment Period for newly eligible Dependents is a period of 30 days that begins after the date of the marriage, birth, Legal Guardianship, adoption or placement for adoption. To be eligible for this Special Enrollment, the Dependent and/or Employee must request enrollment during this 30-day period.

The coverage of the Dependent and/or Employee enrolled in the Special Enrollment Period will be effective:

- (a)** In the case of marriage, the first month beginning after the date of marriage, or in the case of domestic partner relationship, on the date of registration of the domestic partner relationship; or
- (b)** In the case of a Dependent's birth, as of the date of birth; or
- (c)** In the case of a Dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.
- (c)** In the case of Legal Guardianship, as of the date of Legal Guardianship pursuant to the court order.

(4) Eligibility changes in Medicaid or State Child Health Insurance Programs may create a Special Enrollment 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 following calendar month after the loss of coverage unless an earlier date is established by the Employer or by regulation.

EFFECTIVE DATE

Employee Requirement. An Employee must be an Active Employee (as defined by this Plan) for this coverage to take effect. A new Full Time Employee will be covered on the first date of hire, provided the Employee completes the enrollment requirements under the Plan. If an eligible Active Employee wishes to add Dependents to their coverage, the covered Active Employee is required to enroll each Dependent.

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. Part of the enrollment requirement includes providing proof of Dependent eligibility if requested by the Plan Administrator. If proof of eligibility is not provided at the time of enrollment as requested by the Plan Administrator, the Dependent will not be enrolled for coverage until the next open enrollment period after such proof is provided.

TERMINATION OF COVERAGE

The Employer or Plan has the right to rescind any coverage of the Employee and/or Retiree 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 Retirees 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 Retiree'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 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.) It also includes an Employee on disability, leave of absence or other leave of absence, unless the Plan specifically provides for continuation during these periods.
- (3) 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.
- (4) 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 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.

When the Retired 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 last day of the calendar month before the month in which the covered Retiree becomes eligible for Medicare. (See the section entitled Continuation Coverage Rights under COBRA.)
- (3) 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.
- (4) If the Retired 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 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 Employer-Certified Disability, Leave of Absence or Layoff. A person may remain eligible for a limited time if Active, full-time work ceases due to disability, leave of absence or layoff. The eligible Employee is responsible for making any required contributions. This continuance will end as follows:

For disability leave only: the date the Employer ends the continuance.

For leave of absence or layoff only: the date the Employer ends the continuance.

Such continuation of coverage periods will run concurrent with any leave taken under the Family and Medical Leave Act. While continued, coverage will be that which was in force on the last day worked as an Active Employee. However, if benefits reduce for others in the class, they will also reduce for the continued person.

Continuation During Family and Medical Leave. Regardless of the established leave policies mentioned above, this Plan shall at all times comply with the Family and Medical Leave Act, as amended, and as promulgated in regulations issued by the Department of Labor.

During any leave taken under the Family and Medical Leave Act, the Employer will maintain coverage under this Plan on the same conditions as coverage would have been provided if the covered Employee had been continuously employed during the entire leave period.

If Plan coverage terminates during the FMLA leave, coverage will be reinstated for the Employee and his or her covered Dependents if the Employee returns to work in accordance with the terms of the FMLA leave. Coverage will be reinstated only if the person(s) had coverage under this Plan when the FMLA leave started, and will be reinstated to the same extent that it was in force when that coverage terminated. For example, Waiting Periods will not be imposed unless they were in effect for the Employee and/or his or her Dependents when Plan coverage terminated.

Rehiring a Terminated Employee. A terminated Employee who is rehired after a period of 13 consecutive weeks, or an Employee who resumes service after a period of 13 consecutive weeks, during which the Employee did not have any hours of service for the Employer, shall be treated as a new Employee and will be required to satisfy all the Eligibility and Enrollment requirements of the Plan. Notwithstanding the foregoing, a full time Employee returning to work directly from COBRA coverage under this Plan will not have to satisfy the employment Waiting Period, if applicable.

A terminated Employee who is rehired before the end of a 13 consecutive weeks period, or an Employee who resumes service before the end of a 13 consecutive weeks period, during which the Employee did not have any hours of service for the Employer, will have on his rehire date the same eligibility status the Employee had on the Employee's immediately preceding termination of employment date. The Employer shall determine, in its sole and complete discretion, the eligibility status of a rehired Employee in accordance with procedures established by the Employer.

In addition, a terminated Employee who is rehired within 30 days from his or her last termination and who continues to be eligible for coverage on his or her rehire date will be reenrolled according to the same elections that the Employee had in place prior to termination of employment. A terminated Employee who is rehired more than 30 days after termination of employment but before the end of the 13 consecutive week period described above, and who continues to be eligible for coverage on his or her rehired date will be required to complete a new enrollment application. The Employee will have 30 days from the Employee's rehire date to submit his or her re-enrollment application to the Plan Administrator. Coverage will be effective on the date of hire if the Employee resumes employment if his or her re-enrollment application is submitted to the Plan Administrator prior to that time, or as of the first day of the month following the date the required re-enrollment application is submitted to the Plan Administrator, if submitted after that time but prior to the end of the 30 day period..

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.

- (1) The maximum period of coverage of a person and the person's covered Dependents under such an election shall be the lesser of:
 - (a) The 24 month period beginning on the date on which the person's absence begins; or
 - (b) The day after the date on which the person was required to apply for or return to a position of employment and fails to do so.
- (2) A person who elects to continue health plan coverage must pay up to 102% of the full contribution under the Plan, except a person on active duty for 30 days or less cannot be required to pay more than the Employee's share, if any, for the coverage.
- (3) An exclusion or Waiting Period may not be imposed in connection with the reinstatement of coverage upon reemployment if one would not have been imposed had coverage not been terminated because of service. However, an exclusion or Waiting Period may be imposed for coverage of any Illness or Injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of uniformed service.

If the Employee wishes to elect this coverage or obtain more detailed information, contact the Plan Administrator Hendrix College, 1600 Washington Ave, Conway, Arkansas, 72032, 1-501-329-6811. The Employee may also have continuation rights under USERRA. In general, the Employee must meet the same requirements for electing USERRA coverage as are required under COBRA continuation coverage requirements. Coverage elected under these circumstances is concurrent, not cumulative. The Employee may elect USERRA continuation coverage for the Employee and their Dependents. Only the Employee has election rights. Dependents do not have any independent right to elect USERRA health plan continuation.

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. When a Retired Employee becomes eligible for Medicare his or her covered dependents will be permitted to remain on the Plan. In the event there is only one covered dependent, he or she will move to an individual plan (See the section entitled Continuation Coverage Rights under COBRA.)
- (3) The date a covered Spouse loses coverage due to loss of eligibility status. (See the section entitled Continuation Coverage Rights under COBRA.)
- (4) Coverage on the last day of the month in which the Qualified Dependent ceases to meet the applicable eligibility requirements. (See the section entitled Continuation Coverage Rights under COBRA.)
- (5) Coverage will end on the last day of the month in which the Child ceases to meet the applicable eligibility requirements. (See the section entitled Continuation Coverage Rights under COBRA.)
- (6) 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.
- (7) 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 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.

OPEN ENROLLMENT

Every November, during the annual open enrollment period, eligible Employees and Retired Employees and their eligible Dependents who are Late Enrollees will be able to enroll in the Plan. At this time, covered Employees and Retiree Employees and their covered Dependents will also be able to change some of their benefit decisions based on which benefits and coverages are right for them.

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 Special Enrollment 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.

Benefit choices for Late Enrollees made during the open enrollment period will become effective January 1.

A Plan Participant who fails to make an election during open enrollment will automatically retain his or her present coverages.

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

SCHEDULE OF BENEFITS PPO Plan

MEDICAL BENEFITS

All benefits described in this Schedule are available for Covered Charges only and are subject to (1) the Claims Administrator's established Coverage Policy, which the Plan Administrator has adopted for purposes of defining the benefits due under this Plan; (2) the Allowable Charge (as defined herein); and (3) the benefit limits and exclusions described more fully herein including, but not limited to the determination that: care and treatment is or is not Medically Necessary; or that services, supplies, and care are or are not Experimental and/or Investigational. The meanings of these capitalized terms are in the Defined Terms section of this document.

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 web at www.blueadvantagearkansas.com. A listing of In-Network Providers may be also found by accessing www.blueprintportal.com or by downloading the Blueprint Portal app available on Google Play or the App Store. Registration is required.

Deductibles Payable by Plan Participants, per Calendar Year

A deductible is an amount of money that is paid once a Calendar Year per Covered Person or Family Unit. On the first day of each Calendar Year, a new deductible amount is required.

In-Network, Calendar Year Deductible

Per Covered Person	\$500
Per Family Unit	\$1,000

Out-of-Network, Calendar Year Deductible

Per Covered Person	\$1,000
Per Family Unit	\$2,000

Deductible Accumulation

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

For single coverage, the Covered Person must meet the individual deductible before any money is paid by the Plan for any Covered Charge. For two-member or family coverages, each family member must meet his or her own individual deductible until the total amount of deductible expenses paid by all family members meets the overall Family Unit deductible.

Deductible Three Month Carryover. Covered Charges incurred in, and applied toward the deductible in the last three month of the Calendar Year will be applied toward the deductible in the next Calendar Year.

Deductible For A Common Accident. This provision applies when two or more Covered Persons in a Family Unit are injured in the same accident. These persons need not meet separate deductibles for treatment of injuries incurred in this accident; instead, only one deductible for the Calendar Year in which the accident occurred will be required for them as a unit for expenses arising from the accident.

The Calendar Year deductible is waived for the following Covered Charges:

- In-Network Standard and Routine Preventive Care
- In-Network Primary Care Physician office visits
- In-Network independent lab when associated with an In-Network Primary Care office visit
- In-Network routine inpatient newborn care
- Urgent care services when received at PrimeCare Medical Clinic and Conway Regional after hours clinic
- Accident benefits
- Prescription Drugs when purchased at the pharmacy

Out-of-Pocket Limits Payable by Plan Participants, Per Calendar Year

Unless stated otherwise in this document, the Plan will pay 80% of In-Network Covered Charges and 60% of Out-of-Network Covered Charges until the annual out-of-pocket limit is satisfied, at which time the Plan will pay 100% of the remainder of Covered Charges for the rest of the Calendar Year.

In-Network, Calendar Year Out-of-Pocket Limit

Per Covered Person	\$5,500
Per Family Unit	\$11,000

Out-of-Network, Calendar Year Out-of-Pocket Limit

Per Covered Person	\$10,000
Per Family Unit	\$20,000

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.

For single coverage, the Covered Person must meet the individual out-of-pocket limit, at which point the Plan will pay Covered Charges at 100% for the Covered Person for the remainder of the Calendar Year. For two-member or family coverage, each family member must meet his or her own individual out-of-pocket limit until the overall Family Unit out-of-pocket limit has been met, at which point the Plan will pay Covered Charges at 100% for that Family Unit for the remainder of the Calendar Year.

The charges for the following do not apply to the Calendar Year out-of-pocket limit:

- Penalties for failure to obtaining Prior Approval
- Amounts in excess of the Allowable Charge
- Non-covered services

HOSPITAL BENEFITS

Prior Approval is required for all inpatient admissions, except for a Hospital admission following a Medical Emergency

Failure to obtain Prior Approval may result in a reduction in benefits paid by the Plan.

NOTE: For inpatient admissions related to treatment of a Medical Emergency, the Covered Person or the treating Provider should notify the Plan of the admission within 48 hours of the admission.

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.

Inpatient and Outpatient Services

In-Network facility reimbursement rate80% of Covered Charges, after deductible

Out-of-Network* facility reimbursement rate60% of Covered Charges, after deductible

* Covered behavioral health services will be paid at 80% of Covered Charges, after deductible, and will apply to the In-Network out-of-pocket limit.

Emergency Room Services

For treatment sought due to a Medical Emergency, as defined by the Plan:

In-Network and Out-of-Network reimbursement rate80% of Covered Charges, after deductible

· The Out-of-Network emergency room services will apply to the In-Network out-of-pocket limit.

For emergency room services which are not related to a Medical Emergency, as defined by the Plan:

In-Network reimbursement rate80% of Covered Charges, after deductible

Out-of-Network* reimbursement rate60% of Covered Charges, after deductible

* Covered behavioral health services will be paid at 80% of Covered Charges, after deductible, and will apply to the In-Network out-of-pocket limit.

PHYSICIAN BENEFITS

Primary Care Physicians

Includes In-Network: general practitioners, family practitioners, doctors of internal medicine, pediatricians, geriatricians, obstetrician/gynecologists, and Providers who are acting within the scope of his or her license rendering behavioral health services.

Covered Charges billed by physician assistants, registered nurse practitioners, certified nurse practitioners, and clinical nurse specialists that work under the direction of a Primary Care Physician will also be paid at the Primary Care Physician reimbursement rate.

In-Network Primary Care Physician Reimbursement rates

Office services:

Office visit Physician charge \$20 Copay, then 100% of Covered Charges, deductible waived

Related services100% of Covered Charges, deductible waived

Inpatient and Outpatient services80% of Covered Charges, after deductible

Emergency room services, Medical Emergency80% of Covered Charges, after deductible

Emergency room services, Non-Medical Emergency80% of Covered Charges, after deductible

In-Network Specialist reimbursement rates

Office services*80% of Covered Charges, after deductible

Inpatient and Outpatient services80% of Covered Charges, after deductible

Emergency room services, Medical Emergency80% of Covered Charges, after deductible

Emergency room services, Non-Medical Emergency80% of Covered Charges, after deductible

*Covered behavioral health office services will be paid at the In-Network Primary Care Physician reimbursement rate.

Out-of-Network* Physician reimbursement rates

Office services60% of Covered Charges, after deductible

Inpatient and Outpatient services60% of Covered Charges, after deductible

Emergency room services, Medical Emergency80% of Covered Charges, after deductible

Emergency room services, Non-Medical Emergency60% of Covered Charges, after deductible

PREVENTIVE CARE BENEFITS

Standard Preventive Care

Reimbursement rates

In-Network services.....	100% of Covered Charges, deductible waived
Out-of-Network services	100% of Covered Charges, deductible waived

At all times, the Plan will comply with the Patient Protection and Affordable Care Act (PPACA). The list of services included as Standard Preventive Care may change from time to time depending upon government guidelines. The Plan must provide coverage for USPSTF published recommendations for the Plan Year that begins on or after the date that is one year after the date a recommendation is published.

Please visit the following links for a comprehensive list of covered Standard Preventive Care Services:

<https://www.healthcare.gov/preventive-care-benefits/> <https://www.healthcare.gov/preventive-care-children/>
<https://www.healthcare.gov/preventive-care-women/>

Routine Preventive Care

Reimbursement rates

In-Network services.....	100% of Covered Charges, deductible waived
Out-of-Network services	100% of Covered Charges, deductible waived

In addition to the preventive services mandated by the ACA, the Plan also provides more generous coverage for the following services:

- Routine PAP Smear. A routine PAP smear is available once per Calendar Year, all other ACA guidelines and requirements apply.
- Diagnostic 2-D and 3-D mammograms.
- Diagnostic colonoscopies.

OTHER COVERAGES, BENEFIT LIMITS, AND MAXIMUMS

No benefits will be paid in excess of any listed limit.

Accident Benefits

Accident maximum amount payable under this special benefit	\$500 per accident
In-Network and Out-of-Network reimbursement rate.....	100% of Covered Charges, deductible waived
· After accident maximum amount has been met, standard reimbursement rates will apply.	

Ambulance Services

In-Network and Out-of-Network reimbursement rate.....	80% of Covered Charges, after deductible
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Breast pumps, electric

In-Network and Out-of-Network reimbursement rate.....	100%, deductible waived
· Manual breast pumps are classified as a Standard Preventive Care service and payable at Standard Preventive Care reimbursement rates.	

Eyeglasses or contact lenses following cataract surgery

Lifetime limit.....	initial pair of glasses or contact lenses
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Hearing aids and Implantable Devices

Hearing aid limit, per ear.....\$1,400 every three years
Cochlear implant Lifetime limit, per ear one implant with its associated processor
Auditory brain stem implant Lifetime limitone implant

In vitro fertilization (IVF) and related services

Lifetime limit..... 3 egg retrievals
· Infertility services including in vitro fertilization is subject to Prior Approval from the Claims Administrator and in accordance with established Coverage Policy.

Lab, Radiology, and Pathology services

In-Network reimbursement rate100% of Covered Charges, after deductible
Out-of-Network reimbursement rate60% of Covered Charges, after deductible
· Charges for eligible laboratory services billed by an In-Network Provider on the same date of service as an In-Network PCP office visit shall be reimbursed at 100% of Covered Charges, deductible waived.

Maternity Care

Routine obstetrical ultrasound

Limit, per pregnancy one ultrasound
In-Network reimbursement rate.....80% of Covered Charges, after deductible
Out-of-Network reimbursement rate60% of Covered Charges, after deductible

Outpatient services

In-Network reimbursement rate.....100% of Covered Charges, deductible waived
Out-of-Network reimbursement rate60% of Covered Charges, after deductible

Inpatient services

In-Network reimbursement rate.....80% of Covered Charges, after deductible
Out-of-Network reimbursement rate60% of Covered Charges, after deductible

Inpatient routine services for newborn

Limitup to five inpatient days until discharged
In-Network reimbursement rate.....100% of Covered Charges, deductible waived
Out-of-Network reimbursement rate60% of Covered Charges, after deductible

Travel, meals and Lodging Expenses

Reimbursement rate.....80% of Covered Charges, after deductible
· Lodging expenses that are eligible for reimbursement for the patient (while not a Hospital inpatient) and one companion are paid at a per diem (per day) rate of up to \$50 per day for the patient or up to \$100 per day for the patient plus one companion.
· If the patient is an enrolled Dependent minor child, the lodging expenses of two companions will be covered and lodging will be reimbursed at a per diem rate up to \$150 per day.
· See “Travel, Meals and Lodging” in the Medical Benefits section for additional information.

Urgent Care Clinics

PrimeCare Medical Clinic and Conway Regional after hours clinic

Urgent Clinic Physician charge \$20 Copay, then 100% of Covered Charges, deductible waived
Related services100% of Covered Charges, deductible waived

For treatment sought due to a Medical Emergency, as defined by the Plan:

In-Network reimbursement rate.....80% of Covered Charges, after deductible
Out-of-Network reimbursement rate80% of Covered Charges, after deductible
· The Out-of-Network Urgent Care services will apply to the In-Network out-of-pocket limit.

For urgent care services which are not related to a Medical Emergency, as defined by the Plan:

In-Network reimbursement rate.....80% of Covered Charges, after deductible
Out-of-Network reimbursement rate60% of Covered Charges, after deductible

PRESCRIPTION DRUG BENEFITS

The prescription drug card program is administered by the pharmacy benefits manager.

Each Prescription is covered only after the Covered Person pays the applicable Copay or coinsurance to the participating Pharmacy or Mail Order Pharmacy. Deductible is waived. Please contact the customer service number on the back of the Covered Person’s identification card for further information.

Retail Pharmacy Copays, up to a 34-day supply

Generic drugs \$10 Copay
Preferred brand name drugs \$30 Copay
Non-Preferred brand name drugs \$50 Copay

Mail Order Pharmacy Copays, up to a 93-day supply

Generic drugs \$20 Copay
Preferred brand name drugs \$60 Copay
Non-Preferred brand name drugs \$100 Copay

Specialty Pharmacy coinsurance, up to a 34-day supply

In-Network20% of prescription cost up to a \$250 maximum
Out-of-Network.....40% of prescription cost up to a \$250 maximum
· Prior Approval may be required. Please contact pharmacy customer service for further information.

Special Limitation – See “Specialty Drugs” entry under “Exclusions” for more information.

SCHEDULE OF BENEFITS **High Deductible Health Plan**

MEDICAL BENEFITS

All benefits described in this Schedule are available for Covered Charges only and are subject to (1) the Claims Administrator's established Coverage Policy, which the Plan Administrator has adopted for purposes of defining the benefits due under this Plan; (2) the Allowable Charge (as defined herein); and (3) the benefit limits and exclusions described more fully herein including, but not limited to the determination that: care and treatment is or is not Medically Necessary; or that services, supplies, and care are or are not Experimental and/or Investigational. The meanings of these capitalized terms are in the Defined Terms section of this document.

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 web at www.blueadvantagearkansas.com. A listing of In-Network Providers may be also found by accessing www.blueprintportal.com or by downloading the Blueprint Portal app available on Google Play or the App Store. Registration is required.

Deductibles Payable by Plan Participants, per Calendar Year

A deductible is an amount of money that is paid once a Calendar Year per Covered Person or Family Unit. On the first day of each Calendar Year, a new deductible amount is required.

Individual Plan, Calendar Year Deductible

In-Network services	\$1,600
Out-of-Network services	\$4,000

Family Plan, Calendar Year Deductible

In-Network services.....	\$3,200 per family
Out-of-Network services	\$8,000 per family

Deductible Accumulation

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

For single coverage, the Covered Person must meet the individual deductible before any money is paid by the Plan for any Covered Charge. For two-member or family coverage, the overall Family Unit deductible must be satisfied in its entirety before the Plan begins to pay.

The Calendar Year deductible is waived for the following Covered Charges:

- In-Network Standard and Routine Preventive Care

Out-of-Pocket Limits Payable by Plan Participants, Per Calendar Year

Unless stated otherwise in this document, the Plan will pay 80% of In-Network Covered Charges and 60% of Out-of-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.

Individual Plan, Calendar Year Out-of-Pocket Limit

In-Network services	\$6,500
Out-of-Network services	\$10,000

Family Plan, Calendar Year Out-of-Pocket Limit

In-Network services.....	\$11,000 per family with an \$8,000 embedded individual out-of-pocket amount
Out-of-Network services	\$30,000 per family with a \$10,000 embedded individual out-of-pocket amount

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.

For single coverage, the Covered Person must meet the individual out-of-pocket limit, at which point the Plan will pay Covered Charges at 100% for the Covered Person for the remainder of the Calendar Year. For two-member or family coverage, each family member must meet his or her own individual out-of-pocket limit until the overall Family Unit out-of-pocket limit has been met, at which point the Plan will pay Covered Charges at 100% for that Family Unit for the remainder of the Calendar Year.

The charges for the following do not apply to the Calendar Year out-of-pocket limit:

- Penalties for failure to obtaining Prior Approval
- Amounts in excess of the Allowable Charge
- Non-covered services

HOSPITAL BENEFITS

Prior Approval is required for all inpatient admissions, except for a Hospital admission following a Medical Emergency

Failure to obtain Prior Approval may result in a reduction in benefits paid by the Plan.

NOTE: For inpatient admissions related to treatment of a Medical Emergency, the Covered Person or the treating Provider should notify the Plan of the admission within 48 hours of the admission.

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.

Inpatient and Outpatient Services

In-Network facility reimbursement rate	80% of Covered Charges, after deductible
Out-of-Network* facility reimbursement rate	60% of Covered Charges, after deductible

* Covered behavioral health services will be paid at 80% of Covered Charges, after deductible, and will apply to the In-Network out-of-pocket limit.

Emergency Room Services

For treatment sought due to a Medical Emergency, as defined by the Plan:

- In-Network and Out-of-Network reimbursement rate.....80% of Covered Charges, after deductible
- The Out-of-Network emergency room services will apply to the In-Network out-of-pocket limit.

For emergency room services which are not related to a Medical Emergency, as defined by the Plan:

- In-Network reimbursement rate.....80% of Covered Charges, after deductible
- Out-of-Network* reimbursement rate60% of Covered Charges, after deductible
- * Covered behavioral health services will be paid at 80% of Covered Charges, after deductible, and will apply to the In-Network out-of-pocket limit.

PHYSICIAN BENEFITS

Primary Care Physicians

Includes In-Network: general practitioners, family practitioners, doctors of internal medicine, pediatricians, geriatricians, obstetrician/gynecologists, and Providers who are acting within the scope of his or her license rendering behavioral health services.

Covered Charges billed by physician assistants, registered nurse practitioners, certified nurse practitioners, and clinical nurse specialists that work under the direction of a Primary Care Physician will also be paid at the Primary Care Physician reimbursement rate.

In-Network Primary Care Physician Reimbursement rates

- Office services:
 - Office visit Physician charge.....100% of Covered Charges, after deductible and \$30 Copay
 - Related services.....100% of Covered Charges, after deductible
- Inpatient and Outpatient services80% of Covered Charges, after deductible
- Emergency room services, Medical Emergency80% of Covered Charges, after deductible
- Emergency room services, Non-Medical Emergency80% of Covered Charges, after deductible

In-Network Specialist reimbursement rates

- Office services*80% of Covered Charges, after deductible
- Inpatient and Outpatient services80% of Covered Charges, after deductible
- Emergency room services, Medical Emergency80% of Covered Charges, after deductible
- Emergency room services, Non-Medical Emergency80% of Covered Charges, after deductible
- *Covered behavioral health office services will be paid at the In-Network Primary Care Physician reimbursement rate.

Out-of-Network* Physician reimbursement rates

- Office services.....60% of Covered Charges, after deductible
- Inpatient and Outpatient services60% of Covered Charges, after deductible
- Emergency room services, Medical Emergency80% of Covered Charges, after deductible
- Emergency room services, Non-Medical Emergency60% of Covered Charges, after deductible
- *Covered behavioral health office services will be paid at the In-Network Primary Care Physician reimbursement rate.

PREVENTIVE CARE BENEFITS

Standard Preventive Care

Reimbursement rates

In-Network services.....	100% of Covered Charges, deductible waived
Out-of-Network services	100% of Covered Charges, deductible waived

At all times, the Plan will comply with the Patient Protection and Affordable Care Act (PPACA). The list of services included as Standard Preventive Care may change from time to time depending upon government guidelines. The Plan must provide coverage for USPSTF published recommendations for the Plan Year that begins on or after the date that is one year after the date a recommendation is published.

Please visit the following links for a comprehensive list of covered Standard Preventive Care Services:

<https://www.healthcare.gov/preventive-care-benefits/> <https://www.healthcare.gov/preventive-care-children/>
<https://www.healthcare.gov/preventive-care-women/>

Routine Preventive Care

Reimbursement rates

In-Network services.....	100% of Covered Charges, deductible waived
Out-of-Network services	100% of Covered Charges, deductible waived

In addition to the preventive services mandated by the ACA, the Plan also provides more generous coverage for the following services:

- Routine PAP smear. A routine PAP smear is available once per Calendar Year, all other ACA guidelines and requirements apply.
- Diagnostic 2-D and 3-D mammograms.
- Diagnostic colonoscopies.

OTHER COVERAGES, BENEFIT LIMITS, AND MAXIMUMS

No benefits will be paid in excess of any listed limit.

Ambulance Services

In-Network and Out-of-Network reimbursement rate.....80% of Covered Charges, after deductible

Breast pumps, electric

In-Network and Out-of-Network reimbursement rate..... 100%, deductible waived

- Manual breast pumps are classified as a Standard Preventive Care service and payable at Standard Preventive Care reimbursement rates.

Eyeglasses or contact lenses following cataract surgery

Lifetime limit..... initial pair of glasses or contact lenses

Hearing aids and Implantable Hearing Devices

Hearing aid limit, per ear.....\$1,400 every three years

Cochlear implant Lifetime limit, per ear one implant with its associated processor

Auditory brain stem implant Lifetime limitone implant

Lab, Radiology, and Pathology services

In-Network reimbursement rate	80% of Covered Charges, after deductible
Out-of-Network reimbursement rate	60% of Covered Charges, after deductible
· Charges for eligible laboratory services billed by an In-Network Provider on the same date of service as an In-Network PCP office visit shall be reimbursed at 100% of Covered Charges, after deductible .	

In vitro fertilization (IVF) and related services

Lifetime limit.....	3 egg retrievals
· Infertility services including in vitro fertilization is subject to Prior Approval from the Claims Administrator and in accordance with established Coverage Policy.	

Maternity Care

Routine obstetrical ultrasound

Limit, per pregnancy	one ultrasound
In-Network reimbursement rate.....	80% of Covered Charges, after deductible
Out-of-Network reimbursement rate	60% of Covered Charges, after deductible

Outpatient services

In-Network reimbursement rate.....	100% of Covered Charges, after deductible
Out-of-Network reimbursement rate	60% of Covered Charges, after deductible

Inpatient services

In-Network reimbursement rate.....	80% of Covered Charges, after deductible
Out-of-Network reimbursement rate	60% of Covered Charges, after deductible

Inpatient routine services for newborn

Limit	up to five inpatient days until discharged
In-Network reimbursement rate.....	100% of Covered Charges, after deductible

Travel, meals and Lodging Expenses

Reimbursement rate.....	80% of Covered Charges, after deductible
· Lodging expenses that are eligible for reimbursement for the patient (while not a Hospital inpatient) and one companion are paid at a per diem (per day) rate of up to \$50 per day for the patient or up to \$100 per day for the patient plus one companion.	
· If the patient is an enrolled Dependent minor child, the lodging expenses of two companions will be covered and lodging will be reimbursed at a per diem rate up to \$150 per day.	
· See “Travel and Lodging” in the Medical Benefits section for additional information.	

Urgent Care Clinics

For treatment sought due to a Medical Emergency, as defined by the Plan:

- In-Network reimbursement rate.....80% of Covered Charges, after deductible
- Out-of-Network reimbursement rate80% of Covered Charges, after deductible
- The Out-of-Network Urgent Care services will apply to the In-Network out-of-pocket limit.

For urgent care services which are not related to a Medical Emergency, as defined by the Plan:

- In-Network reimbursement rate.....80% of Covered Charges, after deductible
- Out-of-Network reimbursement rate60% of Covered Charges, after deductible

PRESCRIPTION DRUG BENEFITS

The prescription drug card program is administered by the pharmacy benefits manager.

Each Prescription is covered only after the Covered Person pays the applicable Copay or coinsurance to the participating Pharmacy or Mail Order Pharmacy, after deductible. Please contact the customer service number on the back of the Covered Person’s identification card for further information.

Retail Pharmacy Copays, up to a 34-day supply

- Generic drugs \$10 Copay
- Preferred brand name drugs \$30 Copay
- Non-Preferred brand name drugs \$50 Copay

Mail Order Pharmacy Copays, up to a 93-day supply

- Generic drugs \$20 Copay
- Preferred brand name drugs \$60 Copay
- Non-Preferred brand name drugs \$100 Copay

Specialty Pharmacy coinsurance, up to a 34-day supply

- In-Network.....20% of prescription cost up to a \$250 maximum
- Out-of-Network.....40% of prescription cost up to a \$250 maximum
- Prior Approval may be required. Please contact pharmacy customer service for further information.

Special Limitation – See “Specialty Drugs” entry under “Exclusions” for more information.

PROVIDER NETWORK PROVISIONS AND COST SHARING PROCEDURES

The Plan may afford significant savings to members who obtain coverage from In-Network Providers. This Section describes how Covered Persons can maximize their benefits under the Plan by using In-Network Providers.

NETWORK PROCEDURES

Standard Benefits. All benefits described in this document are subject to the Claims Administrator's established Coverage Policy, which the Plan Administrator has adopted for purposes of defining the benefits due under this Plan, the Allowable Charge (as defined herein), and the benefit limits and exclusions described more fully herein including, but not limited to the determination that: care and treatment is or is not Medically Necessary and that services, supplies and care are or are not Experimental and/or Investigational. A charge is incurred on the date that the service or supply is performed or furnished.

In-Network Services. This coverage is most effective and advantageous when the services of In-Network Providers are used. Claims associated with services provided by In-Network Providers may have a more advantageous deductible, coinsurance and Copayment than claims for services of Out-of-Network Providers. The In-Network deductible, coinsurance and any applicable Copayment cited in the Schedule of Benefits are applied to Allowable Charges for services and supplies received from an In-Network Provider, unless this document shows a different deductible, coinsurance or Copayment for the particular service.

Out-of-Network Benefits. Reimbursement for services by Out-of-Network Providers generally will be less than payment for the same services when provided by an In Network Provider and could result in substantial additional out-of-pocket expenses. The Out-of-Network deductible, coinsurance, and any applicable Copayment described in the Schedule of Benefits are applied to Allowable Charges for services and supplies received from an Out-of-Network Provider, except under the following circumstances:

- (1) **Plan Provision.** If, this document specifies elsewhere that a different deductible, coinsurance or Copayment is applicable to the particular service or supply that is the subject of the claim.
- (2) **Emergency Services.** The Intervention is for a Medical Emergency, in which case the In-Network deductible, coinsurance and Copayment apply.
- (3) **Continuity of Care, Change in the Plan's Claims Administrator.** A Covered Person may notify the Claims Administrator that prior to the effective date of the Plan's coverage with BlueAdvantage Administrators of Arkansas as the Claims Administrator, the Covered Person was engaged with an Out-of-Network Provider for a scheduled procedure or ongoing treatment covered under this Plan, that such procedure or treatment is for a condition requiring immediate care, and that the Covered Person requests In-Network benefits for such scheduled procedure or ongoing treatment. If the Claims Administrator approves In-Network coverage for the scheduled procedure or ongoing treatment, any applicable In-Network deductible, coinsurance, and any Copayment will apply to claims for eligible services and supplies rendered by the Out-of-Network Provider for such condition until the procedure or treatment ends or until the end of 90 days, whichever occurs first.
- (4) **Continuity of Care, Pregnancy, Prior to Coverage.** A Covered Person may notify the Claims Administrator that prior to the effective date of coverage, the Covered Person was receiving obstetrical care from an Out-of-Network Provider for a Pregnancy covered under the terms of this Plan, and request In-Network benefits for continuation of such obstetrical care from the Out-of-Network Provider. If the Claims Administrator approves In-Network coverage for the requested obstetrical care, any applicable In-Network deductible, coinsurance and Copayment will apply to claims for services and supplies received from this Out-of-Network Provider and will continue to apply to claims for eligible services and supplies rendered by the Out-of-Network Provider until the completion of the Pregnancy, including two months of postnatal visits.

- (5) **Provider Leaves Network.** A Covered Person may notify the Claims Administrator that their Out-of-Network Provider was formerly an In-Network Provider when ongoing treatment for an acute condition began, and request In-Network benefits for the continuation of such ongoing treatment. If the Claims Administrator approves In-Network coverage for the ongoing treatment, any applicable In-Network deductible, coinsurance and Copayment will apply to claims for eligible services and supplies rendered by the Out-of-Network Provider for such condition until the end of the current episode of treatment or until the end of 90 days, whichever occurs first.
- (6) **Services Not Available or Accessible from In-Network Provider.** If a Covered Person notifies the Claims Administrator prior to receiving a Health Intervention and the Claims Administrator determines that the required covered services or supplies associated with such Health Intervention are not accessible or available from an In-Network Provider, the Claims Administrator may provide the Covered Person with written approval of In-Network coverage for such services or supplies, and any In-Network deductible, coinsurance and Copayment will apply to the claims for the eligible services that are received from the Out-of-Network Provider. In the event that a member fails to notify the Claims Administrator prior to receiving a Health Intervention from an Out-of-Network Provider, the Claims Administrator will determine whether or not an exception will be made to allow In-Network benefits due to potential inaccessibility or unavailability of an In-Network provider.

PROVIDER DIRECTORY

The determination of whether a Physician or Hospital is an In-Network Provider is the responsibility of the Plan and Claims Administrator. The Claims Administrator can provide a list of In-Network Providers upon request. A Covered Person may also obtain a list of In-Network Providers on the web site www.blueadvantagearkansas.com. A Provider's status may change. A Covered Person can verify the Provider's status by calling Customer Service at the phone number on the back of their health plan identification card. If a Covered Person is informed incorrectly prior to receiving a Covered Service, either by accessing the directory or in response to a request for such information (via telephone, electronic, web-based or internet-based means), the Covered Person may be eligible for cost sharing that would be no greater than if the covered service had been provided by an In-Network Provider.

BlueCard PPO Program. The Plan includes access to the BlueCard PPO network. This benefit allows Covered Persons to receive In-Network benefits from Providers located outside of Arkansas, provided such Provider is in the BlueCard PPO network of the local Blue Cross or Blue Shield Company. A Covered Person may obtain a list of In-Network Providers in an out-of-Arkansas location or verify the status of an out of state Provider by calling Customer Service at the phone number on the back of their health plan identification card. A Covered Person may also obtain a list of In-Network Providers on the web site www.blueadvantagearkansas.com.

PROVIDER STATUS MAY CHANGE

It is possible that a Covered Person might not be able to obtain services from a particular In-Network Provider. The network of Providers is subject to change. A particular Network Provider may not be accepting new patients. If a Provider leaves the Network or is otherwise not available, the Covered Person must choose another Provider to get In-Network benefits.

NO BALANCE BILLING FROM PREFERRED PROVIDERS AND CONTRACTING PROVIDERS

In-Network and Preferred Providers are Physicians or Hospitals who are paid directly by the Plan and have agreed to accept payment for covered services as payment in full except for the Covered Person's deductible, coinsurance, Copayment, and any specific benefit limitation, if applicable. In contrast, a Covered Person is responsible for billed charges in excess of the Plan's payment when Out-of-Network Physicians or Hospitals render services, except as provided in OUT-OF-NETWORK PROVIDERS AND BALANCE BILLING, subsection (2), below. These excess charges could amount to thousands of dollars in additional out of pocket expenses to the Covered Person.

OUT-OF-NETWORK PROVIDERS AND BALANCE BILLING

- (1) **NOTICE: Certain Services may not be eligible for In-Network Benefits.** Additional costs, including balance billing, may be incurred for a covered Health Intervention provided by an Out-of-Network Provider, even if treatment is rendered in an In-Network Hospital unless it meets the exception as provided in subsection (2), below. These additional charges may not count toward the In-Network Out-of-Pocket Limit. The Covered Person should not assume that an In-Network Provider's agreement includes all covered benefits or that all services provided at an In-Network Hospital are provided by In-Network Providers. Some Providers are contracted to provide only certain covered benefits, but not all covered benefits.
- (2) **Balance billing by Out-of-Network Providers is prohibited in the following instances:**
 - (a) When Ancillary Services, as described in the No Surprises Act, are received at certain In-Network facilities on a non-emergency basis from Out-of-Network Providers.
 - (b) When Medical Emergency services are provided by an Out-of-Network Provider in an emergency room, a free-standing emergency department, or in an urgent care clinic which is licensed as a free-standing emergency department.
 - (c) When air Ambulance Services are provided by an Out-of-Network Provider.
 - (d) When a Provider leaves the network voluntarily, a Covered Person engaged with the Out-of-Network Provider for a scheduled procedure or ongoing treatment covered under this Plan, when such procedure or treatment is for a condition requiring immediate care, and the Covered Person's request is approved for Continuity of Care benefits until the end of the current episode of treatment or until the end of 90 days, whichever occurs first.

In these instances, when the services are eligible for coverage, the Out-of-Network Provider may not bill the Covered Person for amounts in excess of any In-Network Copayment, coinsurance or deductible (cost share). Except for air ambulance, the cost share is based on the Recognized Amount as described in the No Surprises Act and as set forth in the Defined Terms section. The cost share for air ambulance is based on the rates that would apply if the service was provided by an In-Network Provider.

When Covered Services are received from Out-of-Network Providers as stated above, Allowed Amounts are based upon one of the following as applicable:

- (a) The initial payment made by the Plan or the amount subsequently agreed to by the Out-of-Network Provider.
- (b) The amount determined by Independent Dispute Resolution (IDR).

RELATION OF THE PLAN TO PROVIDERS

The decision about whether to use a particular Provider is the sole responsibility of a Covered Person. A treating Provider is not an agent of the Plan or the Claims Administrator. The Plan and the Claims Administrator makes no representations or guarantees regarding the qualification or experience of any Provider with respect to any service. The evaluation of such factors and the decision about whether to use any Provider is the sole responsibility of the Covered Person.

MEDICAL BENEFITS

All benefits described in this document are subject to the Claims Administrator's established Coverage Policy, which the Plan Administrator has adopted for purposes of defining the benefits under this Plan, the Allowable Charge (as defined herein) and the benefit limits and exclusions described more fully herein including, but not limited to the determination that: care and treatment is or is not Medically Necessary; or that services, supplies and care are or are not Experimental and/or Investigational. A charge is incurred on the date that the service or supply is performed or furnished.

DEDUCTIBLE

Deductible Amount. This is an amount of Covered Charges for which no benefits will be paid. Before benefits can be paid in a Calendar Year a Covered Person under single coverage must meet the individual deductible shown in the Schedule of Benefits. The deductible is waived for certain services as indicated in the Schedule of Benefits.

Family Unit Limit. When the maximum amount shown in the Schedule of Benefits has been incurred by members of a Family Unit toward their Calendar Year deductibles, the deductibles of all members of that Family Unit will be considered satisfied for that year.

BENEFIT PAYMENT

Each Calendar Year, benefits will be paid for the Covered Charges of a Covered Person that are in excess of the deductible. 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. Covered Charges for an individual family member who meets the individual out-of-pocket limit before the out-of-pocket limit for the Family Unit is met will be covered at 100% (except for any charges excluded as shown in 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 "Plan Allowance," and may also be referred to from time to time as the "Allowable Charge" or "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 this section. Please note that the Plan does not pay either billed charges (unless they happen to be less than the Plan Allowance), nor based on the "usual, customary and reasonable" charges that all or a subset of health care providers may routinely or regularly charge for the same or similar services; the Plan has made an intentional decision not to pay Plan benefits based on such criteria, but, instead, to utilize the Plan Allowance as described and defined herein. The Plan Allowance may be established in the following ways:

(1) Covered In-Network Services

For covered In-Network services (those received from an In-Network Provider) received in Arkansas, the Plan Allowance is the Network Fee Schedule established by the terms of the Provider's contract with the Claims Administrator. For covered In-Network services received outside the state of Arkansas, the Claims Administrator may not have a direct contract with each Provider outside Arkansas; where that is the case, the Plan Allowance for covered In-Network services is determined by the allowance or fee schedule of the Provider's contract with the Blue Cross and Blue Shield plan in the state where services were provided (known as the "Host Plan").

(2) Covered Out-of-Network Services

For covered Out-of-Network services (those received from an Out-of-Network Provider), the Plan Allowance is the amount determined by the Claims Administrator, using the following standards:

- (a)** For services received in Arkansas, the Plan Allowance for covered Out-of-Network services of Physicians and other individual Providers, as well as Ambulatory Surgery Centers, Home Health Care Agencies, Hospice Agencies, and freestanding dialysis centers or imaging centers, will be the amount of the fee schedule that the Claims Administrator has contracted with Providers in Arkansas for its Preferred Payment Plan network ("PPP"). For Hospitals classified as acute care Hospitals, the Plan Allowance for covered Out-of-Network Inpatient and Outpatient Services will be the amount calculated using the Arkansas Blue Cross and Blue Shield Facility Pricing Guidelines. On some occasions, the Plan Allowance for Out-of-Network services inside Arkansas may be determined as referenced in (c), below.
- (b)** For services received outside of Arkansas, the Plan Allowance for covered Out-of-Network services will be either the amount provided to the Claims Administrator by the Host Plan in that state or, if no such amount is available to the Claims Administrator from a Host Plan, then the Plan Allowance will be the amount determined under the formulas for services received in Arkansas, as referenced in (a), above, or (c) or (d), below.
- (c)** The Claims Administrator has contracted with an independent network sponsor-facilitator and third party vendor (the "Wrap Network Vendor" or "WNV"), whereby, in many states/locations, the Plan has access to a suite of Out-of-Network potential savings strategies, which range from supplemental or "wrap networks" in numerous states, (in essence providing a discount option for otherwise Out-of-Network services in many areas of the nation), to certain reference pricing services and case-specific pricing negotiation services. The Plan participates in these WNV out-of-network pricing options, where available, and receives the benefit of any cost savings that the WNV may be able to provide in cases where a Plan participant or beneficiary goes outside the Plan's preferred BlueCard network for services. The WNV Out-of-Network pricing option is not available in all instances and thus neither the Claims Administrator nor WNV can or do guarantee any cost savings or availability of a WNV pricing or discount option in any given state or area. However, to the extent that a WNV option is available in a given state/region/location with respect to any Out-of-Network provider services, the Claims Administrator may utilize and apply the WNV option and related pricing, in which case such pricing shall constitute the Plan Allowance for purposes of calculating and applying Plan benefits.
- (d)** For any services of any Provider that are not addressed in any of the existing Provider contracts or pricing guidelines referenced above, the Plan Allowance for covered Out-of-Network services will be the amount established by the Claims Administrator using such pricing methods, benchmarks or sources as the Claims Administrator may deem appropriate in the circumstances.

The Claims Administrator's calculation of a Plan Allowance shall be considered conclusive as to the amount that the Plan covers or will pay in Plan benefits for any covered service, treatment drug, supplies, equipment, or devices.

(3) 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 Copays, 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, leaving Plan participants or beneficiaries with "surprise" medical bills, in the form of so-called "balance billing" by Out-of-Network Providers.

COVERED CHARGES AND RELATED EXCLUSIONS AND LIMITATIONS

Please note that although this section refers to "Covered Charges," none of the items listed below are *always* covered in all circumstances, and all of the items listed below may sometimes be non-covered or subject to coverage limitations or conditions, as otherwise outlined elsewhere in this document. (For example, if a Plan Participant ceases to be eligible for coverage under the Plan, or if a particular service, treatment, drug, supply, device or equipment is not Medically Necessary per the Plan's Medically Necessary standard, then an item listed as within the scope of "Covered Charges" will not, in fact, be covered under the Plan, due to specific coverage criteria that are not met in a particular instance).

All benefits described in this document are available for Coverage Charges only and are subject to (i) the Claims Administrator's established Coverage Policy, which the Plan Administrator has adopted for purposes of defining the benefits due under this Plan; (ii) the Allowable Charge (as defined herein); and (iii) the benefit limits and exclusions described more fully herein including, but not limited to the determination that: care and treatment is or is not Medically Necessary; or that services, supplies and care are or are not Experimental and/or Investigational. A charge is incurred on the date that the service or supply is performed or furnished.

- (1) Hospital Care.** The medical services and supplies furnished by a Hospital or Ambulatory Surgical Center, Long Term Acute Care Hospital, or a Birthing Center. Covered Charges for room and board will be payable as shown in the Schedule of Benefits. After 23 observation hours, a confinement will be considered an inpatient confinement.

If a Covered Person is hospitalized on the date of termination, the Plan will cover eligible Hospital facility charges only through the date of discharge from the Hospital. Any charges other than those billed by the Hospital, which are incurred in conjunction with an inpatient hospitalization, are not covered after the Covered Person's coverage is terminated.

- (2) Physician Care.** The professional services of a Physician for surgical or medical services.

Charges for **multiple surgical procedures** will be a Covered Charge subject to the following provisions:

- (a) 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.
- (b) Payment for a covered assistant surgeon shall be limited to a single Physician, qualified to act as an assistant for the surgical procedure. Covered Charges for assistant surgery services or minimum assistant surgery services will be paid at a reduced rate which will never exceed 20% of the surgeon's Allowable Charge.

- (3) **Coverage of Pregnancy.** The Allowable Charges for the care and treatment of Pregnancy are covered the same as any other Sickness.

Midwives. 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. Services provided by a lay midwife are not covered.

The Expectant Mother is encouraged to enroll in the Special Delivery Program by the 14th week of Pregnancy. Special Delivery can be accessed by calling 1-800-225-1891 ext. 20225. 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.

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).

- (4) **Skilled Nursing Facility Care.** The Inpatient care in a Skilled Nursing Facility, Extended Nursing Facility or Nursing Home, for patients who no longer need the full range of the acute care Hospital's services. The admission must be within seven days of release from an Inpatient stay. Services must be of a temporary nature and increase ability to function. Prior Approval is required.
- (5) **Home Health Care Services.** Charges for Home Health Care Services and Supplies are covered only for care and treatment of an Injury or Sickness when Hospital or Skilled Nursing Facility confinement would otherwise be required. Covered services must be provided through and billed by a licensed Home Health Care Agency.

A Home Health Care visit will be considered a periodic visit by either a nurse or therapist as the case may be, or four hours of home health aide services.

- (6) **Hospice Care Services and Supplies.** Charges for Hospice Care Services and Supplies are covered only when the attending Physician has diagnosed the Covered Person's condition as being terminal, determined that the person is not expected to live more than six months and placed the person under a Hospice Care Plan.

Bereavement counseling services for the patient's immediate family (covered Spouse and/or covered Dependent Children) when rendered by a Hospice Care team.

Respite care in a home or inpatient setting is covered.

- (7) **Diabetes Management Services.** The Plan will pay for diabetes self-management training which is classified as Standard Preventive Care. 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 glucometers and diabetic testing supplies.
- (b) Coverage is provided for insulin pumps and pump supplies.
- (c) The Plan will cover eye examinations to screen for diabetic retinopathy for Covered Persons who are diagnosed with diabetes.
- (d) Coverage of routine foot care, orthopedic shoes and custom foot orthotics is provided when required for prevention of complications associated with diabetes mellitus.

- (8) **Mental Illness and Substance Abuse Services (Alcohol and Drug Abuse).** Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Plan Document, coverage is provided for Health Interventions to treat Mental Illness and Substance Abuse.

Inpatient, Partial Hospitalization Program and Intensive Outpatient Program Health Interventions

- (a) Coverage for inpatient hospitalization, partial hospitalization programs or intensive outpatient programs for Mental Illness or Substance Abuse Health Interventions is subject to the following requirements.
 - (i) Inpatient hospitalization requires a patient to receive covered services 24 hours a day as an inpatient in a Hospital.
 - (ii) 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.
- (b) Inpatient Hospital admissions require Prior Approval.

Non-Hospital Health Interventions

- (a) Coverage is provided for a Health Intervention provided during an office visit with a psychiatrist, psychologist or other Provider licensed to provide psychiatric or Substance Use Disorder treatment.
- (b) Coverage is provided for a Health Intervention at a licensed psychiatric or Substance Use Disorder Residential Treatment Center and accredited by the Joint Commission (TJC) or the Commission on Accreditation of Rehabilitation Facilities (CARF International).

- (c) 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.
- (9) **Therapy Services.** Coverage is provided for inpatient and outpatient therapy services when performed or prescribed by a Physician. Such therapy services include physical, occupational, and speech 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.
- (10) **Standard Preventive Care.** Preventive Care Services are those health care services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of diseases, have been proven to have a beneficial effect on health outcomes and not for the treatment of an Illness or Injury, including those health care services required to be covered under Section 2713 of the Public Health Service Act (42 U.S.C. §300gg-13) and related regulatory guidance. Preventive Care Services include:
 - (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;
 - (b) 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; and
 - (d) With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

Examples of Standard Preventive Care for adults include:

- (a) Screenings for: breast cancer (including 3-D mammograms), cervical cancer, colorectal cancer, high blood pressure, Type 2 Diabetes Mellitus, cholesterol, and obesity.
- (b) Immunizations for adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; and
- (c) Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration, including the following:
 - Women's contraceptives, sterilization procedures, and counseling.
 - Breastfeeding support, supplies, and counseling.
 - Gestational diabetes screening.

Examples of Standard Preventive Care for children include:

- (a) Immunizations for children and adolescents recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. These may include:

- Diphtheria,
- Pertussis,
- Tetanus,
- Polio,
- Measles,
- Mumps,
- Rubella,
- Hemophilus influenza b (Hib),
- Hepatitis B,
- Varicella.

Preventive care and screenings for infants, children and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration

Charges for Routine Preventive Care. Routine Preventive Care is care by a Physician that is not for an Injury or Sickness. Covered Charges under Medical Benefits are payable for Routine Preventive Care as described in the Schedule of Benefits.

- (11) **Infertility testing, artificial insemination and in vitro fertilization.** Subject to Prior Approval from the Claims Administrator and in accordance with established Coverage Policy, coverage is provided for infertility testing, and once a diagnosis of infertility has been established, coverage is also provided for artificial insemination and in vitro fertilization. In vitro fertilization services are limited as described in the Schedule of Benefits.

- (12) **Other Medical Services and Supplies.** These services and supplies not otherwise included in the items above are covered as follows:

- (a) **Abortion.** Induced termination of a Pregnancy by any acceptable means, when one of the following circumstances occurs:
- (i) When the life of the mother would be endangered by the continuance of the Pregnancy;
 - (ii) Medically Necessary;
 - (iii) The Pregnancy is the result of rape or incest; or
 - (iv) In the case of fetal abnormality.

Benefits limited to Employee or Spouse.

NOTE: Expenses incurred in relation to complications from an abortion will be eligible for consideration under this Plan, whether or not the abortion is a Covered Expense.

- (b) Treatment of **Acquired Immunodeficiency Syndrome (AIDS).**
- (c) Covered charges for services billed by **Advanced Practice Registered Nurses** and Physician Assistants.
- (d) **Allergy-related services**, including testing, extracts and injections.

- (e) **Ambulance Services.** Coverage for Ambulance Services is provided as described below, and payable as specified in the Schedule of Benefits.

Benefits are provided under the Plan for ground Ambulance Services to treat a Covered Person in place; for local transportation to the nearest Hospital in the event Medical Emergency care is needed; or to the nearest neonatal special care unit for newborn infants for treatment of Injuries, Illnesses, congenital birth defects or complication of premature birth that require that level of care.

Benefits for air Ambulance Services are provided under the Plan but are limited to transportation to the nearest Hospital capable of providing Medical Emergency care. The Plan's coverage of air ambulance is limited to those situations in which:

- (i) The Covered Person is in a location that cannot be reached by ground ambulance due to weather or road conditions or other circumstances exist that make it impossible for ground Ambulance Services to be obtained; or
- (ii) Transportation by ground ambulance poses a threat to the Covered Person's survival or seriously endangers the Covered Person's health due to the time or distance involved.

NOTE: The Plan excludes benefits for any air ambulance transport between or among different Hospitals unless the first Hospital to which a Covered Person is transported is not capable of providing Medical Emergency care that will stabilize the Covered Person; in such circumstances, the Plan covers one additional air ambulance transport to the nearest alternative Hospital that is capable of providing Medical Emergency care. If the Covered Person's medical condition is capable of being stabilized at any Hospital to which the Covered Person has been transported, the Plan excludes coverage for any air ambulance transfer to another Hospital. In addition, the Plan excludes coverage of air ambulance or ground ambulance for transfer of a Covered Person to any private residence or to any facility that will not furnish further medical treatment to the Covered Person.

Non-emergent medical transportation. Coverage of non-emergent Ambulance Services is limited to situations when all of the following conditions apply:

- (i) The Covered Person is confined to a bed or requires monitoring during transportation from a trained medical professional and cannot be safely transported by any other means; and
- (ii) Transportation is needed to a different location in order to access Medically Necessary treatment that cannot be safely and adequately provided at the Covered Person's location.

Additional Specific Ambulance Service Exclusions (applicable to both air and ground Ambulance Services). No benefits will be paid for:

- (i) Expenses incurred for Ambulance Services covered by a local governmental or municipal body, unless otherwise required by law;
- (ii) Non-emergency Ambulance Service, except as stated above;
- (iii) Ambulance Services that originate:
 - a) Outside the 50 United States and the District of Columbia; or

- b) From a country or territory outside of the United States to a location within the 50 United States or the District of Columbia; or
 - c) From a location within the 50 United States or the District of Columbia to a country or territory outside of the United States; or
- (iv) Ambulance Services provided for comfort or convenience for a Covered Person, their family, caregiver, Provider, or any facility; or
- (v) That portion of any Ambulance Services ride that is farther from the point of origin than the nearest Hospital capable of providing Medical Emergency care.
- (f) **Anesthetic**; oxygen; blood and blood derivatives that are not donated or replaced; intravenous injections and solutions. Administration of these items is included.
- (g) **Autism Spectrum Disorder**. Coverage is provided for the treatment of autism spectrum disorder, including applied behavioral analysis when ordered by a medical doctor or a psychologist and provided by a Board Certified Behavioral Analyst (BCBA).
- (h) **Cardiac rehabilitation** services are covered when the services are ordered by a Physician.
- (i) Radiation or **chemotherapy** and treatment with radioactive substances. The materials and services of technicians are included.
- (i) **Clinical Trial Coverage**. Charges for routine patient costs incurred in connection with a qualified individual's participation in an approved clinical trial will be covered subject to the following conditions and limitations:
 - (i) Routine patient costs include all items and services that would be considered a Covered Charge for a Covered Person that is not enrolled in an approved clinical trial but does not include:
 - a) The investigational item, device or service itself;
 - b) Items and services that are provided solely for data collection and analysis needs and are not used in the direct clinical management of patient; or
 - c) A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis
 - (ii) Qualified individual means a Covered Person who is eligible, according to the trial protocol, to participate in an approved clinical trial for the treatment of cancer or another life threatening disease or condition and either:
 - a) The referring health care professional is a Network Provider and has concluded that the Covered Person's participation would be appropriate; or
 - b) The Covered Person provides medical and scientific information establishing that his or her participation in the trial would be appropriate

- (iii) 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 either:
- a) A federally funded trial that is approved or funded by one or more of the following:
 - National Institutes of Health;
 - The Centers for Disease Control and Prevention;
 - The Agency for Health Care Research and Quality;
 - The Centers for Medicare and Medicaid Services;
 - A cooperative group of any of the entities described above or the Department of Defense or the Department of Veteran Affairs; or
 - Subject to certain additional requirements as set forth in PHSA §2709(d) (2), the Department of Veterans Affairs, the Department of Defense or the Department of Energy.
 - b) A study or investigation conducted in connection with an investigational new drug application reviewed by the FDA; or
 - c) A study or investigation that is a drug trial that is exempt from having to submit for an investigational new drug application.
- (j) Initial **contact lenses** or glasses required following cataract surgery. A single acquisition of eyeglasses or contact lenses within the first six months following cataract surgery is covered. With respect to such eyeglasses or contact lenses, tinting or anti-reflective coating and progressive lenses are not covered. The Allowable Charge is based on the cost for basic glasses or contact lenses.
- (k) **Craniofacial Anomaly Services.** Coverage for related Health Interventions for a Covered Person who is diagnosed as having a craniofacial anomaly provided the Health Interventions are determined to be Medically Necessary and to improve a functional impairment that results from the craniofacial anomaly as determined by a surgical member of 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, and vision care in a manner consistent with Coverage Policy.
- (l) **Dietitian services** for treatment of a covered medical condition.
- (m) Coverage is provided for **Durable Medical Equipment (DME)** when prescribed by a Physician according to the guidelines specified below.
- (i) Durable Medical Equipment is equipment which can:
 - a) Withstand repeated use;
 - b) Is primarily and customarily used to serve a medical purpose;
 - c) Generally is not useful to a person in the absence of an Illness or Injury; and
 - d) Is appropriate for use in the home.

- (ii) DME Delivery and set up charges are included in the Allowable Charge for the DME.
- (iii) 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 Covered Person.
- (iv) When it is more cost effective, the Plan, in its discretion will purchase rather than lease equipment. In making such purchase, the Plan may deduct previous rental payments from its purchase Allowance.
- (n) **Eye exams** are covered when ordered by a Physician during treatment of a medical condition or Injury. Routine eye exams for children are covered under Standard Preventive Care.
- (o) **Genetic testing** is covered in accordance with established Coverage Policy
- (p) **Hearing exams** are covered when ordered by a Physician during treatment of a medical condition or Injury or classified as Standard Preventive Care.
- (q) **Hearing aids and implantable hearing devices.** In accordance with established Coverage Policy, coverage may be provided for the following:
 - (i) Hearing aids;
 - (ii) Cochlear implant (an implantable hearing device inserted into the modiolus of the cochlea and into cranial bone) and its associated speech processor;
 - (iii) Implantable bone conduction (bone-anchored) hearing aids; and
 - (iv) Auditory brain stem implants.

Benefits for covered hearing aids and implantable hearing devices are payable as described in the Schedule of Benefits.

- (r) **Laboratory services.**
- (s) **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 Covered Person diagnosed with a Medical Disorder Requiring Specialized Nutrients or Formulas if:
 - (i) 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
 - (ii) 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.
- (t) **Obesity and Morbid Obesity** treatment coverage, including gastric bypass surgery or any other procedure performed for the purpose of weight loss or reversal of such treatment, is subject to prior written approval from the Claims Administrator, acting on behalf of the Plan Administrator.

- (t) **Oral Surgery, Dental Care and Orthodontic Services.** Oral Surgery, Dental Care and orthodontic services are generally not covered. However, coverage is provided for the following specific conditions.
- (i) **Benefits for 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 Injury to jaws, cheeks, lips, tongue, roof and floor of the mouth. Treatment of an injury to a tooth or teeth incurred while eating is not covered.
 - c) Excision of exostoses of jaws and hard palate.
 - d) External incision and drainage of abscess.
 - e) Incision of accessory sinuses, salivary glands or ducts.
 - f) Removal of impacted teeth is covered.
- (ii) **Benefits for Injury.** If a Covered Person has an 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 Covered Person must seek treatment within seven days of the Accidental Injury for services to be covered.
- a) Only the non-diseased tooth or teeth avulsed or extracted as a direct result of the 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) This benefit is limited to the first 12 months immediately following the Injury. If the Covered Person is under age 15, reimbursement for Dental Care services provided after such 12-month period will be provided if:
 - Such reimbursement is requested within such 12-month period,
 - The request for reimbursement is accompanied by a plan of treatment
 - Under standard dental practices the treatment could not have been provided within such 12-month period, and
 - Coverage for the injured Covered Person is in force when the treatment is rendered.
 - d) Injury to teeth while eating is not considered an Accidental Injury.
 - e) Any Health Intervention related to dental caries or tooth decay is not covered.
- (iii) **Benefits for dental services required in connection with Covered Services.**
- a) Dental services in connection with radiation treatment for any malignancy of the head or neck are covered.

- b) Dental services perioperative to organ transplant when dental infection precludes listing for a transplant are covered.
 - c) Dental services perioperative to valve replacement or surgery when dental infection precludes surgery are covered.
 - d) Dental services perioperative for hematopoietic stem cell transplant when dental infection precludes listing for a transplant are covered; and
 - e) Dental implants of titanium osseointegrated fixtures following radiation treatment for cancer of the head or neck or to replace non-diseased teeth following an accidental Injury are covered.
- (iv) **Benefits for anesthesia services.** Hospital and Ambulatory Surgery Center services and anesthesia services related to dental procedures, including services to children, are covered in connection with treatment for a complex dental condition provided to: (i) a Participant under seven years of age who is determined by two dentists (in separate practices) to require the dental treatment without delay; (ii) a Participant with a diagnosis of serious mental or physical condition; or (iii) a Participant, certified by his or her primary care physician to have a significant behavioral problem.
- (u) **Organ transplant limits.** Coverage is provided for organ or tissue transplants in accordance with the following specific conditions:
 - (i) Not all transplants are covered. There must be a specific Coverage Policy which allows benefits for the transplant in question, and the Covered Person must meet all of the required criteria necessary for coverage set forth in the Coverage Policy and in this Plan Document.
 - (ii) Except for corneal transplants, coverage for transplant services requires Prior Approval from the Claims Administrator. A request for approval must be submitted to the Claims Administrator prior to receiving any transplant services, including transplant evaluation.
 - (iii) The transplant benefit is subject to the deductible, coinsurance and any applicable Copays or maximums specified in the Schedule of Benefits.
 - (iv) Notwithstanding any other provisions, the 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, if the Covered Person chooses to use that facility. If the Covered Person receives the transplant from a facility 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. If the Covered Person receives the transplant from a facility that is not in the Blue Distinction Centers for Transplant network and does not contract with the local Blue Cross and/or Blue Shield plan, the Allowable Charge for the transplant services provided in the Transplant Global Period is 80% of the average usual and reasonable charge authorized by participating facilities in the Blue Distinction Centers for Transplant network located in the geographic region where the transplant is performed.

- (v) Charges for obtaining donor organs or tissues are Covered Charges under the Plan when the recipient is a Covered Person. Benefits under this Plan will be payable only if there is no coverage available under the donor's plan. Donor charges include those for evaluating the organ or tissue, removing the organ or tissue from the donor, and transportation of the organ or tissue from within the United States and Canada to the place where the transplant is to take place.
- (vi) Please note that payments for any transplant (whether performed within the transplant network or by a non-participating facility) are limited to a global payment that applies to all covered transplant services; payment will not be made for 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 for any excess amount above the global payment, except for applicable deductible, coinsurance or non-covered services; however, a non-participating facility may bill the Covered Person for all amounts it may charge above the global payment. These charges above the global payment could amount to thousands of dollars in additional out-of-pocket expenses.
- (vii) When the Covered Person is the potential transplant recipient, a living donor's Hospital costs for the removal of the organ are covered with the following limitations:
 - a) 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; and
 - b) Donor testing is covered only if the tested donor is found compatible.
- (v) The initial purchase, fitting, and repair of **orthotic appliances** such as braces, splints or other appliances which are required for support for an injured or deformed part of the body as a result of a disabling congenital condition or an Injury or Sickness.
- (w) Covered charges billed by a **pharmacist** will be paid at the primary care Physician's benefit level provided the Pharmacist is acting within the scope of their license.
- (x) **Podiatry services** are limited to surgical services, including incision and drainage of infected tissues of the foot, removal of lesions of the foot, removal or débridement of infected toenails, surgical removal of nail root, and treatment of fractures or dislocations of bones of the foot. Coverage includes routine foot care to treat podiatric conditions associated with diabetes mellitus, metabolic (e.g. diabetes, gout, etc.), neurologic (peripheral neuropathy of any etiology), and peripheral vascular disease.
- (y) **Prescription** Drugs (as defined) are covered under the Prescription Drug program administered by the pharmacy benefits manager. Coverage under Medical Benefits is available for injectable medications while confined as an inpatient, or when provided and administered by a Physician in a clinic setting.
- (z) The initial purchase, fitting and repair of fitted **prosthetic devices** which replace body parts.

(aa) **Reconstructive Surgery. Cosmetic Services are not covered.** Coverage is provided for the following reconstructive surgery procedures:

- (i) Treatment provided for the correction of defects incurred in an Accidental Injury sustained by the Covered Person. The Covered Person must seek treatment within seven days of an Injury for services to be covered. Unless Prior Approved by the Claims Administrator, no benefits are provided after 12 months from the Injury.
- (ii) Removal of a port-wine stain or hemangioma (on the head, neck, or face).
- (iii) Treatment provided when it is incidental to disease or for reconstructive surgery following neoplastic (cancer) surgery.
- (iv) In connection with a mastectomy eligible for coverage under this 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 lymphademas.
- (v) Reduction mammoplasty, if such reduction mammoplasty meets coverage criteria, is covered.

NOTE: Reconstructive surgery for any craniofacial anomaly is NOT covered under this subsection; the only Plan coverage for any services related to a craniofacial anomaly is outlined elsewhere in the Medical Benefits Section, under the heading “Craniofacial Anomaly Services.” All coverage of such services is (i) limited to the terms, conditions and limitations outlined and (ii) also limited by all other generally-applicable terms, conditions and limitations of this Plan Document (e.g., eligibility, Medically Necessary, Experimental and Investigational standards, etc.).

- (bb) **Sleep apnea treatment and sleep studies** is covered in accordance with established Coverage Policy.
- (cc) **Spinal Manipulation/Chiropractic services** by a Provider acting within the scope of his or her license.
- (dd) **Sterilization** procedures (tubal ligation and vasectomy).
- (ee) **Surgical dressings**, splints, casts and other devices used in the reduction of fractures and dislocations.
- (ff) **Telehealth benefits.** Coverage is provided for Telemedicine services performed by a person licensed, certified, or otherwise authorized 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 provided the Telemedicine service is comparable to the same service provided in person.

Coverage also includes communications made by a Physician responsible for the direct care of a Covered Person in Case Management with involved health care Providers.

Audio-only communication is covered if it is real-time, interactive, and substantially meets the requirements for a covered service that would otherwise be covered by the Plan.

However, electronic consultations such as, but not limited to fax; email; or for services, which are, by their nature, hands-on (e.g. surgery, interventional radiology, coronary, angiography, anesthesia, and endoscopy) are not covered.

- (gg) Treatment of **Temporomandibular Joint (TMJ) Disorder and Cranial Mandibular Disharmony** consistent with established Coverage Policy.
- (hh) **Travel, meals and Lodging Expenses.** Travel, meals and lodging expenses are eligible when associated with a covered organ transplant service to the following extent:
 - (i) The Plan will cover travel and lodging for the patient and one companion who is traveling on the same day(s) to and/or from the site of an eligible covered service. If the patient is an enrolled Dependent minor child, the Plan will cover travel and lodging expenses for two companions.
 - (ii) Eligible expenses for lodging and meals for the patient (while not a Hospital inpatient) are paid at a per diem (per day) rate of up to:
 - a) \$50 per day for the patient;
 - b) \$100 per day for the patient plus one companion; or,
 - c) \$150 per day for a patient who is an enrolled Dependent minor child plus two companions.
 - (iii) Eligible expenses for transportation include airfare at coach rate, taxi, bus fare, automobile rentals, or personal automobile. For personal transportation, mileage is reimbursed at the IRS-approved rate for the most direct route between the patient's home and the facility.
 - (iv) Travel, meals and lodging expenses are only available if the patient is not covered by Medicare.
 - (v) Travel, meals and lodging expenses for cornea transplants are not eligible.
 - (vi) The Covered Person must submit valid receipts with a travel and lodging claim form for such charges. The travel and lodging claim form is available at www.blueadvantagearkansas.com.
- (ii) Coverage of **Well Newborn Nursery/Physician Care.**

Charges for Routine Nursery Care. 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 in accordance with the Special Enrollment provisions with coverage effective as of the date of birth.

The benefit is limited to Allowable Charges for nursery care for the first five days after birth while the newborn child is Hospital confined as a result of the child's birth or until the mother is discharged, whichever is less.

Charges for covered routine nursery care will be applied toward the Plan of the newborn child limited as shown in the Schedule of Benefits.

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).

Charges for Routine Physician Care. The benefit is limited to the Allowable Charges made by a Physician for routine pediatric care for the first five days after birth while the newborn child is Hospital confined, or until the mother is discharged, whichever is less. Covered routine Physician care benefits are payable as described in the Schedule of Benefits.

Charges for covered routine Physician care will be applied toward the Plan of the newborn child.

- (jj) **Wigs** following chemotherapy are covered.
- (kk) **Diagnostic X-rays.**

COST MANAGEMENT SERVICES

UTILIZATION REVIEW SERVICES PROGRAM

Utilization review is a program for Covered Persons which promotes access to necessary and appropriate health care.

The program consists of:

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

Inpatient Admissions
- (2) Retrospective review of the Medical Necessity for hospitalizations provided on the basis of an Emergency Illness or Emergency Injury.
- (3) Concurrent review, based on the admitting diagnosis, for hospitalizations requested by the attending Physician.
- (4) Planning for discharge from a Hospital or cessation of medical treatment.

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 Prior Approved, 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.

The attending Physician does not have to obtain Prior Approval from the Plan for prescribing a maternity length of stay that is 48 hours or less for a vaginal delivery or 96 hours or less for a cesarean delivery.

To maximize Plan reimbursements, please read the following provisions carefully.

PLEASE NOTE: Failure to receive Prior Approval may result in a denial or reduction of benefits payable by the Plan. The Covered Person will be responsible for reimbursing the Provider for any penalty amounts. Any costs incurred because of reduced reimbursement due to failure to follow Prior Approval procedures will not accrue toward the Covered Person's out-of-pocket limit.

Here's how the program works:

The responsible party must call the appropriate telephone number on the Covered Person's health plan identification card.

Through the Prior Approval process, the number of days of medical care facility confinement which are Medically Necessary will be determined.

Concurrent review, discharge planning. Concurrent review of a course of treatment and discharge planning from a medical care facility are parts of the utilization review 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 are subject to Prior Approval. If the service or procedure is provided by an In-Network Provider, in some cases the Provider may be held financially responsible for failure to obtain Prior Approval. However, it is always in the Covered Person’s best interest to verify that the treating Provider did obtain Prior Approval in order to avoid any potential penalties that could result in additional out-of-pocket expenses. If the service or procedure is provided by an Out-of-Network Provider, any penalty for failure to receive Prior Approval will be the Covered Person’s responsibility.

SERVICES REQUIRING PRIOR APPROVAL	
Inpatient admissions, including concurrent care extensions, at a Hospital and similar facilities, such as:	
Acute Care Facility	Skilled Nursing Facility
Inpatient Rehabilitation (Physical)	Long Term Acute Care
Residential Treatment Facility	
NOTE: For inpatient admissions related to treatment of a Medical Emergency, the Covered Person or the treating Provider should notify the Plan of the admission within 48 hours of the admission.	

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.

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.

CASE MANAGEMENT

Case Management (CM) is a collaborative process of assessment, planning, facilitation, implementation, care coordination, monitoring and evaluation, and advocacy for clinical options and clinical services to meet member, family, and/or caregiver(s) needs. This process is accomplished through communication and the use of available resources to promote quality cost-effective outcomes. The collaborative role of the case manager is clearly defined and communicated to patients and other members of the multidisciplinary team, as well as the Plan Administrator.

This process enables the CM program to achieve patient-centered goals through the following interventions:

- (1) Improve member safety, productivity and promote satisfaction and quality of life;
- (2) Ensure that appropriate clinical program services are generated in a timely and cost-effective manner;
- (3) Assist members to achieve an enhanced level of health and to maintain wellness;
- (4) Assist members to appropriately self-manage care, self-advocate, and make informed health care decisions; and
- (5) Maintain cost-effectiveness in the provision of health services, supporting clinical programs for appropriate outreaches.

As advocates for the member, Case Management:

- (1) Promotes and supports the member and caregiver's self-determination, self-care, shared decision-making regarding interventions, autonomy, growth, and self-advocacy;
- (2) Collaborates with member's PCP and other health care and service Providers including medical and behavioral health, in recognizing the needs, strengths, and goals of the member;
- (3) Collaborates with appropriate services for clinical needs such as behavioral health care services, social services, and Providers; and
- (4) Educates the member, family, and/or caregiver(s) regarding community resource availability as identified;
- (5) Recognizes, prevents, and eliminates disparities in accessing high-quality health care as related to race, ethnicity, national origin, migration background, sex, sexual orientation, marital status, age, religion, political beliefs, physical, mental, or cognitive ability, or other cultural factors.

DEFINED TERMS

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

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.

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

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 Allowable Charge as determined at the discretion of the Plan. 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 Allowable Charge. If services are rendered by a participating Provider, that Provider is obligated to accept the established rate as payment in full, and should only bill the member for deductible, coinsurance and any non-covered services; however, if services are rendered by a non-participating Provider, the member will be responsible for all amounts billed in excess of the Allowable Charge.

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.

Ancillary Services means services provided by Out-of-Network Providers at an In-Network facility such as: related to emergency medicine – anesthesiology, pathology, radiology and neonatology; provided by assistant surgeons, hospitalists and intensivists; diagnostic services, including radiology and laboratory services, unless such items and services are excluded from the definition of ancillary services as determined by the Secretary (as that term is applied in the No Surprises Act); provided by such other specialty practitioners as determined by the Secretary; and provided by an Out-of-Network Physician when no other In-Network Physician is available.

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.

Break in Service means a period of at least 13 consecutive weeks during which the Employee has no Hours of Service. A Break in Service may also include any period for which the Employee has no Hours of Service that is at least four consecutive weeks in duration and longer than the prior period of employment (determined after application of the procedures applicable to Special Unpaid Leaves.

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 Covered Person through a collaborative process that assesses, plans, implements, coordinates, monitors and evaluates options and health care benefits available to a Covered Person. Case management is instituted at the sole option of the Claims Administrator when mutually agreed to by the Covered Person and the Covered Person's Physician.

Claims Administrator means a vendor to whom the Plan Administrator has delegated responsibility and authority to process claims for benefits under the Plan, applying the terms, conditions, limitations, and exclusions of the Plan as set forth in this document. The Claims Administrator and its address are identified in the General Plan Information section of this document. The Claims Administrator is not the Plan Administrator and does not act as a fiduciary of the Plan.

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

Copay or Copayment is the amount of money that is paid each time a particular service is used before the Plan pays. Typically, there may be copays on some services and other services will not have any copays. Copay amounts for eligible services rendered by In-Network Providers accrue toward the In-Network annual out-of-pocket limit.

Cosmetic Surgery means any surgical procedure, including corrective plastic or reconstructive plastic surgical procedures, having the primary purpose of improving physical appearance. Cosmetic Surgery also includes any procedure required in order to correct complications caused by or arising from prior Cosmetic Surgery. However, Cosmetic Surgery does not include in connection with a mastectomy, (a) reconstruction of the breast on which the mastectomy has been performed, and (b) surgery and reconstruction of the other breast to produce a symmetrical appearance.

Coverage Policy - The Plan has delegated to the Claims Administrator, BlueAdvantage Administrators of Arkansas, the development of Coverage Policies that may apply to certain types of claims, drugs, services, supplies, equipment, devices or treatments. In addition, the Plan had adopted existing BlueAdvantage Coverage Policies and intends that all such Coverage Policies, current and future, as developed by BlueAdvantage, shall apply to benefit determinations under the Plan, including any claim for Plan benefits that a Covered Person may have, where applicable. Existing BlueAdvantage Coverage Policies (which are adopted by the Plan and therefore apply to any Plan benefits a Covered Person may claim) are available on the BlueAdvantage website at www.blueadvantagearkansas.com or obtained from BlueAdvantage by calling BlueAdvantage customer service or writing to BlueAdvantage requesting a copy. A Covered Person and their selected health care Provider should review such Coverage Policies prior to undertaking a specific operation, surgery, or treatment regimen, to be sure that coverage is available under the Plan because Plan coverage may be determined by the specific elements, conditions, or limitations of a specific Coverage Policy. Please note that 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 coverage criteria, as other terms, conditions, limitations or exclusions of the Plan may still apply.

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

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

Custodial Care is care (including Room and Board needed to provide that care) that is given principally for personal hygiene or for assistance in daily activities and can, according to generally accepted medical standards, be performed by persons who have no medical training. Examples of Custodial Care are help in walking and getting out of bed; assistance in bathing, dressing, feeding; or supervision over medication which could normally be self-administered.

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. Dental Care shall include any related supplies or oral appliances used in the treatment, diagnosis or prevention of any defects in the teeth or supporting tissues of the mouth. Expenses for such treatment or repair are considered Dental Care regardless of the reason for the services. Generally, hospital services and administration of anesthetic in connection with Dental Care are not covered except in limited circumstances, as specifically outlined elsewhere in this document.

Durable Medical Equipment means equipment which (a) can withstand repeated use, (b) is primarily and customarily used to serve a medical purpose, (c) generally is not useful to a person in the absence of an Illness or Injury and (d) is appropriate for use in the home.

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

Employer is Hendrix College.

ERISA is the Employee Retirement Income Security Act of 1974, as amended.

Experimental or Investigational. The Plan shall have full discretion to determine whether a drug, device or medical treatment is experimental or investigational. Any drug, device or medical treatment may be deemed experimental or investigational, in the Plan's discretion, if:

- (1) The drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and final regulatory approval for marketing has not been announced to the public at the time the drug or device is furnished; or
- (2) The drug, device, treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review and approval; or
- (3) Reliable Evidence (as defined below) shows that the drug, device or medical treatment or procedure is the subject of on-going phase I, II or III clinical trials 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; or
- (4) Reliable Evidence (as defined below) shows that the majority opinion among experts, as stated in the published authoritative literature, regarding the drug, device or medical treatment or procedure is that further studies or clinical trials are necessary 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; or
- (5) Reliable Evidence (as defined below) shows that a majority opinion among experts, as stated in the published authoritative literature, regarding the drug, device or medical treatment or procedure neither supports nor denies its use for a particular condition or disease; or
- (6) Reliable Evidence (as defined below) shows that the majority opinion among experts, as stated in the published authoritative literature, regarding the drug, device or medical treatment or procedure is that it should not be used as a first line therapy for a particular condition or disease.

"Reliable Evidence" shall mean only the following sources:

- (a) The patient's medical records or other information from the treating Physician(s) or from a consultant(s) regarding the patient's medical history, treatment or condition;
- (b) The written protocol(s) under which the drug, device, treatment or procedure is provided to the patient;
- (c) Any consent document the patient has executed or will be asked to execute, in order to receive the drug, device, treatment or procedure;
- (d) Published reports and articles in the authoritative medical and scientific literature, signed by or published in the name of a recognized medical expert, regarding the drug, device, treatment or procedure at issue as applied to the injury, illness or condition at issue; or
- (e) The written protocol(s) used by another facility studying substantially the same drug, device, medical treatment or procedure.

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

Genetic Information means information about the genetic tests of an individual or his family members, and information about the manifestations of disease or disorder in family members of the individual. A "genetic test" means an analysis of human DNA, RNA, chromosomes, proteins or metabolites, which detects genotypes, mutations or chromosomal changes. It does not mean an analysis of proteins or metabolites that is directly related to a manifested disease, disorder or pathological condition that could reasonably be detected by a health care professional with appropriate training and expertise in the field of medicine involved. Genetic information does not include information about the age or gender of an individual.

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

Home Health Care Agency is an organization that meets all of these tests: its main function is to provide Home Health Care Services and Supplies; it is federally certified as a Home Health Care Agency; and it is licensed by the state in which it is located, if licensing is required.

Home Health Care Plan must meet these tests: it must be a formal written plan made by the patient's attending Physician which is reviewed at least every 30 days; it must state the diagnosis; it must certify that the Home Health Care is in place of Hospital confinement; and it must specify the type and extent of Home Health Care required for the treatment of the patient.

Home Health Care Services and Supplies include: part-time or intermittent nursing care by or under the supervision of a registered nurse (R.N.); part-time or intermittent home health aide services provided through a Home Health Care Agency (this does not include general housekeeping services); physical, occupational and speech therapy; medical supplies; and laboratory services by or on behalf of the Hospital.

Hospice Agency is an organization where its main function is to provide Hospice Care Services and Supplies and it is licensed by the state in which it is located, if licensing is required.

Hospice Care Plan is a plan of terminal patient care that is established and conducted by a Hospice Agency and supervised by a Physician.

Hospice Care Services and Supplies are those provided through a Hospice Agency and under a Hospice Care Plan and include inpatient care in a Hospice Unit or other licensed facility, home care, and family counseling during the bereavement period.

Hospice Unit is a facility or separate Hospital Unit that provides treatment under a Hospice Care Plan and admits at least two unrelated persons who are expected to die within six months.

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: 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.

Hours of Service means each hour for which the Employee is paid or entitled to payment for performance of services for the Employer AND any hour for which the employee is paid or entitled to payment by the Employer for a period of time during which no duties are performed due to any of the following, consistent with 29 C.F.R. 2530.200b-2(a)(i):

- Vacation
- Holiday
- Illness or incapacity
- Layoff
- Jury duty
- Military duty or leave of absence

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

Independent Dispute Resolution is the process that Out-of-Network or non-participating Providers may use following the end of an unsuccessful open negotiation period to determine the Out-of-Network rate for certain services. More specifically, the Federal IDR process may be used to determine the Out-of-Network rate for certain emergency services, non-emergency items and services furnished by non-participating Providers at participating health care facilities, and air Ambulance Services furnished by non-participating Providers of air Ambulance Services where an All-Payer Model Agreement or specified state law does not apply. Additionally, a party may not initiate the Federal IDR process if, with respect to an item or service, the party knows or reasonably should have known that the Provider or facility provided notice and obtained consent from a participant, beneficiary, or enrollee to waive surprise billing protections consistent with PHS Act sections 2799B-1(a) and 2799B-2(a) and the implementing regulations at 45 CFR 149.410(b) and 149.420(c)-(i).

Infertility means incapable of producing offspring.

Injury means an accidental physical Injury (not an intentionally self-inflicted injury) sustained by a Covered Person while eligible for coverage under the Plan, 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.

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").

Late Enrollee means a Plan Participant who enrolls under the Plan other than during the first 30-day period in which the individual is eligible to enroll under the Plan or during a Special Enrollment Period.

Legal Guardian means a person recognized by a court of law as having the duty of taking care of the person and managing the property and rights of a minor child.

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.

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

Medical Emergency means 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 Injury is of such a nature that failure to get immediate medical care could result in (a) placing the patient's health in serious jeopardy; (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part.

Medically Necessary means care and/or treatment that 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 the Health Insurance For The Aged and Disabled program under Title XVIII of the Social Security Act, as amended.

Mental Illness means and includes (whether organic or non-organic, whether of biological, non-biological, chemical or non-chemical origin, and irrespective of cause, basis or inducement) mental disorders, mental illnesses, psychiatric illnesses, mental conditions, and psychiatric conditions. This includes, but is not limited to, 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.)

Morbid Obesity is a diagnosed condition in which the body weight exceeds the medically recommended weight by either 100 pounds or is twice the medically recommended weight for a person of the same height, age and mobility as the Covered Person.

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

Out-of-Network Provider means a health care Provider who does not have a network participation contract with the Claims Administrator, or, outside of Arkansas, with the Blue Cross and Blue Shield plan in the state where services were provided ("Host Plan"). Out-of-Network Providers are free to bill and collect from members any charges for Covered Charges which are in excess of the Plan's Allowance or Allowable Charge except when prohibited by law.

Outpatient Care and/or Services is treatment including services, supplies and medicines provided and used at a Hospital under the direction of a Physician to a person not admitted as a registered bed patient; or services rendered in a Physician's office, laboratory or X-ray facility, an Outpatient Surgical Center, or the patient's home.

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.

Plan means Hendrix College Health Benefit Plan, which is a benefits plan for certain Employees of Hendrix College and is described in this document.

Plan Administrator means the Employer.

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, regardless of how much a Provider may bill for the services, drugs, medical devices, equipment, supplies or benefits. 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, Retiree or Dependent who is covered under this Plan.

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

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

Prescription Drug means any of the following: a Food and Drug Administration-approved drug or medicine which, under federal law, is required to bear the legend: "Caution: federal law prohibits dispensing without prescription"; injectable insulin; hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed Physician. Such drug must be Medically Necessary in the treatment of a Sickness or Injury.

Prior Approval means a health plan coverage management feature which requires that an approval be obtained from the Claims Administrator or from a subcontractor engaged by the Claims Administrator, acting on behalf of the Plan, before incurring expenses for certain Covered Charges. The Plan's procedures and timeframes for making decisions on Prior Approval requests may differ depending on when the request is received, and the type of service involved. Ongoing therapy of a prior authorized medication may require periodic assessments that could include an efficacy measure intended to demonstrate positive outcomes for continuation of therapy.

Please note that Prior Approval does NOT guarantee coverage for, or the payment of, the service or procedure reviewed. The sole effect and meaning of receiving Prior Approval is simply that, if Prior Approval is given, coverage for the specific service will not be denied for lack of Medical Necessity, including length of stay in a facility. All other Plan coverage criteria, including but not limited to, eligibility, contribution payment, if any, Coverage Policies, exclusions, and limitations shall continue to apply, and must be satisfied in order to receive Plan coverage for the Prior Approved services. In other words, if a Covered Person or their treating Provider receives Prior Approval, that Prior Approval takes care of the Medical Necessity issue for the particular admission or service that is Prior Approved, but there may be other Plan coverage standards that still must be reviewed, and if any of those standards are not also met, coverage for the Prior Approved service still could be denied upon further review of the Plan benefits claim. Prior Approval does not in any way control or attempt to control whether or not a Covered Person receives any particular medical service, drug, supply, equipment, device, or treatment – the decision on whether to undergo any particular course of treatment is entirely up to the Covered Person and their treating health care Providers. The only effect of a denial of Prior Approval is that a Covered Person may not receive Plan benefits for the service, drug, supply, equipment, device, or treatment in question. Accordingly, if the Covered Person and their treating health care Provider believe that a particular service, drug, supply, equipment, device, or treatment is essential or in the Covered Person's best interests, even though Prior Approval has been denied, the Covered Person should make their own decision regarding such matters, without regard to the Prior Approval decision. In other words, Prior Approval will only affect the Plan's coverage of medical care or treatment; it does not prevent a Covered Person and their doctors or other health care Providers from doing whatever they believe necessary in the best interests of the Covered Person's health and safety.

Privacy Notice means the notice that is required by the Privacy Regulations to be distributed by the Plan to participants regarding the privacy practices of the Plan.

Privacy Regulations means regulations promulgated by the Department of Health and Human Services at 45 Code of Federal Regulations ("CFR") part 160 and 45 CFR part 164, as amended, to regulate the uses and disclosures of Protected Health Information as required by the Health Insurance Portability and Accountability Act of 1996, as amended.

Protected Health Information means Individually Identifiable Health Information:

- (1) Except as provided in paragraph (2) of this definition, that is:
 - (a) Transmitted by Electronic Media;
 - (b) Maintained in any medium described in the definition of Electronic Media; or
 - (c) Transmitted or maintained in any other form or medium.
- (2) Protected Health Information does not include Individually Identifiable Health Information in:
 - (a) Education records covered by the Family Educational Right and Privacy Act, as amended, 20 U.S.C. 1232g;
 - (b) Records described at 20 U.S.C. 1232g(a)(4)(B)(iv); and
 - (c) Employment records held by the Plan in its role as an employer, including enrollment and disenrollment information created by the Employer when performing enrollment functions. Enrollment and disenrollment information is held by the Plan sponsor in the sponsor's capacity as Employer.
- (3) Genetic Information is considered PHI for purposes of the HIPAA Privacy Rule and cannot be used or disclosed for underwriting purposes.

Provider means a Hospital or a Physician. Provider also means a certified registered nurse anesthetist; certified nurse practitioner; clinical nurse specialist; certified nurse midwife; a licensed audiologist; a chiropractor; a dentist; a licensed certified social worker; a licensed Durable Medical Equipment Provider; an optometrist; a pharmacist; a physical therapist; a podiatrist; a psychologist; a respiratory therapist; a speech pathologist and any other type of health care Provider which the Plan Administrator, in its sole discretion, approves for reimbursement for services rendered.

QMCSO means a Qualified Medical Child Support Order within the meaning of Section 609(a) of ERISA that requires coverage under this Plan for an Employee's child or for a foster child who is Dependent on the Employee. The Plan has procedures for determining whether an order qualifies as a QMCSO. Plan Participants can obtain, without charge, a copy of such procedures from the Plan Administrator

Recognized Amount is the amount which a Covered Person's cost sharing is based on for the following Covered Services when provided by Out-of-Network Providers: Out-of-Network Emergency Care; non-Emergency Care received at certain In-Network facilities by Out-of-Network Providers, when such services are Ancillary Services. For the purpose of this provision, "certain In-Network facilities" are limited to a hospital (as defined in 1861(e) of the Social Security Act), a hospital outpatient department, a critical access hospital (as defined in 1861(mm)(1) of the Social Security Act), an ambulatory surgical center described in section 1833(i)(1)(A) of the Social Security Act, and any other facility specified by the Secretary. The Recognized Amount is based on the qualifying payment amount as determined under applicable law.

NOTE: Covered Services that use the Recognized Amount to determine a Covered Person's cost sharing may be higher or lower than if cost sharing for these Covered Services were determined based upon an Allowed Amount.

Retired Employee is a former Active Employee of the Employer who was retired while employed by the Employer under the formal written plan of the Employer and elects to contribute to the Plan the contribution required from the Retired Employee.

- (1) An Active Employee who have been continuously covered, and any eligible Dependent covered, by this Plan prior to August 2, 2012; and
- (2) Has reached age:
 - (i) 55 with at least 20 full-time continuous years of service at the time of retirement; or
 - (ii) 60 with at least 18 full-time continuous years of service at the time of retirement; or
 - (iii) 62 with at least 15 full-time continuous years of service at the time of retirement; and
- (3) He or she is not eligible for Medicare; and
- (4) Enrolls and elect to contribute to the Plan the contribution that is required from a Retired Employee.

Sickness is a Covered Person's Illness, disease or Pregnancy (including complications).

Skilled Nursing Facility is a facility that fully meets all of these tests:

- (1) It is licensed to provide professional nursing services on an inpatient basis to persons convalescing from Injury or Sickness. The service must be rendered by a registered nurse (R.N.) or by a licensed practical nurse (L.P.N.) under the direction of a registered nurse. Services to help restore patients to self-care in essential daily living activities must be provided.
- (2) Its services are provided for compensation and under the full-time supervision of a Physician.
- (3) It provides 24 hour per day nursing services by licensed nurses, under the direction of a full-time registered nurse.
- (4) It maintains a complete medical record on each patient.
- (5) It has an effective utilization review plan.
- (6) It is not, other than incidentally, a place for rest, the aged, Custodial or educational care.
- (7) It is approved and licensed by Medicare.

This term also applies to charges incurred in a facility referring to itself as an extended care facility, convalescent nursing home, rehabilitation hospital, long-term acute care facility or any other similar nomenclature.

Special Unpaid Leave of Absence means any of the following types of unpaid leaves of absence that do not constitute a Break in Service:

- (1) Leave protected by the Family and Medical Leave Act;
- (2) Leave protected by the Uniformed Services Employment and Reemployment Rights Act; or
- (3) Jury Duty (as reasonably defined by the Employer).).

Spinal Manipulation/Chiropractic Care means skeletal adjustments, manipulation or other treatment in connection with the detection and correction by manual or mechanical means of structural imbalance or subluxation in the human body. Such treatment is done by a Physician to remove nerve interference resulting from, or related to, distortion, misalignment or subluxation of, or in, the vertebral column.

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 Disorders 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 health care 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, unless it is real-time, interactive and substantially meets the requirements for a covered service that would otherwise be covered by the Plan, 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 jawbone 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 Injury or Sickness to perform the normal activities of a person of like age and sex in good health.

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

PLAN EXCLUSIONS

This Section describes the conditions, Provider services, Health Interventions and miscellaneous fees or services for which coverage is excluded. However, please note that some additional exclusions are also stated elsewhere in this document, including the Medical Benefits section.

For all Medical Benefits shown in the Schedule of Benefits, a charge for the following is not covered:

- (1) **Active Duty.** Charges for an 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 other insurance carriers or insurance agencies, medical evaluation for life, disability or any type of insurance coverage.
- (3) **Alcohol.** Services, supplies, care or treatment to a Covered Person for an Injury or Sickness which occurred as a result of that Covered Person's illegal use of alcohol. Expenses will be covered for Injured Covered Persons other than the person illegally using alcohol. The following must be present for there to be sufficient evidence for the purpose of this exclusion: (1) the results of a valid blood, breath or urine test performed by a qualified Provider indicating the Covered Person's alcohol level exceeds the legal limit in the state where the Injury or Sickness occurred or (2) a written citation from a law enforcement officer, in attendance where the Injury or Sickness occurred, indicating the Covered Person was under the influence of alcohol. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.
- (4) **Appointments.** Charges resulting from the failure to keep a scheduled visit with a Physician or other Provider.
- (5) **Bereavement services.** Medical social services and outpatient family counseling and/or therapy for bereavement, except if provided as Hospice Care.
- (6) **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.
- (7) **Blood typing.** Blood typing for paternity testing.
- (8) **Clinical Trials.** Services or supplies provided in connection with a phase I, II, III or IV clinical trial or any study to determine the maximum tolerated dose, toxicity, safety, efficacy, or efficacy as compared with a standard means of treatment or diagnosis of a drug, device or medical treatment or procedure are not covered. This exclusion will not apply to routine items and services that (a) would have been Covered Expenses had they not be incurred during an approved clinical trial, and (b) are provided during an approved clinical trial, as required and defined under PHSA Section 2709.
- (9) **Complications of non-covered treatments.** Care, services or treatment required as a result of complications from a treatment not covered under the Plan.
- (10) **Cosmetic Surgery.** Cosmetic 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.

- (11) **Coverage Policy.** The Plan has adopted certain Coverage Policies as defined by the Claims Administrator for certain types of claims, drugs, services, supplies, equipment, devices or treatments. Copies of such Plan-adopted Coverage Policies have been published on the Claims Administrators' website. If a Coverage Policy exists for an Intervention, the Coverage Policy shall determine whether such Intervention meets coverage criteria. If a Coverage Policy determines that a Health Intervention does not meet the 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 is covered.
- (12) **Custodial Care.** Services or supplies for custodial, convalescent, domiciliary or support care and non-medical services to assist a Covered Person with activities of daily living.
- (13) **Custodial Care Facility.** Services or supplies furnished by an institution which is primarily a place of rest or a place for the aged. Youth homes, schools, or therapeutic wilderness, ranch or camp programs, or any similar institution are not covered.
- (14) **Delivery Charges.** Charges for shipping, packaging, handling or delivering Medications are not separately covered.
- (15) **Dental Care or orthodontic services.** Dental Care and orthodontic services are generally not covered. See the Medical Benefits section for a list of limited services.
- (16) **Dietary and nutritional services.** Services or supplies provided for dietary and nutritional services, unless such services are for the sole source of nutrition for a Covered Person.
- (17) **Educational or vocational testing.** Services for educational or vocational testing or training.
- (18) **Environmental change.** Charges for environmental change including hospital or physician charges connected with prescribing an environmental change.
- (19) **Excess charges.** The part of an expense for care and treatment of an Injury or Sickness that is in excess of the Allowable Charge.
- (20) **Exercise programs.** Exercise programs for treatment of any condition, including but not limited to physical education programs in a group setting, health club memberships, athletic training, back schools, or work hardening. This exclusion does not apply to Physician-supervised cardiac rehabilitation, or occupational or physical therapy.
- (21) **Experimental or not Medically Necessary.** Care and treatment that is either Experimental/Investigational or not Medically Necessary.
- (22) **Eyeglasses.** Eyeglasses are generally not covered; however, one pair of eyeglasses or contact lenses are covered within six months following cataract surgery. With respect to such eyeglasses or contact lenses, tinting or anti-reflective coating and progressive lenses are not covered.
- (23) **Foot care.** Treatment of weak, strained, flat, unstable or unbalanced feet, foot orthoses, metatarsalgia, bunions or other such routine foot care, are not covered unless services are medical related open cutting operations, or treatment is in relation to a metabolic or peripheral-vascular disease.
- (24) **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.

- (25) **Hair loss.** Care and treatment for hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a Physician. However, the Plan will allow wigs charges following chemotherapy.
- (26) **Hippo therapy.** Charges associated with hippo therapy.
- (27) **Hospital employees.** Professional services billed by a Physician or nurse who is an employee of a Hospital or Skilled Nursing Facility and paid by the Hospital or facility for the service.
- (28) **Illegal Acts.** Charges for services received as a result of Injury or Sickness caused by or contributed to by engaging in an illegal act or occupation; by committing or attempting to commit any crime, criminal act, assault or other felonious behavior; or by participating in a riot or public disturbance. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.
- (29) **Illegal drugs or medications.** Services, supplies, care or treatment to a Covered Person for an Injury or Sickness resulting from that Covered Person's voluntary taking or being under the influence of any controlled substance, drug, hallucinogen or narcotic not administered on the advice of a Physician. Expenses will be covered for Injured Covered Persons other than the person illegally using the controlled substances. A written citation from a law enforcement officer, in attendance where the Injury or Sickness occurred, indicating the Covered Person was under the influence of a controlled substance, drug, hallucinogen, or narcotic not administered on the advice of a Physician must be present for there to be sufficient evidence for the purpose of this exclusion. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.
- (30) **Jaw Joint Disorder.** Charges for treatment of temporomandibular joint disorder, cranial mandibular disharmony and myofascial pain syndrome by any method, including, but not limited to: charges for treatment to alter vertical dimension or to restore abraded dentition, orthodontia and intra-oral prosthetic devices.
- (31) **Learning Disabilities.** Services or supplies provided for learning disabilities, i.e. reading disorder, alexia, developmental dyslexia, dyscalculia, spelling difficulty, and other learning difficulties.
- (32) **Massage Therapy.** Coverage for massage and manual therapy services provided without a chiropractic manipulation or other physical medicine therapy is not covered.
- (33) **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.
- (34) **No charge.** Care and treatment for which there would not have been a charge if no coverage had been in force.
- (35) **Non-emergency Hospital admissions.** Care and treatment billed by a Hospital for non-Medical Emergency admissions on a Friday or a Saturday. This does not apply if surgery is performed within 24 hours of admission.
- (36) **No obligation to pay.** Charges incurred for which the Plan has no legal obligation to pay.
- (37) **No Physician recommendation.** Care, treatment, services or supplies not recommended and approved by a Physician; or treatment, services or supplies when the Covered Person is not under the regular care of a Physician. Regular care means ongoing medical supervision or treatment which is appropriate care for the Injury or Sickness.

- (38) **Not specified as covered.** Non-traditional medical services, treatments and supplies which are not specified as covered under this Plan.
- (39) **Occupational.** Care and treatment of an Injury or Sickness that is occupational -- that is, arises from work for wage or profit including self-employment.
- (40) **Orthopedic shoes.** Charges for orthopedic shoes (except when they are an integral part of the leg brace and the cost is included in the orthotist's charge) or shoe inserts, or the purchase of orthotic services or appliances. This exclusion does not apply to custom foot orthotics prescribed during the treatment of a metabolic or peripheral-vascular disease.
- (41) **Personal comfort items.** Personal comfort items or other equipment, such as, but not limited to, air conditioners, air-purification units, humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, elastic bandages or stockings, nonprescription drugs and medicines, and first-aid supplies and nonhospital adjustable beds.
- (42) **Prescription drugs** are not covered under Medical Benefits, but are covered under the Prescription Drug Card program administered by the pharmacy benefits manager.
- (43) **Private duty nursing.** Charges for private duty nursing are not covered unless services are provided through and billed by a licensed home health agency.
- (44) **Provider Not Defined.** Services or supplies provided by an individual or entity that is not a Provider as defined in this Plan Document.
- (45) **Recreational therapy.** Services or supplies provided by a recreational therapist.
- (46) **Relative giving services.** Professional services performed by a person who ordinarily resides in the Covered Person's home or is related to the Covered Person as a Spouse, parent, child, brother or sister, whether the relationship is by blood or exists in law.
- (47) **Replacement durable medical equipment, prosthetic or orthotic appliances.** Replacement of durable medical equipment, prosthetic or orthotic appliances due to loss or misuse.
- (48) **Routine care.** Charges for routine or periodic examinations, screening examinations, evaluation procedures, preventive medical care or treatment or services not directly related to the diagnosis or treatment of a specific Injury, Sickness or pregnancy-related condition, which is known or reasonably suspected, unless such care is specifically covered in the Schedule of Benefits or required by applicable law.
- (49) **Seasonal Affective Disorder (SAD).** Use of photo therapy or light therapy to treat seasonal affective disorder or depression.
- (50) **Self-Inflicted.** Any loss due to an intentionally self-inflicted Injury. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.
- (51) **Services before or after coverage.** Care, treatment or supplies for which a charge was incurred before a person was covered under this Plan or after coverage ceased under this Plan. However, if a Covered Person is hospitalized on the date of termination, dependent on the type of contractual agreement with the Hospital, the Plan may cover eligible Hospital facility charges through the date of discharge from the Hospital. Any charges other than those billed by the Hospital, which are incurred in conjunction with an inpatient hospitalization, are not covered after the individual's coverage is terminated.

- (52) **Sex changes/sex therapy.** Care, services or treatment for sexual reassignment or sex change, non-congenital transsexualism or gender dysphoria. This exclusion includes medications, implants, Surgery and medical or psychiatric treatment. Diagnosis and hormone therapy are covered only.
- (53) **Snoring.** Devices, procedures or other Health Interventions to treat snoring are not covered.
- (54) **Surgical sterilization reversal.** Care and treatment for reversal of surgical sterilization.
- (55) **Telephone and Other Electronic Consultation.** Electronic consultations such as, but not limited to fax; email; or for services, which are, by their nature, hands-on (e.g. surgery, interventional radiology, coronary, angiography, anesthesia, and endoscopy) are not covered. Audio-only communication is not covered unless it is real-time, interactive, and substantially meets the requirements for a Covered Service that would otherwise be covered by the Plan.
- (56) **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, unless otherwise covered by this Plan are not covered.
- (57) **Travel or accommodations.** Charges for travel or accommodations, whether or not recommended by a Physician, except for ambulance charges as defined as a covered expense.
- (58) **Unlicensed Provider.** Coverage is not provided for treatment, procedures or services received from any person or entity, including but not limited to Physicians, who is required to be licensed to perform the treatment, procedure or service, but (1) is not so licensed, or (2) has had his license suspended, revoked or otherwise terminated for any reason, or (3) has a license that does not include within its scope the treatment, procedure or service provided.
- (59) **Vertical dimension.** Any charges related to alteration of vertical dimension, including but not limited to dental implants, surgical procedures, or appliances.
- (60) **Vision Enhancement.** Vision enhancements are generally not covered. A procedure, treatment, service, equipment or supply to correct a refractive error of the eye are covered in two instances: (1) if such refractive error results from traumatic injury or corneal disease, infectious or non-infectious, and (2) the implant of a monofocal lens following cataract extraction and the single acquisition of eyeglasses or contact lenses within the first six months following cataract surgery. The Plan does not cover the implantation of a multi-focal lens; however, if a multifocal lens is implanted after cataract extraction, the Plan will pay the Allowable Charge for a monofocal lens.
- (61) **War.** Any loss that is due to a declared or undeclared act of war.
- (62) **Weekend pass.** Charges for room and board in a facility for days on which the covered person is permitted to leave (a weekend pass, for example).
- (63) **Workers' Compensation.** Any condition for which benefits of any nature are payable or are found to be eligible, either by adjudication or settlement, under any Worker's Compensation law, Employer's liability law, or occupational disease law, even though the covered person fails to claim rights to such benefits or fails to enroll or purchase such coverage.

HOW TO SUBMIT A CLAIM

Benefits under this Plan shall be paid only if the Claims Administrator, acting on the Plan's behalf, decides in its discretion that a Covered Person is entitled to them.

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.

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.

Authority and responsibilities of the Plan Administrator under the Claims and Appeal Procedures, including the discretionary authority to interpret the terms of the Plan, have been delegated to the Claims Administrator for those Plan benefits administered by the Claims Administrator. If the Covered Person has any questions regarding these procedures, they should contact the Claims 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 determination72 hours

Insufficient information on the Claim, or failure to follow the Plan's procedure for filing a Claim:

Notification to claimant, orally or in writing24 hours

Response by claimant, orally or in writing48 hours

Benefit determination, orally or in writing48 hours

Notification of Adverse Benefit Determination on Appeal72 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 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 Plan Document for further information about services which require Prior Approval.

In the case of a Pre-Service Claim, the following timetable applies:

Notification to claimant of Adverse Benefit Determination.....	15 days
Extension due to matters beyond the control of the Plan	15 days
Insufficient information on the Claim:	
Notification of.....	15 days
Response by claimant	45 days
Notification, orally or in writing, of failure to follow the Plan's procedures for filing a Claim.....	5 days
Notification of Adverse Benefit Determination on Appeal	30 days
Reduction or termination before the end of the treatment	15 days
Request to extend course of treatment.....	15 days

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 BlueAdvantage Administrators of Arkansas. Participating Providers agree to accept the allowances of BlueAdvantage Administrators of Arkansas 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 web at www.blueadvantagearkansas.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 web at www.blueadvantagearkansas.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 non-participating 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:

 - The billed covered charges for the covered services; or
 - 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 health care 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 non-participating 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 non-participating 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 Medically Necessary Covered Services available under the medical benefits of the Plan. 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 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. 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:

- Obtain a Claim form from the Plan Administrator or at www.blueadvantagearkansas.com.
- Complete the Employee portion of the form. ALL QUESTIONS MUST BE ANSWERED.
- 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:

BlueAdvantage Administrators of Arkansas
P.O. Box 1460
Little Rock, Arkansas
72203

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.

EXPLANATION OF BENEFITS (EOB)

A Plan Participant will be notified within 30 days of receipt of the properly submitted claim as to the acceptance or denial of a claim and if not notified within 30 days, the claim shall be deemed denied. Upon making a determination of a claim, the Claims Administrator will deliver to the Covered Person an Explanation of Benefit Determination (EOB) 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 45 days from the end of the initial 90-day period.

INFORMAL CLAIM REVIEW

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. An informal claim review is not an appeal or a substitute for an appeal. Pursuit of an informal review will not relieve the claimant from the responsibility for exhausting any appeal rights under the Plan within the appeal deadline. 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.

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 the claims 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 an appeal.

Requests for review may be submitted in writing, email, or by telephone to the Claims Administrator. The request should provide the patient's name, Plan identification number and the specific claim(s) to be reviewed. Additional relevant documentation may also be provided to the Claims Administrator to assist in the review. A request for an informal claim review must be submitted within 180 days after notice is received of the denial or reduction in benefits. This 180-day period runs concurrently with the Plan's 180-day deadline to submit an appeal.

A determination shall be rendered with a reasonable period of time, but notification of the determination will be provided not later than 60 days after received. A review of the denial will be made by the Claims Administrator and the Claims Administrator will provide the Plan Participant with a written response within 60 days of the date the Claims Administrator receives the Plan Participant's written request for review and 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.

If the review is in regard to a Pre-Service Claim, response will be provided within 30 days of received.

If the review is in regard to an Urgent Care Pre-Service Claim, response will be provided within 24 hours of receipt.

APPEALS PROCESS

The Plan Participant will receive an EOB 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 file an appeal. This Plan appeal process allows the Plan Participants to:

- (1) Request from the Claims Administrator 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.

DEADLINE FOR SUBMISSION OF APPEALS

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.

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 notification the content required under applicable U.S. Department of Labor claims regulations.

EXTERNAL REVIEW PROCESS

If an appeal of a claim benefit determination is denied, the claimant may be entitled to request and receive an external review by an independent review organization. In order to be eligible for external review, the following conditions must apply:

- (1) The claimant must submit a request for external review in writing to the Claims Administrator within 125 days after receiving notice of the denial of the appeal. External review requests submitted more than 125 days after a claimant receives notice of denial of an appeal will be denied for lack of timely submission.
- (2) The claimant must have been eligible for coverage under the Plan at the time the services in question were or will be provided; and
- (3) The denial or claim must not be based on the claimant's failure to meet the Plan's eligibility requirements;
- (4) The claimant must have completed the Plan appeals process outlined in this document;
- (5) The claimant must have provided all information required by the Claims Administrator in order to process an external review request; and
- (6) The denial of the claim must be based on a medical judgement, which may include but is not limited to questions of Medical Necessity, medical appropriateness or safety of treatment or care, appropriateness of health care setting, or medical effectiveness of a treatment, service or covered benefits.

Upon submission to the Claims Administrator of the claimant's written request for external review, the Claims Administrator will review the request to determine whether the conditions outlined above are met.

Within one business day after completion of this preliminary review, the Claims Administrator will provide written notification to the claimant of whether the external review request satisfies the conditions for external review, including a description of any additional information or material necessary to complete the external review request.

If the Claims Administrator notifies the claimant or their representative that the request is not complete, the claimant will have 48 hours or until the last day of the 125-day filing period, whichever is later, to submit the additional information.

If the request satisfies the conditions for external review, the Claims Administrator will refer the request to a qualified independent review organization (IRO). The IRO will then be responsible for notifying the claimant, in writing, that the request for external review has been accepted. The IRO's notice should include a statement that the claimant may submit in writing, within 10 business days, any additional information the claimant wishes the IRO to consider when conducting the review. The IRO will share this information with the Plan and Claims Administrator. The Claims Administrator, acting as the delegate of the Plan Administrator, may consider this information and decide to reverse its denial of the Claim. If the denial is reversed, the external review process will end.

If the Claims Administrator does not reverse the denial, the IRO will make its decision on the basis of its review of all of the information in the record, as well as additional information where appropriate and available, such as:

- (1) The claimant's medical records as available and relevant;
- (2) The attending health care professional's recommendation;
- (3) Reports from appropriate health care professionals and other documents submitted by the claimant, the Plan, the Claims Administrator, or the treating Provider;
- (4) The terms of the Plan;
- (5) Appropriate practice guidelines;
- (6) Any applicable clinical review criteria developed and used by the plan; and
- (7) The opinion of the IRO's clinical reviewer.

The IRO must provide written notice to the Plan and the claimant of its final decision within 45 days after the IRO receives the request for the External Review. The IRO's decision notice should contain:

- (1) A general description of the reason for the External Review, including information sufficient to identify the claim;
- (2) The date the IRO received the assignment to conduct the review and the date of the IRO's decision;
- (3) References to the evidence or documentation the IRO considered in reaching its decision;
- (4) A discussion of the principal reason(s) for the IRO's decision;
- (5) A statement that the determination is binding and that judicial review may be available to the claimant; and
- (6) Contact information for any applicable office of health insurance consumer assistance or ombudsman established under federal law.

Expedited External Review

Generally, as noted above, a claimant must first complete the Plan's appeals process before requesting and receiving an external review of a claim denial. However, in some cases the Plan provides for an expedited external review of a claim denial if:

- (1) The claimant submits a written request to the Claims Administrator specifically requesting expedited external review; and
- (2) The time to complete the Plan's appeal process would seriously jeopardize the claimant's life or health or ability to regain maximum function; or

- (3) The time to complete the Plan's standard external review process would seriously jeopardize the claimant's life or health or ability to regain maximum function, or if the claim denial in dispute concerns a Hospital admission, availability of care, continued stay, or health care item or service for which the claimant received emergency services, but has not been discharged from a facility.

Immediately upon receipt of a request for external review, the Claims Administrator will undertake to determine and notify the claimant whether the request satisfies the requirements for expedited review, including the conditions for external review listed above. If the request qualifies for expedited external review, it will be assigned to an IRO. The IRO must make its determination and provide a notice of the decision as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited External Review. If the original notice of its decision is not in writing, the IRO must provide written confirmation of the decision within 48 hours to both the claimant and the Claims Administrator.

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 a "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. A "Designation of Authorized Appeal Representative" form is available from the Claims 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. A "Designation of Authorized Appeal Representative" form is available from the Claims Administrator;
- (3) A person holding the Covered Person's durable power of attorney;
- (4) If the Covered Person is incapacitated due to illness or 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.

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 Medicaid or any benefit plan like it 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;
 - (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.
- (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. In accordance with ERISA, 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 Injury, Sickness or other condition.

Whenever the Plan pays for or provides care for such an 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/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. This equitable lien shall remain in effect until the Plan is repaid in full. In addition, each Covered Person agrees to hold recoveries in a constructive trust for the benefit of the Plan. The equitable lien and constructive trust shall remain in effect until the Plan is repaid in full.

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 or 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’s 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.

In the event that the Covered Person dies as a result of his Injuries or Illness and a wrongful death or survivor claim is asserted against a third party, the Plan's reimbursement rights shall still apply, and the entity pursuing such claim shall honor and enforce these Plan rights and terms by which benefits are paid on behalf of the Covered Person and all others that benefit from such payment. The Plan may withhold all future payments under the Plan (whether or not related to the claim in question) if the Covered Person violate the terms of this section and/or the any subrogation or reimbursement agreement.

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 Injury, Sickness or other condition (including insurance carriers who are so 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 Injury or Illness, or is or may be liable for the payment for the medical treatment of such 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.

In the event that the Covered Person dies as a result of his Injuries or Illness and a wrongful death or survivor claim is asserted against a third party, the Plan's subrogation rights shall still apply, and the entity pursuing such claim shall honor and enforce these Plan rights and terms by which benefits are paid on behalf of the Covered Person and all others that benefit from such payment.

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.

Separation of Funds

Benefits paid by the Plan, funds recovered by the Covered Person, and funds held in trust over which the Plan has an equitable lien exist separately from the property and estate of the Covered Person, such that the death of the Covered Person, or filing of bankruptcy by the Covered Person, will not affect the Plan's equitable lien, the funds over which the Plan has a lien, or the Plan's right to subrogation and reimbursement.

CONTINUATION COVERAGE RIGHTS UNDER COBRA

Under federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), certain Employees and their families covered under Hendrix College Health Benefit Plan (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.

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.
- (3) A covered Employee who retired on or before the date of substantial elimination of Plan coverage which is the result of a bankruptcy proceeding under Title 11 of the U.S. Code with respect to the Employer, as is the Spouse, surviving Spouse or Dependent child of such a covered Employee if, on the day before the bankruptcy Qualifying Event, the Spouse, surviving Spouse or Dependent child was a beneficiary under the Plan.

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.

Federal law does not recognize a Domestic Partner or his or her children as Qualified Beneficiaries. However, the Plan will treat a Domestic Partner and his or her Children or Qualified Dependents as Qualified Beneficiaries if they are covered under the Plan on the day before a Qualifying Event. For purposes of interpreting this Section, the Domestic Partner will be treated as the Spouse of the Employee, and a divorce will be deemed to have occurred on the first date that one or more of the eligibility requirements for a Domestic Partner ceases to be met. This gives the Domestic Partner, Children and Qualified Dependents the contractual rights outlined in this Section but does not extend statutory remedies to them. This provision does not apply to same sex spouses who are legally married. Same sex spouses who are covered under the Plan are Qualified Beneficiaries if they are covered under the Plan on the day before the Qualifying Event.

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).
- (6) A proceeding in bankruptcy under Title 11 of the U.S. Code with respect to an Employer from whose employment a covered Employee retired at any time.

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 (or in the case of the bankruptcy of the Employer, any substantial elimination of coverage under the Plan occurring within 12 months before or after the date the bankruptcy proceeding commences), 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.

What factors should be considered when determining to elect COBRA continuation coverage? When considering options for health coverage, Qualified Beneficiaries should consider:

- **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.
- **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.
- **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.
- **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.
- **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/>.
- **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.

· **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.

Are there other coverage options besides COBRA Continuation Coverage? Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for Qualified Beneficiaries through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. More information about these options is available at www.healthcare.gov.

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 her or his 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, termination of domestic partnership 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.

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**.

Be aware that 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 may terminate 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 covered under any other Plan that does not contain any exclusion or limitation with respect to any pre-existing condition, other than such an exclusion or limitation that does not apply to, or is satisfied by, the Qualified Beneficiary.
- (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 for cause the coverage of a Qualified Beneficiary on the same basis that the Plan terminates for cause 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 bankruptcy Qualifying Event, the maximum coverage period for a Qualified Beneficiary who is the covered retiree ends on the date of the retiree's death. The maximum coverage period for a Qualified Beneficiary who is the covered Spouse, surviving Spouse or Dependent child of the retiree ends on the earlier of the Qualified Beneficiary's death or 36 months after the death of the retiree.
- (4) 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.
- (5) 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 Administrator. For more information about rights under ERISA, including 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 ADMINISTRATOR

Hendrix College Health Benefit Plan is the benefit plan of Hendrix College, the Plan Administrator, also called the Plan Sponsor. It is to be administered by the Plan Administrator in accordance with the provisions of ERISA. An individual or committee may be appointed by Hendrix College to be Plan Administrator and serve at the convenience of the Employer. If the Plan Administrator or a committee member resigns, dies or is otherwise removed from the position, Hendrix College shall appoint a new Plan Administrator as soon as reasonably possible.

The Plan Administrator shall administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits, to decide disputes which may arise relative to a Plan Participant's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator will be final and binding on all interested parties.

The Plan Administrator may delegate to any employee authority to sign documents on its behalf, or to perform any act involving the exercise of discretion. The Plan Administrator may employ such legal, medical, accounting, actuarial, clerical, and other assistance as it may reasonably require in carrying out the provisions of this Plan, the charges therefore to be paid by the Plan.

The Employer shall furnish to the Plan Administrator such information as is required or desirable for the purpose of enabling it to carry out the provisions of this Plan. The Plan Administrator may rely upon representations made by the Employer and, if it is desirable to have any fact certified, it may rely upon a certification of such fact by any officer of the Employer.

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 and such interpretation thereof shall be final, conclusive and binding on all persons claiming benefits under the Plan.
- (3) To decide disputes which may arise relative to a Plan Participant's rights and such interpretation thereof shall be final, conclusive and binding on all persons claiming benefits under the Plan.
- (4) To determine the eligibility of an Employee to participate in the Plan, with its interpretation thereof and such decision shall be final, conclusive and binding.
- (5) 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.
- (7) To perform all necessary reporting as required by ERISA.
- (8) To establish and communicate procedures to determine whether a medical child support order is qualified under ERISA Sec. 609.

- (9) To establish and communicate procedures to determine whether a medical child support order is qualified under ERISA Sec. 609.
- (10) To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate.

PLAN ADMINISTRATOR COMPENSATION

The Plan Administrator serves without compensation; however, all expenses for plan administration, including compensation for hired services, will be paid by the Plan.

DISCRETIONARY AUTHORITY

The Plan is administered by the Plan Administrator in accordance with the provisions of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). The Plan Administrator shall have sole, full and final discretionary authority to interpret all Plan provisions, including the right to remedy possible ambiguities, inconsistencies and/or omissions in the Plan and related documents; to make determinations in regards to issues relating to eligibility for benefits and payment of claims and permissible expenses from plan assets; to develop and enforce rules it deems necessary or proper for the efficient administration of the Plan; to decide disputes that may arise relative to a Participant's rights; and to determine all questions of fact and law arising under the Plan.

Without limiting the generality of the foregoing, as it relates to Specialty Drugs, the Plan Administrator is specifically empowered on a case by case basis, in a non-discriminatory fashion and when it finds that doing so is in the best interest of the Participant, is consistent with discharging its duties with respect to the Plan for the exclusive purpose of providing benefits to Participants (and their beneficiaries), and is not unduly burdensome to the Plan, to deem a drug payable which would otherwise be excluded under the Plan's "Specialty Drugs" exclusion. Such payment is subject to all other Plan limitations herein.

CERTIFICATION OF FIREWALL AMENDMENT

The Plan (or Claims Administrator of the Plan) shall disclose PHI to the Employer only upon the receipt of a certification by the Employer that the Plan has been amended to incorporate the provisions of 45 CFR Section 164.504(f)(2)(ii), and that the Employer agrees to conditions of the disclosure.

CERTIFICATION OF FIREWALL AMENDMENT

The Plan (or Claims Administrator of the Plan) shall disclose PHI to the Employer only upon the receipt of a certification by the Employer that the Plan has been amended to incorporate the provisions of 45 CFR Section 164.504(f)(2)(ii), and that the Employer agrees to conditions of the disclosure.

RESTRICTIONS ON USE OR DISCLOSURE OF PHI

The Plan will not disclose Protected Health Information to the Employer, except in accordance with the provisions of the Plan or as allowed in the Privacy Regulations. Specifically, the Plan will:

- (1) Not disclose Protected Health Information to the Employer, except as permitted by the Plan or as required by law;
- (2) Not disclose Protected Health Information to the Employer, except as otherwise permitted by this Article or the Privacy Regulations, unless such disclosure is listed as a permitted disclosure in the Privacy Notice;

- (3) Not disclose Protected Health Information to the Employer for the Employer's use in employment- related actions or decisions; and
- (4) Not disclose Protected Health Information to the Employer for the Employer's use or disclosure in connection with any other benefit or employee benefit plan of the Employer without the Plan Participant's authorization.

PERMITTED USES AND DISCLOSURE OF SUMMARY HEALTH INFORMATION

The Plan (or Claims Administrator of the Plan) may disclose Summary Health Information to the Employer, provided the Employer requests the Summary Health Information for the purpose of (i) obtaining premium bids for insurance coverage under the Plan; or (ii) modifying amending, or terminating the Plan. "Summary Health Information" means: information that (i) summarizes the claims history, claims expenses or type of claims experienced by individuals for whom an Employer had provided health benefits under a health plan; and (ii) from which the information described at 42 CFR Section 164.514(b)(2)(i) has been deleted, except that the geographic information described in 42 CFR Section 164.514(b)(2)(i)(B) need only be aggregated to the level of a five-digit ZIP Code.

PERMITTED PLAN DISCLOSURES

The Plan may disclose Protected Health Information to the Employer for Plan administration purposes, but only after the Employer certifies to the Plan that the Plan amendments required by the Privacy Regulations to allow such disclosures were made. "Plan administration purposes" means administration functions performed by the Employer on behalf of the Plan, such as quality assurance, claims processing, auditing, and monitoring. Plan administration functions do not include functions performed by the Employer in connection with any other benefit or benefit plan of the Employer, and they do not include any employment-related function. Notwithstanding the provisions of this Plan to the contrary, in no event shall the Employer be permitted to use or disclose PHI in a manner that is inconsistent with 45 CFR Section 164.504(f) or 45 CFR Section 164.502(a)(5)(i).

EMPLOYER DISCLOSURES TO AN AGENT

The Employer will not disclose Protected Health Information received from the Plan to its agent, unless such agent has agreed, in writing, to the same restrictions and conditions that apply to the Employer with respect to such Protected Health Information.

AVAILABILITY OF PROTECTED HEALTH INFORMATION

The Employer will make Protected Health Information available only as follows:

- (1) Access to Protected Health Information. The Employer will make available Protected Health Information in accordance with Section 164.524 of the Privacy Regulations. If the Plan maintains an electronic health record of a Plan Participant's Protected Health Information, then the Plan Participant shall be entitled to request the receipt of such information in an electronic format.
- (2) Amendment of Protected Health Information. The Employer will make available Protected Health Information for amendment and incorporate any amendment to PHI in accordance with Section 164.526 of the Privacy Regulations.
- (3) Accountability of Protected Health Information. The Employer will make available Protected Health Information to provide an accounting of disclosures in accordance with Section 164.528 of the Privacy Regulations.
- (4) Disclosure to the Department of Health and Human Services. The Employer will make its internal practices, books, and records relating to its uses and disclosures of Protected Health Information received from the Plan available to the Secretary of Health and Human Services ("Secretary") or other officer or employee of the Department of Health and Human Services so delegated by the Secretary for purposes of determining compliance by the Plan with respect to the Privacy Regulations.

- (5) Destruction of Protected Health Information. To the extent feasible, the Employer will return or destroy all Protected Health Information received from the Plan that the Employer has retained in any form (and will retain no copies of such Protected Health Information) when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, the Employer will limit further uses and disclosures to those purposes that make the return or destruction of the information not feasible.

EMPLOYER REPORT TO THE PLAN

The Employer will report to the Plan any use or disclosure of Protected Health Information of which the Employer becomes aware that is inconsistent with the permitted uses and disclosures allowed in the Privacy Regulations.

ACCESS BY INDIVIDUALS RESPONSIBLE FOR PLAN ADMINISTRATION

The Employer will give access to the Protected Health Information, if any, from the Plan that is used by the Employer in the administration of the Plan only to those employees of (or other persons under the control of) the Employer who must have access to the Protected Health Information, as identified by the Plan pursuant to the Plan's policies and procedures with respect to disclosure and use of the Plan's Protected Health Information. The Plan will create and maintain a list of the persons or classes of persons who will be allowed access to Protected Health Information pursuant to this Section, which list is incorporated in the Plan by this reference. No other employees of the Employer or other persons under the control of the Employer shall have access to Protected Health Information that is held or used by the Employer.

Any person given access to Protected Health Information pursuant to these provisions must abide by the terms of the Plan with respect to disclosure and use of the Plan's Protected Health Information. Failure to follow the terms of the Plan with respect to use or disclosure of Protected Health Information will result in actions being taken against the person in accordance with the Plan's policies and procedures establishing sanctions for those violating the Plan's policies and procedures about Protected Health Information. The Employer will ensure that to the extent its involvement is needed, it will ensure that the adequate separation required by section 164.504(f)(2)(iii) of the Privacy Regulations is established.

RESTRICTIONS ON EMPLOYER'S USES AND DISCLOSURES

The Employer may not use or disclose Protected Health Information it has received from the Plan:

- (1) Other than as permitted by this Article, the Privacy Regulations and other applicable law.
- (2) For employment-related decisions or actions with respect to the individual identified in the Protected Health Information or members of his family.
- (3) In connection with any other benefit or employee benefit plan of the Employer without the Plan Participant's authorization.

SECURITY RULE

The Plan will comply with the security regulations under HIPAA and shall be construed consistent with that purpose. For purposes of this section, the term "Electronic Protected Health Information" shall have the meaning set forth in Section 160.103 of the Privacy Regulations under HIPAA. The Plan Sponsor agrees that if it creates, receives, maintains or transmits Electronic PHI (other than enrollment/disenrollment information and Summary Health Information and information disclosed pursuant to a signed authorization that complies with the requirements of 45 CFR 164.508, which are not subject to these restrictions) on behalf of the covered entity will:

- (1) Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the Electronic Protected Health information that it creates, receives, maintains or transmits on behalf of the Plan.

- (2) Ensure that adequate separation between the Plan and Plan Sponsor is supported by reasonable and appropriate security measures and that such firewall is supported by reasonable and appropriate measures.
- (3) Ensure that any agent, including a subcontractor, to whom it provides Electronic Protected Health information agrees to implement reasonable and appropriate security measures to protect the information; and
- (4) Report to the Plan any security incident of which the Plan Sponsor becomes aware.

The Plan agrees to disclose to the Employer Protected Health Information necessary for the Employer to comply with the requirements of the Medicare Modernization Act of 2003, including without limitation, 42 CFR § 423.884(b) and its filing requirements, and in turn the Employer agrees to comply with the Privacy Regulations and all other applicable law with regard to such Protected Health Information.

PLAN PARTICIPANT'S RIGHT TO REQUEST RESTRICTIONS ON CERTAIN DISCLOSURES

A Plan Participant may request a restriction on the use or disclosure of the Plan Participant's Protected Health Information for treatment, payment or health care operations., The Plan Administrator is generally not required to agree to the Plan Participant's request for restrictions, unless the disclosure (1) is to the Plan for payment or health care operations and (2) pertains to a health care item or service for which the health care Provider was paid in full out- of-pocket.

PLAN PARTICIPANT'S RIGHT TO BE NOTIFIED OF A BREACH

In the event that the Plan Administrator or any of its business associates (as defined in Section 160.103 of the Privacy Regulations) discovers a breach of unsecured Protected Health Information, the Plan Administrator shall notify each Plan Participant whose Unsecured Protected Health Information has been accessed, acquired or disclosed as a result of such breach. For this purpose, a "breach" shall mean the acquisition, access, use, or disclosure of Protected Health Information in a manner not permitted under the Privacy Regulations which compromises the security or privacy of the Protected Health Information. Unsecured Protected Health Information means Protected Health Information that is not rendered unusable, unreadable, or indecipherable to unauthorized individuals through the use of a technology or methodology specified by the Secretary of Health and Human Services.

FUNDING THE PLAN AND PAYMENT OF BENEFITS

The Employer assumes the sole responsibility for funding the Plan benefits out of general assets; however, Employees help cover some of the costs of the covered benefits through contributions, deductibles, and cost-sharing amounts as described in the Schedule of Benefits. All Claim payments and reimbursements are paid out of the general assets of the Employer and there is no separate fund that is used to pay benefits under the Plan. Nothing in this Plan is intended to require the establishment of a trust.

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).

FUNDING THE PLAN AND PAYMENT OF BENEFITS

The cost of the Plan is funded as follows:

For Employee and Dependent Coverage: Funding is derived from the funds of the Employer and contributions made by the covered Employees.

The level of any Employee contributions will be set by the Plan Administrator. These Employee contributions will be used in funding the cost of the Plan as soon as practicable after they have been received from the Employee or withheld from the Employee's pay through payroll deduction.

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

PLAN IS NOT AN EMPLOYMENT CONTRACT

The Plan is not to be construed as a contract for or of employment.

ASSIGNMENT OF BENEFITS

Assignment of benefits due under the Plan are prohibited as stated elsewhere in this document, although the Plan, acting through the Claims Administrator, may choose to accept or honor some assignments, in its sole discretion.

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.

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).

MISCELLANEOUS PROVISIONS

Fraud. The following actions by any Covered Person, or a Covered Person's knowledge of such actions being taken by another, constitute fraud and may result in immediate termination of all coverage under the Plan for the entire family unit of which the Covered Person is a member, and may result in the Employee's termination of employment:

- (1) Attempting to submit a Claim for benefits (which includes attempting to fill a prescription) for a person who is not a Covered Person in the Plan or is not eligible to be covered in the Plan;
- (2) Attempting to file a Claim for a Covered Person for services which were not rendered or Drugs or other items which were not provided;
- (3) Providing false or misleading information in connection with enrollment in the Plan; or
- (4) Providing any false or misleading information to the Plan.

In addition, the Plan may recover any payments made as a result of a Covered Person's actions as deemed appropriate by the Plan Administrator provided such recovery is consistent with the requirements set forth in Treasury Reg. §54.9815-2712T (as amended and finalized).

Gender. The use of masculine pronouns in this Plan shall apply to persons of both sexes unless the context clearly indicates otherwise.

Headings. The headings used in this Plan are used for convenience of reference only and are not to be regarded as part of this Plan or as indicating, or controlling the meaning or construction of any provision.

Limitation On Actions. No action at law or in equity shall be brought to recover under the Plan unless brought within one year after the Plan's claim review procedures have been exhausted as set forth in the Claims Procedure Section. Any action with respect to a named fiduciary's breach of any responsibility, duty or obligation hereunder must be brought within one year after the expenses due to Injury or Illness are incurred or are alleged to have been incurred.

No Waiver Or Estoppel. No term, condition or provision of the Plan shall be deemed to have been waived, and there shall be no estoppel against the enforcement of any provision of the Plan, except by written instrument of the party charged with such waiver or estoppel. No such written waiver shall be deemed a continuing waiver unless specifically stated therein, and each such waiver shall operate only as to the specific term or condition waived and shall not constitute a waiver of such term or condition for the future or as to any act other than the one specifically waived.

Right To Receive And Release Information. For the purpose of determining the applicability of and implementing the terms of these benefits, the Plan Administrator may, subject to applicable privacy regulations, without the consent of or notice to any person, release or obtain any information necessary to determine the acceptability of any applicant or Covered Person for benefits from the Plan. In so acting, the Plan Administrator shall be free from any liability that may arise with regard to such action. Any Covered Person claiming benefits under the Plan shall furnish to the Plan Administrator such information as may be necessary to implement this provision.

Notices. Any notice, application, instruction, designation or other form of communication required to be given or submitted by any Plan Participant shall be in such form as is prescribed from time to time by the Plan Administrator. Any notice, statement, report or other communication from the Employer or Plan Administrator to any Plan Participant, other Employee or beneficiary required or permitted by the Plan shall be deemed to have been duly delivered when given to such person or mailed by first class mail to such person at the Plan Participant's address last appearing on the records of the Plan Administrator or the Employer. Each person entitled to receive a payment under the Plan shall file in accordance herewith the Plan Participant's complete mailing address and each change therein. If the Plan Administrator shall be in doubt as to whether payments are being received by the person entitled thereto, the Plan Administrator may, by registered mail addressed to such person's address last known to the Plan Administrator,

notify such person that all future payments will be withheld until such person submits to the Plan Administrator the proper mailing address and such other information as the Plan Administrator may reasonably request. Any written notice required under the Plan which, as of the Effective Date, is in conflict with the law of any governmental body or agency which has jurisdiction over the Plan shall be interpreted to conform to the minimum requirements of such law.

Right Of Recovery. Whenever payments have been made by the Plan in a total amount, at any time, in excess of the maximum amount of benefits payable under the Plan, the Plan shall have the right to recover such payments, to the extent of such excess, from any one or more of the following as the Plan shall determine: any person to or with respect to whom such payments were made, or such person's legal representative, any insurance companies, or any other individuals or organizations which the Plan determines are responsible for payment of such amount.

Payments To Other Than Plan Participants. If the Plan Administrator shall find that any person to whom any Benefits are payable under this Plan is unable to care for their personal affairs, is a minor or has died, then any payment due such Plan Participant or his estate (unless a prior claim has been made by a duly appointed legal representative) may be paid to the Plan Participant's Spouse, Child, or other relative, or to an institution maintaining or having custody of such Plan Participant who is otherwise entitled to payment; or the Employer may, in its discretion, hold such payment until a legal representative is appointed. Any such payment shall be a complete discharge of the liabilities of this Plan.

Cancellation Of Benefits. If the Plan Administrator is unable to ascertain the whereabouts of any Plan Participant to whom Benefits are payable under this Plan, and if, after one year from the date such payment is due, a notice of such amount due is mailed to the last known address of such person as shown on the records of the Plan Administrator and within three (3) months after such mailing, such person has not filed with the Plan Administrator written claim therefore, the Plan Administrator may direct that such payment be canceled and forfeited and, upon such cancellation by this Plan, shall have no further liability therefore.

Worker's Compensation Not Affected. This Plan is not instead of, and does not affect, any requirement for coverage by workers' compensation insurance.

Nondiscrimination Testing. If the Plan Administrator determines that for any Plan Year that the Plan or any constituent employee health and welfare plan may fail to satisfy any nondiscrimination requirement or other limitation which is imposed by the Code on such plan, the Plan Administrator may (to the maximum extent permitted under the Code) designate two or more separate constituent plans of the same type as constituting a single plan, or, alternatively, may restructure any constituent benefit plan to this Plan into multiple constituent plans of the same type for nondiscrimination testing purposes (each of which shall constitute a separate plan for relevant Code purposes). In the event the Plan Administrator determines that it is necessary to disaggregate this Plan in order to pass nondiscrimination testing under Code §105(h), then this Plan shall be disaggregated according to Employee locations. Except with regard to the eligibility conditions applicable to the classifications set forth above, all terms and provisions of this Plan shall apply equally with respect to each disaggregated Plan. Each Component Benefit Plan shall be treated as a separate plan for purposes of determining whether such plans satisfy the nondiscrimination requirements set forth in the Code.

Alternatively, if the Plan Administrator determines, before or during any Plan Year, that the Plan may fail to satisfy any nondiscrimination requirement or other limitation which is imposed by the Code on such plan, the Plan Administrator may (to the maximum extent permitted under the Code) designate two or more separate plans of the same type as constituting a single plan for nondiscrimination testing.

Filing Of Information. Each eligible Employee, covered Dependent or other interested person shall file with the Plan Administrator such pertinent information concerning participation in the Plan as the Employer or Plan Administrator may specify, including proof or continued proof of dependency or eligibility, and in such manner and form as the Plan Administrator may specify or provide; and such person shall not have rights to be entitled to any Benefits or further Benefits hereunder unless such information is filed by the Plan Participant or on the Plan Participant's behalf.

Misstatements. In the event of any misstatement of any fact(s) affecting coverage under the Plan, the real facts shall be used to determine the proper coverage. Coverage means eligibility as well as the amount of any Benefit thereunder.

Reliance On Participant, Tables, Etc. The Plan Administrator may rely upon the direction, information, or election of a Plan Participant as being proper under the Plan and shall not be responsible for any act or failure to act because of a direction or lack of direction by a Plan Participant. The Plan Administrator will also be entitled, to the extent permitted by law, to rely conclusively on all tables, valuations, certificates, opinions and reports that are furnished by accountants, attorneys, or other experts employed or engaged by the Plan Administrator.

Governing Law. This Plan shall be construed and enforced according to the laws of the State of Arkansas, other than its laws respecting choice of law, but only to the extent not preempted by any federal law.

Severability. Should any part of this Plan subsequently be invalidated by a court of competent jurisdiction, the remainder of the Plan shall be given effect to the maximum extent possible.

Rights To Company's Or Employer's Assets. No Employee or beneficiary shall have any right to, or interest in any assets of the Company or Employer upon termination of employment or otherwise, except as provided from time to time under this Plan, and then only to the extent of the Benefits payable under the Plan to such Employee or beneficiary. All payments of Benefits as provided for in this Plan shall be made solely out of the general assets of the Employer and the Plan Administrator shall not be liable therefore in any manner.

Assignment. Except as required by state Medical law, no attempted assignments of Benefits will be recognized by the Plan. Benefits of this Plan may not be assigned, transferred or in any way made over to another party by a Plan Participant. Nothing contained in the Plan or Summary Plan Description shall be construed to make the Plan, or the Employer, liable to any third-party to whom a Plan Participant may be liable for medical care, treatment, or services.

Protection From Creditors. Except as applicable law may otherwise require, no amount payable at any time hereunder shall be subject in any manner to alienation by anticipation, sale, transfer, assignment, bankruptcy, pledge, attachment, charge or encumbrance of any kinds; and any attempt to alienate, sell, transfer, assign, pledge, attach, charge or otherwise encumber any such amount, whether presently or hereafter payable shall be void. The Plan shall not be liable for or subject to the debt or liabilities of any person entitled to any amount payable under the Plan, or part thereof, if by reason of bankruptcy or other happening at such time such amount would be enjoyed by the Plan Participant.

Effect Of Mistake. In the event of a mistake as to the eligibility or participation of an Employee, or the amount of Benefits paid or to be paid to a Plan Participant or other person, the Plan Administrator shall, to the extent it deems administratively possible and otherwise permissible under the Code or the regulations issued thereunder, cause to be withheld or accelerated, or otherwise make adjustment of, such amounts as it will in its judgment accord to such Participant or other person the benefits to which he or she is properly entitled under the Plan. Such action by the Plan Administrator may include withholding of any amounts due the Plan or the Employer from Compensation paid by the Employer.

Medical Child Support Orders. The Plan Administrator shall adhere to the terms of any judgment, decree, or court order (including a court's approval of a domestic relations settlement agreement) which

- (1) Relates to the provision of child support related to health benefits for a child of a Plan Participant of a group health plan;
- (2) Is made pursuant to a state domestic relations law; and
- (3) Which creates or recognizes the right of an alternate recipient to, or assigns to an alternate recipient the right to receive benefits under the group health plan under which a Plan Participant or other beneficiary is entitled to receive benefits.

The Plan Administrator shall promptly notify the Plan Participant and each alternate recipient named in the medical child support order of the Plan's procedures for determining the qualified status of the medical child support orders. Within a reasonable period after receipt of a medical child support order, the Plan Administrator shall determine whether such order is a qualified medical child support order and shall notify the Plan Participant and each alternate recipient of such determination. If the Plan Participant or any affected alternate payee objects to the determinations of the Plan Administrator, the disagreeing party shall be treated as a Claimant and the Claims Procedures of the Plan shall be followed. The Plan Administrator may bring an action for a declaratory judgment in a court of competent jurisdiction to determine the proper recipient of the benefits to be paid by the Plan.

Any such Qualified Medical Child Support Order (QMCSO) must clearly specify the name and last known mailing address of the Plan Participant, name and address of each alternate recipient covered by the order, a description of the

coverage to be provided by the Group Health Plan or the manner in which such coverage is to be determined, the period of coverage that must be provided, and each plan to which such order applies.

Any such QMCSO shall not require the Plan to provide any type or form of benefit, or any option, that it is not already offering except as necessary to meet the requirements of a state medical child support law described in Section 1908 of the Social Security Act as added by Section 13822 of the Omnibus Reconciliation Act of 1993 (OBRA '93).

Upon determination of a Qualified Medical Child Support Order, the Plan must recognize the QMCSO by providing benefits for the Plan Participant's child in accordance with such order and must permit the parent to enroll under the family coverage any such child who is otherwise eligible for coverage without regard to any enrollment season restrictions.

Plan Audit. The Plan Administrator may conduct an audit of the Plan to ensure that the information submitted by an Employee or health care Provider with respect to eligibility and/or claims submissions is accurate and in compliance with the terms of the Plan. The Plan Administrator may reduce or deny Benefits with respect to current or future Claims depending on the results of the audit. Additionally, the Plan Administrator reserves the right to terminate coverage for an Employee and his or her Dependents if it is discovered that the Employee has submitted fraudulent information to the Plan or if the Employee has made an intentional misrepresentation of material fact with respect to a particular Claim or eligibility for participation.

CERTAIN PLAN PARTICIPANTS RIGHTS UNDER ERISA

Plan Participants in this Plan are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA specifies that all Plan Participants shall be entitled to:

Examine, without charge, at the Plan Administrator's office, all Plan documents and copies of all documents governing the Plan, including a copy of the latest annual report (form 5500 series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator including copies of the latest annual report (Form 5500 series) and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.

Continue health care coverage for a Plan Participant, Spouse, or other dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event. Employees or dependents may have to pay for such coverage.

Review this summary plan description and the documents governing the Plan or the rules governing COBRA continuation coverage rights.

If a Plan Participant's claim for a benefit is denied or ignored, in whole or in part, the participant has a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps a Plan Participant can take to enforce the above rights. For instance, if a Plan Participant requests a copy of Plan documents or the latest annual report from the Plan and does not receive them within 30 days, he or she may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and to pay the Plan Participant up to \$110 a day until he or she receives the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If the Plan Participant has a claim for benefits which is denied or ignored, in whole or in part, the participant may file suit in state or federal court.

In addition, if a Plan Participant disagrees with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, he or she may file suit in federal court after exhausting the remedies available under the Plan's Claims Procedures.

In addition to creating rights for Plan Participants, ERISA imposes obligations upon the individuals who are responsible for the operation of the Plan. The individuals who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of the Plan Participants and their beneficiaries. No one, including the Employer or any other person, may fire a Plan Participant or otherwise discriminate against a Plan Participant in any way to prevent the Plan Participant from obtaining benefits under the Plan or from exercising his or her rights under ERISA.

If it should happen that the Plan fiduciaries misuse the Plan's money, or if a Plan Participant is discriminated against for asserting his or her rights, he or she may seek assistance from the U.S. Department of Labor, or may file suit in a federal court. The court will decide who should pay court costs and legal fees. If the Plan Participant is successful, the court may order the person sued to pay these costs and fees. If the Plan Participant loses, the court may order him or her to pay these costs and fees, for example, if it finds the claim or suit to be frivolous.

If the Plan Participant has any questions about the Plan, he or she should contact the Plan Administrator. If the Plan Participant has any questions about this statement or his or her rights under ERISA, or if assistance is needed in obtaining documents from the Plan Administrator, the Plan Participant should contact the nearest Office of the Employee Benefits Security Administration (EBSA), U.S. Department of Labor, listed in the telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210 (or visit the EBSA website at www.dol.gov/ebsa/ addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) Plan Participants may also obtain certain publications about his or her rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

GENERAL PLAN INFORMATION

TYPE OF ADMINISTRATION

The Plan is a self-funded group health Plan and the 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 Hendrix College Health Benefit Plan

PLAN NUMBER: 501

TAX ID NUMBER: 71-0236897

PLAN EFFECTIVE DATE: January 1, 2024

PLAN YEAR ENDS: December 31st

EMPLOYER INFORMATION

Hendrix College
1600 Washington Ave
Conway, Arkansas 72032
1-501-329-6811

PLAN ADMINISTRATOR

Hendrix College
1600 Washington Ave
Conway, Arkansas 72032
1-501-329-6811

NAMED FIDUCIARY

Hendrix College
1600 Washington Ave
Conway, Arkansas 72032

AGENT FOR SERVICE OF LEGAL PROCESS

Hendrix College
1600 Washington Ave
Conway, Arkansas 72032

CLAIMS ADMINISTRATOR

BlueAdvantage Administrators of Arkansas
P.O. Box 1460
Little Rock, Arkansas 72203
1-800-370-5852

BlueAdvantage Administrators of Arkansas is an independent licensee of the Blue Cross and Blue Shield Association. BlueAdvantage Administrators does not underwrite or assume any financial risk with respect to the claims liability of the Plan.

BY THIS AGREEMENT, Hendrix College Health Benefit Plan is hereby adopted as shown.

IN WITNESS WHEREOF, this instrument is executed for Hendrix College on or as of the day and year first below written.

By Benedicta Hill, EVP-CFO
Hendrix College

Date 6-12-24

Witness Crystal B. Williamson

Date 6/12/24

AMENDMENT ONE

to the

**HENDRIX COLLEGE
HEALTH BENEFIT PLAN**

BY THIS AGREEMENT, the Hendrix College Health Benefit Plan is hereby amended as follows, effective January 1, 2025.

In the SCHEDULE OF BENEFITS PPO PLAN Section, Medical Benefits Subsection, the language describing the “Deductible payable by Plan Participants per Calendar Year” is AMENDED to read as follows:

Deductibles Payable by Plan Participants, per Calendar Year

A deductible is an amount of money that is paid once a Calendar Year per Covered Person or Family Unit. On the first day of each Calendar Year, a new deductible amount is required.

In-Network, Calendar Year Deductible

Per Covered Person \$1,500

Per Family Unit \$3,000

Out-of-Network, Calendar Year Deductible

Per Covered Person \$3,000

Per Family Unit \$6,000

In the SCHEDULE OF BENEFITS PPO PLAN Section, Medical Benefits Subsection, the language describing the “Out-of-Pocket Limits Payable by Plan Participants, Per Calendar Year” is AMENDED to read as follows:

Out-of-Pocket Limits Payable by Plan Participants, Per Calendar Year

Unless stated otherwise in this document, the Plan will pay 80% of In-Network Covered Charges and 60% of Out-of-Network Covered Charges until the annual out-of-pocket limit is satisfied, at which time the Plan will pay 100% of the remainder of Covered Charges for the rest of the Calendar Year.

In-Network, Calendar Year Out-of-Pocket Limit

Per Covered Person \$6,500

Per Family Unit \$13,000

Out-of-Network, Calendar Year Out-of-Pocket Limit

Per Covered Person \$13,000

Per Family Unit \$26,000

In the SCHEDULE OF BENEFITS HDHP PLAN Section, Medical Benefits Subsection, the language describing the “Deductible payable by Plan Participants per Calendar Year” is AMENDED to read as follows:

Deductibles Payable by Plan Participants, per Calendar Year

A deductible is an amount of money that is paid once a Calendar Year per Covered Person or Family Unit. On the first day of each Calendar Year, a new deductible amount is required.

Individual Plan, Calendar Year Deductible

In-Network services	\$2,500
Out-of-Network services	\$4,000

Family Plan, Calendar Year Deductible

In-Network services	\$5,000 per family
Out-of-Network services	\$8,000 per family

In the SCHEDULE OF BENEFITS HDHP PLAN Section, Medical Benefits Subsection, the language describing the “Out-of-Pocket Limits Payable by Plan Participants, Per Calendar Year” is AMENDED to read as follows:

Out-of-Pocket Limits Payable by Plan Participants, Per Calendar Year

Unless stated otherwise in this document, the Plan will pay 80% of In-Network Covered Charges and 60% of Out-of-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.

Individual Plan, Calendar Year Out-of-Pocket Limit

In-Network services	\$7,400
Out-of-Network services	\$10,000

Family Plan, Calendar Year Out-of-Pocket Limit

In-Network services	\$11,800 per family, with an \$7,400 embedded individual out-of-pocket amount
Out-of-Network services	\$30,000 per family, with a \$10,000 embedded individual out-of-pocket amount

In the PPO Plan-SCHEDULE OF BENEFITS Section, the following Subsection is ADDED immediately after OTHER BENEFIT LIMITS AND MAXIMUMS Subsection:

PRESCRIPTION DRUG BENEFITS

The prescription drug card program is administered by the pharmacy benefits manager.

Each Prescription is covered only after the Covered Person pays the applicable Copay or coinsurance to the participating Pharmacy or Mail Order Pharmacy. Deductible is waived. Please contact the customer service number on the back of the Covered Person’s identification card for further information.

Retail Pharmacy Copays, up to a 34-day supply

Generic drugs	\$10 Copay
Preferred brand name drugs.....	\$30 Copay
Non-Preferred brand name drugs	\$50 Copay

Mail Order Pharmacy Copays, up to a 100-day supply

Generic drugs	\$20 Copay
Preferred brand name drugs.....	\$60 Copay
Non-Preferred brand name drugs	\$100 Copay

Specialty Pharmacy
Specialty Medicationsnot covered

Special Limitation – See “Specialty Drugs” entry under “Exclusions” for more information.

In the HDHP Plan-SCHEDULE OF BENEFITS Section, the following Subsection is ADDED immediately after OTHER BENEFIT LIMITS AND MAXIMUMS Subsection:

PRESCRIPTION DRUG BENEFITS

The prescription drug card program is administered by the pharmacy benefits manager.

Each Prescription is covered only after the Covered Person pays the applicable Copay or coinsurance to the participating Pharmacy or Mail Order Pharmacy, after deductible. Please contact the customer service number on the back of the Covered Person’s identification card for further information.

Retail Pharmacy Copays, up to a 34-day supply

Generic drugs \$10 Copay, after deductible
Preferred brand name drugs..... \$30 Copay, after deductible
Non-Preferred brand name drugs \$50 Copay, after deductible

Mail Order Pharmacy Copays, up to a 100-day supply

Generic drugs \$20 Copay, after deductible
Preferred brand name drugs..... \$60 Copay, after deductible
Non-Preferred brand name drugs \$100 Copay, after deductible

Specialty Pharmacy

Specialty Medications not covered

Special Limitation – See “Specialty Drugs” entry under “Exclusions” for more information.

In the DEFINED TERMS Section, the following definitions are ADDED alphabetically:

Formulary means a specified list of Prescription Medications covered by the Plan. The Plan has elected to adopt the Formulary established by the Claims Administrator based upon recommendations from the pharmacy benefit manager’s Pharmacy and Therapeutics Committee, a national external advisory body of experts composed of Physicians and pharmacists who have broad clinical backgrounds and/or academic expertise regarding prescription drugs. Prescription Medications on the Formulary are classified into various tiers. Prescription Medications in the first tier are Generic Medications. Prescription Medications in the subsequent tiers are Brand Name Medications. The list of Prescription Medications that make up the Formulary and the tier classification of a Prescription Medication on the Formulary are subject to change by the Plan and the Pharmacy and Therapeutics Committee. In recommending whether to place a Prescription Medication on the Formulary or to place a Prescription Medication in a tier classification in the Formulary, the Pharmacy and Therapeutics Committee compares a Prescription Medication's safety, effectiveness, cost efficiency and uniqueness with other Prescription Medications in the same category. **Prescription Medications including new Prescription Medications approved by the FDA are not covered under this Plan unless or until the medication is placed on the Formulary.**

Maintenance drugs are prescriptions commonly used to treat conditions that are considered chronic or long-term. These conditions usually require regular, daily use of medicines. Examples of maintenance drugs are those used to treat high blood pressure, heart disease, asthma and diabetes.

Preventive Medications are those Prescription Medications prescribed to a Covered Person to prevent the occurrence of a disease or condition for those individuals with risk factors, or to prevent the recurrence of a disease or condition for those who have recovered, and do not include Prescription Medications used to treat an existing Illness, Injury or condition.

Specialty Medications means a Prescription Medication that requires special handling, administration or monitoring. Specialty Medications are used to treat complex, chronic and often life-threatening conditions.

Step Therapy is the practice of beginning drug therapy for a medical condition with the most cost-effective and safest drug therapy and progressing to other more costly or risky therapy, only if necessary.

Immediately after the PLAN EXCLUSIONS Section, a new section titled “Prescription Drug Benefits” is ADDED:

PRESCRIPTION DRUG BENEFITS

MANAGED PHARMACY PROGRAM

The Plan accesses services with the pharmacy benefits manager to provide Plan Participants with Prescription Drug coverage. To use this benefit, Plan Participants should present their identification card to a participating Pharmacy. Participants can obtain Prescription Medications subject to the terms, conditions and limitations outlined in this Plan Document.

Copayment. Each Prescription Medication is covered only after the Covered Person pays the applicable copayment to the participating Pharmacy. Individuals will be charged one copayment for each 34-day supply of a Prescription Drug.

Cost-Sharing. Please refer to the Schedule of Benefits for information regarding deductible, copay, and coinsurance applicable to prescription drug benefits.

Generic Incentive. If a Brand Name drug is filled when a Generic equivalent is available and the Brand Name drug is not indicated as Medically Necessary, the Covered Person pays the difference in cost of the Brand Name drug plus the higher Brand copay.

Specialty Medications. Coverage of Specialty Medications is limited to a 30-day supply per fill. Specialty Medications must be purchased through CVS Caremark Specialty Pharmacy.
This may not apply to limited distribution Specialty Medications.

COVERED PRESCRIPTION DRUGS

- (1) All drugs prescribed by a Physician that require a prescription either by Federal or State law (other than drugs not covered under this Plan).
- (2) Insulin (and syringes) and diabetic supplies when prescribed by a Physician.

- (3) Injectable drugs, subject to Prior Approval,
- (4) Coverage of any Prescription Medication is subject to the Formulary. Note: the Formulary is subject to change throughout the year as new medications, dosages or strengths are added to the market.

BENEFIT LIMITS

- (1) **Contraceptives** coverage is limited to a list of product specific rings, patches, diaphragms and prescribed generic oral contraceptives, at no cost. At all times, this Plan will comply with the Affordable Care Act. A complete listing of Affordable Care Act women preventative services can be accessed at www.HealthCare.gov/center/regulations/prevention.html.
- (2) **Smoking cessation products** available over the counter and medications prescribed for the treatment of nicotine addiction are subject to the following criteria.
 - (i) Coverage is limited to a 168-day supply per Calendar Year of each of the following products: generic nicotine replacement products (nicotine patch, gum and lozenges), brand Nicotrol (inhaler system), brand Nicotrol NS (nasal spray), brand Chantix and generic Zyban.
 - (ii) Prescription Medications and over-the-counter products require a prescription.
 - (iii) Brand Name drugs are only covered until Generic versions of the same become available.
- (3) **Immunizations** from a retail Pharmacy are limited to list of specific immunizations identified in the Formulary, available at zero-cost to the member.
- (4) **Preventive Medications.** Coverage is provided for Preventive Medications when prescribed by a Physician. Preventive Medications are not subject to any copay, deductible or coinsurance requirements.
- (5) **Quantity-Versus-Time Edits.** Some medications have quantity limitations that are more restrictive than the Plan's standard 34-day supply. These are medications that are appropriate for dispensing through an outpatient pharmacy, but because of their high cost and potential for misuse, should be monitored closely.

Often, Physicians will write open-ended or "as needed" prescriptions for non-addictive pain treatments (such as the migraine-relief medications on this list). This allows the member to decide how much of the prescription to have filled within their 34-day supply benefit period.

By regulating the quantity that can be obtained each time the prescription is filled and within each 34-day supply benefit period, the Plan can monitor those cases where the member is getting a quantity that is greater than the manufacturer recommends. This is beneficial information for the prescribing Physician and protects the Plan's financial risk.

- (6) **Prior Approval.** Medications that are expensive, have a high risk for misuse, or whose effectiveness is limited to very specific indications are placed on the Prior Approval list. Also on the list are medications which cause adverse or harmful reactions, or have been ineffective in the treatment of a particular disease or condition.

To obtain coverage for a medication that requires Prior Approval, the prescribing Physician should provide a letter of Medical Necessity or contact the customer service department at the number printed on the Plan Participant's health insurance identification card. Once a determination is made, a letter will be sent to the Plan Participant announcing the decision.

- (7) **Step Therapy.** Some Prescription Medications are subject to Step Therapy restrictions. Such Step Therapy must be completed before coverage for the selected Prescription Medication is provided. For example, a Step Therapy may require that medication "X" be used for a period of time before medication "Y" or that a weaker strength of a medication be used for a period before a stronger strength of the same medication. The Step Therapy requirements for a particular Prescription Medication are available from the Plan upon request.
- (8) **Specialty Medications.** Select Prescription Medications are designated 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. Coverage for Specialty Medications is subject to Prior Approval and may only be purchased through a specialty pharmacy vendor under contract with the pharmacy benefits manager. The benefit for a Specialty Medication is payable as specified in the Schedule of Benefits. A list of Specialty Medications is available upon request or, on the web at www.blueadvantagearkansas.com

Some Specialty Medications may qualify for third party copayment assistance programs which could lower the Covered Persons out-of-pocket costs for those products. For any such Specialty Medication where third party copayment assistance is used, the Covered Person shall not receive credit toward their out-of-pocket limit or deductible for any copayment amounts or coinsurance amounts that are applied from a manufacturer coupon or rebate.

EXPENSES NOT COVERED

The following medications and supplies are not covered:

- (1) **Abuse of Medications.** Medications, drugs or substances used in an abusive, destructive or injurious manner are not covered.
- (2) **Administration.** Any charge for the administration of a covered Prescription Drug. This exclusion does not apply to covered immunizations received at a participating Pharmacy.
- (3) **Consumed on premises.** Any drug or medicine that is consumed or administered at the place where it is dispensed.
- (4) **Cosmetic purposes.** Charges for drugs used for cosmetic purposes, such as anabolic steroids or medications for hair growth or removal.
- (5) **Delivery.** Charges for delivering medications.
- (6) **Devices.** Devices of any type, which are not included on the Formulary, even though such devices may require a prescription. These include (but are not limited to) therapeutic devices, artificial appliances, braces, support garments, or any similar device.

- (7) **Excess refills.** A prescription refill in excess of the quantity specified in the Prescription order, any Prescription Medication refill dispensed after one year from the date of the prescription order, or any refill of a Prescription Medication not authorized by a Physician is not covered.
- (8) **Excessive Use.** Excessive use of medications is not covered. For purposes of this exclusion, the Plan shall be entitled to deny coverage of medications on grounds of excessive use when it is determined:
- (a) That a Covered Person has exceeded the dosage level, frequency or duration of medications recommended as safe or reasonable by medical literature, standard reference compendia or by the pharmacy benefits manager; or
 - (b) That a Covered Person has obtained or attempted to obtain the same medication from more than one Physician for the same or overlapping periods of time; or
 - (c) That the pattern of Prescription Medication purchases, changes of Physicians or pharmacy or other information indicates that a Covered Person has obtained or sought to obtain excessive quantities of medications. The Plan may communicate with any necessary Physician, health care provider or pharmacy for the purpose of reviewing and discussing the Covered Person's prescription history, use or activity to evaluate for excessive use.
- (9) **Experimental.** Experimental drugs and medicines, even though a charge is made to the Covered Person.
- (10) **FDA.** Any drug not approved by the Food and Drug Administration.
- (11) **Fraud or Material Misrepresentation.** Medications obtained by unauthorized or fraudulent use of the identification card or by material misrepresentation are not covered.
- (12) **Growth hormones.** Charges related to growth hormones unless Prior Approval is received.
- (13) **Illegal Use.** Medications for use or intended use of which would be illegal or abusive.
- (14) **Injectable drugs.** Injectable drugs, unless Prior Approval has been received from the Plan.
- (15) **Injectable supplies.** A charge for hypodermic syringes and/or needles unless they are bundled with covered medications such as insulin.
- (16) **Inpatient medication.** A drug or medicine that is to be taken by the Covered Person, in whole or in part, while Hospital confined. This includes being confined in any institution that has a facility for the dispensing of drugs and medicines on its premises.
- (17) **Intravenous drugs.** Fluids, solutions, nutrients, or medications (including all additives and chemotherapy) used or intended to be used by intravenous or gastrointestinal (enteral) infusion.
- (18) **Investigational.** A drug or medicine labeled: "Caution - limited by federal law to Investigational use".

- (19) **Lost medications.** Replacement of previously filled Prescription Medication because the initial Prescription Medication was lost, stolen, spilled, contaminated, etc. are not covered.
- (20) **Medical exclusions.** A charge excluded under Medical Plan Exclusions.
- (21) **Medical supplies.** Charges for medical supplies such as colostomy supplies, bandages, and similar items.
- (22) **No charge.** A charge for Prescription Medications which may be properly received without charge under local, state or federal programs.
- (23) **Non-legend drugs.** A charge for FDA-approved drugs that are prescribed for non-FDA-approved uses.
- (24) **No prescription.** A drug or medicine that can legally be bought without a written prescription. This does not apply to injectable insulin.
- (25) **Non-participating pharmacy.** Medications purchased from a non-participating Pharmacy are not covered.
- (26) **Not covered.** Medications used or intended to be used in the treatment of a condition, sickness, disease, injury, or bodily malfunction, which is not covered by the Plan, or for which benefits have been exhausted.
- (27) **Not Medically Necessary.** Medications which are not Medically Necessary.
- (28) **Off-Label Use.** Prescription Medications that are not approved by the FDA for a particular use or purpose or when used for a purpose other than the purpose for which FDA approval is given are not covered. From time to time a particular clinical use of a Prescription Medications may be determined to be safe and efficacious by the pharmacy benefits manager, even without labeling of such indication or use by the FDA. This occurs because of clear and convincing evidence from the medical literature, and often in consultation with practicing Physicians of the appropriate specialty in the community. Such "off-label" use will be covered, though Prior Approval is often (but not always) required. A complete list of medications and their approved off-label indications is not available.
- (29) **Over the Counter Medications.** Medications (except insulin) which do not by law require a prescription from a Physician are not covered.
- (30) **Vitamins.** Vitamins or food/nutrient supplements except those which are Prescription Medications.
- (31) **Weight Loss.** A charge for appetite suppressants or medications prescribed and dispensed for the treatment of obesity, or for use in any program of weight reduction, weight loss, or dietary control.

In the MEDICAL BENEFITS Section, Other Medical Services and Supplies Subsection, the language describing coverage of Prescription Medications is AMENDED to read as follows:

Prescription Medications (*as defined*) are covered under the Prescription Drug program administered by the pharmacy benefits manager. Coverage under Medical Benefits is available for injectable medications while confined as an inpatient, or when provided and administered by a Physician in a clinic setting. Prior Approval is required for certain Prescription Medications as identified on the Formulary when administered by a Provider. For further assistance regarding Prior Approval requirements please call the customer service phone number located on the back of the Plan Participant's health plan identification card.

AMENDMENT TWO

to the

HENDRIX COLLEGE HEALTH BENEFIT PLAN

BY THIS AGREEMENT, the Hendrix College Health Benefit Plan is hereby amended as follows, effective June 1, 2025.

In the ELIGIBILITY Section, the Eligible Classes of Employees Subsection is AMENDED to read as follows:

Eligible Classes. All Active Employees and Retired Employees, who qualify under one of the classes below.

New Hires:

- **Regular Full-Time Employees:** Employees are considered Full-Time Employees if the Employee, on his or her date of hire, is reasonably expected to work an average of at least 30 hours per week as determined by the Employer and is on the regular payroll of the Employer for that work. Coverage for Full-Time Employees becomes effective on the date of hire, subject to completion of enrollment requirements. A new hire Employee must enroll within 30 days of date of hire otherwise he or she is considered a Late Enrollee.

Retired Employees

- **Employees who retired prior to July 1, 2024 and meet the following qualifications:**
 - (1) They were an Active Employee at the time of retirement who had been continuously covered by this Plan since August 2, 2012; and
 - (2) They had reached age:
 - (a) 55 with at least 20 full-time continuous years of service at the time of retirement; or
 - (b) 60 with at least 18 full-time continuous years of service at the time of retirement; or
 - (c) 62 with at least 15 full-time continuous years of service at the time of retirement; and
 - (3) He or she is not eligible for Medicare; and
 - (4) They enrolled and elected to pay to the Plan the contribution that is required from a Retired Employee.

- **Employees who retired on or after July 1, 2024 and meet the following qualifications:**
 - (1) They are an Active Employee at the time of retirement who has been continuously covered by this Plan since August 2, 2012;
 - (2) They have reached age 55 with at least 15 full-time continuous years of service at the time of retirement;
 - (3) He or she is not eligible for Medicare; and
 - (4) They enroll and elect to pay to the Plan the contribution that is required from a Retired Employee.
- **Employees who retire on or after June 1, 2025 and meet the following qualifications:**
 - (1) The Employee has received a written contract with the Employer to allow them to remain enrolled in the Plan at the time of retirement;
 - (2) They are an Active Employee at the time of retirement who has been continuously covered by this Plan since August 2, 2012;
 - (3) They have reached age 55 with at least 15 full-time continuous years of service at the time of retirement;
 - (4) He or she is not eligible for Medicare; and
 - (5) They enroll and elect to contribute to the Plan the contribution that is required from a Retired Employee.

In the ELIGIBILITY Subsection, under Eligible Classes of Dependents, the language under “(2) A Covered Employee’s Child(ren)” is AMENDED to read as follows:

- (2) A covered Employee or Retiree's Child(ren).

An Employee or Retiree's "Child" includes his natural child, stepchild, adopted child, or a child placed with the Employee for adoption. An Employee or Retiree's child will also include children, adopted children and children placed for adoption with the Employee or Retiree's Domestic Partner. An Employee or Retiree's Child will be an eligible Dependent until reaching the limiting age of 26, without regard to student status, marital status, financial dependency or residency status with the Employee or Retiree or any other person. When the child reaches the applicable limiting age, coverage will end on the last day of the child's birthday month.

The phrase "placed for adoption" refers to a child whom a person intends to adopt, whether or not the adoption has become final, who has not attained the age of 18 as of the date of such placement for adoption. The term "placed" means the assumption and retention by such person of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child must be available for adoption and the legal process must have commenced.

For a Retired Employee’s Child to be eligible for coverage, he or she must have been enrolled as a Dependent in the Plan at the time of the Employee’s retirement.

AMENDMENT THREE

To the

**HENDRIX COLLEGE
HEALTH BENEFIT PLAN**

BY THIS AGREEMENT, the Hendrix College Health Benefit Plan is hereby amended as follows, effective as of October 1, 2025.

In the SCHEDULE OF BENEFITS PPO PLAN Section, Medical Benefits Subsection, the following language describing “Deductible Three Month Carryover” is DELETED in its entirety:

Deductible Three Month Carryover. Covered Charges incurred in, and applied toward the deductible in the last three month of the Calendar Year will be applied toward the deductible in the next Calendar Year.

AMENDMENT FOUR

To the

HENDRIX COLLEGE HEALTH BENEFIT PLAN

BY THIS AGREEMENT, the Hendrix College Health Benefit Plan is hereby amended as follows, effective as of January 1, 2024.

In the HOW TO SUBMIT A CLAIM Section, the following language is AMENDED to read as follows:

HOW TO SUBMIT A CLAIM

Benefits under this Plan shall be paid only if the Claims Administrator, acting on the Plan's behalf, decides in its discretion that a Covered Person is entitled to them.

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.

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 Plan 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.

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 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 Plan Document for further information about services which require Prior Approval.

In the case of a Pre-Service Claim, the following timetable applies:

Notification to claimant of Adverse Benefit Determination	15 days
Extension due to matters beyond the control of the Plan	15 days
Insufficient information on the Claim:	
Notification of	15 days
Response by claimant.....	45 days
Notification, orally or in writing, of failure to follow the Plan's procedures for filing a Claim.....	5 days
Notification of Adverse Benefit Determination on Appeal.....	30 days
Reduction or termination before the end of the treatment	15 days
Request to extend course of treatment	15 days

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 BlueAdvantage Administrators of Arkansas. Participating Providers agree to accept the allowances of BlueAdvantage Administrators of Arkansas 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 web at www.blueadvantagearkansas.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 web at www.blueadvantagearkansas.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 non-participating 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:

 - The billed covered charges for the covered services; or
 - 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 health care 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 non-participating 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 non-participating 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 Medically Necessary Covered Services available under the medical benefits of the Plan. 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 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. 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:

- Obtain a Claim form from the Plan Administrator or at www.blueadvantagearkansas.com.
- Complete the Employee portion of the form. ALL QUESTIONS MUST BE ANSWERED.
- 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:

BlueAdvantage Administrators of Arkansas
P.O. Box 1460
Little Rock, Arkansas
72203

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.

EXPLANATION OF BENEFITS (EOB)

A Plan Participant will be notified within 30 days of receipt of the properly submitted claim as to the acceptance or denial of a claim and if not notified within 30 days, the claim shall be deemed denied. Upon making a determination of a claim, the Claims Administrator will deliver to the Covered Person an Explanation of Benefit Determination (EOB) 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 45 days from the end of the initial 90-day period.

INFORMAL CLAIM REVIEW

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. An informal claim review is not an appeal or a substitute for an appeal. Pursuit of an informal review will not relieve the claimant from the responsibility for exhausting any appeal rights under the Plan within the appeal deadline. 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.

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 the claims 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 an appeal.

Requests for review may be submitted in writing, email, or by telephone to the Claims Administrator. The request should provide the patient's name, Plan identification number and the specific claim(s) to be reviewed. Additional relevant documentation may also be provided to the Claims Administrator to assist in the review. A request for an informal claim review must be submitted within 180 days after notice is received of the denial or reduction in benefits. This 180-day period runs concurrently with the Plan's 180-day deadline to submit an appeal.

A determination shall be rendered with a reasonable period of time, but notification of the determination will be provided not later than 60 days after received. A review of the denial will be made by the Claims Administrator and the Claims Administrator will provide the Plan Participant with a written response within 60 days of the date the Claims Administrator receives the Plan Participant's written request for review and 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.

If the review is in regard to a Pre-Service Claim, response will be provided within 30 days of received.

If the review is in regard to an Urgent Care Pre-Service Claim, response will be provided within 24 hours of receipt.

APPEALS PROCESS

The Plan Participant will receive an EOB 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 file an appeal. This Plan appeal process allows the Plan Participants to:

- (1) Request from the Plan Administrator 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.

DEADLINE FOR SUBMISSION OF APPEALS

The request for review must be submitted to the Plan 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 Plan 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 Plan Administrator is unable to complete the review process within 60 days, the Plan 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 Plan Administrator received the Plan Participant's written request for review.

The Plan 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.

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 Plan Administrator shall provide written or electronic notification of the Adverse Benefit Determination, including in such notification the content required under applicable U.S. Department of Labor claims regulations.

EXTERNAL REVIEW PROCESS

If an appeal of a claim benefit determination is denied, the claimant may be entitled to request and receive an external review by an independent review organization. In order to be eligible for external review, the following conditions must apply:

- (1) The claimant must submit a request for external review in writing to the Plan Administrator within 125 days after receiving notice of the denial of the appeal. External review requests submitted more than 125 days after a claimant receives notice of denial of an appeal will be denied for lack of timely submission.
- (2) The claimant must have been eligible for coverage under the Plan at the time the services in question were or will be provided; and
- (3) The denial or claim must not be based on the claimant's failure to meet the Plan's eligibility requirements;
- (4) The claimant must have completed the Plan appeals process outlined in this document;
- (5) The claimant must have provided all information required by the Plan Administrator in order to process an external review request; and
- (6) The denial of the claim must be based on a medical judgement, which may include but is not limited to questions of Medical Necessity, medical appropriateness or safety of treatment or care, appropriateness of health care setting, or medical effectiveness of a treatment, service or covered benefits.

Upon submission to the Plan Administrator of the claimant's written request for external review, the Plan Administrator will review the request to determine whether the conditions outlined above are met.

Within one business day after completion of this preliminary review, the Plan Administrator will provide written notification to the claimant of whether the external review request satisfies the conditions for external review, including a description of any additional information or material necessary to complete the external review request.

If the Plan Administrator notifies the claimant or their representative that the request is not complete, the claimant will have 48 hours or until the last day of the 125-day filing period, whichever is later, to submit the additional information.

If the request satisfies the conditions for external review, the Plan Administrator will refer the request to a qualified independent review organization (IRO). The IRO will then be responsible for notifying the claimant, in writing, that the request for external review has been accepted. The IRO's notice should include a statement that the claimant may submit in writing, within 10 business days, any additional information the claimant wishes the IRO to consider when conducting the review. The IRO will share this information with the Plan and Claims Administrator. The Claims Administrator, acting as the delegate of the Plan Administrator, may consider this information and decide to reverse its denial of the Claim. If the denial is reversed, the external review process will end.

If the Claims Administrator does not reverse the denial, the IRO will make its decision on the basis of its review of all of the information in the record, as well as additional information where appropriate and available, such as:

- (1) The claimant's medical records as available and relevant;
- (2) The attending health care professional's recommendation;
- (3) Reports from appropriate health care professionals and other documents submitted by the claimant, the Plan, the Claims Administrator, or the treating Provider;
- (4) The terms of the Plan;
- (5) Appropriate practice guidelines;
- (6) Any applicable clinical review criteria developed and used by the plan; and
- (7) The opinion of the IRO's clinical reviewer.

The IRO must provide written notice to the Plan and the claimant of its final decision within 45 days after the IRO receives the request for the External Review. The IRO's decision notice should contain:

- (1) A general description of the reason for the External Review, including information sufficient to identify the claim;
- (2) The date the IRO received the assignment to conduct the review and the date of the IRO's decision;
- (3) References to the evidence or documentation the IRO considered in reaching its decision;
- (4) A discussion of the principal reason(s) for the IRO's decision;
- (5) A statement that the determination is binding and that judicial review may be available to the claimant; and
- (6) Contact information for any applicable office of health insurance consumer assistance or ombudsman established under federal law.

Expedited External Review

Generally, as noted above, a claimant must first complete the Plan's appeals process before requesting and receiving an external review of a claim denial. However, in some cases the Plan provides for an expedited external review of a claim denial if:

- (1) The claimant submits a written request to the Plan Administrator specifically requesting expedited external review; and
- (2) The time to complete the Plan's appeal process would seriously jeopardize the claimant's life or health or ability to regain maximum function; or
- (3) The time to complete the Plan's standard external review process would seriously jeopardize the claimant's life or health or ability to regain maximum function, or if the claim denial in dispute concerns a Hospital admission, availability of care, continued stay, or health care item or service for which the claimant received emergency services, but has not been discharged from a facility.

Immediately upon receipt of a request for external review, the Plan Administrator will undertake to determine and notify the claimant whether the request satisfies the requirements for expedited review, including the conditions for external review listed above. If the request qualifies for expedited external review, it will be assigned to an IRO. The IRO must make its determination and provide a notice of the decision as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited External Review. If the original notice of its decision is not in writing, the IRO must provide written confirmation of the decision within 48 hours to both the claimant and the Plan Administrator.

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 a "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. A "Designation of Authorized Appeal Representative" form is available from the Claims 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. A "Designation of Authorized Appeal Representative" form is available from the Claims Administrator;
- (3) A person holding the Covered Person's durable power of attorney;
- (4) If the Covered Person is incapacitated due to illness or 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.

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.