Health Advantage

An Independent Licensee of the Blue Cross and Blue Shield Association

BLUE CHOICE
OPEN ACCESS

POINT OF SERVICE
EVIDENCE OF COVERAGE

Bronze

(Fulfillment Deductible)

IMPORTANT NOTICE. Except in certain circumstances (see Section 5.0), additional costs, **including balance billing,** may be incurred for covered benefits received from a non-preferred provider. (See your schedule of benefits.) **Do not assume that a preferred provider's agreement includes all covered benefits or that all services provided a PPO Hospital are provided by preferred providers.**

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

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ATTACH SCHEDULE OF BENEFITS

NON-DISCRIMINATION NOTICE

NOTICE: Our Company complies with applicable federal and state civil rights laws and does not discriminate, exclude, or treat people differently on the basis of race, color, national origin, age, disability, or sex.

We provide free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters, and written information in various formats (large print, audio, accessible electronic formats, other formats), and language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. **If you need these services, contact our Civil Rights Coordinator.**

If you believe that we have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Civil Rights Coordinator
601 Gaines Street,
Little Rock, AR 72201
Phone: 1-844-662-2276; TDD: 1-844-662-2275
Email: civilrightscoordinator@arkbluecross.com

You can file a grievance in person, by mail, or by email. If you need help filing a grievance our Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW.,
Room 509F, HHH Building,
Washington, DC 20201
Phone: 1-800-368-1019; TDD: 1-800-537-7697

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

LANGUAGE ASSISTANCE NOTICE

ATTENTION: Language assistance services, free of charge, are available to you. Call 1-800-238-8379.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-238-8379.

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-238-8379.

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-238-8379

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-238-8379 번으로 전화해 주십시오.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-238-8379.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-238-8379.

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-238-8379

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-238-8379.

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-238-8379.

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-238-8379.

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-238-8379.

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-238-8379.

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-238-8379 まで、お電話にてご連絡ください。

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-238-8379.

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-800-238-8379 تماس بگیرید.

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-800-238-8379.

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-800-238-8379 पर कॉल करें।

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-800-238-8379.

خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں 1-800-238-8379

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-800-238-8379.

LALE: Ñe kwōj kōnono Kajin Ṃajōḷ, kwomaroñ bōk jerbal in jipañ ilo kajin ṇe aṃ ejjeḷọk wōṇāān. Kaalọk 1-800-238-8379

PATIENT PROTECTIONS

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

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

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

1.0 HOW THE COVERAGE UNDER YOUR INSURANCE PLAN WORKS

1.1 Your employer has established and maintains an employee health benefit plan ("Plan") for employees and their eligible dependents. The Employer administers that Plan and actively promotes the Plan to its employees. The Employer and you, through your premium contributions, have purchased a Plan of insurance benefits provided by the Group Contract and Evidence of Coverage issued by HMO Partners, Inc. d/b/a Health Advantage that provides a range of coverage for medical services you may need. This is a very valuable benefit for you, but you should understand clearly that your Plan does NOT cover all medical services, drugs, supplies, tests or equipment ("Health Interventions" or "Interventions"). A Plan covering all health Interventions would be prohibitively expensive. For that reason, we have offered and you have purchased a more limited Plan. This document is your guide to what you have and have not purchased; in other words, what is and is not eligible for benefits under your Plan. **Accordingly, you should read this entire document carefully both now and BEFORE you obtain medical or preventive health services be sure you understand what is covered and the limitations on your coverage.**

1.2 The philosophy and purpose behind your Plan is that we want you to have coverage for the vast majority of medical needs or emergencies you may face, including most Hospital and Physician Services, emergency care, preventive and wellness services, medications, supplies and equipment. However, in order to keep costs of your Plan within reasonable limits, we have deliberately excluded coverage of a number of specific Health Interventions, we have placed coverage limits on some other Interventions, and we have established an overall standard we call the "Primary Coverage Criteria" that each and every claim for benefits must meet in order to be covered under your Plan.

1.3 Here is an important thing for you to clearly understand. For any Health Intervention, there are six general coverage criteria that must be met in order for that intervention to qualify for coverage under your Plan.

1. The Primary Coverage Criteria must be met.
2. The Health Intervention must conform to specific limitations stated in your Plan.
3. The Health Intervention must not be specifically excluded under the terms of your Plan.
4. At the time of the intervention, you must meet the Plan's eligibility standards.
5. You must comply with the Plan's Provider network and cost sharing arrangements; and
6. You must follow the Plan's procedures for filing claims.

The following discussion will give you a brief description of each of these qualifications.

1.4 **The Primary Coverage Criteria**. The Primary Coverage Criteria apply to ALL benefits you may claim under your Plan. It does not matter what types of Health Intervention may be involved or when or where you obtain the intervention. The Primary Coverage Criteria are designed to allow Plan benefits for only those Health Interventions that are proven as safe and effective treatment. The Primary Coverage Criteria also provide benefits only for the less invasive or less risky intervention when such intervention would safely and effectively treat the medical condition; or they provide benefits for treatment in an outpatient, doctor's office or home care setting when such treatment would be a safe and effective alternative to Hospitalization. Examples of the types of Health Interventions that the Primary Coverage Criteria exclude from coverage include such things as the cost of a hospitalization for a minor cold or some other condition that could be treated outside the Hospital, or the cost of some investigational drug or treatment such as herbal therapy or some forms of high dose Chemotherapy not shown to have any beneficial or curative effect on a particular cancerous condition. Finally, the Primary Coverage Criteria require that if there are two or more effective alternative Health Interventions, the Plan should limit its payment to the Allowance or Allowable Charge for the most cost effective intervention. The specific coverage standards that must be met under the Primary Coverage Criteria are outlined in detail in Section 2.0 of this document.

1.5 **Specific Limitations in Your Plan.** Because of the high cost of some Health Interventions, as well as the difficulty in some cases of determining whether an intervention is really needed, we include coverage for such Health Interventions but place limits on the extent of coverage by limiting the number of Provider visits or treatments, or treatment received during a Contract Year or other specified time period. Examples of such limitations include a limit on the number of covered visits for home health services, physical, occupational and speech therapy. Other types of limitations include requirements that an intervention be provided in a particular location or by a Provider holding a particular type of license, or in accordance with a written treatment plan or other documentation. Common benefits and limitations are outlined in detail in Section 3.0 of this document. You will note that this document refers

to Coverage Policies we have developed that may address limitations of coverage for a particular service, treatment or drug. You may request a copy of our Coverage Policy with respect to a particular service, treatment or drug, or, if you have Internet access, you may review all our established Coverage Policies on our web site at WWW.HEALTHADVANTAGE-HMO.COM.

1.6 **Specific Exclusions in Your Plan.** There are many possible reasons why we have selected a particular condition, health care Provider, Health Intervention, or service to be excluded from your Plan. Some exclusions are based on the availability of other coverage or financing for certain types of injuries. For example, injuries you receive on the job are generally covered by workers' compensation. Other exclusions are based on the need to try to keep your coverage affordable, covering basic health care service needs, but not covering every possible desired intervention. The exclusion for Cosmetic Services is an example of this type of exclusion. The plan excludes coverage of some health care Providers because we believe the Provider is not qualified or because the Provider lacks experience. For example the plan does not cover services rendered by unlicensed Providers or by Hospital residents, interns, students or fellows. Other exclusions are based on our judgment that the need for such Health Intervention is questionable in many cases, or that the services are of unknown or unproven beneficial effect. Examples of these types of exclusions include biofeedback and cranial electrotherapy stimulation devices, as well as some forms of high dose Chemotherapy and bone marrow transplantation. **Before you undergo treatment or tests, you should review the specific exclusions listed in Section 4.0 of this document. If you have any question about whether a specific exclusion applies, discuss it with your doctor(s). Call our Customer Service representatives if you need assistance.** You may also request a copy of our Coverage Policy with respect to a particular service, treatment or drug, or, if you have Internet access, you may review all our established Coverage Policies on our web site at WWW.HEALTHADVANTAGE-HMO.COM.

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

1.8 **Eligibility Standards.** You must be eligible for benefits under your Plan at the time you receive a Health Intervention. Eligibility standards are set forth in Section 6.0 of this document. Since your coverage is through a group contract, this means you must be an eligible member of the Group, either as a Subscriber or an eligible Dependent of a Subscriber. In order to be an eligible member of the Group, you must meet the Group eligibility standards, which often include limited enrollment periods or Waiting Periods, before your Group coverage takes effect. In all cases, in order to be considered "eligible" for coverage, your Plan must be valid and in force at the time the services or treatment are provided. All premiums must be timely paid. It is important to understand the provisions of Section 6.0 that outline the circumstances under which your coverage may terminate under the Plan. This section also describes the special situations provided by state and federal law that allow continued coverage under the Plan for a limited time after you are no longer an Subscriber or Dependent. This section also describes the circumstances under which you may convert your coverage to an individual plan.

1.9 **Claim Filing Procedures.** Your Plan provides procedures that you, your Provider or your Authorized Representative must follow in filing claims with Health Advantage. Your failure to follow these procedures could result in significant delays in the processing of your claim, as well as potential denial

of benefits. For example not informing a provider of your coverage under the Evidence of Coverage which causes the claim to not meet timely filing requirements will make you fully responsible for charges for services from that provider. These procedures are set out in Section 7.0. In addition, Section 7.0 explains how you can appeal a benefit determination in the event you believe that such benefit determination does not comply with the terms of the Plan.

1.10 **Plan Administration.** Information about the financial incentives Health Advantage provides In-Network Providers, including Physicians, is set out in Section 8.0. Certain important matters, not otherwise described in this Evidence of Coverage, are described in Section 9.0. Section 10.0 is a glossary of defined terms used in the Evidence of Coverage. Finally, Section 11.0 provides information the Plan is required to provide in accordance with the Employee Retirement Income Security Act of 1974 (ERISA).

2.0 PRIMARY COVERAGE CRITERIA

2.1 **Purpose and Effect of Primary Coverage Criteria.** The Primary Coverage Criteria are set out in this Section 2.0 of this document. The Primary Coverage Criteria are designed to allow Plan benefits for only those Interventions that are proven as safe and effective treatment. Another goal of the Primary Coverage Criteria is to provide benefits only for the less invasive or least risky Intervention when such Intervention would safely and effectively treat the medical condition, or to provide benefits for treatment in an outpatient, doctor's office or home care setting when such treatment would be a safe and effective alternative to hospitalization. Finally, if there is more than one effective Health Intervention available, the Primary Coverage Criteria allow the Plan to limit its payment to the Allowance or Allowable Charge for the most cost-effective Intervention. Regardless of anything else in this Plan, and regardless of any other communications or materials you may receive in connection with your Plan, you will not have coverage for any service, any medication, any treatment, any procedure or any equipment, supplies or associated costs UNLESS the Primary Coverage Criteria set forth in this Section are met. At the same time, bear in mind that just because the Primary Coverage Criteria are met does not necessarily mean the treatment or services will be covered under your Plan. For example, a Health Intervention that meets the Primary Coverage Criteria will be excluded if the condition being treated is a non-covered treatment excluded by the Plan. (See Subsection 4.2.) As explained in the preceding Section 1.0, the Primary Coverage Criteria represent one category of six general coverage criteria that must be met for coverage in all cases. The Primary Coverage Criteria are as follows:

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

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

   "Cost-effective" means a Health Intervention where the benefits and harms relative to the costs represent an economically efficient use of resources for patients with the medical condition being treated through the Health Intervention. For example, if the benefits and risks to the patient of two alternative Interventions are comparable, a Health Intervention costing $1,000 will

be more cost effective than a Health Intervention costing $10,000. "Cost-effective" shall not necessarily mean the lowest price.

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

1. **Effective defined**

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

i. scientific evidence, as defined in Subsection 2.3.2, below (where available); or

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

iii. if scientific evidence is not available, and if expert opinion is either unavailable for some reason or is substantially equally divided, professional standards, as defined and qualified in Subsection 2.3.3, below, may be consulted.

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

b. A new Intervention (one that is not commonly recognized as accepted or standard treatment or which has not gained widespread, substantially unchallenged use and acceptance throughout the United States) will be deemed "effective" for purposes of the Primary Coverage Criteria if there is scientific evidence (as defined in Subsection 2.3.2, below) showing that the Intervention will achieve its intended purpose and will cure, alleviate or enable diagnosis or detection of a medical condition without exposing the patient to risks that outweigh the potential benefits. Scientific evidence is deemed to exist to show that a new Intervention is **not** effective if the procedure is the subject of an ongoing phase I, II, or III trial or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis. If there is a lack of scientific evidence regarding a new Intervention, or if the available scientific evidence is in conflict or the subject of continuing debate, the new Intervention shall be deemed "not effective," and therefore not covered in accordance with the Primary Coverage Criteria, with one exception -- if there is a new Intervention for which clinical trials have not been conducted because the disease at issue is rare or new or affects only a remote population, then the Intervention may be deemed "effective" if, but only if, it meets the definition of "effective" as defined for existing Interventions in Subsection 2.3.1.a., above.

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

a. Results of randomized controlled clinical trials, as published in the authoritative medical and scientific literature that directly demonstrate a statistically significant positive effect of an Intervention on a medical condition. For purposes of this Subsection a., "authoritative medical and scientific literature" shall be such publications as are recognized by Health Advantage, listed in its Coverage Policy or otherwise listed as authoritative medical and scientific literature on Health Advantage's web site at WWW.HEALTHADVANTAGE-HMO.COM; or

b. Published reports of independent technology or pharmaceutical assessment organizations recognized as authoritative by Health Advantage. For purposes of this Subsection b. an independent technology or pharmaceutical assessment organization shall be considered "authoritative" if it is recognized as such by Health Advantage, listed in its Coverage Policy or otherwise listed as authoritative on Health Advantage's web site at WWW.HEALTHADVANTAGE-HMO.COM.

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

2.4 **Application and Appeal of Primary Coverage Criteria.**

1. The following rules apply to any application of the Primary Coverage Criteria. Health Advantage shall have full discretion in applying the Primary Coverage Criteria, and in interpreting any of its terms or phrases, or the manner in which it shall apply to a given Intervention. No Intervention shall be deemed to meet the Primary Coverage Criteria unless the Intervention qualifies under ALL of the following rules:

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

b. FDA Position – An Intervention does not meet the Primary Coverage Criteria if it involves any device or drug that requires approval of the U.S. Food and Drug Administration ("FDA"), and FDA approval for marketing of the drug or device for a particular medical condition has not been issued prior to your date of service. In addition, an Intervention does not meet the Primary Coverage Criteria if the FDA or the U.S. Department of Health and Human Services or any agency or division thereof, through published reports or statements, or through official announcements or press releases issued by authorized spokespersons, have concluded that the Intervention or a means or method of administering it is unsafe, unethical or contrary to federal laws or regulations. Neither FDA Pre-Market Approval nor FDA finding of substantial equivalency under 510(k) automatically guarantees coverage of a drug or device.

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

d. Plan Exclusions, Limitations or Eligibility Standards – Even if an Intervention otherwise meets the Primary Coverage Criteria, it is not covered under this Plan if the Intervention is subject to a Plan exclusion or limitation, or if you fail to meet Plan eligibility requirements.

e. Position Statements of Professional Organizations – Regardless of whether an Intervention meets some of the other requirements of the Primary Coverage Criteria, the Intervention shall not be covered under the Plan if any national professional association, any accrediting or certification organization, any widely-used medical compendium, or published guidelines of any national or international workgroup of scientific or medical experts have classified such Intervention or its means or method of administration as "experimental" or "investigational" or as questionable or of unknown benefit. However, an Intervention that fails to meet other requirements of the Primary

Coverage Criteria shall not be covered under the Plan, even if any of the foregoing organizations or groups classify the Intervention as not "experimental" or not "investigational," or conclude that it is beneficial or no longer subject to question. For purposes of this Subsection e., "national professional association" or "accrediting or certifying organization," or "national or international workgroup of scientific or medical experts" shall be such organizations or groups recognized by Health Advantage, listed in its Coverage Policy or otherwise listed as authoritative on Health Advantage's web site at WWW.HEALTHADVANTAGE-HMO.COM.

f. Coverage Policy – With respect to certain drugs, treatments, services, tests, equipment or supplies, Health Advantage has developed specific Coverage Policies, which have been put into writing, and are published on Health Advantage's web site at WWW.HEALTHADVANTAGE-HMO.COM. If Health Advantage has developed a specific Coverage Policy that applies to the drug, treatment, service, test, equipment or supply that you received or seek to have covered under your Plan, the Coverage Policy shall be deemed to be determinative in evaluating whether such drug, treatment, service, test, equipment or supply meets the Primary Coverage Criteria; however, the absence of a specific Coverage Policy with respect to any particular drug, treatment, service, test, equipment or supply shall not be construed to mean that such drug, treatment, service, test, equipment or supply meets the Primary Coverage Criteria.

2. You may appeal a determination by Health Advantage that an Intervention does not meet the Primary Coverage Criteria to the Appeals Coordinator. Use the procedures for appeals outlined in Sections 7.2 and 7.3.

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

3.0 BENEFITS AND SPECIFIC LIMITATIONS IN YOUR PLAN

Because of the high cost of some services or treatments, as well as the difficulty in some cases of determining whether services are really needed, we include coverage for such services or treatments but place limits on the extent of coverage, either by limiting the number of Provider visits or treatments during a Contract Year or other specified period of time. This Section 3.0 describes medical services, drugs, supplies, tests and equipment for which coverage is provided of the Plan, provided all terms, conditions, exclusions and limitations of the Plan, including the six coverage criteria, are satisfied. This Section 3.0 sets out specific limitations applicable to each covered medical service, drug, supply, test or equipment.

You will note references to Deductible, Coinsurance and Copayment obligations. For a description of the amount of these obligations and how they may vary depending upon whether you select an In-Network Provider or an Out-of-Network Provider, refer to Section 5.0, the definition of Allowance or Allowable Charge as set out in the Glossary of Terms and the Schedule of Benefits.

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

1. **Primary Care Physician Office Visits.** Coverage is provided for services provided by a Primary Care Physician or an advanced practice nurse or physician's assistant who provides primary medical care in the areas of general practice, pediatrics, family practice, internal medicine or obstetrics/gynecology, which are performed in the Primary Care Physician's office. The Coinsurance amount Health Advantage will pay for the services listed below is one hundred percent (100%) of the Allowance or Allowable Charge or the amount of the billed charge for the service, whichever is less, subject to the Primary Care Physician copayment amount listed in the Schedule of Benefits. Services subject to the copayment include, but are not limited to, office visits, diagnostic x-rays, lab, surgery by the Primary Care Physician, accident or Emergency Care, allergy shots and injections.

   You are encouraged to select and maintain a patient-physician relationship with a PCP. A PCP can be helpful to you in managing your health care. The PCP selected must be an In-network

Physician listed in the Preferred Provider Directory as a PCP and must be accepting new patients. You may contact Customer Service to select a PCP or change your PCP.

Please note: Services performed by a Non-Preferred Provider are subject to the Out-of-Network Deductible and Out-of-Network Coinsurance, not the Primary Care Physician copayment.

2. **Specialty Care Physician Office Visits.** Coverage is provided for the diagnosis and treatment of illness or injury when provided in the medical office of the Specialty Care Provider. The Member is responsible for the Deductible, Copayment and Coinsurance specified in the Schedule of Benefits.
3. **Physician Hospital Visits.** Coverage is provided for services of Physicians for diagnosis, treatment and consultation while the Member is admitted as an inpatient in a Hospital for Covered Services.
4. **Surgical Services.** Coverage is provided for services of Physicians for surgery, either as an inpatient or outpatient. If coverage is provided for two (2) or more surgical operations performed during the same surgical encounter or for bilateral procedures, payment for the secondary or subsequent procedure will be made at a reduced rate. In general, overall payment for one or more procedures during the same operative setting will be no more than if the procedures had been done by one Physician. Details as to how such payments are calculated are provided to In-Network Physicians through *Provider News* and Coverage Policy. Further, Health Advantage's payment for an assistant surgeon shall be limited to one physician qualified to act as an assistant for the surgical procedure.
5. **Telephone and Other Electronic Consultation.** Subject to all other terms, conditions, exclusions, and limitations of this Plan set forth in this Evidence of Coverage,
    i. Coverage is provided for Telemedicine services performed by a Provider licensed, certified, or otherwise authorized by the laws of Arkansas to administer health care in the ordinary course of the practice of his or her profession at the same rate as if it had been performed in-person provided the Telemedicine service is comparable to the same service provided in person.
    ii. However, electronic consultations such as, but not limited to, telephonic, interactive audio, 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.
    iii. Communications made by a Physician responsible for the direct care of a Member in Case Management with involved health care Providers, however, are covered.
6. **Assistant Surgeon Services.** Not all surgeries merit coverage for an assistant surgeon. Further, the Health Advantage's payment for a covered assistant surgeon shall be limited to one Physician qualified to act as an assistant for the surgical procedure. Surgical first assistants are not covered. See Subsection 4.1.10.
7. **Standby Physicians.** Services of standby physicians are only covered in the event such physician is required to assist with certain high-risk services specified by Health Advantage, and only for such time as such physician is in immediate proximity to the patient.
8. **Abortions.** Abortions are not covered, see Subsection 4.2.1. Pregnancy terminations under the direction of a Physician are covered, but only when performed in an In-Network Hospital or Outpatient Hospital setting.

3.2 **Preventive Health Services.** Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Evidence of Coverage, Health Advantage will pay one hundred percent (100%) of the Allowance or Allowable Charges for the routine preventive health services listed below when provided by a an In-Network Primary Care Physician or an advanced practice nurse or physician's assistant who provides primary medical care in the areas of general practice, pediatrics, family practice, internal medicine or obstetrics/gynecology, which are performed in the Primary Care Physician's office. Coverage is also provided for certain preventive health services listed below when performed in an In-Network Outpatient Hospital or Ambulatory Surgery Center setting when the service cannot be performed in an office by a Primary Care Physician.

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

2. routine immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved; and
3. with respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
4. with respect to women, such additional preventive care and screenings not described in paragraph (1) as provided for in comprehensive guidelines supported by the Health Resources and Services Administration for purposes of this subsection; and
5. the current recommendations of the United States Preventive Service Task Force regarding breast cancer screening, mammography, and prevention shall be considered the most current other than those issued in or around November 2009, unless state law provides a greater benefit.

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

1. **Inpatient Hospital Services.** This benefit is subject to the following specific limitations:
   a. Payment for Hospital charges for inpatient admissions shall be limited to the lesser of the billed charge or the Allowance or Allowable Charge established by Health Advantage.
   b. If you have a condition requiring that you be isolated from other patients, Health Advantage will pay for an isolation unit equipped and staffed as such.
   c. In the event services are rendered for a covered benefit during an inpatient admission to a Hospital where the admitting diagnosis was for a non-covered benefit, Health Advantage will pay that portion of the Hospital charge which is attributable to services rendered for the covered benefit.
   d. The services of social workers shall be included in the basic daily room and board allowance.
   e. Hospital admissions outside the state of Arkansas are subject to Pre-admission Notification. Please call the number listed on the Identification Card to notify Health Advantage of the admission.
   f. Services rendered in a Hospital in a country outside of the United States of America shall not be paid except at the sole discretion of Health Advantage.
   g. Admissions to a Long Term Acute Care Hospital or to a Long Term Acute Care division of a Hospital are subject to Pre-admission Notification. Please call the number listed on the Identification Card to notify Health Advantage of the admission.
2. **Outpatient Hospital Services.** Coverage is provided for services of an Outpatient Hospital, Outpatient Surgery Center or Outpatient Radiation Therapy Center. **However, if you use an out of state Outpatient Surgery Center that does not contract with the local Blue Cross and Blue Shield Plan, payment for all such services, including Professional Services, will be limited to the Allowance or Allowable Charge for all the services or $500 whichever is less. See Subsection 3.4.**
3. **Hospital Services in Connection with Dental Treatment.** Subject to Prior Approval from Health Advantage, coverage is provided for Hospital services, including anesthesia, services in connection with treatment for a complex dental condition provided to: (i) a Member under seven (7) years of age who is determined by two (2) dentists (in separate practices) to require the dental treatment without delay; (ii) a Member with a diagnosis of serious mental or physical condition; or (iii) a Member, certified by his or her Primary Care Physician to have a significant behavioral problem. **Failure of the Member's treating Provider to submit a pre-service claim for Prior Approval will result in denial of coverage. PLEASE NOTE: Prior Approval does not guarantee payment or assure coverage; it means only that the information furnished to Health Advantage in the pre-service claim indicates that the hospital service in connection with dental treatment meet the Primary Coverage Criteria requirements set out in Subsection 2.2 and the Applications of the Primary Coverage Criteria set out in Subsections 2.4.1.b, e., or f. and is not subject to a Specific Plan Exclusion (see Section**

4.0). All Health Interventions receiving Prior Approval must still meet all other coverage terms, conditions, and limitations. Coverage for approved services may still be limited or denied if, when the claims for such services are received by us, investigation shows that a benefit exclusion or limitation applies because of a difference in the Health Intervention described in the pre-service claim and the actual Health Intervention, that the MemberMember ceased to be eligible for benefits on the date services were provided, that coverage lapsed for non-payment of premium, that out-of-network limitations apply, or any other basis specified in this Evidence of Coverage. For more information about pre-service claims and Prior Approval, please see Subsection 7.1.3.b.

3.4 **Ambulatory Surgery Center.** Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Evidence of Coverage and subject to the Deductible, Copayment and Coinsurance specified in the Schedule of Benefits, coverage is provided for specific surgical services received at an Ambulatory Surgery Center that are performed or prescribed by a Physician. Covered services include diagnostic imaging and laboratory services required to augment a surgical service and performed on the same day as such surgical service. Ambulatory Surgery Center services in connection with treatment for a complex dental condition are provided in accordance with Subsection 3.3.3. **However, if you use an out of state Ambulatory Surgery Center that does not contract with the local Blue Cross and Blue Shield Plan, payment for all such services, including Professional Services, will be limited to the Allowance or Allowable Charge incurred for all the services or $500, whichever is less.**

3.5 **Outpatient Diagnostic Services.** Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Evidence of Coverage, coverage is provided for diagnostic services and materials, including but not limited to, diagnostic imaging (e.g. x-rays, fluoroscopy, ultrasounds, radionuclide studies) electrocardiograms, electroencephalograms and laboratory tests when performed or prescribed by a Physician and subject to the Deductible, Copayment and Coinsurance specified in the Schedule of Benefits.

3.6 **Advanced Diagnostic Imaging Services.** Unless the Advanced Diagnostic Imaging Services are provided in accordance with Emergency Care Services (See Subsection 3.11) and subject to the Deductible and Coinsurance specified in the Schedule of Benefits, computed tomography scanning ("CT SCAN"), Magnetic Resonance Angiography or Imaging ("MRI/MRA"), Nuclear Cardiology and positron emission tomography scans ("PET SCAN") (collectively referred to as "Advanced Diagnostic Imaging") require Prior Approval from Health Advantage. **Failure of the Member's treating Provider to submit a pre-service claim for Prior Approval will result in denial of coverage. PLEASE NOTE: Prior Approval does not guarantee payment or assure coverage; it means only that the information furnished to Health Advantage in the pre-service claim indicates that the advanced diagnostic imaging services meet the Primary Coverage Criteria requirements set out in Subsection 2.2 and the Applications of the Primary Coverage Criteria set out in Subsections 2.4.1.b, e., or f. and is not subject to a Specific Plan Exclusion (see Section 4.0). All Health Interventions receiving Prior Approval must still meet all other coverage terms, conditions, and limitations. Coverage for approved services may still be limited or denied if, when the claims for such services are received by us, investigation shows that a benefit exclusion or limitation applies because of a difference in the Health Intervention described in the pre-service claim and the actual Health Intervention, that the Member ceased to be eligible for benefits on the date services were provided, that coverage lapsed for non-payment of premium, that out-of-network limitations apply, or any other basis specified in this Evidence of Coverage. For more information about pre-service claims and Prior Approval, please see Subsection 7.1.3.b.**

3.7 **Maternity.** Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Evidence of Coverage, coverage is provided for Maternity Care when performed or prescribed by a Physician subject to the Deductible, Copayment and Coinsurance amounts specified in the Schedule of Benefits.

1. **Maternity and Obstetrical Care.** Coverage is provided for Maternity and Obstetrical Care, including Routine Prenatal Care and postnatal care; and use of Hospital delivery rooms and related facilities; special procedures as may be necessary. Routine Prenatal Care includes the coverage of one routine ultrasound only. See Subsection 4.2.98 concerning exclusion of additional routine ultrasounds.
2. **Midwives**. Services provided by any lay midwife are not covered. See Subsection 4.1.4. However, subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Evidence of Coverage, coverage is provided for services provided by a certified nurse

midwife who has a collaborative agreement with a Physician who is within immediate proximity to the facility utilized by the certified nurse midwife, in case there is need for assistance during the delivery.

3. **Newborn Care in the Hospital.** Provided the Child's coverage becomes effective on his or her date of birth in accordance with the provisions of Section 6.0, coverage is provided for a Hospital stay for the mother and newborn child of at least forty-eight (48) hours following a vaginal delivery or at least ninety-six (96) hours following a cesarean section, unless the treating provider, after consulting with the mother, discharges the mother or newborn child earlier. A Subscriber or Spouse's newborn Child will be covered from the date of birth, including use of newborn nursery (for up to five (5) days or until the mother is discharged, whichever is the lesser period of time) and related services. However, if such Child is born in an Out-of-Network Hospital, the Child's coverage for Out-of-Network services in the first 90 days is limited to the Allowance or Allowable Charges incurred or $2,000, whichever is less.

   If a Child is born in an Out-of-Network Hospital because the Employee's Spouse has other coverage, or if such Child is an adopted child born in an Out-of-Network Hospital, nursery charges are covered up to the Allowance or Allowable Charge incurred or $2,000, whichever is less.

4. **Family Planning Services**. Subject to all terms, conditions, exclusions, and limitations of the Plan as set forth in the Evidence of Coverage, coverage is provided for the following family planning services when authorized and provided by In-Network Physicians:

   a. Counseling and planning services for infertility;

   b. Pregnancy terminations under the direction of a Physician are covered, but only when performed in an In-Network Hospital or In-network Outpatient Hospital setting. Abortion is not Covered. See Subsection 4.2.1.

   c. Oral Contraceptives are only covered under Subsection 3.23 - Medications.

   d. Voluntary sterilizations (vasectomies and tubal ligations). Reversals of a voluntary sterilization are not covered.

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

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

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

3.8 **Rehabilitation and Habilitation Services.** Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Evidence of Coverage, coverage is provided for Rehabilitation and Habilitation when performed or prescribed by an In-Network Physician and performed in an In-Network facility. Such therapy and developmental services include physical and occupational therapy as well as services provided for developmental delay, developmental speech or language disorder, developmental coordination disorder and mixed developmental disorder. Therapy must be performed by an appropriate registered physical, occupational or speech-language therapist licensed by the appropriate State Licensing Board and must be furnished in accordance with a written treatment Plan established and certified by the treating Physician. Developmental Services must be provided by a provider licensed by the state or certified by an organization approved by Health Advantage, and must be furnished in accordance with a written treatment plan established and certified by the treating Physician.

This benefit is subject to the Copayment and/or Deductible and Coinsurance specified in the Schedule of Benefits.

1. **Rehabilitation Services**
   a. **Inpatient Therapy.** Coverage is provided for inpatient therapy services, including professional services, when performed or prescribed by a Physician and rendered in a Hospital. Inpatient stays for therapy are limited to sixty (60) days per Member per Contract Year.
   b. **Outpatient Therapy.** Coverage is provided for outpatient therapy services when performed or prescribed by a Physician. Coverage for outpatient visits for physical therapy, occupational therapy, speech therapy and chiropractic services is limited to an aggregate maximum of thirty (30) visits per Member per Contract Year. See Subsection 10.73 - Outpatient Therapy Visit.
   c. **Cardiac and Pulmonary Rehabilitation Therapy.** Coverage for cardiac and pulmonary rehabilitation therapy is provided in accordance with Coverage Policy. Coverage for cardiac rehabilitation therapy limited to a maximum of 36 visits per Member per Contract Year. However, coverage is not provided for cardiac or pulmonary rehabilitation therapy from Freestanding Facilities. Peripheral vascular disease rehabilitation therapy is not covered. See Subsection 4.2.78.
   d. **Cognitive Rehabilitation.** Cognitive Rehabilitation is generally not covered. See Subsections 4.2.16 and 10.12.
   e. **Radio-Frequency Thermal Therapy.** The use of radio-frequency thermal therapy for treatment of orthopedic conditions is not covered. See Subsection 4.2.80.
2. **Habilitation Services.**
   a. **Outpatient Therapy.** Coverage is provided for outpatient therapy services when performed or prescribed by a Physician. Coverage for outpatient visits for physical therapy, occupational therapy, speech therapy and chiropractic services is limited to an aggregate maximum of thirty (30) visits per Member per Contract Year. See Subsection 10.73 - Outpatient Therapy Visit.
   b. **Developmental Services.** Coverage is provided for Developmental Services when performed or prescribed by a Physician and is limited to a maximum of 180 Developmental Services Visits per Member per Contract Year. See Subsection 10.26 - Developmental Service Visit.
   c. **Durable Medical Equipment.** Durable Medical Equipment required for Habilitation is covered in accordance with Subsection 3.12.

3.9 **Mental Illness and Substance Use Disorder.** Subject to all terms, conditions, exclusions, and limitations of the Plan as set forth in this Evidence of Coverage, and the Deductible, Copayment, and Coinsurance set out in the Schedule of Benefits, coverage is provided for Health Interventions to treat Mental Illness and Substance Use Disorder.

1. **Inpatient, Partial Hospitalization Program and Intensive Outpatient Program Health Intervention**s. Coverage for Inpatient Hospitalization, Partial Hospitalization Programs, or Intensive Outpatient Programs for Mental Illness or Substance Use Disorder Health Interventions is subject to the following requirements.
   a. Inpatient Hospitalization requires a patient to receive Covered Services 24 hours a day as an inpatient in a Hospital.
   b 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.
   c. 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.
2. **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 Psychiatric or Substance Use Disorder Residential Treatment Facility.

i. The facility is licensed by the State of Arkansas or the appropriate agency in the state where the facility is located.

ii. The facility is accredited by the Joint Commission (TJC) or the Commission on Accreditation of Rehabilitation Facilities (CARF International).

iii. A request for Prior Approval must be submitted to Health Advantage prior to admission to the residential treatment facility. **Failure of the Member's treating Provider to submit a pre-service claim for Prior Approval will result in denial of coverage. PLEASE NOTE: Prior Approval does not guarantee payment or assure coverage; it means only that the information furnished to Health Advantage in the pre-service claim indicates that the admission to the residential treatment facility meet the Primary Coverage Criteria requirements set out in Subsection 2.2 and the Applications of the Primary Coverage Criteria set out in Subsections 2.4.1.b, e., or f. and is not subject to a Specific Plan Exclusion (see Section 4.0). All Health Interventions receiving Prior Approval must still meet all other coverage terms, conditions, and limitations. Coverage for approved services may still be limited or denied if, when the claims for such services are received by us, investigation shows that a benefit exclusion or limitation applies because of a difference in the Health Intervention described in the pre-service claim and the actual Health Intervention, that the Member ceased to be eligible for benefits on the date services were provided, that coverage lapsed for non-payment of premium, that out-of-network limitations apply, or any other basis specified in this Evidence of Coverage. For more information about pre-service claims and Prior Approval, please see Subsection 7.1.3.b.**

3. 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.

4. Hypnotherapy is not covered for any diagnosis or medical condition. See Subsection 4.3.54.

5. Repetitive Transcranial Magnetic Stimulation Treatment (rTMS). Coverage is provided for repetitive transcranial magnetic stimulation treatment (rTMS) subject to Prior Approval by Health Advantage. **Failure of the Member's treating Provider to submit a pre-service claim for Prior Approval will result in denial of coverage. PLEASE NOTE: Prior Approval does not guarantee payment or assure coverage; it means only that the information furnished to Health Advantage in the pre-service claim indicates that the repetitive transcranial magnetic stimulation treatment (rTMS) meet the Primary Coverage Criteria requirements set out in Subsection 2.2 and the Applications of the Primary Coverage Criteria set out in Subsections 2.4.1.b, e., or f. and is not subject to a Specific Plan Exclusion (see Section 4.0). All Health Interventions receiving Prior Approval must still meet all other coverage terms, conditions, and limitations. Coverage for approved services may still be limited or denied if, when the claims for such services are received by us, investigation shows that a benefit exclusion or limitation applies because of a difference in the Health Intervention described in the pre-service claim and the actual Health Intervention, that the Member ceased to be eligible for benefits on the date services were provided, that coverage lapsed for non-payment of premium, that out-of-network limitations apply, or any other basis specified in this Evidence of Coverage. For more information about pre-service claims and Prior Approval, please see Subsection 7.1.3.b.**

3.10 **Autism Spectrum Disorder Benefits.** Subject to all other terms, conditions, exclusions, and limitations of the Plan as set forth in this Evidence of Coverage as well as the Deductible, Copayment, and Coinsurance set out in the Schedule of Benefits, coverage is provided for:

1. Members with autism spectrum disorder.

2. Applied behavioral analysis as specified in Coverage Policy and subject to Prior Approval from Health Advantage, when ordered by a medical doctor or a psychologist for a Member under the age of 19 and provided under the direction of a Board Certified Behavioral Analyst (BCBA).

Failure of the Member's treating Provider to submit a pre-service claim for Prior Approval will result in denial of coverage. PLEASE NOTE: Prior Approval does not guarantee payment or assure coverage; it means only that the information furnished to Health Advantage in the pre-service claim indicates that the applied behavioral analysis meet the Primary Coverage Criteria requirements set out in Subsection 2.2 and the Applications of the Primary Coverage Criteria set out in Subsections 2.4.1.b, e., or f. and is not subject to a Specific Plan Exclusion (see Section 4.0). All Health Interventions receiving Prior Approval must still meet all other coverage terms, conditions, and limitations. Coverage for approved services may still be limited or denied if, when the claims for such services are received by us, investigation shows that a benefit exclusion or limitation applies because of a difference in the Health Intervention described in the pre-service claim and the actual Health Intervention, that the Member ceased to be eligible for benefits on the date services were provided, that coverage lapsed for non-payment of premium, that out-of-network limitations apply, or any other basis specified in this Evidence of Coverage. For more information about pre-service claims and Prior Approval, please see Subsection 7.1.3.b.

3.11 **Emergency Care Services.** Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Evidence of Coverage, coverage is provided for Emergency Care. When Emergency Care is needed the Member should seek care at the nearest facility. Emergency Care received within forty-eight (48) hours of the emergency is subject to the Deductible, Copayment and Coinsurance specified in the Schedule of Benefits. If the Member is admitted as an inpatient to the same Hospital where Emergency Care was rendered, the Emergency Care Copayment is waived and all services are subject to the inpatient Deductible, Copayment and Coinsurance.

1. **After-Hours Clinic or Urgent Care Center.** Services provided in an after-hours or urgent care center are subject to the Deductible, Copayment and Coinsurance for each visit.
2. **Observation Services.** Observation services are covered when ordered by an In-Network Physician. Observation Services ordered in conjunction with an emergency room visit or outpatient visit are subject to the Emergency Care Copayment and Coinsurance for each visit.
3. **Transfer to In-Network Hospital.** Continuing or follow-up treatment for Injury or Emergency Care is limited to care that meets Primary Coverage Criteria before you can be safely transferred, without medically harmful or injurious consequences, to an In-Network Hospital. Services are subject to all applicable Deductible, Copayment and Coinsurance.
4. **Emergency Hospital Admissions.** You are responsible for notifying Health Advantage of an emergency admission to a Hospital within 24 hours or the next business day.
5. **Medical Review of Emergency Care.** Emergency Care is subject to medical review. If, based upon the signs and symptoms presented at the time of treatment as documented by attending health care personnel, Health Advantage determines that a visit to the emergency room fails to meet the definition of Emergency Care as set out in this Evidence of Coverage (See Subsection 10.32 - Emergency Care), coverage shall be denied and the emergency room charges will become the Member's liability.
6. **Allowable Charge.** If You need Emergency Care, Health Advantage will cover You at the highest Allowance or Allowable Charge that federal regulations allow. You will have to pay any charges that exceed the Allowance or Allowable Charge as well as for any Deductibles, Coinsurance, Copayments and amounts that exceed any benefit maximums.

3.12 **Durable Medical Equipment.** Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Evidence of Coverage, coverage is provided for Durable Medical Equipment (DME) when prescribed by an In-Network Physician according to the guidelines specified below. This benefit, together with the benefit for equipment under Subsection 3.18, Home Health Services, is subject to the Deductible, Copayment and Coinsurance specified in the Schedule of Benefits.

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

3. Durable Medical Equipment for which the cost exceeds $5000 requires Prior Approval from Health Advantage. **Failure of the Member's treating Provider to submit a pre-service claim for Prior Approval will result in denial of coverage. PLEASE NOTE: Prior Approval does not guarantee payment or assure coverage; it means only that the information furnished to Health Advantage in the pre-service claim indicates that the durable medical equipment meet the Primary Coverage Criteria requirements set out in Subsection 2.2 and the Applications of the Primary Coverage Criteria set out in Subsections 2.4.1.b, e., or f. and is not subject to a Specific Plan Exclusion (see Section 4.0). All Health Interventions receiving Prior Approval must still meet all other coverage terms, conditions, and limitations. Coverage for approved services may still be limited or denied if, when the claims for such services are received by us, investigation shows that a benefit exclusion or limitation applies because of a difference in the Health Intervention described in the pre-service claim and the actual Health Intervention, that the Member ceased to be eligible for benefits on the date services were provided, that coverage lapsed for non-payment of premium, that out-of-network limitations apply, or any other basis specified in this Evidence of Coverage. For more information about pre-service claims and Prior Approval, please see Subsection 7.1.3.b.**

4. For adults, a single acquisition of eyeglasses or contact lenses within the first six months following cataract surgery is covered. (See Section 3.30 - Pediatric Vision Services for coverage of lenses for children.) With respect to such eyeglasses or contact lenses, tinting or anti-reflective coating and progressive lenses are not covered. The Allowance or Allowable Charge is based on the cost for basic glasses or contact lenses. Eyeglass frames are subject to a $65 maximum Allowance or Allowable Charge.

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

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

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

3.13 **Medical Supplies.** Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Evidence of Coverage, Medical Supplies (See Subsection 10.59), other than Medical Supplies that can be purchased without a prescription, are covered when prescribed by a Physician.

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

2. Coverage for Medical Supplies is limited to a 90-day supply per purchase.

3. Coverage for Medical Supplies used in connection with Durable Medical Equipment, Subsection 3.12, is subject to the Deductible, Coinsurance and Copayment specified in the Schedule of Benefits.

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

3.14 **Prosthetic and Orthotic Devices and Services.** Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Evidence of Coverage, and subject to the Deductible, Copayment and Coinsurance specified in the Schedule of Benefits, coverage is provided for Prosthetic and Orthotic devices, including associated services, and its repair if such device is required for treatment of a condition arising from an illness or Accidental Injury. Health Advantage will provide you the Allowable Charge for a Prosthetic device. Replacement of a Prosthetic or Orthotic device is covered no more frequently than once per three-year period except when necessitated by normal growth or when the age of the Prosthetic or Orthotic device exceeds the device's useful life. Maintenance and repair resulting from misuse or abuse of a Prosthetic or Orthotic device are the responsibility of the Member.

Prosthetic devices to assist hearing or talking devices are not generally covered. See Subsection 4.2.44. However, subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Evidence of Coverage, coverage is provided for:

1. cochlear implant (an implantable hearing device inserted into the modiolus of the cochlea and into cranial bone) and its associated speech processor up to a lifetime maximum benefit of one cochlear implant per ear per Member; and
2. one auditory brain stem implant per lifetime for an individual twelve years of age and older with a diagnosis of Neurofibromatosis Type II (NF2) who has undergone or is undergoing removal of bilateral acoustic tumors; and
3. surgically implantable osseointegrated hearing aid for patients with single-sided deafness and normal hearing in the other ear, subject to Prior Approval. Coverage is further limited to Members with
    a. congenital or surgically induced malformations (e.g. atresia) of the external ear canal or middle ear;
    b. chronic external otitis or otitis media;
    c. tumors of the external canal and/or tympanic cavity; and
    d. sudden, permanent, unilateral hearing loss due to trauma, idiopathic sudden hearing loss, or auditory nerve tumor.
4. Prosthetic devices for which the cost exceeds $20,000 requires Prior Approval from Health Advantage. **Failure of the Member's treating Provider to submit a pre-service claim for Prior Approval will result in denial of coverage. PLEASE NOTE: Prior Approval does not guarantee payment or assure coverage; it means only that the information furnished to Health Advantage in the pre-service claim indicates that the prosthetic devices meet the Primary Coverage Criteria requirements set out in Subsection 2.2 and the Applications of the Primary Coverage Criteria set out in Subsections 2.4.1.b, e., or f. and is not subject to a Specific Plan Exclusion (see Section 4.0). All Health Interventions receiving Prior Approval must still meet all other coverage terms, conditions, and limitations. Coverage for approved services may still be limited or denied if, when the claims for such services are received by us, investigation shows that a benefit exclusion or limitation applies because of a difference in the Health Intervention described in the pre-service claim and the actual Health Intervention, that the Member ceased to be eligible for benefits on the date services were provided, that coverage lapsed for non-payment of premium, that out-of-network limitations apply, or any other basis specified in this Evidence of Coverage. For more information about pre-service claims and Prior Approval, please see Subsection 7.1.3.b.**

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

Foot care is generally not covered, see Subsection 4.2.39. However, subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Evidence of Coverage, coverage of foot care is provided when required for prevention of complications associated with diabetes mellitus.

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

If provided in Coverage Policy, Health Advantage will pay for Durable Medical Equipment, Medical Supplies and services for the treatment of diabetes.

3.16 **Ambulance Services.** Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Evidence of Coverage, coverage is provided for ground, water or air Ambulance Services to the nearest Hospital in the event Emergency Care is needed. (See Subsection 10.32 - Emergency Care.) The coverage for ground or water Ambulance Services may not exceed $1,000 per trip, subject to the Deductible, Copayment and Coinsurance specified in the Schedule of Benefits. The coverage for air Ambulance Services may not exceed $5,000 per trip, subject to the Deductible, Copayment and Coinsurance specified in the Schedule of Benefits.

3.17 **Skilled Nursing Facility Services.** Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Evidence of Coverage, coverage is provided for Skilled Nursing Facility services when authorized in advance by a Physician. See Subsection 10.99 for the definition of Skilled Nursing Facility. This benefit is subject to the Deductible, Copayment and Coinsurance specified in the Schedule of Benefits. This Skilled Nursing Facility services benefit is subject to the following conditions:

1. The admission must be within seven days of release from an inpatient Hospital stay;
2. A request for Prior Approval must be submitted to Health Advantage prior to admission to the Skilled Nursing Facility. **Failure of the Member's treating Provider to submit a pre-service claim for Prior Approval will result in denial of coverage. PLEASE NOTE: Prior Approval does not guarantee payment or assure coverage; it means only that the information furnished to Health Advantage in the pre-service claim indicates that the admission to a skilled nursing facility meet the Primary Coverage Criteria requirements set out in Subsection 2.2 and the Applications of the Primary Coverage Criteria set out in Subsections 2.4.1.b, e., or f. and is not subject to a Specific Plan Exclusion (see Section 4.0). All Health Interventions receiving Prior Approval must still meet all other coverage terms, conditions, and limitations. Coverage for approved services may still be limited or denied if, when the claims for such services are received by us, investigation shows that a benefit exclusion or limitation applies because of a difference in the Health Intervention described in the pre-service claim and the actual Health Intervention, that the Member ceased to be eligible for benefits on the date services were provided, that coverage lapsed for non-payment of premium, that out-of-network limitations apply, or any other basis specified in this Evidence of Coverage. For more information about pre-service claims and Prior Approval, please see Subsection 7.1.3.b.**
3. The Skilled Nursing Facility services are of a temporary nature and increase ability to function;
4. Custodial Care is not covered (See Subsections 4.3.7 and 10.22);
5. Coverage is provided for a maximum of sixty (60) days per Member per Contract Year.

3.18 **Home Health Services.** Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Evidence of Coverage, including but not limited to the exclusion of Custodial Care (see Subsections 4.3.7 and 10.22), coverage is provided for Home Health Services when Coverage Policy supports the need for in-home service and such care is prescribed or ordered by a Physician. Covered Services must be provided through and billed by a licensed home health agency. Covered Services provided in the home include services of a Registered Professional Nurse (R.N.), a Licensed Practical Nurse (L.P.N.) or a Licensed Psychiatric Technical Nurse (L.P.T.N.), provided the nurse is not related to you by blood or marriage or does not ordinarily reside in your home. Home Health visits are subject to the Deductible, Copayment and Coinsurance specified in the Schedule of Benefits. Coverage is provided for a maximum of fifty (50) visits per Member per Contract Year. (Home infusion services are not covered by this Section 3.18, but are covered under Subsection 3.23.1.d.)

3.19 **Hospice Care.** Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Evidence of Coverage**,** if the Member has been diagnosed and certified by the attending Physician as having a terminal illness with a life expectancy of six months or less, Health Advantage will pay the Allowance or Allowable Charge for Hospice Care. The services must be rendered by an entity licensed by the Arkansas Department of Health or other appropriate state licensing agency and accepted by Health Advantage as a Provider. This benefit is subject to the Deductible, Copayment and Coinsurance specified in the Schedule of Benefits.

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

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

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

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

3.22 **Reconstructive Surgery. Cosmetic Services are not covered. (See Subsections 4.3.5 and 10.19)** Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Evidence of Coverage, and subject to the Deductible and Coinsurance specified in the Schedule of Benefits, coverage is provided for the following reconstructive surgery procedures when prescribed or ordered by an In-Network Physician:

1. Treatment provided for the correction of defects incurred in an Accidental Injury sustained by the Member
2. Surgery performed for the correction of a cleft palate or cleft lip, removal of a port-wine stain or hemangioma (on the head, neck, or face). Dental Care to correct congenital defects is not a covered benefit.
3. Subject to Prior Approval from Health Advantage, coverage for corrective surgery and related Health Interventions for a Member who is diagnosed as having a craniofacial anomaly provided the Health Interventions meet Primary Coverage Criteria to improve a functional impairment that results from the craniofacial anomaly as determined by a nationally accredited cleft-craniofacial team approved by the American Cleft Palate Craniofacial Association in Chapel Hill, North Carolina. A nationally accredited cleft-craniofacial team for cleft-craniofacial conditions shall evaluate Members with craniofacial anomalies and coordinate a treatment plan for each Member. Coverage includes corrective surgery, dental care, vision care and the use of at least one (1) hearing aid. **Failure of the Member's treating Provider to submit a pre-service claim for Prior Approval will result in denial of coverage. PLEASE NOTE: Prior Approval does not guarantee payment or assure coverage; it means only that the information furnished to Health Advantage in the pre-service claim indicates that the treatment of a craniofacial anomalies meet the Primary Coverage Criteria requirements set out in Subsection 2.2 and the Applications of the Primary Coverage Criteria set out in Subsections 2.4.1.b, e., or f. and is not subject to a Specific Plan Exclusion (see Section 4.0). All Health Interventions receiving Prior Approval must still meet all other coverage terms, conditions, and limitations. Coverage for approved services may still be limited or denied if, when the claims for such services are received by us, investigation shows that a benefit exclusion or limitation applies because of a difference in the Health Intervention described in the pre-service claim and the actual Health Intervention, that the Member ceased to be eligible for benefits on the date services were provided, that coverage lapsed for non-payment of premium, that out-of-network limitations apply, or any other basis specified in this Evidence of Coverage. For more information about pre-service claims and Prior Approval, please see Subsection 7.1.3.b.**

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

5. In connection with a mastectomy resulting from cancer surgery, services for (a) reconstruction of the breast on which the cancer-related surgery was performed; (b) surgery to reconstruct the other breast to produce a symmetrical appearance; and (c) prostheses and services to correct physical complications for all stages of the mastectomy, including lymphademas.

6. Reduction mammoplasty, if such reduction mammoplasty meets Coverage Criteria and is Prior Approved by Health Advantage is covered.

3.23 **Medications.** Subject to all terms, conditions, exclusions and limitations of the Plan set forth in this Evidence of Coverage, coverage is provided for Prescription Medication. (See Subsection 10.86-Prescription Medication.) This coverage varies, depending upon the sites of service where the Medication is received by the Member.

1. **Sites of Service**

a. **Hospital or Ambulatory Surgical Center.** The benefit for Medications received from a Hospital or an Ambulatory Surgical Center is included in the Allowance or Allowable Charge for the Hospital or Ambulatory Surgery Center Services. See Subsections 3.3 and 3.4.

b. **Physician's Office.** The benefit for Medications administered in a Physician's office is covered based upon the Allowance or Allowable Charge for the Medication and subject to the Deductible, Coinsurance and Copayment specified in the Schedule of Benefits. Conditions of coverage set forth in Subsections 3.23.2.a, b and c are applicable to this coverage.

c. **Retail Pharmacy (Drug Store).** The benefit for Medications received from a licensed retail pharmacy is covered based upon the Allowable Charge for the Medication and subject to the applicable Prescription Drug Copayment specified in the Schedule of Benefits.

i. **Covered Medications.** Generally only A Medications are covered under this Subsection 3.23.1.c., however a limited number of B Medications are covered under this Subsection 3.23.1.c. B Medications are covered under Subsections 3.23.1.a, b and d. (See Subsection 9.89 for definitions of "A Medications" and "B Medications.")

ii. **Administration Charges.** Charges to administer or inject any Medication are not covered under this Subsection 3.23.1.c.

iii. **Conditions of Coverage.** Conditions of coverage set forth in Subsections 3.23.2. a, b, c, d and e are applicable to this coverage.

iv. **ID Card Presentation.** In order to receive benefits for a Prescription Medication under this Subsection 3.23.1.c, a Member must present his or her Health Advantage ID card to a Participating Pharmacy at the time the Member purchases the Prescription Medication. ("Participating Pharmacy" is defined in Subsection 9.75.) The pharmacist will electronically notify Health Advantage's prescription benefits processor. The prescription benefits processor will electronically inform the pharmacist whether the Plan provides benefits for the Prescription Medication. If the prescription benefits processor indicates that the Plan does not provide benefits, the Member may call the Pharmacy Help Line telephone number on the back of his or her ID card. If the Plan provides benefits, the pharmacist will charge the Member the applicable Copayment for the Prescription Medication. Applicable Prescription Copayments are listed in Schedule of Benefits. Health Advantage will only accept a post-purchase or paper claim for Prescription Medications purchased through a retail pharmacy (drug store) if such claim is submitted (1) for an Emergency Prescription, (See Subsection 10.33.), (2) for Prescription Medication purchased prior to the date the Member received his or her Health Advantage ID card or (3) in accordance with Subsection 3.23.1.c.v. below.

v. **Claim Submission.** The presentation of a Prescription to a pharmacist in accordance with this Subsection 3.23.1.c is not a claim for benefits under the terms of the Plan. However, a Member may submit a claim if, upon such a

presentation, the pharmacist informs the Member that, because of the provisions of the Plan, the Plan has rejected benefits for the requested Prescription Medication.

vi. **Non-Participating Pharmacies.** Medications purchased from a non-Participating Pharmacy, except in an emergency situation, are not covered.

vii. **Emergency.** When a Member receives a Prescription Medication in connection with Emergency Care as defined in this Evidence of Coverage (See Subsection 10.32) and is unable to obtain the Medication from a Participating Pharmacy, the Member should purchase the Medication at the nearest pharmacy and submit a prescription claim form for reimbursement. The claim payment will be limited to the Allowable Charge, less the applicable Prescription Copayment.

viii. **Medical Supplies.** Medical supplies such as, but not limited to, colostomy supplies, bandages and similar items are not generally covered under this Subsection 3.23.1.c; however, refer to Subsections 3.13 Medical Supplies and Subsection 3.23.1.d, below. Furthermore, subject to the terms, conditions, exclusions and limitations of the Plan as set forth in this Evidence of Coverage, coverage is provided under this Subsection 3.23.1.c for insulin and syringes purchased at the same time as insulin and which are to be used for the sole purpose of injecting insulin. Syringes not meeting this standard are not covered. In addition, certain blood glucose test meter supplies such as test strips and lancets are covered under the pharmacy benefit.

ix. **Immunizations.** Immunization agents and vaccines identified as preventive care vaccines for adults and children, see Subsection 3.2., are covered when obtained at a retail pharmacy.

x. **Durable Medical Equipment.** Durable Medical Equipment, even though such device may require a prescription, such as, but not limited to, therapeutic devices, artificial appliances, blood glucose test meters, or similar devises, are not covered under this Subsection 3.23.1.c. Refer to Subsection 3.12. – Durable Medical Equipment. However, certain blood glucose test meter supplies, such as test strips and lancets, are covered under the pharmacy benefit.

xi. **Prescriptions, Excluded Providers**. Prescriptions ordered or written by any Physician or Provider who is excluded from coverage under the Plan, are not covered. Prescriptions presented to or filled by any Pharmacy which is excluded from coverage under the Plan, are not covered. See Subsection 4.1.

xii. **Copayment Information**

Each Prescription is covered only after the Member pays the applicable Copayment (listed on the Member's Schedule of Benefits) to the Participating Pharmacy. Members will be charged the appropriate Copayment for each Prescription or refill. An initial fill of a Maintenance Medication Prescription is covered for one month only. A refilled Maintenance Medication Prescription may be covered for up to a 3-month supply with one Copayment applied for each month's supply. (See Subsection 10.56 - Maintenance Medication.)

When a Generic Medication is dispensed, the Member will pay the second tier Medication Copayment specified in the Schedule of Benefits for each initial and refill Prescription. If there is no generic equivalent, the Member will pay the Brand Name Medication Prescription Drug Copayment for each initial and refill Prescription.

If a Brand Name Medication is dispensed when a Generic Medication is available, the Member will pay the Prescription Drug Copayment plus the difference in the cost of the Brand Name Medication and Generic Medication, or the cost of the medication, whichever is less.

d. **Home Infusion Therapy Pharmacy.** The benefit for Medications received from a licensed retail pharmacy designated by Health Advantage as a home infusion therapy Provider is covered based upon the Allowance or Allowable Charge for the Medication.

i. **Covered Medications.** A Medications and B Medications are covered under this Subsection 3.23.1.d. (See Subsection 10.86 for definitions of "A Medications" and "B Medications.") A Medications are covered subject to the Prescription Medication Copayment as listed in the Schedule of Benefits. B Medications are covered subject to the Contract Year Deductible and Coinsurance listed in the Schedule of Benefits.

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

iii. **Conditions of Coverage.** Conditions of coverage set forth in Subsections 3.23.2. a, b, c, d and e are applicable to this coverage.

iv. **Medical Supplies.** Medical Supplies used in connection with home infusion therapy are covered under this Subsection 3.23.1.d. See Subsection 3.13.

v. **Administration Charges.** Charges to administer or inject Medication by a licensed medical professional operating under his/her scope of practice are covered under this Subsection 3.23.1.d. according to the allowable fee schedule for skilled nursing under both home infusion therapy and Home Health.

2. **Conditions of Coverage**

a. **Prior Approval.** Selected Prescription Medications, as designated from time to time by Health Advantage, are subject to Prior Approval through criteria established by Health Advantage before coverage is allowed. A list of Medications for which Prior Approval is required is available from Health Advantage upon request or, if you have Internet access, you may review this list on Health Advantage's web site at WWW.HEALTHADVANTAGE-HMO.COM. This Subsection 3.23.2.a. is applicable to Prescription Medication covered by Subsections 3.23.1.b, c. and d.

b. **Specialty Medications.** Selected Prescription Medications are designated by Health Advantage as "Specialty Medications" due to their route of administration, approved indication, unique nature, or inordinate cost. These medications usually require defined handling and home storage demands, crucial patient education, and careful monitoring. Such medications include, but are not limited to growth hormones, blood modifiers, immunoglobulins, and medications for the treatment of hemophilia, deep vein thrombosis, hepatitis C, Crohn's disease, cystic fibrosis, multiple sclerosis and rheumatoid arthritis. Specialty Medications may be A Medications or B Medications. Coverage for Specialty Medications is subject to Prior Approval and may only be purchased through a specialty pharmacy vendor under contract with Health Advantage. The benefit for a Specialty Medication is subject to the Contract Year Deductible and Coinsurance specified in the Schedule of Benefits. A list of Specialty Medications is available from Health Advantage upon request or, if you have Internet access, you may review this list on Health Advantage's web site at WWW.HEALTHADVANTAGE-HMO.COM. This Subsection 3.23.2.b is applicable to Prescription Medication covered by Subsections 3.23.1.b, c. and d.

c. **Formulary.** Except in limited circumstances set out in this Subsection 3.23.2.c. and elsewhere in this Evidence of Coverage, a Prescription Medication must be listed in the Formulary in order to be covered. (See Subsection 10.36 Formulary.) However, if a Prescription Medication in the Formulary causes or has caused adverse or harmful reactions for a particular Member, or has been shown to be ineffective in the treatment of a Member's particular disease or condition, such Member may be able to obtain coverage for a Prescription Medication not in the Formulary by requesting Prior Approval. This Subsection 3.23.2.c is applicable to Prescription Medication covered by Subsections 3.23.1. b., c. and d.

d. **Step Therapy.** Selected Prescription Medications as designated from time to time by Health Advantage in its discretion, are subject to Step Therapy restrictions. (See Subsection 10.103 - Step Therapy.) Such Step Therapy must be completed before coverage for the selected Prescription Medication is provided. The Step Therapy requirements for a particular Prescription Medication are available from Health

Advantage upon request. This Subsection 3.23.2.d is applicable to Prescription Medication covered by Subsections 3.23.1.c. and d.

e. **Dispensing Quantities — Limitations**

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

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

Coverage of selected Prescription Medications as designated from time to time by Health Advantage in its discretion, is subject to Dose Limitations. (See Subsection 10.29 - Dose Limitation.) The Dose Limitation for a particular Prescription Medication is available from Health Advantage upon request.

This Subsection 3.23.2.e is applicable to Prescription Medication covered by Subsections 3.23.1. d.

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

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

2 *Except for kidney and cornea transplants, coverage for transplant services requires Prior Approval by Health Advantage.* A request for approval must be submitted to Health Advantage prior to receiving any transplant services, including transplant evaluation. **Failure of the Member's treating Provider to submit a pre-service claim for Prior Approval will result in denial of coverage. PLEASE NOTE: Prior Approval does not guarantee payment or assure coverage; it means only that the information furnished to Health Advantage in the pre-service claim indicates that the organ transplant meets the Primary Coverage Criteria requirements set out in Subsection 2.2 and the Applications of the Primary Coverage Criteria set out in Subsections 2.4.1.b, e., or f. and is not subject to a Specific Plan Exclusion (see Section 4.0). All Health Interventions receiving Prior Approval must still meet all other coverage terms, conditions, and limitations. Coverage for approved services may still be limited or denied if, when the claims for such services are received by us, investigation shows that a benefit exclusion or limitation applies because of a difference in the Health Intervention described in the pre-service claim and the actual Health Intervention, that the Member ceased to be eligible for benefits on the date services were provided, that coverage lapsed for non-payment of premium, that out-of-network limitations apply, or any other basis specified in this Evidence of Coverage. For more information about pre-service claims and Prior Approval, please see Subsection 7.1.3.b**

3. The transplant benefit is subject to the Deductible, Copayment and Coinsurance specified in the Schedule of Benefits.

4. Notwithstanding any other provisions of this Evidence of Coverage, at the option of Health Advantage, the Allowance or Allowable Charge for an organ transplant, including any charge for the procurement of the organ, Hospital services, Physician Services and associated costs, including costs of complications arising from the original procedure that occur within the Transplant Global Period, shall be limited to the lesser of (a) ninety percent (90%) of the billed charges or (b) the global payment determined as payment in full by a Blue Cross and Blue Shield Association Blue Distinction Centers for Transplant participating facility, if the Member chooses to use that facility. If the Member receives the transplant from a facility outside of Arkansas that is not in the Blue Distinction Centers for Transplant network, but is contracted with a local Blue Cross and/or Blue Shield Plan, the Allowable Charge shall be the price contracted by such Blue Cross and/or Blue Shield Plan. (See Section 7.1.10 Out of Arkansas Claims). If the Member 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 Allowance or Allowable Charge for the transplant services provided in the Transplant Global Period is eighty (80%) percent of an amount equaling the lesser of (a) ninety (90%) percent of billed charges or (b) the average allowable charge authorized by participating facilities in the Blue Distinction Centers for Transplant network located in the geographic region

where the transplant is performed. **Please note that our payments for any transplant (whether performed within the transplant network or by a non-participating facility) are limited to a global payment that applies to all covered transplant services; we will not pay any amounts in excess of the global payment for services the facility or any physician or other health care Provider or supplier may bill or attempt to bill separately, because the global payment is deemed to include payment for all related necessary services (other than non-covered services). If you use a facility participating in the Blue Distinction Centers for Transplant network, that facility has agreed to accept the global payment as payment in full, and should not bill you for any excess amount above the global payment, except for applicable Deductible, Coinsurance or non-covered services; however, a non-participating facility may bill you for all amounts it may charge above the global payment. These charges above the global payment could amount to thousands of dollars in additional out of pocket expenses to you.**

5. When the Member is the potential transplant recipient, a living donor's Hospital costs for the removal of the organ are covered with the following limitations:
   a. Allowance or Allowable Charges are only covered for the period beginning on the day before the transplant to the date of discharge or 39 days, whichever is less.
   b. Donor testing is covered only if the tested donor is found compatible.
6. Solid organ transplants of any kind are not covered for individuals with a malignancy that is presently active or in partial remission. A solid organ transplant of any kind is not covered for a Member that has had a malignancy removed or treated in the 3 years prior to the proposed transplant. For purposes of this section, malignancy includes a malignancy of the brain or meninges, head or neck, bronchus or lung, thyroid, parathyroid, thymus, pleura, esophagus, heart or pericardium, liver, stomach, small or large bowel, rectum, kidney, bladder, prostate, testicle, ovary, uterus, other organs associated with the genito-urinary tract, bones, muscle, nerves, blood vessels, leukemia, lymphoma or melanoma, and breast. The only exception to this non-coverage is for solid organ transplant for hepatocellular carcinoma under certain circumstances, as outlined in the Coverage Policy for hepatocellular carcinoma.
7. Coverage for high-dose or non-myeloablative chemotherapy, allogeneic or autologous stem or progenitor cell transplantation for the treatment of a medical condition is provided subject to Health Advantage's specific Coverage Policies relative to these specific conditions.

3.25 **Medical Disorder Requiring Specialized Nutrients or Formulas.** Subject to all terms, conditions, exclusions, and limitations of the Plan as set forth in this Evidence of Coverage, and any Deductible, Copayment, and Coinsurance specified in the Schedule of Benefits, coverage is provided for Medical Foods and Low Protein Modified Food Products, amino-acid-based elemental formulas, extensively hydrolyzed protein formulas, formulas with modified vitamin or mineral content and modified nutrient content formulas for the treatment of a Member diagnosed with a Medical Disorder Requiring Specialized Nutrients or Formulas if

1. 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
2. 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.

3.26 **Prenatal Tests and Testing of Newborn Children.** Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Evidence of Coverage, coverage is provided for prenatal tests and tests of newborn children that are supported by Coverage Policy. Examples of such tests that are covered include testing for Down's syndrome, hypothyroidism, sickle-cell anemia, phenylketonuria/galactosemia, (PKU) and other disorders of metabolism.

3.27 **Testing and Evaluation.** Subject to all other terms, conditions, exclusions and limitations of the Plan set forth in this Evidence of Coverage, coverage is provided for the following testing and evaluation. This benefit is further subject to the Deductible, Copayment and Coinsurance specified in the Schedule of Benefits.

1. Psychological testing, including but not limited to, assessment of personality, emotionality and intellectual abilities;

2. For Children under the age of six (6), childhood developmental testing, including but not limited to assessment of motor, language, social, adaptive or cognitive function by standardized developmental instruments;
3. Neurobehavioral status examination, including, but not limited to assessment of thinking, reasoning and judgment;
4. Neuropsychological testing, including, but not limited to Halstead-Reitan, Luria and WAIS-R.

3.28 **Complications of Smallpox Vaccine.** Subject to all other terms, conditions, exclusions and limitations of the Plan as set forth in this Evidence of Coverage, coverage is provided for complications resulting from a smallpox vaccination. This benefit is subject to the Deductible, Copayment and Coinsurance specified in the Schedule of Benefits.

3.29 **Neurologic Rehabilitation Facility Services.** Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Evidence of Coverage, coverage is provided for Neurologic Rehabilitation Facility services. This benefit is subject to the Deductible, Copayment and/or Coinsurance specified in the Schedule of Benefits. This Neurologic Rehabilitation Facility services benefit is subject to the following conditions:

1. The Member must be suffering from Severe Traumatic Brain Injury;
2. The admission must be within seven days of release from an inpatient Hospital stay;
3. A request for Prior Approval must be submitted to Health Advantage to the Member receiving Neurologic Rehabilitation Facility services. **Failure of the Member's treating Provider to submit a pre-service claim for Prior Approval will result in denial of coverage. PLEASE NOTE: Prior Approval does not guarantee payment or assure coverage; it means only that the information furnished to Health Advantage in the pre-service claim indicates that the neurologic rehabilitation facility services meet the Primary Coverage Criteria requirements set out in Subsection 2.2 and the Applications of the Primary Coverage Criteria set out in Subsections 2.4.1.b, e., or f. and is not subject to a Specific Plan Exclusion (see Section 4.0). All Health Interventions receiving Prior Approval must still meet all other coverage terms, conditions, and limitations. Coverage for approved services may still be limited or denied if, when the claims for such services are received by us, investigation shows that a benefit exclusion or limitation applies because of a difference in the Health Intervention described in the pre-service claim and the actual Health Intervention, that the Member ceased to be eligible for benefits on the date services were provided, that coverage lapsed for non-payment of premium, that out-of-network limitations apply, or any other basis specified in this Evidence of Coverage. For more information about pre-service claims and Prior Approval, please see Subsection 7.1.3.b.**
4. The Neurologic Rehabilitation Facility services are of a temporary nature with a potential to increase ability to function;
5. Custodial Care is not covered (See Subsections 4.3.7 and 10.22); and
6. Coverage is provided for a maximum of 60 days per Member per lifetime.

3.30 **Pediatric Vision Services.** Subject to all terms, conditions, exclusions and limitations of the Plan set forth in this Evidence of Coverage, coverage is provided for the following pediatric vision services when performed or prescribed by a Physician subject to the Deductible, Copayment and Coinsurance amounts specified in the Schedule of Benefits.

1. Annual routine eye examinations with refraction are covered beginning at age six, or earlier if medically indicated, through age 18.
2. One pair of lenses in a Contract Year, if prescribed by a physician.
   a. Lenses may be prescription glasses or contact lenses.
   b. Lenses may be plastic or polycarbonate lenses.
3. One frame in a Contract Year if lenses are prescribed and prescription glasses selected.
4. Eye Glass repair if glasses were originally covered by this Evidence of Coverage.
5. Replacement of lost or broken glasses, only one time within a year, each additional pair requires prior approval from Health Advantage.
6. Eye prosthesis or polishing services, subject to Prior Approval from Health Advantage
7. Eyeglasses for children diagnosed as having the following diagnoses must have a surgical evaluation in conjunction with supplying eyeglasses:

a. Ptosis (droopy lid)
b. Congenital cataracts
c. Exotropia or vertical tropia
d. Children between the ages of twelve (12) and twenty-one (21) exhibiting exotropia

8. Vision therapy developmental testing with Prior Approval.
   a. orthoptic and pleoptic training with continuing medical direction and evaluation;
   b. sensorimotor examination with multiple measurements of ocular deviation (e.g., restrictive or paretic muscle with diplopia) with interpretation and report (separate procedure);
   c. developmental testing extended (includes assessment of motor, language, social, adaptive and/or cognitive functioning by standardized developmental instruments) with interpretation and report.

Failure of the Member's treating Provider to submit a pre-service claim for Prior Approval will result in denial of coverage. PLEASE NOTE: Prior Approval does not guarantee payment or assure coverage; it means only that the information furnished to Health Advantage in the pre-service claim indicates that the pediatric vision services meet the Primary Coverage Criteria requirements set out in Subsection 2.2 and the Applications of the Primary Coverage Criteria set out in Subsections 2.4.1.b, e., or f. and is not subject to a Specific Plan Exclusion (see Section 4.0). All Health Interventions receiving Prior Approval must still meet all other coverage terms, conditions, and limitations. Coverage for approved services may still be limited or denied if, when the claims for such services are received by us, investigation shows that a benefit exclusion or limitation applies because of a difference in the Health Intervention described in the pre-service claim and the actual Health Intervention, that the Member ceased to be eligible for benefits on the date services were provided, that coverage lapsed for non-payment of premium, that out-of-network limitations apply, or any other basis specified in this Evidence of Coverage. For more information about pre-service claims and Prior Approval, please see Subsection 7.1.3.b.

3.31 **Adult Vision Services.** Subject to all terms, conditions, exclusions and limitations of the Plan set forth in this Evidence of Coverage, coverage is provided for one routine vision examination every 2 years by a Provider who is an optometrist or ophthalmologist.

3.32 **Hearing Aid Benefits.** Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Evidence of Coverage, coverage is provided for a Hearing Aid sold by a professional licensed by the State of Arkansas to dispense a Hearing Aid or hearing instrument. Coverage shall not be subject to member cost sharing but shall be limited to $1,400 per ear.

3.33 **Temporomandibular Joint Benefits.** Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Evidence of Coverage, the coverage is provided for the Allowance or Allowable Charges for medical treatment of musculoskeletal disorders affecting any bone or joint in the face, neck or head, including temporomandibular joint disorder and craniomandibular disorder. Medical treatment shall include both surgical and nonsurgical procedures.

3.34 **Miscellaneous Health Interventions.** Subject to all other terms, conditions, exclusions and limitations of the Plan set forth in this Evidence of Coverage, coverage is provided for the following:

1. **Chelation Therapy.** Chelation therapy is generally not covered, see Subsection 4.2.14. However, subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Evidence of Coverage, chelation therapy for control of ventricular arrhythmias or heart block associated with digitalis toxicity, emergency treatment of hypercalcemia, extreme conditions of metal toxicity, including thalassemia intermedia with hemosiderosis, Wilson's disease (hepatolenticular degeneration), lead poisoning and hemochromatosis is covered.
2. **Clinical Trials.** Phase I, II, III or IV clinical trials or any study to determine the maximum tolerated dose, toxicity, safety, efficacy, or efficacy as compared with a standard means of treatment or diagnosis of a drug, device or medical treatment or procedure are not covered. See Subsection 4.3.3. However, subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Evidence of Coverage, Routine Patient Costs for items and services furnished in connection with participation in the clinical trial are covered, provided the Member is eligible to participate and has been approved for participation in accordance with the protocols of the clinical trial and the clinical trial is an Approved Clinical Trial**.** See Subsections 10**.**7 and 10.96.

3. **Contraceptive Devices.** Subject to all other terms, conditions, exclusions and limitations of the Plan as set forth in this Evidence of Coverage, coverage is provided for contraceptive devices when prescribed by a Physician.

4. **Dietary and Nutritional Counseling Services.** Subject to all other terms, conditions, exclusions and limitations of the Plan as set forth in this Evidence of Coverage, and subject to the Deductible, Copayment and Coinsurance specified in the Schedule of Benefits, coverage is provided for dietary and nutritional counseling services when provided in conjunction with Diabetic Self-Management Training, for services needed by Members in connection with cleft palate management and for nutritional assessment programs provided in and by a Hospital and approved by Health Advantage.

5. **Electrotherapy stimulators.** Treatment using electrotherapy stimulators are generally not covered, see Subsection 4.2.30. However, coverage is provided for a Transcutaneous Electrical Nerve Stimulator (TENS) to treat chronic pain due to peripheral nerve injury when that pain is unresponsive to medication.

6. **Enteral Feedings.** Enteral feedings are generally not covered, see Subsection 4.2.32. However, enteral feedings are covered when such feedings have been approved and documented by an In-Network Physician as being the Member's sole source of nutrition. Enteral feedings require Prior Approval from Health Advantage. **Failure of the Member's treating Provider to submit a pre-service claim for Prior Approval will result in denial of coverage. PLEASE NOTE: Prior Approval does not guarantee payment or assure coverage; it means only that the information furnished to Health Advantage in the pre-service claim indicates that the enteral feedings meet the Primary Coverage Criteria requirements set out in Subsection 2.2 and the Applications of the Primary Coverage Criteria set out in Subsections 2.4.1.b, e., or f. and is not subject to a Specific Plan Exclusion (see Section 4.0). All Health Interventions receiving Prior Approval must still meet all other coverage terms, conditions, and limitations. Coverage for approved services may still be limited or denied if, when the claims for such services are received by us, investigation shows that a benefit exclusion or limitation applies because of a difference in the Health Intervention described in the pre-service claim and the actual Health Intervention, that the Member ceased to be eligible for benefits on the date services were provided, that coverage lapsed for non-payment of premium, that out-of-network limitations apply, or any other basis specified in this Evidence of Coverage. For more information about pre-service claims and Prior Approval, please see Subsection 7.1.3.b.**

7. **Gastric Pacemaker Coverage.** Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Evidence of Coverage including the Deductible, Copayment and/or Coinsurance set out in the Schedule of Benefits, coverage is provided for gastric pacemakers that receive Prior Approval from Health Advantage. **Failure of the Member's treating Provider to submit a pre-service claim for Prior Approval will result in denial of coverage. PLEASE NOTE: Prior Approval does not guarantee payment or assure coverage; it means only that the information furnished to Health Advantage in the pre-service claim indicates that the gastric pacemaker meet the Primary Coverage Criteria requirements set out in Subsection 2.2 and the Applications of the Primary Coverage Criteria set out in Subsections 2.4.1.b, e., or f. and is not subject to a Specific Plan Exclusion (see Section 4.0). All Health Interventions receiving Prior Approval must still meet all other coverage terms, conditions, and limitations. Coverage for approved services may still be limited or denied if, when the claims for such services are received by us, investigation shows that a benefit exclusion or limitation applies because of a difference in the Health Intervention described in the pre-service claim and the actual Health Intervention, that the Member ceased to be eligible for benefits on the date services were provided, that coverage lapsed for non-payment of premium, that out-of-network limitations apply, or any other basis specified in this Evidence of Coverage. For more information about pre-service claims and Prior Approval, please see Subsection 7.1.3.b.**

8. **High Frequency Chest Wall Oscillators.** Subject to all other terms, conditions, exclusions and limitations of the Plan as set forth in this Evidence of Coverage, and subject to the Deductible, Copayment and Coinsurance specified in the Schedule of Benefits, coverage is

provided, to Member's age two (2) or older with cystic fibrosis, for one high frequency chest wall oscillator during such Member's lifetime.

9. **Inotropic Agents for Congestive Heart Failure.** Chronic, intermittent infusion of positive inotropic agents for patients with severe congestive heart failure is not covered. See Subsection 4.2.52. However, subject to all terms, conditions, exclusions and limitations of the Plan set forth in this Evidence of Coverage, where the patient is on a cardiac transplant list at a Hospital where there is an ongoing cardiac transplantation program, the Plan will cover infusion of inotropic agents.

10. **Pilot Project Coverage.** Subject to all terms, conditions, exclusions and limitations of the Plan set forth in this Evidence of Coverage, from time to time, Health Advantage may provide coverage of medical Interventions that are excluded under the terms of the Plan as set out in this Evidence of Coverage, under terms, conditions, exclusions and limitations of a Company authorized Pilot Program. You can learn the medical Interventions that are covered by a Company authorized Pilot Program, and the terms, conditions, exclusions and limitations of such coverage by visiting Health Advantage's website at WWW.HEALTHADVANTAGE-HMO.COM or by calling Customer Service.

11. **Trans-telephonic Home Spirometry**. Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Evidence of Coverage, trans-telephonic home or ambulatory spirometry is covered for patients who have had a lung transplant.

12. **Vision Enhancement.** For persons 19 years and older vision enhancements are generally not covered, see Subsection 4.2.99. However, subject to all other terms, conditions, exclusions and limitations of the Plan as set forth in this Evidence of Coverage, a procedure, treatment, service, equipment or supply to correct a refractive error of the eye is covered in two instances: (1) if such refractive error results from traumatic injury or corneal disease, infectious or non infectious, and (2) the single acquisition of eyeglasses or contact lenses within the first six months following cataract surgery. The Plan does not cover the implantation of a multifocal lens; however, if a multifocal lens is implanted after a cataract extraction, the Plan will pay the Allowance or Allowed Charge for a monofocal lens. With respect to such eyeglasses or contact lenses, tinting or anti-reflective coating and progressive lenses are not covered. See Subsection 3.12.4. In addition, subject to all other terms, conditions, exclusions and limitations of the Plan as set forth in this Evidence of Coverage, certain vision enhancement is provided to Members under the age of 19. See Subsection 3.30 - Pediatric Vision Services.

4.0 SPECIFIC PLAN EXCLUSIONS

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

4.1 Health Care Providers.

1. Custodial Care Facility. Services or supplies furnished by an institution which is primarily a place of rest or a place for the aged are not covered. Youth homes, boarding schools, or any similar institution are not covered.
2. Freestanding Cardiac Care Facility. Treatment received at a Freestanding Cardiac Care Facility is not covered.
3. Immediate Relatives. Professional services performed by a person who ordinarily resides in the Member's home, including self, or is related to the Member as a Spouse, parent, Child, brother or sister, grandparent and grandchild, whether the relationship is by blood or exists in law are not covered.
4. Midwives, Not Certified. Services provided by a midwife who is not a licensed certified nurse midwife in the state where he or she renders services and who does not have a collaborative agreement with a Physician are not covered.
5. Physical Therapy Aide. Services or supplies provided by a physical therapy aide are not covered.
6. Provider, Excluded. Health Interventions received from any Provider who has been excluded from participation in any federally funded program, are not covered.

7. Provider, Undefined. Services or supplies provided by an individual or entity that is not a Provider as defined in this Evidence of Coverage are not covered. (See Subsection 10.91 Provider.)
8. Recreational Therapist. Services or supplies provided by a recreational therapist are not covered.
9. Residents, interns, students or fellows. Services performed or provided by a Hospital resident, intern, student or fellow of any medical related discipline are not covered.
10. Surgical First Assistants. Health Advantage does not recognize surgical first assistants as a covered provider eligible for reimbursement for Covered Services. Any services performed by a surgical first assistant will be denied.
11. Unlicensed Providers or Provider Outside Scope of Practice. Coverage is not provided for treatment, procedures or services received from any person or entity, including but not limited to Physicians, who is required to be licensed to perform the treatment, procedure or service, but (1) is not so licensed, or (2) has had his license suspended, revoked or otherwise terminated for any reason, or (3) has a license that does not, in the opinion of Health Advantage's Medical Director, include within its scope the treatment, procedure or service provided.

4.2 **Health Interventions.**

1. Abortion. Abortion is not covered. However, subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Evidence of Coverage, pregnancy terminations under the direction of a Physician are covered, but only when performed in an In-Network Hospital or In-Network Outpatient Hospital setting.
2. Abuse of Medications. Medications, drugs or substances used in an abusive, destructive or injurious manner are not covered, except when caused by a mental or physical illness.
3. Acupuncture. Acupuncture and services related to acupuncture are not covered.
4. Adoptive Immunotherapy. Adoptive immunotherapy, (lymphokine-activated killer (LAK) therapy, tumor-infiltrating lymphocyte (TIL) therapy, autolymphocyte therapy (ATL)) is not covered.
5. Antigen immunotherapy. Antigen immunotherapy for repeat fetal loss is not covered.
6. Arthroereisis for Pes Planus (Flat Feet). This treatment is sometimes used to treat flat feet and is not covered.
7. Balloon Sinuplasty. A balloon sinuplasty device is sometimes used for treatment of sinusitis and is not covered.
8. Bereavement services. Medical social services and outpatient family counseling and/or therapy for bereavement, except if provided as Hospice Care, are not covered.
9. Biochemical Markers for Alzheimer's Disease. Measurement of cerebrospinal fluid and urinary biomarkers of Alzheimer's disease including but not limited to tau protein, amyloid beta peptides and neural thread proteins are not covered.
10. Biofeedback. Biofeedback and other forms of self-care or self-help training, and any related diagnostic testing are not covered for any diagnosis or medical condition.
11. Blood Typing. Blood Typing or DNA analysis for paternity testing is not covered.
12. Bone Growth Stimulation, electrical, as an adjunct to cervical fusion surgery. Electrical Bone Growth Stimulation used as an adjunct to cervical fusion surgery is not covered.
13. Chelation therapy**.** Services or supplies provided as, or in conjunction with, chelation therapy, are generally not covered. Subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Evidence of Coverage, chelation therapy for control of ventricular arrhythmias or heart block associated with digitalis toxicity, emergency treatment of hypercalcemia, extreme conditions of metal toxicity, including thalassemia intermedia with hemosiderosis, Wilson's disease (hepatolenticular degeneration), lead poisoning and hemochromatosis is covered. See Subsection 3.34.1.
14. Chemical Ecology. Diagnostic studies and treatment of multiple chemical sensitivities, environmental illness, environmental hypersensitivity disorder, total allergy syndrome or chemical ecology is not covered.
15. Cognitive Rehabilitation. Services or supplies provided as or in conjunction with, Cognitive Rehabilitation are not covered. See Subsection 10.12. However, subject to all terms, conditions, exclusions and limitation of the Plan as set forth in this Evidence of Coverage,

coverage is provided for Neurologic Rehabilitation Facility Services for Members with Severe Traumatic Brain Injury. See Subsection 3.29.

16. Cold Therapy. Cold Therapy devices are used in place of ice packs. The use of active or passive, intermittent or continuous, with or without pneumatic compression, cold therapy is not covered. Examples of cold therapy devices include, but are not limited to, the Cryocuff device, the Polar Care Cub device, the Autochill device, and the Game Ready device.
17. Compound Medications. Except for compounded morphine, Compound Medications are not covered.
18. Complications of non-covered treatments. Care, services or treatment required as a result of complications from a treatment or service not covered under this Evidence of Coverage are not covered.
19. Compression Garments. All types of compression garments, support hose or elastic supports are not covered even when purchased with a Prescription. However, subject to all terms conditions, exclusions and limitation of the Plan as set forth in this document, coverage is provided for compression garments specifically designed to treat severe burns or compression sleeves and gloves used to treat lymphedemas following mastectomy.
20. Cord Blood. The collection and/or storage of cord or placental blood cells for an unspecified future use as an autologous stem-cell transplant in the original donor or for some other unspecified future use as an allogeneic stem-cell in a related or unrelated donor is not covered.
21. Coverage Policy. Health Advantage has developed and published on its website specific Coverage Policies in relation to certain Health Interventions. If a Coverage Policy exists for an Intervention, the Coverage Policy shall determine whether such intervention meets the Primary Coverage Criteria. *If, based on the Coverage Policy, it is determined that a Health Intervention does not meet the Primary Coverage Criteria, this Plan does not provide coverage for that Intervention.* The absence of a specific Coverage Policy with respect to any particular Health Intervention should not be construed to meant that the Intervention meets the Primary Coverage Criteria.
22. Cranial electrotherapy or cranial electromagnetic stimulation devices. Cranial electrotherapy or electromagnetic stimulation devices are not covered.
23. Current Perception Threshold Testing. This testing performed as a substitute for standard nerve conduction studies in diagnosing carpal tunnel or tarsal tunnel syndrome is not covered.
24. Dental Care or orthodontic services. Dental Care and orthodontic services are not covered.
    a. Benefits for Accidental Injury. However, if a Member has an Accidental Injury, benefits will be provided, subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Evidence of Coverage, for Dental Care and x-rays necessary to correct damage to a Non-diseased Tooth or surrounding tissue caused by the Accidental Injury. The Member must seek treatment within 72 hours of injury for services to be covered. Coverage is subject to the Deductible, Copayment and Coinsurance specified in the Schedule of Benefits with the following limitations:
        i. Only the Non-diseased Tooth or Teeth avulsed or extracted as a direct result of the Accidental Injury and the Non-diseased Tooth or Teeth immediately adjacent will be considered for replacement.
        ii. Orthodontic services are limited to the stabilization and re-alignment of the accident-involved teeth to their pre-accident position. Reimbursement for this service will be based on a per tooth allowance.
        iii. Injury to teeth while eating is not considered an Accidental Injury.
        iv. Double abutments are not covered.
        v. Any Health Intervention related to dental caries or tooth decay is not covered.
        vi. Removal of teeth is not covered.
    b. Benefits for dental services. Dental services in connection with radiation treatment for cancer of the head or neck are covered.
    c. Benefits for anesthesia services. Hospital and Ambulatory Surgery Center services and anesthesia services related to dental or orthodontic procedures, including services to children, are covered in accordance with Subsection 3.3.3.

25. Dietary and Nutritional Services. Any services or supplies provided for dietary and nutritional services, including but not limited to medical nutrition therapy, unless such dietary supplies are the sole source of nutrition for the Member, are not covered. Baby formula or thickening agents, whether prescribed by a Physician or acquired over the counter, is not a covered benefit. However, subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Evidence of Coverage, coverage is provided for Medical Foods and Low Protein Modified Food Products for the treatment of a Medical Disorder Requiring Specialized Nutrients or Formulas. See Subsection 3.25.

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

27. Dynamic Orthotic Cranioplasty. Dynamic orthotic cranioplasty is not covered.

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

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

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

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

32. Enteral Feedings. Enteral feedings are generally not covered. However, subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Evidence of Coverage, enteral feedings are covered when such feedings have been approved and documented by an In-Network Physician as the Member's sole source of nutrition with Prior Approval by Case Management.

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

34. Epiduroscopy/spinal myeloscopy. This service is used in the diagnosis and treatment of spinal pain and is not covered.

35. Excessive Use. Excessive use of Medications is not covered. For purposes of this exclusion, each Member agrees that Health Advantage shall be entitled to deny coverage of medications on grounds of excessive use when Health Advantage's medical director, in his sole discretion, determines (1.) that a Member has exceeded the dosage level, frequency or duration of medications recommended as safe or reasonable by major peer-reviewed medical journals specified by the United States Department of Health and Human Services pursuant to section 1861(t)(2)(B) of the Social Security Act, 42 U.S.C. §1395(x)(t)(2)(B), as amended, standard

reference compendia or by the Pharmacy & Therapeutics Committee; or (2.) that a Member has obtained or attempted to obtain the same medication from more than one Physician for the same or overlapping periods of time; or (3.) that the pattern of Prescription purchases, changes of Physicians or pharmacy or other information indicates that a Member has obtained or sought to obtain excessive quantities of Medications. Each Member hereby authorizes Health Advantage to communicate with any Physician, health care Provider or pharmacy for the purpose of reviewing and discussing the Member's Prescription history, use or activity to evaluate for excessive use.

36. Exercise programs. Exercise programs for treatment of any condition are not covered.

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

38. Family Planning. The following family planning services are not covered.
    a. reversal of sterilization
    b. preimplantation
    c. surrogate mothers providing services for a Member
    d. treatment of infertility
    e. in vitro fertilization

39. Foot care. Non-custom shoe inserts are not covered. Services or supplies for the treatment of subluxations of the foot, arthroeresis for flat feet, care of corns, bunions, (except capsular or bone surgery), calluses, toe nails, fallen arches, weak feet, chronic foot strain, and symptomatic complaints of the feet are not covered. However, subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Evidence of Coverage, foot care is provided when required for prevention of complications associated with diabetes mellitus.

40. Fraud or Material Misrepresentation. Health Interventions, including but not limited to Medications, obtained by unauthorized or fraudulent use of the ID card or by material misrepresentation are not covered.

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

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

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

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

44. Hearing devices or talking aids. Regardless of the reason for the hearing or speech disability, prosthetic devices to assist hearing (except for hearing aids as covered in Subsection 3.32), or talking devices including special computers are not covered. The testing for, the fitting of or the repair of such prosthetic devices to assist hearing or talking devices is not covered. However, subject to all terms, conditions, exclusions and limitations of the Plan set forth in this Evidence of Coverage, coverage is provided for:

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

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

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

   i. congenital or surgically induced malformations (e.g. atresia) of the external ear canal or middle ear;

   ii. chronic external otitis or otitis media;

   iii. tumors of the external canal and/or tympanic cavity; and

   iv. sudden, permanent, unilateral hearing loss due to trauma, idiopathic sudden hearing loss, or auditory nerve tumor.

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

46. High dose Chemotherapy, Autologous Transplants, Allogeneic Transplants or Nonmyeloablative Allogeneic Stem Cell Transplantation. High dose Chemotherapy, Autologous Transplants, Allogeneic Transplants or Nonmyeloablative Allogeneic Stem Cell Transplantation are not covered except in accordance with Health Advantage's specific Coverage Policies. See Subsection 3.25.

47. Hippo Therapy. Hippo therapy is not covered.

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

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

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

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

52. Inotropic Agents for Congestive Heart Failure. Chronic, intermittent infusion of positive inotropic agents for patients with severe congestive heart failure is not covered. However, subject to all terms, conditions, exclusions and limitations of the Plan set forth in this Evidence of Coverage, where the patient is on a cardiac transplant list at a Hospital where there is an ongoing cardiac transplantation program, the Plan will cover infusion of inotropic agents.

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

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

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

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

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

58. Measurement of Exhaled Nitric Oxide. Measurement of Exhaled Nitric Oxide used in the diagnosis and management of asthma and other respiratory disorders is not covered.

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

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

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

62. Medical Supplies. Medical Supplies that can be purchased without a prescription or over the counter, whether or not a prescription was obtained, are not covered; for example, medication coated dressings, tape and gauze are not covered even with a Physician Prescription. However, subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Evidence of Coverage, Medical Supplies necessary for the management of diabetes mellitus or for home health services are covered. See Subsection 3.13 Medical Supplies, Subsection 3.15 Diabetes Management Services and Section 3.18 Home Health Services. Expenses for Medical Supplies provided in a Physician's office are included in the reimbursement for the procedure or service for which the supplies are used.

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

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

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

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

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

68. Off-Label Use. (a) Except as provided in subsection (b) or (c) of this subsection, Prescription Medications and devices that are not approved by the FDA for a particular use or purpose or when used for a purpose other than the purpose for which FDA approval is given are not covered. (b) From time to time a particular clinical use of a Prescription Medication may be determined to be safe and efficacious by the medical director, managed pharmacy director, and/or the Pharmacy and Therapeutics Committee, even without labeling of such indication or use by the FDA. This occurs because of clear and convincing evidence from the Medical Literature, and often in consultation with practicing Physicians of the appropriate specialty in the community. Such "off-label" use will be covered, though Prior Approval is often (but not always) required. Other than the list of Medications requiring Prior Approval cited above, a complete list of Medications and their approved off-label indications is not available. (c) A Prescription Medication approved by the FDA for the treatment of cancer, though not approved to treat the specific cancer for which it has been prescribed, will be covered provided:

    a. the Prescription Medication has been recognized as safe and effective for treatment of that specific type of cancer in any of the following standard reference compendia, unless

the use is identified as “not indicated” or otherwise inappropriate or not recommended, in one or more of these standard reference compendia: (A) The American Hospital Formulary Service Drug Information; (B) The National Comprehensive Cancer Network Drugs and Biologics Compendium; (C) The Elsevier Gold Standard’s Clinical Pharmacology; or

b. the Prescription Medication has been recognized as safe and effective for treatment of that specific type of cancer in two (2) articles from Medical Literature that have not had their recognition of the Prescription Medication’s safety and effectiveness contradicted by clear and convincing evidence presented in another article from Medical Literature; or

c. other authoritative compendia as identified by the Secretary of the United States Department of Health and Human Services or the commissioner may be used to provide coverage by Health Advantage at Health Advantage’s discretion.

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

70. Orthoptic, Pleoptic or Vision Therapy. Orthoptic, pleoptic or vision therapy services are generally not covered. However, subject to all terms, conditions, exclusions and limitations of the Plan as set out in this Evidence of Coverage, coverage is provided in the following instances: 1.) office-based orthoptic training in the treatment of convergence insufficiency when supported by the Coverage Policy on Orthoptic Training for the Treatment of Vision and Learning Disabilities or 2.) vision therapy developmental testing provided in accordance with Pediatric Vision Services. See Subsection 3.30.

71. Out-of-Network Infertility. Testing, counseling and planning services for infertility are not covered when provided by Out-of-Network Providers.

72. Out-of-Network Reconstructive Surgery. Services rendered for any Reconstructive Surgery, including reduction mammoplasty, are not covered when rendered by an Out-of-Network Provider.

73. Out-of-Network Therapy. Services rendered Out-of-Network for physical, occupational and speech therapy, chiropractic services and cardiac rehabilitation therapy are not covered.

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

75. Pain Pump, Disposable. Disposable pain pumps following surgery are not covered.

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

77. Percutaneous Sacroplasty. Percutaneous sacroplasty is not covered.

78. Peripheral Vascular Disease Rehabilitation Therapy. Peripheral vascular disease rehabilitation therapy is not covered.

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

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

81. Rest cures. Services or supplies for rest cures are not covered.

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

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

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

85. Short stature syndrome. Any services related to the treatment of short stature syndrome, except for laboratory documented growth hormone deficiency, are not covered.

86. Sleep Apnea, Portable Studies. Studies for the diagnosis, assessment or management of obstructive sleep apnea are generally not covered. However, subject to all other terms, conditions, exclusions and limitations of the Plan as set forth in this Evidence of Coverage, coverage is provided for portable (at home) sleep studies when all of the following seven channel monitoring information is included: EEG, heart rate, Chin EMG, ECG, airflow, effort and oxygen saturations, channels to identify awake versus asleep and apnea events. Devices used are considered portable comprehensive polysomnography devices monitoring a minimum of seven channels.

87. Smoking cessation/Caffeine addiction. Treatment of caffeine or nicotine addiction, smoking cessation Prescription Medication products not on our Formulary, including, but not limited to, nicotine gum and nicotine patches are not covered.

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

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

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

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

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

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

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

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

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

97. Transplant procedures. The following transplant procedures and services are not covered:
    a. Solid organ transplants of any kind are not covered for a Member with a malignancy of any kind that is presently active, in partial remission or in complete remission less than two years. A solid organ transplant of any kind is not covered for a Member that has had a malignancy removed or treated in the 3 years prior to the proposed transplant. For purposes of this section, malignancy includes a malignancy of the brain or meninges, head or neck, bronchus or lung, thyroid, parathyroid, thymus, pleura, esophagus, heart or pericardium, liver, stomach, small or large bowel, rectum, kidney, bladder, prostate, testicle, ovary, uterus, other organs associated with the genito-urinary tract, bones, muscle, nerves, blood vessels, leukemia, lymphoma or melanoma, and breast. Exceptions to this non-coverage are (i) hepatocellular carcinoma under certain circumstances, as outlined in the Coverage Policy for hepatocellular carcinoma, and (ii) basal cell and squamous cell carcinomas of the skin, absent lymphatic or distant metastasis.
    b. Organ transplants not authorized by Coverage Policy are not covered.

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

99. Viscosupplementation for treatment of Osteoarthritis. Intra-articular hyaluronan such as Synvisc, Hyalgan, Supartz, Orthovisc and Euflexxa are not covered.

100. Vision enhancement. For Members age 19 or older, any procedure, treatment, service, equipment or supply used to enhance vision by changing the refractive error of the eye is not covered. Examples of non-covered visual enhancement services include, but are not limited to, the refraction for and the provision of eyeglasses and contact lenses, intraocular lenses, and Refractive Keratoplasty, with the exception of excessive, visually debilitating residual astigmatism following anterior segment surgery, i.e. corneal transplantation, cataract extraction, etc. Laser Assisted Insitu Keratomileusis (LASIK) and all other related refractive procedures are not covered. However, subject to all other terms, conditions, exclusions and limitations of the Plan as set forth in this Evidence of Coverage, a procedure, treatment, service, equipment or supply to correct a refractive error of the eye is covered in two instances: (1) if such refractive error results from traumatic injury or corneal disease, infectious or non infectious, and (2) the single acquisition of eyeglasses or contact lenses within the first six months following cataract surgery. With respect to such eyeglasses or contact lenses, tinting or anti-reflective coating and progressive lenses are not covered. Eyeglass frames are subject to a $50 maximum Allowance or Allowable Charge. See Subsection 3.12.3. In addition, subject to all other terms, conditions, exclusions and limitations of the Plan as set forth in this Evidence of Coverage, certain vision enhancement is provided to Members under the age of 19. See Subsection 3.30 - Pediatric Vision Services.

101. Vitamins or Baby Formula. Vitamins or food/nutrient supplements, except those that are Prescription Medications not available over the counter, are not covered. Baby formula and thickening agents, even if prescribed by a Physician, is not covered. However, subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Evidence of Coverage, coverage is provided for Medical Foods and Low Protein Modified Food Products for the treatment of Medical Disorder Requiring Specialized Nutrients or Formulas. See Subsection 3.25.

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

103. Weight Control. Medications prescribed, dispensed or used for the treatment of obesity, or for use in any program of, weight control, weight reduction, weight loss or dietary control are not covered. Weight loss surgical procedures, including complications relating thereto and any concomitant surgical procedures, including, but not limited to, hiatal hernia repairs, are not covered.

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

105. Wound Treatment. Blood derived growth factors are not covered.

4.3 **Miscellaneous Fees and Services.**

1. Administrative Fees. Fees incurred for acquiring or copying medical records, sales tax, preparation of records for insurance carriers or insurance agencies, medical evaluation for life, disability or any type of insurance coverage are not covered.

2. Appointments. Charges resulting from the failure to keep a scheduled visit with a Physician or other Provider are not covered.

3. Clinical Trials. Phase I, II, III or IV clinical trials or any study to determine the maximum tolerated dose, toxicity, safety, efficacy, or efficacy as compared with a standard means of treatment or diagnosis of a drug, device or medical treatment or procedure are not covered. However, subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Evidence of Coverage, routine patient costs for items and services furnished in connection with participation in the trial are covered. See Subsection 3.34.2.

4. Comfort items. Personal hygiene or comfort items including but not limited to, spray nozzle, heating pad, heating lamp, hot water bottle, ice cap, television, radio, telephone, guest meals, whirlpool bath, adjustable bed, automobile/van conversion or addition of patient lifts, hand control, or wheel chair ramp, and home modifications such as overhead patient lift and wheelchair ramps are not covered.

5. Cosmetic Services. All services or procedures related to or complications resulting from Cosmetic Services are not covered even if coverage was provided through a previous carrier.

6. Court ordered or third party recommended treatment. Services required or recommended by third parties, including physicals and/or vaccines/immunizations for employment, overseas travel, camp, marriage licensing, insurance, and services ordered by a court or arranged by law enforcement officials, unless otherwise covered by the Plan, are not covered.
7. Custodial Care. Services or supplies for custodial, convalescent, domiciliary or supportive care and non-medical services to assist a Member with activities of daily living are not covered. (See Subsection 10.22 - Custodial Care.)
8. Donor services. Services or supplies incident to organ and tissue transplant, or other procedures when the Member acts as the donor are not covered except for Autologous services.

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

   a. Allowance or Allowable Charges for the organ removal as well as any complications resulting from the organ removal are only covered for the period beginning on the day before the transplant to the date of discharge or 39 days, whichever is less.
   b. Services for testing of a donor who is found to be incompatible are not covered.
9. Education Programs. Education programs, including but not limited to physical education programs in a group setting, health club memberships, athletic training, back schools, Work Hardening and Work Integration (Community) training, are not covered. However, subject to all terms, conditions, exclusions and limitations of the Plan as set forth in this Evidence of Coverage, coverage is provided for Diabetes Self-Management Training. See Subsection 3.15.
10. Excess charges. The part of an expense for care and treatment of an illness or Accidental Injury that is in excess of the Allowance or Allowable Charge is not covered.
11. Prescription Medications used in connection with Health Interventions Not Covered by Plan. Prescription Medications used or intended to be used in connection with or arising from a treatment, service, condition, sickness, disease, injury, or bodily malfunction that is not covered under this Evidence of Coverage, or for which this Evidence of Coverage's benefits have been exhausted, are not covered.
12. Services Received Outside the United States. Services or supplies received outside of the United States of America shall not be covered except at the sole discretion of Health Advantage.
13. Telephone and Other Electronic Consultation. Subject to all other terms, conditions, exclusions, and limitations of this Plan set forth in this Evidence of Coverage,

    i. Coverage is provided for Telemedicine services performed by a Provider licensed, certified, or otherwise authorized by the laws of Arkansas to administer health care in the ordinary course of the practice of his or her profession at the same rate as if it had been performed in-person provided the Telemedicine service is comparable to the same service provided in person.
    ii. However, electronic consultations such as, but not limited to, telephonic, interactive audio, 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.
    iii. Communications made by a Physician responsible for the direct care of a Member in Case Management with involved health care Providers, however, are covered.
14. Travel or accommodations. Travel or transportation as a treatment or to receive consultation or treatment, except Ambulance Services covered under Subsection 3.16, are not covered. Accommodations, while receiving treatment or consultation or for any other purpose, are not covered.
14. War. Services or supplies provided for treatment of disease or injuries sustained while serving in the military forces of any nation are not covered.
15. Workers Compensation. Treatment of any compensable injury, as defined by the Workers' Compensation Law is not covered, regardless of whether or not the Member filed a claim for workers' compensation benefits in a timely manner. See Subsection 5.3 Other Plans and Benefit Programs.

5.0 PROVIDER NETWORK AND COST SHARING PROCEDURES

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

5.1 Network Procedures

1. **Standard Benefits.** Subject to all terms, conditions, exclusions and limitations of the Plan set forth in this Evidence of Coverage, coverage is provided for Health Interventions you receive from a Provider as defined by the Plan. See Subsection 10.91. This coverage is most effective and advantageous for you when the services of In-Network Providers are used. All Benefits are subject to the Health Advantage Allowance or Allowable Charge.
2. **Primary Care Physician (PCP) Selection.** You are encouraged to select and maintain a patient-physician relationship with your PCP. The PCP selected must be an In-Network Physician listed in the Health Advantage Provider Directory as a PCP and must be accepting Members. You may contact Customer Service to select a PCP or change your PCP. The Provider Directory is available at WWW.HEALTHADVANTAGE-HMO.COM. PCP changes are effective on the first day of the following month. If you change your PCP, any outstanding Referral(s) from a previous PCP will terminate, unless the new PCP reauthorizes such Referral.
3. **Open Access.** This plan is an Open Access Plan, which allows you to receive In-Network benefits for Covered Services provided by In-Network Providers without first having these services authorized, referred or arranged by a PCP.
4. **Point of Service (POS) Option.** This plan is a Point of Service (POS) Plan. A POS Plan allows a Member the option of obtaining Covered Services from an Out-of-Network Provider without first receiving authorization from the Member's Primary Care Physician or Health Advantage. However, the POS option is not as effective or advantageous for you as when the services of In-Network Providers are used. Claims associated with services provided by Out-of-Network Providers may have less advantageous Deductible, Coinsurance and Annual Limitation on Cost Sharing than claims for services of In-Network Providers. For the definitions and explanation of the terms "Deductible," "Coinsurance," and "Annual Limitation on Cost Sharing" please refer to Section 10.0 Glossary of Terms and Subsection 5.2.
5. **Out-of-Network Providers.** Reimbursement for services by Out-of-Network Providers generally will be less than payment for the same services when provided by an In-Network Provider and could result in substantial out-of-pocket expense. The Out-of-Network Deductible, Coinsurance and Annual Coinsurance Maximum set forth in the Schedule of Benefits are applied to the Allowance or Allowable Charges for services and supplies you receive from an Out-of-Network Provider, unless:
   a. **Emergency or Imperative Care Services.** The Intervention is for Emergency Care (see Subsection 10.32) or Imperative Care (see Subsection 10.49) and initial services are provided within forty-eight (48) hours of the onset of the injury or illness, in which case the applicable In-Network Copayment, Coinsurance and Annual Coinsurance Maximum apply;
   b. **Continuity of Care, Prior to Coverage.** You request coverage by notifying Health Advantage that prior to the effective date of your coverage, you were engaged with an Out-of-Network Provider for a scheduled procedure or ongoing treatment otherwise covered under the terms of this Plan, and that a change from such Out-of-Network Provider for such procedure or treatment would be detrimental to your health. If Health Advantage approves coverage for the scheduled procedure or ongoing treatment, benefits will be provided, subject to applicable In-Network Copayments, Coinsurance and Annual Coinsurance Limit to claims for services and supplies rendered by the Out-of-Network Provider for such condition after Health Advantage's written approval until the procedure or treatment ends or until the end of ninety (90) days, whichever occurs first;
   c. **Continuity of Care, Pregnancy, Prior to Coverage.** You request coverage by notifying Health Advantage that prior to the effective date of your coverage, you were receiving obstetrical care from an Out-of-Network Provider for a pregnancy otherwise

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

d. **Provider Leaves Health Advantage Network.** You request coverage by notifying Health Advantage that your Provider was formerly an In-Network Provider when your ongoing treatment for an acute condition covered under the terms of the Plan began and that you request In-Network benefits for the continuation of such ongoing treatment. If Health Advantage approves coverage for the ongoing treatment, benefits will be provided, subject to applicable In-Network Copayments, Coinsurance and Annual Coinsurance Limits for services and supplies rendered by the Out-of-Network Provider for such condition after Health Advantage's written approval until the end of the current episode of treatment or until the end of ninety (90) days, whichever occurs first;

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

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

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

6. **No Balance Billing from In-Network Providers.** In-Network Providers are paid directly by Health Advantage and have agreed to accept Health Advantage's payment for covered services as payment in full except for applicable Copayments, Coinsurance and any specific benefit limitation, if applicable. **A Member is responsible for billed charges in excess of Health Advantage's payment when Providers who are not In-Network Providers render services. These excess charges could amount to thousands of dollars in additional out of pocket expenses to the Member.**

7. **Provider Directory.** The determination of whether a Provider is In-Network or Out-of-Network is the responsibility of Health Advantage. Health Advantage or your Employer can provide a list of In-Network Providers. You may also obtain a list of In-Network Providers on the Health Advantage web site WWW.HEALTHADVANTAGE-HMO.COM. A Provider's network status may change; therefore You should verify a Provider's status by calling Customer Service at (800) 843-1329 prior to your receipt of services.

8. **Blue Card Program.** Your plan includes the BlueCard program. This program allows you to receive in-network benefits without the provider billing more than the Allowance or Allowed Charge for Emergency Care or Imperative Care from a Provider located outside of Arkansas,

provided such Provider contracts with the local Blue Cross or Blue Shield Company. Your expenses will be limited to the applicable In-Network Deductible, Copayment and Coinsurance. You may verify the BlueCard status of an out of state Provider by calling 1-800-810-2583. For a description of how to file BlueCard claims, refer to Subsection 7.1.10.

9. **Provider Status may Change.** It is possible that you might not be able to obtain services from a particular In-Network Provider. The network of Providers is subject to change. You might find that a particular In-Network Provider may not be accepting new patients. If a Provider leaves the Health Advantage Network or is otherwise not available to you, unless Subsection 5.1.4 applies, you must choose another In-Network Provider to receive In-Network benefits.

10. **Providers may not be In-Network for All Services.** An In-Network Provider's agreement may not include all covered benefits. In particular all services provided at as In-Network Hospital may not be provided by an In-Network Provider; e.g. anesthesia, radiology or laboratory tests. Some In-Network Providers contract with Health Advantage to provide only certain covered benefits, but not all covered benefits. Some Providers choose to be an In-Network Provider for only some Covered Services. Refer to the Provider directory, ask your Provider or contact Customer Service for assistance.

11. **Relation of Health Advantage to Providers.** The relationship between Health Advantage and In-Network Providers is that of independent contractors. Health Advantage is not a provider of health care services but instead offers health plan coverage for services provided by treating provider(s). Health Advantage does not recommend, direct or control delivery of any health care services. In-Network Providers are not agents or employees of Health Advantage. Neither Health Advantage nor any employee of Health Advantage is an employee or agent of In-Network Providers. Health Advantage shall not be liable for any claim or demand because of damages arising out of, or in any manner connected with, any injuries suffered by the Member while receiving care from any In-Network Provider.

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

    For example, a physician who performs certain surgical procedures in the physician's office might choose to engage an equipment and supply company to set up the surgical table, furnish an assisting nurse, and also furnish certain surgical instruments, devices or supplies used by the physician. When the physician bills Health Advantage for the physician's performance of the surgical procedure described in a specific CPT or HCPCS code, Health Advantage will make a

single, global payment to the physician for Covered Services described in the CPT or HCPCS code, and will not be obligated to pay for any charges of the equipment and supply company. In such circumstances, any charge or claim of payment due the equipment and supply company shall be the exclusive responsibility of the physician (or other provider) who engaged the equipment and supply company, and permitted or facilitated such company's access to the physician's patient. In any event, as noted above, no benefits are available under this Evidence of Coverage for any services, drugs, materials or supplies of the equipment and supply company. It is Health Advantage's policy (and this Evidence of Coverage is specifically intended to adopt the same) that no benefits shall be paid for "unbundled services" in excess of Health Advantage's Allowance or Allowable Charge for any service as described in the applicable CPT or HCPCS code. This means, for example, that if a physician and another category of provider (such as a durable medical equipment supplier, a laboratory, a nurse practitioner, a nurse, a physician's assistant or any other category of provider) agree together to divide up, split or "unbundle" the components of any CPT or HCPCS code, and attempt to bill separately for the various components each allegedly provides for the patient, benefits under this Evidence of Coverage shall nevertheless be limited to one Allowance per CPT or HCPCS code; in such circumstances, your benefits under this Evidence of Coverage will pay only one Allowance or Allowable Charge for any Covered Service described in any single CPT or HCPCS code, and the various providers involved in any such "unbundling" action or agreement must resolve among themselves any division of that single Allowance or Allowable Charge between or among them. You can protect yourself from the possibility of billing in excess of the Allowance or Allowable Charge in these circumstances by always inquiring in advance to be sure that each provider involved in your care or treatment is an In-Network Provider.

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

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

1. **Deductible.** For those covered Health Interventions specified in the Schedule of Benefits as subject to a Deductible, each Contract Year, before the Plan makes a Coinsurance payment, a Member must pay the cost of a Covered Service equal to the annual Deductible limitation specified in the Schedule of Benefits. If the Plan provides family coverage, once two family members meet their individual Deductible no further Deductible will be required for the balance of the year, regardless of what member of the family incurs a claim. Deductible payments count toward the Annual Limitation on Cost Sharing.
2. **Coinsurance.** Once the Deductible is satisfied, a Member is responsible for Coinsurance, which is a percentage of the Allowance or Allowable Charges paid, for claims incurred until the payment equals the Annual Limitation on Cost Sharing specified in the Schedule of Benefits.

3. **Copayments.** In order to receive certain Health Interventions from an In-Network Provider, a Member may have to pay a Copayment, which is expressed as either a dollar amount or a percentage of the Allowance or Allowable Charge in the Schedule of Benefits. Copayments count toward the Annual Limitation on Cost Sharing specified in the Schedule of Benefits.

4. **Annual Limitation on Cost Sharing.** A Member with individual coverage must incur Allowable Charges for services and supplies from In-Network Providers equal to or exceeding the In-Network Individual Annual Limitation on Cost Sharing specified in the Schedule of Benefits. If the Plan provides family coverage (coverage other than individual coverage), all the Members in the family will meet the Family Annual Limitation on Cost Sharing once one member of the family incurs Allowable Charges for services and supplies from In-Network Providers that equal or exceed the In-Network Individual Annual Limitation on Cost Sharing specified in the Schedule of Benefits and one or more of the remaining family members incur Allowable Charges that results in the family total Allowable Charges equal to or exceeding the In-Network Family Annual Limitation on Cost Sharing specified in the Schedule of Benefits. After the Annual Limitation on Cost Sharing is satisfied, subject to the provisions of Subsection 5.2.5 of this Evidence of Coverage, the Policyholder will have no further responsibility with respect to Allowances or Allowable Charges incurred during the balance of the calendar year.

5. **Allowable Charges Not Applicable to Annual Limitation on Cost Sharing.** No Allowance or Allowable Charges paid for services or supplies from Out-of-Network shall accumulate to or be impacted by the satisfaction of the Annual Deductible Limitation or the Annual Limitation on Cost Sharing, unless Health Advantage determines that the Out-of-Network Provider should be treated as an In-Network Provider in accordance with one of the provisions listed in Subsection 5.1.5.

5.3 **Other Plans and Benefit Programs**

1. **Coordination of Benefits.** Coordination of Benefits (COB) applies when a Member has coverage under more than one Health Benefit Plan. Health Advantage may annually request that a Member verify the existence of other coverage.

   a. **Definitions.** For purposes of this Subsection 5.3 only, the following words and phrases shall have the following meanings:

      i. "Allowable Expenses" means any necessary, reasonable and customary item of expense at least a portion of which is covered under at least one of the Health Benefit Plans covering the person for whom claim is made. When a Health Benefit Plan provides benefits in the form of coverage for services, the reasonable cash value of each service rendered shall be deemed to be both an Allowable Expense and a benefit paid.

      ii. "Health Benefit Plan" means any of the following which provide coverage for medical care or treatment:

         (1) Coverage under government programs, including Medicare, required or provided by any statute unless coordination of benefits with any such program is forbidden by law.

         (2) Group coverage or any other arrangement of coverage for individuals in a group whether on an insured or uninsured basis, including health maintenance organization or other form of group coverage; Hospital indemnity benefits in excess of $200 per day; medical care components of group long-term care contracts; and medical benefits under group or individual automobile contracts.

         (3) An individually underwritten accident and health insurance policy which reduces benefits because of the existence of other insurance.

         (4) Coverage under any automobile insurance policy, including but not limited to medical payment, personal injury protection or no-fault benefits.

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

         (1) Each Policy, contract or other arrangement for benefits or services.

         (2) That portion of any such Policy, contract or other arrangement which reserves the right to take the benefits of other Health Benefit Plans into

consideration in determining its benefits and that portion which does not.

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

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

i. The benefits of a Health Benefit Plan which does not have a "coordination of benefits with other health plans" provision shall in all cases be determined and applied to claims before the benefits of this Evidence of Coverage.

ii. If according to the rules set forth in Subsection c. of this Section, the benefits of another Health Benefit Plan that contains a provision coordinating its benefits with this Plan would be determined and applied, before the benefits of this Plan have been determined and applied, the benefits of such other Health Benefit Plan will be considered before the determination of benefits under this Plan.

iii. Under no circumstances shall benefits payable and paid under this Plan together with any other Health Benefit Plans exceed the total charge for services a Member received.

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

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

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

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

(1) When the parents are separated or divorced and there is a court decree which fixes financial responsibility on one of the parents for the medical, dental, or other health care expenses with respect to the child, the benefits of a plan which covers the child as a dependent of the parent with such financial responsibility shall be determined before the benefits of any other plan which covers the child as a dependent child.

(2) When the parents are separated or divorced and the parent with custody of the child has not remarried, if there is no court decree fixing financial responsibility on one of the parents for the medical, dental or other health care expense with respect to the child, the benefits of a plan which covers the child as a dependent of the parent with custody of the child will be determined before the benefits of a plan which covers the child as a dependent of the parent without custody.

(3) When the parents are divorced and the parent with custody of the child has remarried, if there is no court decree fixing financial responsibility on one parent for the medical, dental or other health care expense with

respect to the child, the benefits of a plan which covers the child as a dependent of the parent with custody shall be determined before the benefits of a plan which covers that child as a dependent of the step-parent, and the benefits of a plan which covers that child as a dependent of the step-parent will be determined before the benefits of a plan which covers that child as a dependent of the parent without custody.

iii. **Active or Inactive Employee.** When paragraphs (i) or (ii) above do not apply so as to establish an order of benefits determination, the plan that covers a person as a Subscriber who is neither laid off nor retired, is primary. The same would hold true if a person is a dependent of a person covered as a retiree and a Subscriber. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored. Coverage provided to an individual as a retired worker and as a dependent of an actively working spouse will be determined under the rule set out in paragraph (i) above.

iv. **Continuation coverage.** When paragraphs (i), (ii) or (iii) above do not apply so as to establish an order of benefits determination, if a person whose coverage is provided under a right of continuation provided by federal or state law also is covered under another plan, the plan covering the person asa an employee, Member, Subscriber policyholder or retiree (or as that person's dependent) is primary, and the continuation coverage is secondary. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

v. **Longer or Shorter Length of Coverage.** When paragraphs (i), (ii), (iii) or (iv) above do not apply so as to establish an order of benefits determination, the plan that covered the person as an employee, policyholder, Member, Subscriber or retiree longer is primary.

vi. If the preceding rules do not determine the primary plan, the allowable expenses shall be shared equally between the plans meeting the definition of health benefit plan, Subsection 5.3.1.a.(ii). In addition, this plan will not pay more than it would have paid had it been primary.

2. **Medicare, Military or Government Benefits.** If a Member is a Medicare beneficiary, benefits will be determined in accordance with the Medicare Secondary Payer rules. Services and benefits for treatment of military service-connected disabilities to which a Member is legally entitled from a military or government benefit plan shall in all cases be provided before the benefits of this Evidence of Coverage.

3. **Workers' Compensation.** There are no benefits under this Evidence of Coverage for treatment of any injury which will sustain a claim for damages from Workers' Compensation. This regardless of whether or not the Member filed a claim for workers' compensation benefits.

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

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

In the event that Health Advantage pays any claim by the Member for benefits under this Evidence of Coverage, and subsequently learns that the Member has filed a claim for workers' compensation benefits as to such claim, or that the Member has settled a workers'

compensation claim with any workers' compensation carrier, or has otherwise received any amount toward payment of such a claim under the Workers' Compensation Law, state or federal workers' compensation, employer's liability or occupational disease law, or motor vehicle no-fault law, the Member agrees to reimburse Health Advantage to the full extent of its payments on such claim.

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

6.0 ELIGIBILITY STANDARDS

Even if a Health Intervention you receive would be covered under the other coverage standards of this document, you still must be eligible for benefits under your Plan and your coverage must be in effect at the time you receive such Intervention in order to receive benefits. This Section sets out the standards for eligibility under the Plan, Subsection 6.1; the policies for determining a Member's effective date, Subsection 6.2; policies governing termination of coverage, Subsection 6.3; the options a person who has lost eligibility may have under state and federal law to continue coverage under the Plan, Subsection 6.4; and the rights a person who has lost eligibility may have to receive a Conversion Plan from Health Advantage, Subsection 6.5.

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

1. **Subscriber Coverage.** To be eligible, a Subscriber must:
   a. work on a full-time basis for the Employer;
   b. complete the required Waiting Period, if applicable;
   c. be in a class of employees who are included in the Plan;
   d. regularly and routinely work the minimum number of hours and the minimum number or weeks per year specified in the Group Application; and
   e. live or work in the Service Area.
2. **Dependent Coverage.** Eligible Dependents are the Subscriber's:
   a. Spouse;
   b. Child less than 26 years of age.

c. unmarried Child who is incapable of self support because of mental retardation or physical disability, provided (1) such Child is or was under the limiting age of dependency stated in Subsections b. above at the time of application for coverage in the Plan or (2) if not under such limiting age, has had continuous health plan coverage, i.e. no break in coverage greater than 63 days, at the time of application for coverage in the Plan.

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

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

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

1. **Application and Effective Date.** In order for a Subscriber's coverage to take effect, the Subscriber must submit a written application for coverage for the Subscriber and any Dependents. The effective date(s) of coverage shall be determined in accordance with this Subsection 6.2 and indicated by Health Advantage on the ID card, Schedule of Benefits or letter issued to Members by Health Advantage.
2. **Subscribers and Dependents on Contract Effective Date.** Coverage under this Evidence of Coverage shall become effective on the Group Contract effective date for all Subscribers and Dependents for whom an enrollment application is completed and premium is paid during the Initial Open Enrollment Period prior to the Group Contract effective date. Coverage, subject to all other terms, conditions, exclusions and limitations of the Plan, will be extended to an eligible Subscriber or Dependent who is an inpatient in a Hospital on the effective date. This includes any eligible employee or dependent that is confined in a Hospital or other institution.
3. **New Subscriber Effective Date.** If Health Advantage receives a Subscriber's enrollment application within thirty (30) days of the date the Subscriber is first eligible for coverage, the Subscriber's coverage will become effective 12:01 a.m. on the first day of the Contract Month following the date the Subscriber is first eligible for coverage. However, if the date the Subscriber is first eligible for coverage falls on the first day of the Contract Month, the Subscriber's coverage will become effective at 12:01 a.m. on that day.
4. **Coverage in the Case of Late Enrollment**: If an employee or an employee's dependent who is eligible for coverage does not make application for coverage in the Plan when initially eligible

for coverage, the employee or dependent cannot subsequently obtain coverage, except during a Special Enrollment Period or Open Enrollment Period.

5. **Open Enrollment Period**: Annually, during the month designated by the Employer and set forth in the Group Contract, employees who are eligible for coverage may enroll in the Plan. During the Open Enrollment Period, employees covered in the Plan may change their coverage, and that of their covered dependents. Unless otherwise designated in the Group Contract, enrollments and coverage changes made during the Open Enrollment Period become effective on the anniversary date of the Group Contract.

6. **Initial Enrollment Period for Existing Dependents:** If the Subscriber has eligible Dependents on the date the Subscriber's coverage begins, the Subscriber's Dependents' coverage will begin on the Subscriber's Effective Date if:

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

   If the Subscriber submits an application for such existing eligible Dependent(s) after 30 days of the Subscriber's effective date, coverage for such Dependent(s) shall begin on the first of the month following Health Advantage's receipt of the application and the Dependent(s) shall be classified as a Late Enrollee. See Subsection 6.2.4 above.

7. **Effective Date for Newly Acquired Dependents.** In no event will a Subscriber's Dependent's coverage become effective prior to the Subscriber's effective date. If a Subscriber acquires a new eligible Dependent after the date the Subscriber's coverage begins, coverage for a new Dependent will become effective in accordance with the following provisions:

   a. **Spouse.** When a Subscriber marries and wishes to have the Subscriber's Spouse covered, the Subscriber shall submit an application or change form within 30 days of the date of marriage. The effective date will be the first of the month following the date of marriage and the Spouse will not be a Late Enrollee. If a Subscriber submits the application or change form after the 30-day period, coverage for the Spouse will become effective in accordance with the provisions for Late Enrollees. See Subsection 6.2.4, above.

   b. **Newborn Children.** Coverage for a Subscriber's newborn Child shall become effective as of the Child's date of birth if the Subscriber gives Health Advantage notice by submitting an application or change form to Health Advantage for the Child within 90 days of the Child's date of birth and the appropriate premium to cover the newborn Child from the date of birth is paid. If the Subscriber submits the application or change form after the applicable 90-day time period, coverage for the Subscriber's newborn Child will become effective in accordance with the provisions for Late Enrollees. See Subsection 6.2.4, above.

   c. **Court Ordered Coverage for a Child.** If a court has ordered a Subscriber to provide coverage for a Child, coverage will be effective on the first day of the month following the date Health Advantage receives written notification and satisfactory proof of the court order. If the Subscriber fails to apply to obtain coverage for a Child, Health Advantage shall enroll the Child on the first day of the month following Health Advantage's receipt of a written application from a custodial parent of the Child, a child support agency having a duty to collect or enforce support for the Child, or the Child, provided, however that the premium is received when due. In the event a court has ordered an employee of the Group who is not covered by the Plan to provide coverage for a child, the employee will be enrolled with the child on the first day of the month following Health Advantage's receipt of a written application from the Group, a custodial parent of the Child, a child support agency having a duty to collect or enforce support for the Child, or the Child, provided, however that the premium is received when due.

   d. **Newly Adopted Children**. Subject to payment of all applicable premiums, coverage for a Child placed with a Subscriber for adoption or for whom the Subscriber has filed a petition for adoption, shall begin on the date the Child is placed for adoption or the date of the filing of the petition for adoption, provided an application for the Child's coverage is submitted to Health Advantage within 60 days after the placement or the filing of the petition. The coverage shall begin from the moment of birth if the petition for adoption or placement for adoption occurred and the application for coverage is submitted to

Health Advantage within 60 days of the Child's birth. If the Subscriber submits the application or change form after such 60-day period, coverage for the adopted Child will become effective in accordance with the provisions for Late Enrollees. See Subsection 6.2.4, above. The coverage shall terminate upon the dismissal, denial, abandonment or withdrawal of the adoption, whichever occurs first.

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

8. **Special Enrollment Period** is the 30-day period during which time an Employee or Dependent may enroll in the Plan, after his or her initial Eligibility Date or Open Enrollment Period and not be a Late Enrollee. Special Enrollment Periods occur in the following instances:

a. A Dependent of the Employees loses Minimum Essential Coverage under another health plan for reasons other than failure to pay premiums or justified rescission.

b. The Employee gains a Dependent through marriage, birth, adoption or placement for adoption. Note that the Special Enrollment Period for an adopted child is 60 days and for a new born child is 90 days.

c. A Dependent of the Policyholder that is a Qualified Employee who was not previously a citizen, national or lawfully present becomes a Qualified Individual by gaining the applicable status.

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

a. **After the Termination of Medicaid or CHIP Coverage.** A Medicaid or CHIP Special Enrollment Period begins on the day an employee's or dependent's coverage under Medicaid or CHIP terminates as a result of Loss of Eligibility.

b. **After Eligibility for Employment Assistance under Medicaid or CHIP.** A Medicaid or CHIP Special Enrollment Period occurs for an employee or employee's dependent who becomes eligible for assistance, with respect to coverage under group health plans or health insurance plans under Medicaid or CHIP (including under any waiver or demonstration project conducted under or in relation Medicaid or CHIP).

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

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

a. Coverage shall terminate at 12:00 midnight Central time on the date of event when:

i. This Plan terminates.

ii. The Employer to which the Group Contract is issued, terminates or ceases to sponsor the Plan.

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

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

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

c. A Member's coverage shall terminate at 12:00 midnight Central Time on the last day of the applicable premium period for which premium was paid if premium is not paid on or before the next premium due date.

2. **Termination of a Member's Coverage for Cause.**

a. **Bases for Termination.** Health Advantage may terminate coverage under this Evidence of Coverage, including termination by rescission of all coverage retroactive to the Member's original effective date, upon fifteen (15) days' written notice for:

i. concealment of information, misrepresentation (whether intentional or not) or fraud in obtaining coverage; or

ii. concealment of information, misrepresentation (whether intentional or not) or fraud in the filing of a claim for services, supplies, or in the use of services or facilities.

b. **Concealment or Misrepresentation.** For purposes of this termination for cause provision, concealment of information or a misrepresentation occurs if (i) information is withheld or if incorrect information is provided that is material to the risk assumed by Health Advantage, or (ii) Health Advantage would not have issued this Evidence of Coverage, would have charged a higher premium, or would not have paid a claim in the manner it was paid had Health Advantage known the facts concealed or misrepresented, or (iii) there is a causal relationship between the concealed information or the incorrect information provided and an illness resulting in a claim under this Evidence of Coverage.

c. **Termination Effective Date.** Rescission of coverage shall become effective on the Member's original effective date. If Health Advantage elects to terminate the coverage other than by rescission, the termination shall be effective upon the later of (i) fifteen (15) days after a written notice of termination for cause is posted in the U.S. Mail, addressed to the Member at his or her last known address as provided by the Member to Health Advantage; or (ii) the date stated in the termination notice letter to Member.

d. **Appeal Procedure.** A Member may appeal a termination for cause. Such an appeal must be submitted in writing, addressed to "Health Advantage—For Cause Appeals, Post Office Box 8069, Little Rock, Arkansas 72203." In order for the appeal to be considered Health Advantage must receive the appeal prior to the later of (i) fifteen (15) days after a written notice of termination for cause is posted in the U.S. Mail, addressed to the Member at his or her last known address as provided by Member to Health Advantage; or (ii) the termination effective date stated in the termination notice letter to Member.

3. **Premium Refunds.** If Health Advantage terminates the coverage of a Member, premium payments received on account of the terminated Member applicable to periods after the effective date of termination shall be refunded to the Employer within 30 days, and Health Advantage shall have no further liability under the Group Policy.

4. **Employer Terminations.** If the Employer terminates coverage of a Member, the Employer must request Health Advantage refund premiums paid for such Member's coverage within 60 days from the effective date of termination of such coverage. Failure of the Employer to make a refund request within 60 days of the effective date of termination of the Member's coverage shall result in the Employer waiving refund of any premiums paid for such coverage. If claims have been paid past the termination date, the payment amount of the claims will be deducted from premium refunds.

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

6.4 **Continuation Privileges**

1. **Continuation of Hospital Benefits When Group Contract is Replaced**. If a Member is hospitalized on the date the Group terminates coverage with Health Advantage and replaces the coverage with another company, coverage for the Member will continue until the date the Member is discharged or until benefits under the Plan are exhausted, whichever occurs first.

2. **Continuation Rights under State Law**

a. If a Member's employment terminates or dependency status changes the Member shall have the right under state law to elect continuation of coverage under the Plan as

outlined below. In order to be eligible for this option, Member must:

i. have been continuously covered under this Evidence of Coverage for at least three (3) consecutive months prior to employment termination or change in dependency status; and

ii. make the election by notifying Health Advantage in writing no later than ten (10) days after the employment termination or change in dependency status.

b. Continuation shall terminate on the earliest of:

i. one hundred twenty (120) days after the date the election is made;

ii. the date the Member fails to make any premium payments or the Employer fails to pay the premium to Health Advantage;

iii. the date the Member is or could be covered by Medicare;

iv. the date on which the Member is covered for similar benefits under another group or individual contract;

v. the date on which the Member becomes eligible for similar benefits under another group Plan;

vi. the date on which similar benefits are provided for or available to the Member under any state or federal law; or

vii. the date on which the Group Contract terminates.

c. If a Member qualifies for continuation of coverage, the Member may elect a conversion contract instead of continuation of group coverage. See Section 6.5 Conversion Privileges. If a Member has elected continuation under this Subsection 6.4.2, the Member shall have the option of conversion coverage at the end of the maximum continuation period.

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

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

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

i. A Subscriber's death.

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

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

iv. A Subscriber becoming entitled to Medicare.

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

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

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

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

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

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

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

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

(2) the date coverage under the Plan terminates.

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

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

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

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

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

i. The date the Group Contract terminates;

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

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

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

v. The date the Member becomes entitled to Medicare;

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

6.5 Conversion Privileges

1. **Eligibility.** If a Member's coverage under the Plan terminates for any reason other than

a. failure to pay any sum required by the Group toward the cost of coverage under this Evidence of Coverage, if any, or

b. cause (see Section 6.3.2) or,

c. the Group Contract being replaced by a health benefit plan provided by an organization other than Health Advantage, then the Member may apply for a conversion plan issued by Health Advantage if

i. the Member is not eligible for Medicare coverage; or

ii. the Member is not eligible for coverage under any other group health plan that provides coverage for preexisting conditions.

2. **Benefits.** The Conversion Plan will be arranged by Health Advantage at the conversion rates in effect at the time of the conversion. The benefits in the Conversion Plan will not necessarily equal or match those benefits provided in the Group Contract. No evidence of good health or insurability will be required to effect the conversion.

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

7.0 CLAIM PROCESSING AND APPEALS

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

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

This Section 7 sets out the procedures you must follow in submitting a request for coverage, called a "claim for benefits" or a “claim," with your Plan, Subsection 7.1. The section describes procedures you must follow to file oral or written complaints, Subsection 7.2. The section also describes your rights to appeal if a claim for benefits is denied either in whole or in part, Subsections 7.3 and 7.4. Finally, this section sets out how you may have an Authorized Representative to represent you in submitting claims or appeals, Subsection 7.5.

7.1 Claim Processing.

1. **Claim for Benefits.** "Claim for benefits" means (1) a request for payment for a service, supply, medication, equipment or treatment covered by the Plan or (2) a request for Prior Approval for a service, supply, medication, test, equipment or treatment covered by the Plan where the Plan conditions receipt of payment for such service, supply, medication, equipment or treatment on approval in advance by Health Advantage.

2. **Who May Submit a Claim.** A Member, a Provider with an assignment of the claim that is approved by Health Advantage or the Member’s Authorized Representative may submit a claim. See Subsection 7.5 below concerning the Authorized Representative.

3. **Classifications of Claims.** There are four general types of claims for benefits possible under the Plan. The type of claim involved affects the procedures for filing the claim and the timing of the benefit determination by Health Advantage.

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

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

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

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

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

b. **Pre-Service Claims.** The terms of the Plan condition receipt of certain benefits on Prior Approval by Health Advantage, whereby Health Advantage gives approval in advance of the Member obtaining a requested medical service, drug, supply, test, or equipment that such medical service, drug, supply, test, or equipment meets Primary Coverage Criteria. Plan benefits requiring pre-service claims are claims for Hospital services with anesthesia for complex dental conditions (Subsection 3.3.3); Advanced Diagnostic Imaging (Subsection 3.6); applied behavioral analysis (Subsection 3.11); durable medical equipment for which costs exceed $5000 (Subsection 3.13.3); surgically implantable osseointegrated hearing aids (Subsection 3.15.3); prosthetic devices for which cost exceed $20,000 (Subsection 3.15.4); corrective surgery for craniofacial anomalies (Subsection 3.23.3); reduction mammoplasty (Subsection 3.23.6); certain Prescription Medications (Subsection 3.24); most organ transplants (Subsection 3.25); admission to neurologic rehabilitation facilities (Subsection 3.30); some pediatric vision services (Subsection 3.31); enteral feedings (Subsection 3.34.6); gastric pacemakers (Subsection 3.34.7).

Please note Prior Approval does not guarantee payment or assure coverage, it means only that the information furnished to Health Advantage in the pre-service claim indicates that the Health Intervention meets the Primary Coverage Criteria requirements set out in Subsection 2.2 and the Applications of the Primary Coverage Criteria set out in Subsections 2.4.1.b., e., or f. and is not subject to a Specific Plan Exclusion (see Section 4.0) All Health Interventions must still meet all other coverage terms, conditions, and limitations, and coverage for these services may still be limited or denied if, when the post-service claim for the services is received by us, investigation shows that a benefit exclusion or limitation applies because of a difference in the Health Intervention, that the Member ceased to be eligible for benefits on the date services were provided, that coverage lapsed for non-payment of premium, that out-of-network limitations apply, or any other basis specified in this Evidence of Coverage.

Pre-service claims for medical Health Interventions may be submitted to Health Advantage by (1) calling the Customer Service telephone number found on the reverse side of your Health Advantage ID Card, (2) sending an email to PRESERVICEBENEFITINQUIRY@ARKBLUECROSS.COM, (3) submitting the pre-service claim to Health Advantage Medical Audit and Review Services, FAX (501) 378-6647, or (4) mailing the claim to Post Office Box 3688, Little Rock, Arkansas 72203. Pre-service claims for Prescription Medications should be submitted to Health Advantage Managed Pharmacy, FAX (501) 378-6980, or mailed to Post Office Box 2181, Little Rock, Arkansas 72203.

If Health Advantage is able to process your pre-service claim without requesting additional information, it will notify you of its determination in a time appropriate for the medical exigencies, but in no case later than 2 business days from the date it received the pre-service claim.

If Health Advantage requires information reasonably necessary to determine whether the requested medical service, drug, supply, test or equipment meets the Primary Coverage Criteria under the Plan, Health Advantage will suspend the claim and request the needed information. If you or your treating Provider supplies Health Advantage the required information within ninety (90) days of the claim suspension, Health Advantage will notify you of its claim determination within 2 business days after Health Advantage receives such information. If Health Advantage does not receive the required information within the 90-day period, 15 days later, the suspended claim will become a denied claim, subject to appeal. See Subsection 7.2. Claim Appeals to the Plan.

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

c. **Provider Initiated Pre-Service Claims.** A Provider treating a Member may initiate a pre-service claim to obtain Prior Approval for a medical service, drug, supply, test, or equipment covered by the Plan when the Plan does not condition receipt of such medical service drug, supply, test, or equipment on Prior Approval. Pre-service claims should be submitted to the Health Advantage Medical Audit and Review Services, FAX (501) 378-6647 or mailed to Post Office Box 3688, Little Rock, Arkansas 72203. Pre-service claims for Prescription Medications should be submitted to Health Advantage Managed Pharmacy, FAX (501) 378-6980, or mailed to Post Office Box 2181, Little Rock, Arkansas 72203.

If Health Advantage is able to process the Provider initiated pre-service claim without requesting additional information, Health Advantage will notify the treating Provider of its determination within 10 days from the date it received the pre-service claim.

If Health Advantage requires information reasonably necessary to determine whether the requested medical service, drug, supply, test, or equipment meets the Primary Coverage Criteria under the Plan, Health Advantage will suspend the claim and request the needed information. If the treating Provider supplies Health Advantage the required information within ninety (90) days of the claim suspension, Health Advantage will notify the treating Provider of its claim determination within 10 days after Health Advantage receives such information. If Health Advantage does not receive the required information within the 90-day period, 15 days later, the suspended claim will become a denied claim, subject to appeal. See Subsection 7.2. Claim Appeals to the Plan.

After the Provider has performed the Health Intervention the Health Intervention that was the subject of an approved Provider initiated pre-service claim, the treating Provider must submit a post-service claim in accordance with Subsection 7.1.3.a., above.

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

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

If Health Advantage is able to process your claim involving urgent care without requesting additional information, it will notify you of its determination in a time appropriate for the medical exigencies, but in no case later than 1 business day from the date it received the pre-service claim.

If Health Advantage requires information reasonably necessary to determine whether the requested medical service, drug, supply, test or equipment meets the Primary Coverage Criteria under the Plan, Health Advantage will notify your physician within 24 hours of receiving the claim and request the needed information. If you or your treating Provider supplies Health Advantage the required information within 48 hours, Health

Advantage will notify you of its claim determination within 1 business day after Health Advantage receives such information. If Health Advantage does not receive the required information within the 48-hour period, the claim will be denied, subject to appeal. See Subsection 7.3 Claim Appeals to the Plan.

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

Please note that approval of a claim involving urgent care does not guarantee payment or assure coverage; it means only that the information furnished to Health Advantage at the time indicates that the Health Intervention that is the subject of the claim involving urgent care meets the Primary Coverage Criteria and is not subject to a Specified Plan Exclusion (see Section 4.0) A Health Intervention receiving prior approval as a claim involving urgent care, must still meet all other coverage terms, conditions, and limitations. Coverage for any such claim may still be limited or denied if, when the claimed Intervention is completed and Health Advantage receives the post-service claim(s), investigation shows that a benefit exclusion or limitation applies because of a difference in the Health Intervention described in the prior approved claim and the actual Health Intervention, that the Member ceased to be eligible for benefits on the date services were provided, that coverage lapsed for non-payment of premium, that out-of-network limitations apply, or any other basis specified in this Evidence of Coverage applies to limit or exclude the claim.

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

e. **Claims involving Ongoing Care or Concurrent Review.** Health Advantage's termination or reduction of a previously granted benefit under the Plan (other than by Plan amendment or termination) results in a claim involving ongoing care or concurrent review. Health Advantage shall give an explanation of the reduction or termination of a benefit to the Member, as specified in Subsection 7.1.6, with sufficient time prior to the termination or reduction to allow for an appeal under Subsection 7.2.8.d., to be completed before the termination or reduction takes place.

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

a. In order to be a claim, the submission must comply with the filing and coding polices and procedures established by Health Advantage. You may request a copy of the claim coding policies and procedures from Health Advantage or from your Provider. If the submission fails to comply with the claim filing or code policies or procedures, Health Advantage shall return the submission to the person that submitted it. If the claim involved is a pre-service claim, the submission shall be returned as soon as possible, but no later than 5 days (24 hours for a claim involving urgent care), and Health Advantage shall indicate on the returned submission the proper procedures to be followed.

b. In addition to the claim completed in accordance with Health Advantage's claim filing procedures, depending upon the service, supply, medication, equipment or treatment that is the subject of the claim, Health Advantage may require one or more of the following items of information to enable Health Advantage to determine whether or to what extent the claimed benefit is covered by the Plan:

i. Information in order to determine if a limitation or exclusion of the Plan is applicable to the claim, or

ii. Medical information in order to determine the price for a medical procedure, or

iii. Information in order to determine if the Member who received the claimed services is eligible under the terms of the Plan, or

iv. Information in order to determine if the claim is covered by another health benefit plan, workers' compensation, a government supported program, or a liable third party, or

v. Information in order to determine the obligation of each health benefit plan or government program under coordination of benefits rules, or

vi. Information in order to determine if there has been fraud or a fraudulent or material misrepresentation with respect to the claim.

5. **Member's Responsibility with Respect to Claim Information.** Before any benefits can be paid, you agree, as a condition of coverage under the Plan, to authorize and direct any Provider of medical services or supplies to furnish to Health Advantage, its agents, or any of its affiliates, upon request, all records, or copies thereof, relating to such services or supplies. Further, as a condition of your coverage, you agree to authorize the release of such records to any third party review person or entity, for purposes of medical review or second opinion surgery. Finally, as a condition of coverage, you agree to fully and truthfully respond to inquiries from Health Advantage about your claim or condition, including, but not limited to, your other, health benefit coverage, insurance coverage, third party liability, or workers' compensation benefits and to request that any Physician or other Provider respond to all such inquiries. You understand and agree that your failure to respond to inquiries from Health Advantage or failure to cooperate fully to obtain information requested by Health Advantage from your Physician or other health care Provider shall be, by itself, grounds for denial of benefits under the Plan.

6. **Explanation of Benefit Determination.** Upon making a determination of a claim, Health Advantage will deliver to you the following information:

   a. The specific reason or reasons for the determination with information sufficient to identify the claim involved (including the date of service, the health care provider, the claim amount and a way that the Member may learn the diagnosis and treatment codes and their descriptions);

   b. Reference to the specific plan provision(s) on which the determination is based;

   c. A description of any additional information necessary for the claim to be perfected and an explanation of why such information is necessary;

   d. A description of the Plan's appeal process, see Subsection 7.3 below. If the claim involves urgent care, a description of the expedited appeals process, see Subsection 7.3.10. below.

   e. If the determination was based in whole or in part on a Health Advantage Coverage Policy an explanation of how to obtain a copy of the Coverage Policy at no cost. See Subsection 2.4.1.f. above.

7. **Informal Claim Review.** If you have questions about an Explanation of Benefit Determination, you may contact Customer Service (Telephone toll free (800) 843-1329, or write Health Advantage, Customer Service, Post Office Box 8069, Little Rock, Arkansas 72203) and ask that the determination be reviewed. Customer Service will respond in like manner with answers to your request. This informal review is not an Appeal (see Subsection 7.3 below) nor a substitute for an appeal. Nor must you ask for an informal review in order to request an appeal.

8. **Informal Coverage Information.** From time to time you or your Provider may want an indication whether a service, supply, prescription drug, equipment, or treatment is an eligible benefit of the Plan. You may make an Informal Coverage Information to Health Advantage Customer Service Division, Post Office Box 8069, Little Rock, Arkansas 72203, or by Telephone to toll free (800) 843-1329.

   a. An Informal Coverage Information is not a claim. You should understand that Informal Coverage Information is different from a pre-service claim. In the case of an Informal Coverage Information the Plan does not specify that receipt of the benefit in question is conditioned upon Prior Approval of Health Advantage (see Subsection 7.1.3.b., Pre-Service Claims, above).

   b. **Health Advantage's response to an Informal Coverage Information is not a guarantee of payment. The Company's ultimate determination of a claim will be based upon the relevant facts as applied to the terms, conditions, limitations and exclusions of the Plan.** An Informal Coverage Information is not a claim. The Company's response to an Informal Coverage Information is not a claim determination. Health Advantage's response is based upon the information available to Health Advantage at the time of the inquiry and such information may not be current or accurate. Health Advantage reserves the right to make a final determination of the post-

service claim resulting from a Health Intervention that may have been the subject of an Informal Coverage Information after the intervention has been completed and all relevant facts are known.

c. An Informal Coverage Information is not subject to appeal.

d. A Provider wanting to know whether a service, supply, prescription drug, equipment, or treatment meets the Primary Coverage Criteria and all other requirements for payment under the Plan should submit a Provider Initiated Pre-Service Claim. (See Subsection 7.1.3.c.)

9. **Member's Responsibility with Respect to Erroneous Claim Payments.** Despite our best efforts, we may make a claim payment which is not for a benefit provided under the Plan, or we may make payment to you when payment should have gone directly to the Provider of treatment or services instead. In the event of an erroneous or mistaken payment, you agree to refund the full amount of such payment to us promptly upon our request. If Health Advantage does not receive the full amount of the refund due, Health Advantage will have the right to offset future payments made to you or your Provider under this Policy/ Evidence of Coverage or under any other Policy/Evidence of Coverage you have with Health Advantage now or in the future.

10. **Out-of-Area Services**

We have a variety of relationships with other Blue Cross and/or Blue Shield Plans and their Licensed Controlled Affiliates ("Licensees"). Generally, these relationships are called "Inter-Plan Arrangements." These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association ("Association"). Whenever you obtain healthcare services outside of our service area, the claims for these services may be processed through one of these Inter-Plan Arrangements.

When you receive care outside of our service area, you will receive it from one of two kinds of providers. Most providers ("participating providers") contract with the local Blue Cross and/or Blue Shield Plan in that geographic area ("Host Blue"). Other providers do not contract with the Host Blue ("non-participating providers"). We explain below how we pay both kinds of providers.

We cover only limited healthcare services received outside of our service area. As used in this section, "Out-of-Area Covered Healthcare Services" include emergency care or urgent care obtained outside the geographic area we serve. Any other services will not be covered when processed through any Inter-Plan Arrangements.

a. **BlueCard® Program**

i. Under the BlueCard® Program, when you receive Out-of-Area Covered Healthcare Services within the geographic area served by a Host Blue, we will remain responsible for doing what we agreed to in the contract. However the Host Blue is responsible for contracting with and generally handling all interactions with its participating providers.

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

b. **Emergency Care Services:** If you experience a Medical Emergency while traveling outside of the service area, go to the nearest Emergency facility. When you receiver Out-of-Area Covered Healthcare Services outside our service area and the claim is processed through the BlueCard Program, the amount you pay for Out-of-Area Covered Healthcare Services, if not a flat dollar copayment, is calculated based on the lower of:

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

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

similar types of healthcare providers after taking into account the same types of transactions as with an estimated price.

ii. Estimated pricing and average pricing also take into account adjustments to correct for over- or underestimation of modifications of past pricing of claims as noted above. However, such adjustments will not affect the price we have used for your claim because they will not be applied after a claim has already been paid.

iii. Federal or state laws or regulations may require a surcharge, tax, or other fee that applies to insured accounts. If applicable, we will include any such surcharge, tax, or other fee as part of the claim charge passed onto you.

c. **Blue Cross Blue Shield Global Core.**

If you are outside of the United States, you may be able to take advantage of Blue Cross Blue Shield Global Core when accessing Covered Services. Blue Cross Blue Shield Global Core is unlike the BlueCard Program available in the United States in certain ways. For instance For instance, although the Blue Cross Blue Shield Global Core assists you with accessing a network of inpatient, outpatient and professional providers, the network is not served by a Host Blue. As such, when you receive care from providers outside the United States, you will typically have to pay the providers and submit the claims yourself to obtain reimbursement for these services. If you need medical assistance services (including locating a doctor or hospital) outside the United States, you should call the service center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week. An assistance coordinator, working with a medical professional, will arrange a physician appointment or hospitalization, if necessary.

i. **Inpatient Services.** In most cases, if you contact the service center for assistance, hospitals will not require you to pay for covered inpatient services, except for your deductibles, coinsurance, etc.. In such cases, the hospital will submit your claims to the service center to begin claims processing. However, if you paid in full at the time of service, you must submit a claim to receive reimbursement for Covered Services. You must contact us to obtain precertification for non-emergency inpatient services.

ii. **Outpatient Services.** Physicians, urgent care centers and other outpatient providers located outside the United States will typically require you to pay in full at the time of service. You must submit a claim to obtain reimbursement for Covered Services.

iii. **Submitting a Blue Cross Blue Shield Global Core Claim.** When you pay for Covered Services outside the BlueCard service area, you must submit a claim to obtain reimbursement. For institutional and professional claims, you should complete a Blue Cross Blue Shield Global Core claim form and send the claim form 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 your claim. The claim form is available from us, the service center or online at www.bcbsglobalcore.com. If you need assistance with your claim submission, you should call the service center at 1 (800) 810-BLUE (2583) or call collect at 1 (804) 673-1177, 24 hours a day, seven days a week.

7.2 **Complaints**

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

30 calendar days due to circumstances beyond its control, Health Advantage will provide notice of the reason for the delay before the 30th calendar day.

7.3 **Claim Appeals to the Plan (Internal Review).**

1. **Legal Actions**. Prior to initiating legal action, you must file an appeal of your claim in accordance with this Subsection 7.3. No legal action shall be brought after the expiration of three (3) years from the time that a claim is required to be submitted.
2. **Who May Request a Review.** A Member or the Member's Authorized Representative may file an appeal to request a review of a claim denial. See Subsection 7.5 concerning the Authorized Representative.
3. **Where and When (Deadline) to Submit an Appeal.** If a claim for benefits is denied either in whole or in part, you will receive a notice explaining the reason or reasons for the denial. See Subsection 7.1.6, above. You may request a review of a denial of benefits for any claim or portion of a claim by sending a request marked "Appeal Request" to Health Advantage, Attention: Member Response Coordinator, Post Office Box 8069, Little Rock, Arkansas 72203. Your request must be made within one hundred eighty (180) days after the initial adverse determination. You may contact the Health Advantage Member Response Coordinator toll free at (800) 843-1329 for assistance in making an appeal.
4. **Appeals Subject to Direct External Review.**

   Health Advantage may waive internal review of any claim determination. If Health Advantage waives internal review, Health Advantage shall defer the claim for external review in accordance with Section 7.4 below.
5. **Two Levels of Review.** Health Advantage provides two levels of review.
   a. **First Level Review.** The First Level Reviewer, a person located at the Health Advantage, conducts the first level review.
   b. **Second Level Review.** If the outcome of the first level review is adverse, you may appeal to the second level. The request for a second level appeal must be made within 60 days after you have been notified of the result of the first level review. The Second Level Appeal Committee, a committee that meets at the Health Advantage Office located at 5 Allied Drive, Suite 500, Little Rock, Arkansas, conducts the second level review. You have a right to appear in person or attend via teleconference to supplement the written appeal and respond to the Second Level Appeal Committee's questions.
6. **Documentation.**
   a. **Written Appeals.** You must submit your appeal in writing. However, an appeal related to a claim involving urgent care may initially be submitted orally. Although Health Advantage will immediately commence consideration of an oral appeal, the Health Advantage requires written confirmation of the appeal.
   b. **Appellant's Right to Information.** Health Advantage shall provide you free of charge and sufficiently in advance of the date of the final internal adverse benefit determination to give you a reasonable opportunity to respond, reasonable access to, and copies of, all documents, records or other information that:
      i. were relied upon in making the benefit determination;
      ii. were submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record or other information was relied upon in making the benefit determination;
      iii. demonstrate compliance with the terms of the Plan; or
      iv. constitute a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for the your diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.
   c. **Appellant's Right to Submit Information.** You may submit with your request for review any additional written comments, issues, documents, records and other information relating to your claim.
   d. **Appeals Reviewer's Right to Information.** You and the treating health care professional are required to provide the Appeals Reviewer, upon request, access to

information necessary to determine the appeal. Such information should be provided not later than five (5) days after the date on which the Appeals Reviewer's request for information is received, or, in the case of a claim involving urgent care or concurrent review, at such earlier time as may be necessary to comply with the applicable timelines. See Subsections 7.3.8.c. and d. Your failure to provide access to such information shall not remove the obligation of the Appeals Reviewer to make a determination on the appeal, but the Appeals Reviewer determination may be affected if such requested information is not provided.

7. **Conduct of Review.**

   a. **Scope of Review.** The Appeals Reviewer shall conduct a complete review of all information relating to the claim and shall not afford deference to the initial claim determination in conducting the review.

   b. **Qualifications of Appeals Reviewer.** The Appeals Reviewer is an individual or committee with appropriate expertise who is neither the individual who denied the claim that is the subject of the appeal, nor the subordinate of such individual.

   c. **Review of Medical Judgment.** When reviewing a claim in which the determination was based in whole or in part on medical judgment, including determinations with regard to the application of the Primary Coverage Criteria or a Coverage Policy, the Appeals Reviewer shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. Such health care professional shall not be an individual that was consulted in the initial claim determination, nor the subordinate of such individual. The Appeals Reviewer shall, upon request, provide the identity of health care professional(s) consulted in conducting the review, without regard to whether the health care professional's advice was relied upon in making the benefit determination.

8. **Timing of Appeal Determination.**

   a. **Post-Service Claim.** The Appeals Reviewer at each level of appeal shall render a decision on an appeal related to a post-service claim within a reasonable period of time, but notification of the Appeals Reviewer's determination shall be provided to you not later than sixty (60) days after the Health Advantage Member Response Coordinator received the appeal.

   b. **Pre-Service Claim.** The Appeals Reviewer at each level of appeal shall render a decision and provide notification of the decision on an appeal related to a pre-service claim in accordance with the medical exigencies of the case and as soon as possible, but in no case later than thirty (30) days after the date the Health Advantage Member Response Coordinator received the appeal.

   c. **Claims Involving Urgent Care.** If you request an expedited review, and a health care professional certifies that determination as a general pre-service claim would seriously jeopardize your life or health or your ability to regain maximum function, the Appeals Reviewer at both levels of appeal shall make a determination on review in accordance with the medical exigencies of the case and as soon as possible, but in no case later than 72 hours after the time the Health Advantage Member Response Coordinator initially receives the request for review. See Subsection 7.3.10., below.

   d. **Concurrent Care Determination.** The Appeals Reviewer shall administer an appeal involving concurrent care in accordance with Subsections 7.3.8.a., b. or c. depending upon whether the claim is a post-service claim, a pre-service claim or a claim involving urgent care.

9. **Notification of Determination of Appeal to Plan.** The Appeals Reviewer shall provide notice of the review determination in a printed form and written in a manner calculated to be understood by the claimant. The notice shall include:

   a. The specific reason or reasons for the review determination with information sufficient to identify the claim involved (including the date of service, the health care provider, the claim amount and a way that the Member may learn the diagnosis and treatment codes and their descriptions);

   b. reference to the specific plan provision(s) on which the review determination is based;

c. a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of all documents, records, and other information Relevant to the Claim for benefits;

d. a statement that any internal rule, guideline, protocol or other similar criterion relied upon by the Plan is available upon request and free of charge;

e. a statement describing the voluntary external review procedures offered by the Plan; and

f a statement of the claimant's right to bring an action under the Employee Retirement Income Security Act of 1974.

10. **Expedited Appeal Procedure.** An appeal of a claim involving urgent care or of a claim involving ongoing care is conducted in accordance with this Subsection 7.3.10. Note that submission to the Appeals Reviewer may be done electronically, FAX No. (501) 212-8518, e-mail: APPEALS@HEALTHADVANTAGE-HMO.COM. In accordance with Subsection 7.3.6.a., an expedited appeal may be submitted by telephone, toll free (800) 843-1329, followed by a written confirmation. Please refer to Subsection 7.3.6.d. with respect to submission of information concerning a claim involving urgent care or concurrent review to the Appeals Reviewer. In accordance with Subsection 7.3.8.c., the Appeals Reviewer will notify you and your treating health care professional of the determination of your expedited appeal in accordance with the medical exigencies of the case and soon as possible, but in no case later than 72 hours after the Appeals Reviewer receives the expedited appeal.

7.4 **Independent Medical Review of Claims (External Review)**

1. **Claim Appeals Subject to External Review.**

a. **Waiver of Internal Review.** If we have waived internal review, your appeal shall be to external review in accordance with this Section 7.4.

b. **Application of Primary Coverage.** If your claim has not been the subject of a prior external review and if we have denied your claim in whole or in part because the intervention did not meet the Primary Coverage Criteria (other than under the conditions outlined in Subsections 2.4.1.a., b., c. or d.) or because of the application of a Coverage Policy, you may request an independent medical review by an Independent Review Organization in accordance with the provisions of this Subsection 7.4 provided:

i. The claim denial was upheld in whole or in part as a result of the Plan's internal review process, or

ii. You have not requested or agreed to a delay in the Plan's internal review process and the First Level Reviewer has not given you notification of the determination involving a pre-service claim appeal within fifteen (15) days following receipt of your appeal to the Plan; or

iii. You have not requested or agreed to a delay in the Plan's internal review process and the First Level Reviewer has not given you notification of the determination involving a post-service claim appeal within thirty (30) days following receipt of your appeal to the Plan; or

iv. Your claim meets the requirements for expedited external review, (see Subsection 7.3.10) and you have simultaneously submitted an appeal to the Plan.

2. **Where and When to Submit External Review Appeal.** You may request external review by submitting a request for external review to the Arkansas Insurance Commissioner, 1200 West Third Street, Little Rock, Arkansas 72201 or by calling 1-800-282-9134. Your request must be made within four (4) months after you were notified that the claim denial was upheld in whole or in part as a result of the Plan's internal review process. If Subsection 7.4.1.b.ii. or 7.4.1.b.iii. apply, your request may be made at the end of the fifteen (15) day period or thirty (30) day period. If Subsection 7.4.1.b.iv. applies, you must file your request for external review at the same time you file your appeal to the Plan.

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

a. **The Arkansas Insurance Commissioner** shall determine if the claim is subject to external review, and if he or she so determines, assign an Independent Review Organization from the list of approved Independent Review Organizations compiled and maintained by the Commissioner.

b. **The Independent Review Organization** is not affiliated with, owned by or controlled by Health Advantage. Health Advantage pays a reasonable fee to the Independent Review Organization to conduct the review, but such fee is not contingent upon the determination of the Independent Review Organization or Independent Medical Reviewer.

c. **An Independent Medical Reviewer** is a physician that is licensed in one or more States to deliver health care services and typically treats the condition or illness that is the subject of the claim under review. The Independent Medical Reviewer is not a Subscriber of Health Advantage and does not provide services exclusively for Health Advantage or for individuals holding insurance coverage with Health Advantage. The Independent Medical Reviewer has no material financial, familial or professional relationship with Health Advantage, with an officer or director of Health Advantage, with the claimant or the claimant's Authorized Representative, with the health care professional that provided the intervention involved in the denied claim; with the institution at which the intervention involved in the denied claim was provided; with the manufacturer of any drug or other device used in connection with the intervention involved in the denied claim; or with any other party having a substantial interest in the denied claim.

4. **Documentation**

a. **Written Appeals.** You must submit your appeal in writing in a form and in a manner determined by the Arkansas Insurance Commissioner. You may submit with your request for review any additional written comments, issues, documents, records and other information relating to your claim.

b. **Authorization to Release Information.** In filing your request for external review, you must include the following authorization: "I, [Member's name], authorize HMO Partners Inc. d/b/a Health Advantage and my healthcare Provider(s) to release all medical information or records pertinent to this claim to the Independent Review Organization that is designated by Health Advantage. I further authorize such Independent Review Organization to release such medical information to any Independent Medical Reviewer(s) selected by the Independent Review Organization to conduct the review."

5. **Referral of Review Request to an Independent Review Organization.** Upon receipt of the documentation set out in Subsection 7.4.4, the Arkansas Insurance Commissioner shall immediately refer the request for external review, along with Health Advantage's initial determination of the claim and the Appeals Reviewer's internal review determination (if applicable) to an Independent Review Organization.

6. **Independent Review Organization Right to Information.** You and your treating health care professional are required to provide the Independent Review Organization and the Independent Medical Reviewer(s), upon request, access to information necessary to determine the appeal. Access to such information shall be provided not later than seven (7) business days after the date on which the request for information is received.

7. **Rejection of Request for Review by the Independent Review Organization.** The Independent Review Organization shall reject a request for review and notify you, your Authorized Representative and the Appeals Reviewer in writing within five (5) business days (or within 72 hours for an Expedited Appeal) of its determination, if it determines that the appeal does meet the standards for an appeal for external review. See Subsections 7.4.1.

8. **Rejection of the Review for Failure to Submit Requested Information.** The Independent Review Organization may reject a request for review if:

a. you have not provided the authorization for release of medical records or information pertinent to the claim required by Subsection 7.4.4.b; or

b. you or your health care professional have not provided information requested by the Independent Review Organization in accordance with Subsection 7.4.6.

9. **Independent Medical Review Determination.** If the Independent Review Organization does not reject the request for review in accordance with Subsections 7.4.7 or 7.4.8, it shall assign the request for review to an Independent Medical Reviewer. Such Independent Medical Reviewer shall make a determination after reviewing the documentation submitted by you, your health care professional and Health Advantage. The Independent Medical Reviewer shall

consider the terms of the Evidence of Coverage to assure that the reviewer's decision is not contrary to the terms of the Plan. In making the determination the reviewer need not give deference to the determinations made by Health Advantage or the recommendations of the treating health care professional (if any).

10. **Timing of Appeal Determination.**
    a. **Standard Review.** The Independent Medical Reviewer shall complete a review on an appeal within a reasonable period of time, but in no case later than forty five (45) days after the Independent Review Organization received the appeal.
    b. **Expedited Review.** If you request an expedited review, and a health care professional certifies that the time for a standard review would seriously jeopardize your life or health or your ability to regain maximum function, the Independent Medical Reviewer shall make a determination on review in accordance with the medical exigencies of the case and as soon as possible, but in no case later than 72 hours after the time the Independent Review Organization received the request for review.
11. **Notification of Determination of Independent Medical Review.**
    a. **Recipients of Notice.** Upon receipt of the determination of the Independent Medical Reviewer, the Independent Review Organization shall provide written notification of the determination to you, you health care Provider and Health Advantage.
    b. **The Notification shall include**.
        i. A general description of the reason for the request for external review;
        ii. The date the Independent Review Organization was notified by Health Advantage to conduct the review;
        iii. The date the external review was conducted;
        iv. The date of the Independent Medical Reviewer's determination;
        v. The principal reason(s) for the determination;
        vi. The rationale for the determination; and
        vii. References to the evidence or documentation, including practice guidelines, considered in the determination.
12. **Expedited External Review.**
    a. **Requirement for Expedited Review.** You may submit a pre-service claim denial or a denial of a claim involving concurrent care for an expedited external review provided your health care professional certifies that the time to complete a standard review would seriously jeopardize your life or health or your ability to regain maximum function.
    b. **Expedited External Review without prior Appeal to Plan (internal review).** You may request an expedited review at the same time you submit a request for an appeal to the Plan (internal review) if your health care professional certifies that the time to complete the Plan's expedited appeal process would seriously jeopardize your life or health or your ability to regain maximum function. If you make such a request, the Independent Review Organization may determine and notify you in accordance with Subsections 7.4.10.b and 7.4.11 whether you will be required to complete the internal review process.
    c. **Same procedures as standard external review.** Unless otherwise specified, the provisions of this Section 7.4 applicable to independent medical review of claims apply to expedited external review of claims.
13. **Other Rights under Plan.** Your decision to submit an appeal to external review will have no effect on your other rights and benefits under the Plan.
14. **Arkansas Insurance Commissioner.** You may contact the Arkansas Insurance Commissioner for assistance. The mailing address is Arkansas Insurance Department, Attention External Review Assistance, 1200 West Third Street, Little Rock, Arkansas 72201. The telephone number is 501-371-2640 or toll free 800-282-9134. The e-mail address is insurance.consumers@arkansas.gov.
15. **Binding on the Plan.** The determination of an Independent Review Organization and an Independent Medical Reviewer is binding on both the Plan and you, except to the extent that other remedies are available under applicable federal or state law.

7.5 Authorized Representative

1. **One Authorized Representative.** A Member may have one representative, and only one representative at a time, to assist in submitting a claim or appealing an unfavorable claim determination.
2. **Authority of Authorized Representative.** An Authorized Representative shall have the authority to represent the Member in all matters concerning the Member's claim or appeal of a claim determination. If the Member has an Authorized Representative, references to "You" or "Member" in this document refer to the Authorized Representative.
3. **Designation of Authorized Representative.** One of the following persons may act as a Member's Authorized Representative:
    a. An individual designated by the Member in writing in a form approved by Health Advantage;
    b. The treating Provider, if the claim is a claim involving urgent care, or if the Member has designated the Provider in writing in a form approved by Health Advantage;
    c. A person holding the Member's durable power of attorney;
    d. If the Member is incapacitated due to illness or injury, a person appointed as guardian to have care and custody of the Member by a court of competent jurisdiction; or
    e. If the Member is a minor, the Member's parent or legal guardian, unless Health Advantage is notified that the Member's claim involves health care services where the consent of the Member's parent or legal guardian is or was not required by law and the Member shall represent himself or herself with respect to the claim.
4. **Communication with Authorized Representative.**
    a. If the Authorized Representative represents the Member because the Authorized Representative is the Member's parent or legal guardian or attorney in fact under a durable power of attorney, Health Advantage shall send all correspondence, notices and benefit determinations in connection with the Member's claim to the Authorized Representative.
    b. If the Authorized Representative represents the Member in connection with the submission of a pre-service claim, including a claim involving urgent care, or in connection with an appeal, Health Advantage shall send all correspondence, notices and benefit determinations in connection with the Member's claim to the Authorized Representative.
    c. If the Authorized Representative represents the Member in connection with the submission of a post-service claim, Health Advantage will send all correspondence, notices and benefit determinations in connection with the Member's claim to the Member, but Health Advantage will provide copies of such correspondence to the Authorized Representative upon request.
5. **Term of the Authorized Representative.** The authority of an Authorized Representative shall continue until
    a. the claim(s) or appeal(s) for which the Authorized Representative was designated has been fully adjudicated; or
    b. the Member is legally competent to represent himself or herself and notifies Health Advantage that the Authorized Representative is no longer required.

8.0 NOTICE OF PROVIDER/PHYSICIAN INCENTIVES THAT COULD AFFECT YOUR ACCESS TO HEALTHCARE

8.1 **General Description and Purpose of Incentive Programs:** Health Advantage contracts with physicians and other types of health care providers who agree to perform services for Health Advantage Members, often at a discount from their usual charges. In contracting with providers, including physicians, Health Advantage sometimes offers financial incentives to encourage providers to practice medicine in a cost-effective manner, and to improve the quality of health care services. These incentive arrangements sometimes offered by Health Advantage may take a variety of forms but the main goals of the incentive arrangements are designed to do one or both of two things: (1) give the provider (including physicians) a financial incentive to control the overall cost of treatment; and (2) give the provider (including physicians) a financial incentive to pay increased attention to well-established quality standards and thereby hopefully improve the overall quality of care being provided. The financial

incentives sometimes offered by Health Advantage to providers (including physicians) sometimes involve a financial reward if specified goals are met; at other times, the financial incentives may include a financial penalty if the provider (including physicians) fails to achieve specified goals. In other cases, the financial incentive program that Health Advantage offers to providers (including physicians) may include both the opportunity for financial rewards, as well as the possibility of financial penalties, depending on how the provider performs.

8.2 **Specific Types of Incentive Programs Offered:** The financial incentives offered by Health Advantage to providers (including physicians) may change significantly over time and on short notice due to provider preferences or larger changes taking place in the health care field; however, the following describes a number of financial incentive programs that are either currently being offered by Health Advantage, or may be offered in the future:

1. Capitation: This is a system of provider (including physician) payment in which Health Advantage agrees to pay the provider a per-Member-per-month fee as total compensation for all of the care received by each Member from the contracting provider during the month. Sometimes, capitation involves a "withhold" feature in which a portion of the capitation payment is withheld until the provider's overall cost performance is determined at the end of a defined settlement period. In such instances, if the provider's overall cost of care for Members is lower than a pre-determined target budget, the provider is then paid an additional amount from the withhold fund; conversely, in some instances, if the provider's overall cost of care for Members is higher than a pre-determined target budget, the provider may forfeit some or all of the withhold fund.

2. Episodes of Care: This is a system of provider (including physician) payment in which Health Advantage and the provider agree on a pre-determined set of cost and quality measurements that will apply to a specific type of health care episode, such as, for example, total hip or knee replacement surgery. In this "episodes of care" incentive payment system, a provider may qualify for incentive bonus payments by accomplishing two things: first, the provider must establish that certain quality standards have been met with respect to Members treated by the provider within the applicable review period and, secondly, the provider must keep average costs for the particular "episode of care" in question within pre-established ranges. At the same time, if the provider's average costs for Members treated in a particular "episode of care" exceed an "acceptable" range that is pre-established in the agreement with Health Advantage, the provider will not earn bonus payments and may also be required to refund a portion of the claims payments the provider previously received from Health Advantage. Please keep in mind that Health Advantage currently applies this form of provider payment to only a small number of health care treatments or "episodes" but may expand the list to cover additional "episodes of care" over time. Please note as well that a provider's referral of Members to other providers, including specialists, could affect the provider's qualification for bonus payments, or the provider's obligation to refund some payments made by Health Advantage. For example, if a provider makes referrals to other providers whose costs of care are substantially higher, or who do not meet applicable quality standards, the referring provider could lose bonus payments, or could incur refund obligations to Health Advantage under the "episodes of care" payment system.

3. Total Cost of Care or Medical Trends: In some instances, Health Advantage may offer financial incentives to providers (including physicians) that are tied to the total cost of care for a pre-defined set of Members within a pre-defined period of time, offering to pay such providers a bonus payment if, during the defined period, total costs of care for such Members remains at or below a pre-defined target level. Sometimes this form of payment is based on calculations of the "medical trend" during a defined period, which means whether the cost of care for Members served by the provider during the applicable period increased or decreased by a specific percentage.

4. Pharmacy/Drug Incentives: Health Advantage may also offer physicians financial incentives to encourage them to provide education to Members on the costs of Prescription Medications, and, where appropriate in the physician's independent medical judgment, to write prescriptions for Prescription Medications listed as "Second Tier" on the Health Advantage Formulary, or to write prescriptions for Generic Medications listed as "First Tier" on the Health Advantage Formulary.

8.3 **Incentive Arrangements Subject to Change.** The incentive arrangements described here concern provider contracts that are either in place and regularly used by Health Advantage at the time this Evidence of Coverage was issued, or are being contemplated for use in the future. Because of the rapid pace of change in health care financing in today's marketplace, provider negotiating positions, regulatory changes, or other developments, the precise content of Health Advantage provider reimbursement and incentive plans may change significantly in the future. See subsection 8.4, below, for ways in which you can obtain additional or updated information regarding Health Advantage provider incentive programs.

8.4 **For Further Information.** If you have any concerns about how the various incentive programs offered to Health Advantage-participating providers may affect your access to health care services, you should discuss such concerns with your physician or other treating health care professional. You may ask your health care provider's administrative staff about compensation methods, including incentives, which apply to the services provided by your health care provider. In addition, you may submit written questions to Health Advantage at Post Office Box 8069, Little Rock, Arkansas 72203.

9.0 OTHER PROVISIONS

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

9.1 **Assignment of Benefits.** No assignment of benefits under this Evidence of Coverage shall be valid until approved and accepted by Health Advantage. Health Advantage reserves the right to make payment of benefits, in its sole discretion, directly to the Provider of service or to you.

9.2 **Right of Rescission.** The performance of an act or practice constituting fraud or intentional misrepresentation of material fact may be used by Health Advantage as the basis for rescission of coverage of the Policyholder, any Employee or any Dependents. Health Advantage must provide the Policyholder 30 days' advance written notice of its intent to rescind the Evidence of Coverage.

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

1. In the event that such a recovery relates to a claim paid more than two years before the recovery, no adjustment will be made to any Deductible or Coinsurance paid by a Member and Health Advantage shall be entitled to retain such recoveries for its own use.

   If the recovery relates to a claim paid within two years and is not otherwise addressed in this subsection, Deductibles and Coinsurance amounts for a Member will be adjusted if affected by the recovery.

2. Only recoveries made within two years of the date of the error by Health Advantage or overpayments to health care Providers or to Members by Health Advantage will be applied for the purpose of group rating or divisible surplus calculation, if applicable. The cost actually paid by Health Advantage to procure such recoveries will be treated as an administrative expense in considering group rating or divisible surplus, if applicable.

3. In the event Health Advantage receives from pharmaceutical manufacturers rebates based upon amounts of claims paid for certain specified pharmaceuticals, Health Advantage shall be entitled to retain such rebates for its own use, and no adjustments will be made to claims paid or to Deductibles or Coinsurance amounts paid by a Member.

4. If a Member is no longer covered by Health Advantage at the time of any such recovery, regardless of the amount or of the time of such recovery, Health Advantage shall be entitled to retain such recovery for its own use.

5. If such recovery amounts cannot be attributed on an individual basis, because of having been paid as a lump sum settlement for less than the total amount of claims expense of Health Advantage or otherwise, no adjustments will be made to any Deductible or Coinsurance amounts paid by the Member and Health Advantage shall be entitled to retain such recovery for its own use.

9.4 **Amendment.** Health Advantage reserves the right to change the benefits, conditions and premiums covered under the Group Policy or Group Insurance Contract, including the terms of this Evidence of Coverage. If we do so, we will give thirty (30) days written notice to your Employer or its agent and the change will go into effect on the date fixed in the notice. No agent or employee of Health Advantage may change or modify any benefit, term, condition, limitation or exclusion of this Evidence of Coverage. Any change or amendment must be in writing and signed by an officer of Health Advantage and approved by the Arkansas Insurance Department.

9.5 **Physician Incentives.** In some parts of Arkansas, but not necessarily in the whole State, Health Advantage may offer incentives to encourage Physicians to practice medicine in a cost-effective manner. Physicians located in part of Arkansas may be entitled to incentive payments in the event that Medical Trends for that part of Arkansas are lower than Medical Trends for the State as a whole for a given year. The incentive payments will be calculated based on a percentage of total medical claims received from the Physicians practicing in that part of Arkansas and will reflect the lower Medical Trends for that part of Arkansas. A Member may want to ask their Physician's administrative staff about compensation methods, including incentives, which apply to the services provided by their Physician.

9.6 **Pediatric Dental Plan.** Your Plan is bundled with pediatric dental coverage. A Pediatric Dental plan provides dental services for Members under the age of nineteen (19) subject to the terms, conditions, exclusions, and limitations of the Pediatric Dental plan. While coverage is provided under this plan, Health Advantage will not send the Pediatric Dental policy materials to any family that does not cover a child under the age of nineteen (19). If your coverage is amended to include a Member under the age of nineteen (19), you will receive a Pediatric Dental Benefit Certificate and materials at the address currently on file with Health Advantage.

10.0 GLOSSARY OF TERMS

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

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

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

10.3 **Allowance or Allowable Charge,** when used in connection with covered services or supplies delivered in Arkansas, will be the amount deemed by Health Advantage, in its sole discretion, to be reasonable. The Health Advantage customary allowance is the basic Allowance or Allowable Charge. However, the Allowance or Allowable Charge may vary, given the facts of the case and the opinion of Health Advantage's medical director.

At the option of Health Advantage, Allowances or Allowable Charges for services or supplies received out of Arkansas may be determined by the local Blue Cross and Blue Shield Plan, See Subsection 7.1.10 dealing with Out of Arkansas Claims. See Subsection 3.24.4 with respect to Allowance or Allowable Charge for transplants. See Subsection 3.3.2 with respect to Allowance or Allowable Charge for Outpatient Surgery Centers. **Please note that all benefits under this Evidence of Coverage are subject to and shall be paid only by reference to the Allowance or Allowable Charge as determined at the discretion of Health Advantage. This means that regardless of how much your health care Provider may bill for a given service, the benefits under this Evidence of Coverage will be limited by the Allowance or Allowable Charge we establish. If you use an Health Advantage-participating Provider, that Provider is obligated to accept our established rate as payment in full, and should only bill you for your Deductible, Coinsurance and any non-covered services; however, if you use a non-participating Provider, you will be responsible for all amounts billed in excess of the Health Advantage Allowance or Allowable Charge.**

The payment to a Provider for their services as described in a Current Procedural Terminology ("CPT") or Healthcare Common Procedure Coding System ("HCPCS") code and reimbursed in accordance with the Resource-Based Relative Value System ("RBRVS") used by the Centers for Medicare & Medicaid Services ("CMS") is an all-inclusive, global payment that covers all elements of the service as described in the particular code billed. This means that whatever staffing, overhead costs, equipment, drugs, machinery, tools, technology, supplies, or materials of any kind that may be required in order for the billing Provider to perform the service or treatment described in the CPT or HCPCS code billed, Health Advantage's payment to the billing Provider of the Allowance or Allowable Charge for that CPT or

HCPCS code constitutes the entire payment and the limit of benefits under this Evidence of Coverage with respect to the CPT or HCPCS code billed. A Provider who bills for a particular CPT or HCPCS code is deemed to represent that the billing Provider has performed and is responsible for provision of all services or treatments described in the CPT or HCPCS code, and is entitled to bill for such services or treatments. If Health Advantage pays for a Covered Service by applying the Allowance or Allowable Charge to the bill of a Provider who represents that the Provider has performed a service or treatment described in a CPT or HCPCS code as submitted to Health Advantage, Health Advantage shall have no further obligation, nor is there coverage under this Evidence of Coverage, for bills from or payment to any other provider, entity or person, regardless of whether they assisted the billing Provider or furnished any staffing, equipment, drugs, machinery, tools, technology, supplies or materials of any kind to or for the benefit of the billing Provider. In other words, benefits under this Evidence of Coverage are limited to one, global payment for all components of any services falling within the scope of any CPT or HCPCS code service or treatment description, and Health Advantage will make only one payment with respect to such CPT or HCPCS code, even if multiple parties claim to have contributed a portion of the staffing, equipment, machinery, tools, technology, supplies or materials used by the billing Provider in the course of providing the service or treatment described in the CPT or HCPCS code.

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

Please note that Health Advantage makes the following exceptions to the preceding general policy of one global payment (Allowance) per CPT or HCPCS code: (i) where CMS has developed and published an RBRVS policy that specifically recognizes that the Relative Value Units (RVUs) associated with a specific CPT or HCPCS code should be divided into both a professional and a technical component; or (ii) billing of the services of an assistant surgeon for those CPT or HCPCS codes that specifically recognize assistant surgery services as applicable; or (iii) billing of radiopharmaceuticals used in nuclear medicine procedures where such radiopharmaceuticals clearly are not included in the practice expense portion of the associated RVU as published and defined by CMS; or (iv) billing of a procedure or set of procedures that, per the applicable CPT or HCPCS code definition, is based solely on time consumed so that it is necessary to submit multiple units of the procedure in order to accurately report the total time devoted to the patient. In the specific four circumstances outlined in the preceding sentence, Health Advantage will recognize and pay more than one Allowance per CPT or HCPCS code, provided all other terms and conditions of this Evidence of Coverage are met. With respect to the first such circumstance involving RVUs divided between a professional and a technical component, Health Advantage's payment will be limited to one global payment (Allowance) for the applicable professional component, and one global payment (Allowance) for the technical component. In other words, even

where CMS policy specifically recognizes division of an RVU into professional and technical components, Health Advantage will not be responsible for paying multiple providers or multiple billings for the professional component, nor will Health Advantage be responsible for paying multiple providers or multiple billings for the technical component. Benefits under this Evidence of Coverage will be limited in such circumstances to one global payment (Allowance) for the professional component and one global payment (Allowance) for the technical component.

10.4 **Ambulance Service** means surface or air transportation in a regularly equipped ambulance licensed by an appropriate agency and where the use of any other means of transportation is not medically indicated. All services provided by the ambulance personnel, including but not limited to, the administration of oxygen, medications, life support, etc. are included in the specific Evidence of Coverage limitation applied to ambulance benefits per Contract Year.

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

10.6 **Annual Limitation on Cost Sharing** means the amount of Allowance or Allowable Charges a Member must incur for claims in a Contract Year before the Member is relieved of the obligation to pay Copayments, Deductible or Coinsurance for the remainder of the Contract Year. The Annual Limitation on Cost Sharing is set forth in the Schedule of Benefits.

10.7 **Approved Clinical Trial** means a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is described in any of the following subparagraphs:

1. Federally Funded Trials- The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
   - a The National Institutes of Health;
   - b The Centers for Disease Control and Prevention;
   - c The Agency for Health Care Research and Quality;
   - d The Centers for Medicare & Medicaid Services;
   - e cooperative group or center of any of the entities described in clauses a. through b. or the Department of Defense or the Department of Veterans Affairs; or
   - f A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
2. The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration.
3. The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

10.8 **Brand Name Medication** means any Prescription Medication that has a patented trade name separate from its generic or chemical designation.

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

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

10.11 **Child** means a Subscriber's natural Child, legally adopted Child or Stepchild. "Child" also means a Child that has been placed with the Subscriber for adoption. "Child" also means a Child for whom the Subscriber must provide medical support under a qualified medical child support order or for whom the Subscriber has been appointed the legal guardian.

10.12 **Cognitive Rehabilitation** means a treatment modality designed specifically for the remediation of disorders of perception, memory and language in brain-injured persons. Services or supplies provided

as or in conjunction with, Cognitive Rehabilitation are not covered. See Subsection 4.2.16.

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

10.14 **Compound Medication** means a non FDA approved medication prescribed by a Physician that is admixed by a pharmacist using multiple ingredients which may or may not be FDA approved individually. FDA approved medications that exist as separate components and are intended for reconstitution prior to administration are not Compound Medications.

10.15 **Contract Holder** means the Employer that established and maintains the Plan, as shown in the Application of the Group Enrollment Contract.

10.16 **Contract Month** means a month commencing on the first day of a calendar month and expiring on the last day of that calendar month or commencing on the fifteenth day of a month and expiring on the fourteenth day of the following month, depending upon the billing cycle applied by Health Advantage.

10.17 **Contract Year** means the twelve consecutive month period commencing on the Group Contract effective date and ending on the day before the anniversary of that effective date.

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

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

10.20 **Coverage Policy** means a statement developed by Health Advantage that sets forth the medical criteria for coverage under a Health Advantage Evidence of Coverage. Some limitations of benefits related to coverage, of a drug, treatment, service equipment or supply are also outlined in the Coverage Policy. A copy of a Coverage Policy is available from Health Advantage, at no cost, upon request, or a Coverage Policy can be reviewed on Health Advantage's web site at WWW.HEALTHADVANTAGE-HMO.COM.

10.21 **Covered Services** means services for which a Member is entitled to benefits under the terms of this Group Policy and Evidence of Coverage.

10.22 **Custodial Care** means care rendered to a Member (1) who is disabled mentally or physically and such disability is expected to continue and be prolonged, and (2) who requires a protected, monitored, or controlled environment whether in an institution or in a home, and (3) who requires assistance to support the essentials of daily living, and (4) who is not under active and specific medical, surgical, or psychiatric treatment that will reduce the disability to the extent necessary to enable the patient to function outside the protected, monitored, or controlled environment. A custodial determination is not precluded by the fact that a Member is under the care of a supervising or attending Physician and that services are being ordered or prescribed to support and generally maintain the Member's condition, or provide for the Member's comfort, or ensure the manageability of the Member. Further, a Custodial Care determination is not precluded because the ordered and prescribed services and supplies are being provided by an R.N., L.P.N., or L.V.N. or the ordered and prescribed services and supplies are being performed in a Hospital, Nursing Home, a skilled nursing facility, an extended care facility or in the home. The determination of Custodial Care in no way implies that the care being rendered is not required by the Member; it only means that it is a type of care that is not covered under this Evidence of Coverage.

10.23 **Deductible** means the amount of out of pocket expense a Member must incur for Covered Services each Contract Year before any expenses are paid by Health Advantage under the Plan. This amount is calculated from Allowance or Allowable Charges, not the billed charges. Once the Deductible has been met, subject to all other terms, conditions, limitations and exclusions in the Plan, payment for Covered Services begins.

10.24 **Dental Care** means the treatment or repair of the teeth, bones and tissues of the mouth and defects of the human jaws and associated structures and shall include surgical procedures involving the mandible and maxilla where such is done for the purpose of correcting malocclusion of the teeth or for the purpose, at least in part, of preparing such bony structure for dentures or the attachment of teeth, artificial or natural. Generally, hospital services and administration of anesthetic in connection with Dental Care are not covered except in limited circumstances, as provided in Subsection 3.3.3.

10.25 **Dependent** means any member of a Subscriber's family who meets the eligibility requirements of Section 6.0, who is enrolled in the Group, and for whom Health Advantage has received premium.

10.26 **Developmental Service Visit** means one unit of Developmental Service (usually one day or less) provided by a licensed or certified provider. A Developmental Service Visit may include services provided by more than one provider.

10.27 **Developmental Services** means assistance activities that are coordinated with physical, occupational and speech therapy to reinforce impact of such therapy provided in connection with Habilitation.

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

10.29 **Dose Limitation** means a limitation in the number of doses of a Prescription Medication in a single prescription or a limit in the number of doses over a defined period of time. For example, a Dose Limitation for a particular medication may be set at no more than 10 doses in a dispensed prescription and no more than 20 doses during a 30-day period.

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

10.31 **Eligibility Date** means:

For a Subscriber, the latest of the following dates:

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

For a Dependent, the latest of the following dates:

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

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

10.33 **Emergency Prescription** means any Prescription Medication prescribed in conjunction with Emergency Care and deemed necessary by a Physician to be immediately needed by the Member.

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

10.35 **Evidence of Coverage** means this document containing the benefits, conditions, limitations and

exclusions of the Group Contract plus the Schedule of Benefits and any amendments signed by an Officer of Health Advantage.

10.36 **Formulary** means a specified list of Prescription Medications covered by Health Advantage. The services of an independent National Pharmacy and Therapeutics Committee (P&T Committee) are utilized to approve sage and clinically effective drug therapies on the Formulary. The P&T Committee is an external advisory body of experts from across the United States. The P&T Committee's voting members include physicians, pharmacists, a pharmacoeconomist and a medical ethicist, all of whom have a broad background of clinical and academic expertise regarding prescription drugs.

Prescription Medications on the Formulary are classified into various cost tier designs based on the benefit. Prescription Medication tiers are classified as Preventive Medications, Generic Medications, Brand Name Medications, and Specialty Medications. The list of Prescription Medications that make up the Formulary and the tier classification of a Prescription Medication on the Formulary are subject to change by Health Advantage 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 Evidence of Coverage unless or until Health Advantage places the medication on the Formulary.**

10.37 **Freestanding Facility** means an entity that furnishes health care services and that is neither integrated with, nor a department of, a Hospital. Physically separate facilities on the campus of a Hospital are considered freestanding unless they are integrated with, or a department of, the Hospital. Examples of Freestanding Facilities include, but are not limited to, Free-Standing Cardiac Care Facilities and Free-Standing Residential Treatment Centers. Ambulatory Surgery Centers performing covered services provided in 3.4 are not considered Freestanding Facilities. Laboratories are not considered Freestanding Facilities.

10.38 **Full-Time Employment,** full-time active Subscriber, and like terms, mean a job with the Employer:

1. on a permanent and active basis;
2. for compensation; and
3. for at least thirty (30) hours a week, forty-eight (48) weeks per year.

10.39 **Generic Medication** means any US Food and Drug Administration ("FDA") approved, chemically identical, reproduction of a Brand Name Medication for which the patent has expired. A Prescription Medication must have a price at least twenty percent (20%) lower than the Brand Name Medication in order to qualify as a Generic Medication for reimbursement purposes.

10.40 **Group** means the Employer or party that has entered into a Group Contract with Health Advantage under which Health Advantage will cover Health Interventions for eligible Subscriber's and their Dependents.

10.41 **Group Contract** or **Contract** means the contract between Health Advantage and the Employer and any attachments thereto, including this Evidence of Coverage, the Group Application, the Enrollment Application, Change Forms and any attachments, riders, endorsements or amendments, whereby Health Advantage coverage for Subscribers and their Dependents is elected.

10.42 **Habilitation** means health care services provided in order for a person to attain and maintain a skill or function that was never learned or acquired and is due to a disabling condition.

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

10.44 **Hearing Aid** means an instrument or device, including repair and replacement parts, that

1. is designed and offered for the purpose of aiding persons with or compensating for impaired hearing;
2. is worn in or on the body; and
3. is generally not useful to a person in the absence of a hearing impairment.

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

10.46 **Homeopathic** means healing the underlying cause of disease not simply eliminating the symptoms caused by the disease. Some forms of homeopathic treatment may include, but are not limited to diet

therapy, environment services, minimum doses of natural medications. Homeopathic treatments are not covered. See Subsection 4.2.65.

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

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

10.49 **Imperative Care** means care for an unexpected illness or injury that cannot be delayed until the Member consults with his or her Primary Care Physician.

10.50 **In-Network Provider** means a Provider who has signed a Contract with Health Advantage to provide the services covered by this Evidence of Coverage to Health Advantage Members. Health Advantage pays an In-Network Provider directly.

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

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

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

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

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

10.55 **Low Protein Modified Food Products** means a food product that is specifically formulated to have less than one (1) gram of protein per serving and intended to be used under the direction of a Physician for the dietary treatment of a Medical Disorder Requiring Specialized Nutrients or Formulas.

10.56 **Maintenance Medication** means a specific Prescription Medication: 1.) for ongoing therapy of a chronic illness; and 2.) that has been designated as a Maintenance Medication by Health Advantage. You may obtain a list of Maintenance Medications by calling Customer Service.

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

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

10.59 **Medical Supply or Supplies** means an item which (1) is consumed or diminished with use so that it cannot withstand repeated use; and (2) is primarily or customarily used to serve a medical purpose; and (3) generally is not useful to a person in the absence of an illness or injury.

10.60 **Medicare** means the two programs cited as the "Health Insurance for the Aged Act," Title I, Part I, of Public Law 89-97, as amended. Part A refers to Hospital insurance. Part B covers physician services and other clinical services.

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

10.62 **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.).

10.63 **Minimum Essential Coverage** means coverage provided by any of the following:

1 A government sponsored plan such as Medicare, Medicaid, Department of Defense coverage for uniformed services, or the Department of Veterans Affairs;

2. An employer sponsored health benefit plan;

3. Comprehensive health coverage in the individual market;

4. Other coverage, such as a State health benefits risk pool, recognized by the Secretary of Health and Human Services.

10.64 **Naturopathic** means a system of therapeutics in which neither surgical or medicine agents are used, dependence placed only on natural (non-medicinal) focus. Naturopathic treatments are not covered. See Subsection 4.2.65.

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

1. be operated pursuant to law;

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

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

4. maintain a daily progress record for each patient.

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

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

10.68 **Open Enrollment Period** means the time period annually, during the month designated by the Employer and set forth in the Group Contract when employees who are eligible for coverage may enroll in the Plan. During the Open Enrollment Period, Subscribers covered in the Plan may change their coverage, and that of their covered Dependents. If the Open Enrollment Period is not designated in the Group Contract, it is the month period preceding the anniversary date of the Group Contract.

10.69 **Outpatient Care** means all care received including services, supplies and Medications in a Physician's office, Outpatient Surgery Center, x-ray or Laboratory, the Member's home or at a Hospital where the Member receives services but is not admitted to the Hospital.

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

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

10.72 **Outpatient Surgery Center or Radiation Therapy Center** means a facility licensed as such by the

appropriate state agency.

10.73 **Outpatient Therapy Visit** means one unit of therapeutic service (usually one hour or less) provided by licensed Provider(s). An Outpatient Therapy Visit may include services provided by more than one Provider and in the case of physical therapy. Any physical therapy or occupational therapy modality, regardless of who provides the service, is included in the visit limit. Outpatient therapy visit applies to therapy provided in a physician's office or in a physical therapy setting.

10.74 **Out-of-Area Services** mean those services provided outside the Service Area in a location outside the state of Arkansas where covered medical services are not available through In-Network Providers. See Subsection 7.1.10 Out of Service Area Services.

10.75 **Out-of-Network Provider** means a Provider who does not have a contract with Health Advantage to provide to Members services covered by this Evidence of Coverage. Out-of-Network Providers are free to bill and collect from you charges for covered services which are in excess of Health Advantage's Allowance or Allowable Charge.

10.76 **Partial Hospitalization** means continuous treatment for a Member who requires care or support, or both, in a Hospital but who does not require 24-hour supervision. A Physician must prescribe services for at least 4 hours, but not more than 16 hours in any 24-hour period.

10.77 **Participating Pharmacy** means a licensed pharmacy that has contracted directly or indirectly with Health Advantage to provide pharmacy services to Members subject to all terms, conditions, exclusions and limitations of the Plan set forth in this Evidence of Coverage.

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

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

10.80 **Placement, or being placed, for adoption** means the assumption and retention of a legal obligation for total or partial support of a Child by a person with whom the Child has been placed in anticipation of the Child's adoption. The Child's Placement for adoption with such person terminates upon the termination of such legal obligation.

10.81 **Plain Film Radiograph** means a routine film x-ray performed in a Specialty Care Provider's office and provided in accordance with Coverage Policy established by Health Advantage.

10.82 **Plan** means the Subscriber health benefit Plan established by your Employer. The terms of the Plan are set forth in the Group Contract between Health Advantage and your Employer.

10.83 **Plan Administrator** means the Employer.

10.84 **Plan Year** means the Plan Year stated in the Subscriber Health Benefit Plan Summary Plan Description, or if not stated in that document, or if that document does not exist, the twelve month period ending on the day before the anniversary date of the effective date of this Group Contract.

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

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

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

10.88 **Prior Approval** means the process by which Health Advantage determines in advance of the Member obtaining a requested medical service, Medication, supply, test or equipment that such medical service, Medication, supply, test or equipment meets Primary Coverage Criteria. **PLEASE NOTE: Prior Approval does not mean that the service, supply or treatment will be covered regardless of other terms, conditions or limitations outlined in this Evidence of Coverage, but means only that the information furnished to Health Advantage in the pre-service claim indicates that the requested**

medical service, Medication, supply, test or equipment meet the Primary Coverage Criteria requirements set out in Subsection 2.2 and the Applications of the Primary Coverage Criteria set out in Subsections 2.4.1.b., e., or f. and is not subject to a Specific Plan Exclusion (see Section 4.0). All Health Interventions receiving Prior Approval must still meet all other coverage terms, conditions, and limitations, and coverage for these services may still be limited or denied if, when the post-service claim for the services is received by Health Advantage, investigation shows that a benefit exclusion or limitation applies because of a difference in the Health Intervention described in the pre-service claim and the actual Health Intervention, that the Member ceased to be eligible for benefits on the date the services were provided, that coverage lapsed for non-payment of premium, that out-of-network limitations apply, or any other basis specified in this Evidence of Coverage. For more information about Prior Approval, please see Subsection 7.3.1.b.

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

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

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

10.92 **Psychiatric Residential Treatment Center** means a facility, or a distinct part of a facility, for psychiatric care which provides a total 24-hour therapeutically planned and professionally staffed group living and learning environment.

10.93 **Referral** means an authorization to cover services issued by the Member's Primary Care Physician.

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

1. was relied upon in making the benefit determination;
2. was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record or other information was relied upon in making the benefit determination;
3. demonstrates compliance with the administrative processes and safeguards required by 7.2.5.b.; and
4. constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for the Member's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

10.95 **Retransplantation** means a second transplant performed within sixty (60) days of the failure of an initial transplant.

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

1. the investigational item, device or service, itself;
2. items and services that are provided solely to satisfy data collection and analysis needs and that are not used in direct clinical management of the individual undergoing the clinical trial; or
3. a service that is clearly inconsistent with widely accepted and established standards of care for the particular diagnosis.

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

10.98 **Service Area** is the state of Arkansas.

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

1. be operated pursuant to law;
2. be approved for payment of Medicare benefits or be qualified to receive such approval, if so requested;
3. be primarily engaged in providing, in addition to room and board accommodations, skilled nursing care under the supervision of a duly licensed Physician (M.D. or D.O.);
4. provide continuous 24 hours a day nursing service by or under the supervision of a registered graduate professional nurse (R.N.) for at least 8 hours per day and a registered graduate professional nurse (R.N.) or licensed practical nurse (L.P.N.) for the remaining 16 hours; and
5. maintain a daily medical record of each patient.

However, a Skilled Nursing Facility does not include:

1. any home, facility or part thereof used primarily for rest;
2. a home or facility for the aged or for the care of drug addicts or alcoholics; or
3. a home or facility primarily used for the care and treatment of mental diseases, or disorders, or Custodial Care or educational care.

10.100 **Special Enrollment Period** means a thirty (30) day period during which time a Subscriber or Subscriber's Dependent may enroll in the Plan, after his or her initial Waiting Period (Eligibility Period or Eligibility Date) or Open Enrollment Period and not be a Late Enrollee. Special Enrollment Periods occur in two instances:

1. AFTER THE TERMINATION OF ANOTHER HEALTH PLAN: A Special Enrollment Period occurs (i) after a Subscriber's or Dependent's coverage under another health plan terminated as a result of Loss of Eligibility or (ii) after the employer providing such other health Plan terminated its contributions.
2. AFTER THE ADDITION OF A DEPENDENT: A Special Enrollment Period occurs for a Subscriber, Subscriber's Spouse or Subscriber's new Dependent Child (i) after the Subscriber marries; (ii) after a Subscriber's Child is born or (iii) a Subscriber adopts a Child or has a Child placed with the Subscriber for adoption.

10.101 **Specialty Care Physician** means a Preferred Provider Physician with any specialty other than primary care who practices such specialty and who has met the participation standards of Health Advantage. (Specialty Care Physicians do not include the following: Family Practice, General Practice, Internal Medicine, Pediatrics or Obstetrics/Gynecology.).

10.102 **Spouse** means an individual who is the husband or wife of the Policyholder as a result of a marriage that is legally recognized in a jurisdiction within the United States of America.

10.103 **Step Therapy** means a process that establishes a required order of use for a specific Prescription Medication. For example, a Step Therapy may require that medication "X" be used for a period of time before medication "Y" or that a weaker strength of a medication be used for a period before a stronger strength of the same medication.

10.104 **Stepchild** means a natural or adopted Child of the Spouse of the Subscriber.

10.105 **Subscriber** means a person who is directly employed by the Employer for Full-Time Employment. This person must reside in the United States and be paid for full-time work in the conduct of the Employer's regular business. No director or officer of the Employer shall be considered a Subscriber unless he meets the above conditions.

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

10.107 **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.

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

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

10.110 **Waiting Period** means the time beginning with the Subscriber's most recent date of continuous employment with the Employer and ending on the date he is eligible for coverage. The Employer establishes the Waiting Period, but for purposes of coverage or eligibility determinations under this Evidence of Coverage, the Waiting Period shall be such period as is reflected in the enrollment records of Health Advantage.

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

10.112 **Work Hardening** means a highly specialized rehabilitation program that spans the transition from traditional rehabilitation therapies to return to work by simulating the workplace activities and surroundings in a monitored environment. Programs may be developed and carried out by an occupational therapist and/or physical therapist. The goal is to create an environment in which returning workers can rebuild psychological self-confidence and physical reconditioning by replicating their work routine.

10.113 **Work Integration (Community)** means training in shopping, transportation, money management, vocational activities and/or work environment/modification analysis, and/or work task analysis. This is not considered medical treatment.

10.114 **You and Your** mean a Member.

11.0 YOUR RIGHTS UNDER ERISA

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

11.1 Information about the Plan

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

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

11.2 Continuation of Coverage

The Plan provides an opportunity to continue coverage for yourself, spouse, dependents if there is a loss of coverage under the Plan as a result of a qualifying event. See Subsection 6.4.3.a. You or your dependents may have to pay for such coverage. Review this Evidence of Coverage, Subsection 6.4.3 and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

11.3 Creditable Coverage

The Plan provides a reduction or elimination of exclusionary periods of coverage for Preexisting Conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it up to 24 months after losing coverage. You may also request a certificate of creditable coverage at any time during your coverage period by writing Health Advantage, Customer Service Division, Post Office Box 8069 Little Rock, Arkansas 72203, or by Telephone toll free (800) 843-1329. Without evidence of creditable coverage, you may be subject to Preexisting Condition exclusion for 12 months after your enrollment in your coverage.

11.4 Prudent Actions by Plan Fiduciaries

1. In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your

plan, called “fiduciaries” of the plan, have a duty to do so prudently and in the interest of you and other participants and beneficiaries.

2. No one, including your employer, or any other person, may fire you or otherwise discriminate against you in a way to prevent you from obtaining a benefit or exercising your rights under ERISA.

11.5 **Enforce your Rights**

1. If your claim for a benefit is denied, in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the plan review and reconsider your claim.

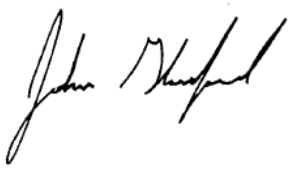
2. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you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

11.6 **Assistance with Your Questions**

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

11.7 **Claim and Appeal Procedures**

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



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